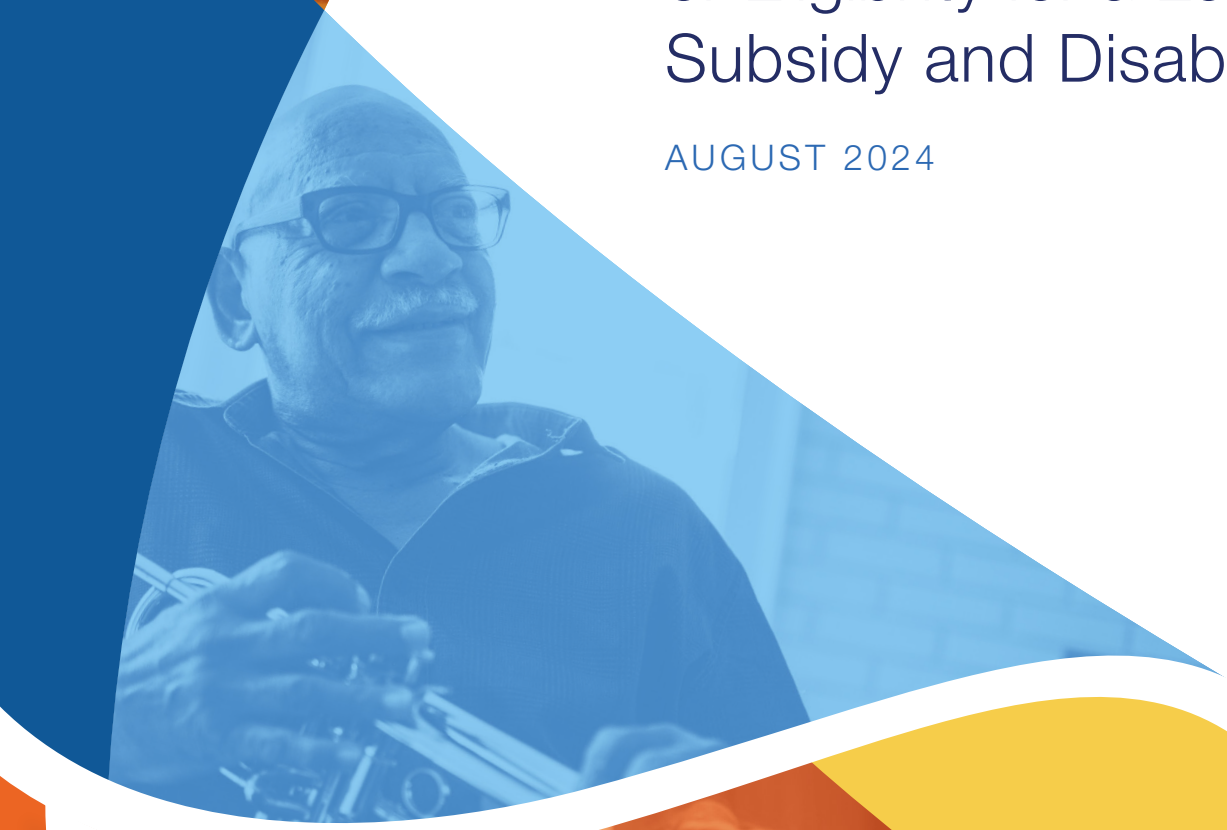

Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy and Disability

AUGUST 2024

CMS

Preface

This report compares the quality of clinical care nationwide for four groups of Medicare Advantage (MA) enrollees, which are defined based on the combination of two characteristics: (1) dual eligibility for both Medicare and Medicaid or eligibility for the Part D Low-Income Subsidy (LIS) and (2) disability. One part of the report focuses on quality of clinical care reported in 2022, which corresponds to care received in 2021. A second part of the report presents an analysis of historical trends in quality of clinical care across a seven-year period, 2016–2022.

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Executive Summary

This report compares the quality of clinical care nationwide for four groups of Medicare Advantage (MA) enrollees, which are defined based on the combination of two characteristics: (1) dual eligibility for Medicare and Medicaid or a recipient of the Part D Low-Income Subsidy (LIS) and (2) disability. In this report, MA enrollees who are dually eligible for Medicare and Medicaid (DE) or LIS-eligible are referred to as *DE/LIS MA enrollees* and those who are neither DE nor LIS-eligible are referred to as *non-DE/LIS MA enrollees*.

One part of this report, Appendix A, focuses on quality of clinical care reported in 2022 (hereafter, *Reporting Year 2022*), which corresponds to care received in 2021 (also referred to as *Measurement Year 2021*). A second part, Appendix B, presents an analysis of historical trends in quality of clinical care across a seven-year period, Reporting Years 2016–2022.

This report is based on an analysis of Healthcare Effectiveness Data and Information Set (HEDIS®) data on the quality of care delivered to people with Medicare who are enrolled in MA plans (National Committee for Quality Assurance, undated-a). HEDIS is composed of information collected from medical records and administrative data on the clinical quality of care that MA enrollees receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease.

In all, 39 clinical care measures were examined for Appendix A, which focuses on Reporting Year 2022. These measures were chosen based on their reliability and informativeness for comparing four groups to the national average: (1) DE/LIS MA enrollees with disabilities (*DE/LIS with disabilities*), (2) DE/LIS MA enrollees without disabilities (*DE/LIS without disabilities*), (3) non-DE/LIS MA enrollees with disabilities (*non-DE/LIS with disabilities*), and (4) non-DE/LIS MA enrollees without disabilities (*non-DE/LIS without disabilities*).

Only a subset of the 39 measures included in the cross-sectional analysis of Reporting Year 2022 data were included in the trend analysis. To be eligible for inclusion, a measure had to exist and be specified consistently from Reporting Year 2016 to Reporting Year 2022 (HEDIS clinical quality data were not released for Reporting Year 2020 because of the coronavirus disease 2019 [COVID-19] pandemic). From the 24 measures that met those criteria, 9 measures were chosen that provide broad representation of the areas of clinical care covered by the full set and for which there were interesting patterns of differences over time. Trends on these 9 measures might not be representative of the entire set of 39 measures.

Key Findings

- Low income (as indicated by DE/LIS eligibility) and disability were each independently associated with scores that were below the Reporting Year 2022 national average by 3 or more percentage points on about a third of the clinical care measures examined, as shown on pages 12–14.
- In combination, low income and disability were associated with below average scores on nearly half of all measures in Reporting Year 2022. In other words, having both low income and a disability put MA enrollees at a substantially higher risk for below average clinical care than having only low income or a disability.
- In Reporting Year 2022, large disparities (differences from the national average of 5 or more percentage points) were far more common among DE/LIS MA enrollees with disabilities (10 measures) than they were among DE/LIS MA enrollees without disabilities (2 measures) or non-DE/LIS MA enrollees with disabilities (5 measures; see Appendix A).
- In Reporting Year 2022, non-DE/LIS MA enrollees without disabilities had above-average scores much more often than they had below-average scores.

- In Reporting Year 2022, scores on diabetes care measures, such as blood sugar testing and blood sugar control, were consistently below the national average for MA enrollees with disabilities, regardless of their DE/LIS status (see pages 31–39).
- Performance on care coordination measures was well below the national average for DE/LIS MA enrollees in Reporting Year 2022, regardless of their disability status (see pages 57–66).
- MA enrollees with disabilities, regardless of their DE/LIS status, had scores that were below the national average for all MA enrollees—often by 3 or more percentage points—in both Reporting Years 2016 and 2022 on 7 of the 9 measures included in the trend analysis (see Appendix B). Patterns of change from Reporting Years 2016 to 2022 were similar for DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees with disabilities and often favorable relative to national average change. This led to the reduction of initial gaps for DE/LIS MA enrollees with disabilities on 2 of 9 measures (Controlling High Blood Pressure and Diabetes Care—Eye Exam) and for non-DE/LIS enrollees with disabilities on 4 of 9 measures (Testing to Confirm Chronic Obstructive Pulmonary Disease [COPD], Controlling High Blood Pressure, Antidepressant Medication Management—Acute Phase, and Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia).
- Observed trends for DE/LIS MA enrollees without disabilities were more complex. On 5 of the 9 measures included in the trend analysis, DE/LIS MA enrollees without disabilities had scores that were below the national average for all MA enrollees at both the start and end of the period examined. Their pattern of change on these 5 measures was comparable to national average change; thus, the magnitude of their existing and ending gaps relative to the national average was generally unchanged. On 1 measure (Diabetes Care—Eye Exam), this group had scores that were above the national average by comparable amounts at the start and end of the period examined. On 1 measure (Diabetes Care—Blood Sugar Controlled), this group had scores that were similar to the national average at the start and end of the period examined. On 1 measure (Osteoporosis Management in Women Who Had a Fracture), this group had a score that was similar to the national average in 2016 but below the national average in Reporting Year 2022. On 1 measure (Testing to Confirm COPD), this group had an initial gap relative to the national average that widened over time.
- On all 9 measures included in the trends analysis, non-DE/LIS MA enrollees without disabilities had scores that were above the national average at the start and end of the period examined. From Reporting Years 2016 to 2022, the changes in this group's scores on the selected measures were such that they either maintained their initial advantage or saw that initial advantage erode slightly.

Policy and Program Implications

Diabetes care was identified as a clinical care area with unique disparities for MA enrollees with disabilities in Reporting Year 2022, regardless of DE/LIS status. The Centers for Medicare & Medicaid Services (CMS) have implemented several policies in recent years to improve care for enrollees at risk for or diagnosed with diabetes. For example, the Medicare Diabetes Prevention Program offers a health behavior change program for at-risk enrollees, cost-sharing for Part B– and Part D–covered insulin is now capped at $35 for a one-month supply of each covered insulin product, and Medicare Part B covers diabetes self-management training for eligible enrollees. Additionally, Medicare will pay for certain types of caregiver education and training through three new Current Procedural Terminology (CPT) codes, which could be particularly useful to support caregivers of individuals with disabilities who are navigating diabetes care. CMS also offers several tools that can help health care organizations enhance care for people with disabilities, such as advice on how to get needed care, resources on improving the physical accessibility of health care facilities, and materials on improving accessibility of communication for individuals who are blind or have low vision or are deaf or hard of hearing.

On all measures of care coordination, scores for DE/LIS enrollees with or without disabilities were significantly below the 2022 national average while scores for non-DE/LIS enrollees were similar to or above the national average. CMS has made recent policy changes that could improve care coordination for DE/LIS enrollees. Through the Contract Year (CY) 2023 MA and Part D Final Rule (87 FR 27704), CMS granted states new authorities to ensure that DE enrollees receive integrated care. Specifically, the CY 2023 Final Rule codified a new pathway at 42 CFR 422.107(e) through which states can use state Medicaid agency contracts (SMACs) to require that dual eligible special needs plans (D-SNPs) with exclusively aligned enrollment (1) establish contracts that only include one or more D-SNPs within a state, and (2) integrate certain materials and notices for enrollees. The authorities provided beginning in CY 2023 were also designed to help improve oversight of dual eligible special needs plans, which are specifically designed to provide targeted care and limit enrollment to dually eligible individuals. Through the CY 2025 Final Rule, CMS finalized another set of changes that will improve experiences and outcomes for dually eligible individuals by increasing the percentage of dually eligible MA enrollees who are in affiliated Medicaid managed care plans, as opposed to MA plans that differ from the enrollee's Medicaid plan. States are also able to require plans to coordinate some care from the Medicaid side, and CMS ensures that states have timely access to MA claims data for DE enrollees, which helps improve care coordination, coordination of benefits, and care transitions for these enrollees. Health care organizations might examine interprovider communication and follow-up processes to see if improvements can be made that would result in quality improvement for DE/LIS enrollees.

Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy and Disability

Introduction

The Institute of Medicine (now the National Academy of Medicine) has identified the equitable delivery of care as a hallmark of quality (Institute of Medicine, 2001). Assessing equitability in the delivery of care requires making comparisons of quality by personal characteristics of patients and clients, such as socioeconomic status, race, and ethnicity. Since 2015, the CMS Office of Minority Health (OMH) has issued reports that highlight racial and ethnic differences in the quality of health care received by MA enrollees nationwide. In 2017, OMH began issuing reports comparing the quality of health care for male and female MA enrollees nationwide and looking at racial and ethnic differences separately among male and female MA enrollees (the most recent of these reports can be accessed here [Martino et al. 2024]). In 2018, OMH initiated a series of annual reports comparing the quality of health care for people with Medicare residing in rural versus urban areas nationwide; these reports have also looked at how racial and ethnic differences vary between rural and urban areas and how rural and urban differences vary across racial and ethnic groups (the most recent of these reports can be accessed here [Martino, Elliot, et al., 2023]). In 2021, OMH published a report comparing the quality of clinical care for MA enrollees who were dually eligible for Medicare and Medicaid (DE) or who received the Part D Low-Income Subsidy (LIS) with the quality of care for MA enrollees who were neither DE nor LIS-eligible (that report can be accessed here [Martino, Mathews, et al., 2023]). That report also examined how differences by DE/LIS status varied across racial and ethnic groups and between rural and urban areas.[1]

This report compares the quality of clinical care for four groups of MA enrollees that are defined based on the combination of two characteristics: (1) DE/LIS status and (2) disability (as defined in the next paragraph). It is the second report to do so; the first was published in 2023 and included data about care received in 2020 that was reported in 2021.

To meet DE requirements, a Medicare enrollee must meet the income requirements of their state's Medicaid program, meaning that they have income and assets below a certain amount in addition to meeting Medicare eligibility requirements (being age 65 or older or having a qualifying disability, end-stage renal disease, or amyotrophic lateral sclerosis [ALS]). Similarly, to receive the Part D LIS, a person must meet requirements set by CMS for having low income and assets (Mulcahy, 2023). In this report, we refer to MA enrollees who met DE requirements and enrolled in their state's Medicaid program[2] or who received the Part D Low-Income Subsidy[3] as *DE/LIS MA enrollees* and to those who are neither DE nor LIS recipients as *non-DE/LIS MA enrollees*. We also refer to *DE/LIS status*, which indicates whether an MA enrollee is DE or an LIS recipient. For this report, *disability status* is based on an MA enrollee's original reason for Medicare entitlement.[4] In this report, *people with disabilities* refers to those who had disability insurance benefits as their original reason for Medicare entitlement, while *people without disabilities* refers to those who had only old-age and survivors insurance or end-stage renal disease as their original reason for Medicare entitlement. Thus, the four groups of MA enrollees that we compare are (1) DE/LIS MA enrollees with disabilities (*DE/LIS with disabilities*), (2) DE/LIS MA enrollees without

[1] Text from this report draws heavily—and sometimes verbatim—from language in this earlier report.
[2] In this report, all DE individuals (i.e., those who would be considered full-benefit, partial-benefit, and Qualified Medicare Beneficiaries) are included in this group.
[3] Either a full or partial subsidy.
[4] Information about an enrollee's original reason for entitlement is used as a measure of disability status because it is the only such measure that is currently available for all people with Medicare. There are limitations to using this information for this purpose. In particular, information about the original reason for Medicare entitlement does not identify people who developed a disability after age 65, and it does not capture detail about the nature or severity of the disabling condition or conditions.

disabilities (*DE/LIS without disabilities*), (3) non-DE/LIS MA enrollees with disabilities (*non-DE/LIS with disabilities*), and (4) non-DE/LIS MA enrollees without disabilities (*non-DE/LIS without disabilities*).

Although it also is an indicator of high medical need, dual eligibility is often used as a proxy for low socioeconomic position (National Academies of Sciences, Engineering, and Medicine, 2016). People who are DE or LIS-eligible are more socially and medically at risk than people who are not DE or LIS-eligible, and thus they tend to have more-costly and more-complex health care needs. Social risk factors for this group include having lower health literacy, higher rates of poverty, less access to reliable transportation, food and housing insecurity, and a higher likelihood of living in an underresourced community (Peikes et al., 2023). More than two-thirds of people who are DE or LIS-eligible have three or more chronic conditions and about 40 percent have a behavioral health disorder (Brown-Podgorski and Roberts, 2022). Health care coverage for this group is more complex than it is for people who are not DE or LIS-eligible, and there is evidence that coverage might not always be configured in a way that meets their needs (Grabowski, 2007). For these reasons, people who are DE or LIS-eligible are at higher risk for receiving suboptimal care than are people who are not DE or LIS-eligible.

Likewise, people with disabilities are at higher risk of receiving suboptimal care than are people without disabilities. People with disabilities face systemic barriers to health care because of stigma and discriminatory practices (Iezzoni et al., 2021). They also face challenges related to access and accessibility, such as physical barriers and gaps in accessibility of communication and information (National Council on Disability, 2022; Okoro et al., 2018). Compared with people without disabilities, people with disabilities are more likely to report poor health and experience higher rates of preventable conditions, including asthma, cardiac disease, diabetes, nicotine dependence, and obesity (Havercamp and Scott, 2015; Paul et al., 2021; Reichard et al., 2011). These barriers and challenges can exacerbate disparities related to low income and other social determinants of health (Iezzoni et al., 2022; Mitra et al., 2022; National Council on Disability, 2022).

There is substantial overlap between people who are DE or LIS-eligible and people with disabilities. For example, the poverty rate for working aged people with disabilities is more than twice the rate for their peers without disabilities (Yee et al., 2018), and adults with disabilities are 2.5 times more likely than adults without disabilities to report forgoing or delaying health care because of costs (Krahn et al., 2015). Despite this overlap, only about one-third of people who have either DE/LIS coverage or disabilities have both (see Table 1). In other words, the categories are related but distinct. Thus, the analysis presented here was designed to help further understanding of the unique and common health care disparities faced by people with low income (i.e., those who are DE or LIS-eligible) and people with disabilities.

Data Sources

One part of this report, Appendix A, presents summary information on the performance of MA plans on specific measures of clinical care quality reported in 2022 (*Reporting Year 2022*), which corresponds to care received in 2021 (also referred to as *Measurement Year 2021*).[5] A second part, Appendix B, presents an analysis of historical trends in quality of clinical care across a seven-year period, Reporting Years 2016–2022, with the exception of 2020 (measures were not released for reporting early in the COVID-19 pandemic).

In all, 39 clinical care measures were examined in Appendix A, which focuses on care reported in 2022. These measures were chosen based on their reliability and informativeness for making comparisons across the four groups described in the preceding section. A comprehensive list of the 39 clinical care

[5] One measure reported here—Breast Cancer Screening—pertains to care received in the past two years.

measures included in Appendix A is presented on pages 9–10. Data on these measures were gathered through medical records and insurance claims or encounter data 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 on the National Committee for Quality Assurance's HEDIS webpage [National Committee for Quality Assurance, undated-b]). In this report, clinical care measures are grouped into nine categories: prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse and appropriate use of medication, and access to and availability of care.[6] The 2022 HEDIS data reported here pertain to care received from January to December 2021.

A prior version of this report, published in 2023 and available on the Stratified Reporting page at CMS.gov (CMS, 2024b), presented information on the quality of clinical care received by MA enrollees nationwide by DE/LIS and disability status using data reported in 2021. That report did not include information on trends in clinical quality of care over time. One clinical care measure that was included in the 2023 report, Rheumatoid Arthritis Management, was excluded from this report because it was retired from HEDIS effective Measurement Year 2021. Four clinical care measures have been added to this year's report: Kidney Health Evaluation for Patients with Diabetes, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Avoiding Use of High-Risk Medications in Older Adults, and Avoiding Use of Opioids at High Dosage. The first of these debuted in HEDIS Measurement Year 2020 but was not included in the 2023 report because two years of data are needed to evaluate a measure for inclusion in this report. The second is a longer-standing HEDIS measure that has met our measurement criteria for the first time. The third and fourth measures were undergoing specification changes at the time the 2023 report was being prepared and thus were not included in that report.

Only a subset of the 39 measures included in Appendix A were selected for inclusion in the trend analysis. To be selected, a measure had to exist and be specified consistently from Reporting Year 2016 to Reporting Year 2022. From the 24 measures that met those criteria, nine were chosen that provide broad representation of the areas of clinical care covered by the full set and for which there were interesting patterns of differences over time (i.e., measures for which there were either large initial differences in scores across group or for which differences increased or decreased notably over time).

Most of the HEDIS measures presented in this report are available only for those people with Medicare who are enrolled in MA plans. Thus, comparisons are presented only for MA enrollees and not for people with Medicare fee-for-service (FFS) coverage. Table 1 shows the distribution of MA enrollees across groups defined by DE/LIS and disability status in 2021. For comparison, the table also shows that distribution in the Medicare FFS population. In 2022, 48 percent of all people with Medicare were enrolled in MA (Ochieng et al., 2023). In general, people with DE/LIS coverage and/or disabilities were more likely to be enrolled in MA than were people with neither DE/LIS coverage nor disabilities.

Appendix C contains more information about the data sources and methods used in this report.

[6] Other OMH reports on inequities in care have presented data on patient experience measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, in addition to data on clinical care. Because DE/LIS functions as a case-mix adjustor in the official scoring of CAHPS measures, this report is limited to HEDIS measures so that all analyses reflect official scoring of the measures.

Table 1. Distribution of the MA and Medicare FFS Populations by Groups Defined by DE/LIS Status and Disability, Reporting Year 2022

Group	MA	Medicare FFS
DE/LIS and disabled	12.1	9.4
DE/LIS and non-disabled	11.9	6.3
Non-DE/LIS and disabled	10.1	9.7
Non-DE/LIS and non-disabled	65.8	74.6

NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities in Health Care in MA by DE/LIS and Disability Status: Cross-Sectional Analysis of 2022 Data Results Summary

The stacked bar chart on page 12 shows the number of clinical care measures on which members of each group had results in Reporting Year 2022 that were above, similar to, or below the national average for all MA enrollees. Measures are scored on a 0–100 scale. In the stacked bar chart, the focus is on practically significant differences—that is, differences that are statistically significant in magnitude and meet or exceed a magnitude threshold of 3 points. The 3-point criterion was selected because a difference this size is considered to be of moderate magnitude (Paddison et al., 2013).

As the figure on page 12 shows, scores for DE/LIS MA enrollees with disabilities were below the national average for 18 measures, similar to the national average for 20 measures, and above the national average for 1 measure (Initiation of Alcohol and Other Drug [AOD] Dependence Treatment). Scores for DE/LIS MA enrollees without disabilities were below the national average for 14 measures, similar to the national average for 23 measures, and above the national average for 2 measures (Pharmacotherapy Management of COPD Exacerbation—Bronchodilator and Statin Use in Patients with Diabetes). Scores for non-DE/LIS MA enrollees with disabilities were below the national average for 11 measures and similar to the national average for 28 measures. Scores for non-DE/LIS MA enrollees without disabilities were below the national average on 1 measure (Initiation of AOD Dependence Treatment), similar to the national average for 30 measures, and above the national average for 8 measures.

The percentage of measures on which both DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees with disabilities had scores that were below the national average increased considerably from Reporting Year 2021 to Reporting Year 2022. In contrast, the percentage of measures on which DE/LIS MA enrollees without disabilities and non-DE/LIS MA enrollees without disabilities scored below the national average remained about the same.

Large disparities (5 or more percentage points) were more common among DE/LIS MA enrollees with disabilities (10 measures) than among DE/LIS MA enrollees without disabilities (2 measures) or non-DE/LIS MA enrollees with disabilities (5 measures). Four of the 10 measures on which there were large disparities for DE/LIS MA enrollees with disabilities pertained to inappropriate use of medications, 2 to care for patients with diabetes, and 2 to care coordination. Examining patterns of large disparities across groups suggests that deficient care for diabetes is uniquely problematic for MA enrollees with disabilities whereas inadequate care coordination is uniquely problematic for DE/LIS MA enrollees.

Because measures included in the trend analysis were selected partly based on observed patterns of difference over time, findings for this set of measures might not generalize to the set of clinical care measures as a whole.

With two exceptions, MA enrollees with disabilities, regardless of DE/LIS status, had scores on the 9 measures included in the trend analysis that were below the national average for all MA enrollees, often by 3 or more percentage points, at the start and end of the period examined.[7] Patterns of change from 2016 to 2022 were similar for DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees with disabilities and often favorable relative to national average change. This led to the reduction of initial gaps for DE/LIS MA enrollees with disabilities on 2 of 9 measures (Controlling High Blood Pressure and Diabetes Care—Eye Exam) and for non-DE/LIS MA enrollees with disabilities on 4 of 9 measures (Testing to Confirm COPD, Controlling High Blood Pressure, Antidepressant Medication Management—Acute Phase, and Avoiding Potentially Harmful Drug-Disease Interactions for Older Adults with Dementia).

For 5 of the 9 measures included in the trend analysis, DE/LIS MA enrollees without disabilities had scores that were below the national average for all MA enrollees at both the start and end of the period examined. The pattern of change in their scores on these 5 measures was comparable to national average change; thus, the magnitude of their existing and ending gaps relative to the national average was generally unchanged. On 1 measure (Diabetes Care—Eye Exam), this group had scores that were above the national average by comparable amounts at the start and end of the period examined. On 1 measure (Diabetes Care—Blood Sugar Controlled), this group had scores that were similar to the national average at the start and end of the period examined. On 1 measure (Osteoporosis Management in Women Who Had a Fracture), this group had a score that was similar to the national average in 2016 but below the national average in 2022. On 1 measure (Testing to Confirm COPD), this group had an initial gap relative to the national average that widened over time.

On all 9 measures chosen for inclusion in the trends analysis, non-DE/LIS MA enrollees without disabilities had scores above the national average at the start and end of the period examined. From 2016 to 2022, the changes in this group's scores on the selected measures were such that they either maintained their initial advantage or saw that initial disadvantage erode slightly (by 1.5 percentage points in each case). The 2 measures on which this group had an initial advantage that was larger than its ending advantage relative to the national average were Controlling High Blood Pressure and Diabetes Care—Blood Sugar Controlled.

Policy and Program Implications: Actions to Eliminate Disparities in Health Care Quality

Addressing Disparities in Diabetes Care Among MA Enrollees with Disabilities

People with disabilities are approximately three times more likely than people without disabilities to develop diabetes (CDC, 2020). This increased risk is particularly evident in people with intellectual and developmental disabilities (Reichard et al., 2011). Quality of education on diabetes self-management for individuals with all disabilities is often poor, and gaps in education in this population are often attributed to reduced cognitive ability, insufficient time for consultations, and communication barriers (Brown et al., 2017; Shireman et al., 2010). Proper diabetes management involves changing and monitoring dietary habits, routinely checking blood glucose levels, administering insulin, and taking medications. For people with any type of disability, these ongoing tasks can pose challenges. For people with intellectual and

[7] The exceptions were that non-DE/LIS enrollees with disabilities had scores on Controlling High Blood Pressure and Antidepressant Medication Management—Acute Phase that were similar to the 2022 national average.

developmental disabilities, these challenges are often greatly magnified. To better support individuals with disabilities and diabetes, health care organizations could allow extra consultation time for people with disabilities and their caregivers, minimize barriers to booking follow-up appointments, and adapt resources to provide education in a way that is most relevant and accessible (Ng, 2023).

Diabetes care was identified as a clinical care area with unique disparities for MA enrollees with disabilities in reporting year 2022, regardless of DE/LIS status (see pages 31–39). Enrollees with disabilities and diabetes, regardless of DE/LIS status, were significantly below the national average on the following measures: Blood Sugar Testing, Eye Exam, Kidney Disease Monitoring, Blood Sugar Controlled, Statin Use, Medication Adherence—Statins, and Kidney Health Evaluation. Two diabetes measures were included in the trends analysis in Appendix B, Diabetes Care—Eye Exam and Diabetes Care—Blood Sugar Controlled (see pages 90–95). Examining the trend on the Diabetes Care—Blood Sugar Controlled measure from 2016-2022, enrollees with diabetes in the non-DE/LIS without disabilities group were above the national average each year, while those with disabilities, regardless of DE/LIS status, were consistently below the national average. All groups improved from Reporting Years 2016 to 2019, with a decrease in 2021 following the missing data for Reporting Year 2020 during the COVID-19 pandemic, and a subsequent increase in 2022. The effect of the COVID-19 pandemic on patient care can serve as an impetus for care providers, and health care organizations to plan for how to maintain care for higher-risk enrollees, such as those with disabilities and diabetes, during any future public health emergencies.

Several of the diabetes measures examined in this report are reported for quality monitoring and included in MA plan Star Ratings calculations. As such, plans are incentivized to focus on diabetes care for their enrollees. The Diabetes Care-Blood Sugar Controlled measure is also part of the Universal Foundation measurement set released by CMS, identifying it as an essential measure for assessing quality in all CMS programs.

CMS has implemented several programs and policies in recent years to improve care for enrollees at risk for or diagnosed with diabetes. With preventing diabetes and associated health outcomes as the ultimate goal, the Medicare Diabetes Prevention Program offers a health behavior change program for at-risk enrollees, with coverage for both FFS and MA (Medicare.gov, undated-b). Further, to reduce drug costs for enrollees with diabetes, Medicare enrollee cost-sharing for Part B– and Part D–covered insulin is now capped at $35 for a one-month supply of each covered insulin product. Additionally, Medicare Part B covers diabetes self-management training for eligible enrollees (Medicare.gov, undated-a). Medicare Part B also allows for billing of caregiver training through three new CPT codes (CMS, undated-b), which could be particularly useful to support caregivers of individuals with disabilities who are navigating diabetes care. Finally, the MA Value-Based Insurance Design Model (CMS, undated-a) allows MA organizations to offer lowered cost-sharing for Part D drugs to DE/LIS enrollees, which has been found to improve medication adherence among DE/LIS enrollees with diabetes (Agarwal et al., 2018).

CMS offers several tools that can help health care organizations enhance care for this population, such as a plain language resource, Medicare Coverage of Diabetes Supplies, Services, & Prevention Programs (Medicare.gov, 2024b), and Getting the Care You Need: A Guide for People with Disabilities, which is available in 8 languages, resources on improving the physical accessibility of health care facilities (CMS, 2023b), and materials on improving accessibility of communication for individuals who are blind or have low vision or are deaf or hard of hearing (CMS, 2023b).

Addressing Disparities in Care Coordination for DE/LIS MA Enrollees

This report finds that in 2022 care coordination was problematic for DE/LIS MA enrollees regardless of disability status. On all measures in the care coordination domain, scores for DE/LIS enrollees, with or without disabilities, were significantly below the national average while scores for those without DE/LIS eligibility were similar to or above the national average. These measures included Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions and each of the Transitions of Care measures: Notification of Inpatient Admission, Receipt of Discharge Information, Medication Reconciliation After Inpatient Discharge, Patient Engagement After Inpatient Discharge, and Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (pages 57–66).

CMS has made recent policy changes that could improve care coordination for DE/LIS enrollees. Through the CY 2023 MA and Part D Final Rule, CMS granted states new authorities to ensure that DE enrollees receive integrated care. Specifically, the 2023 Final Rule codified a new pathway at 42 CFR 422.107(e) through which states can use state Medicaid agency contracts (SMACs) to require that dual eligible special needs plans (D-SNPs) with exclusively aligned enrollment (a) establish contracts that only include one or more D-SNPs within a state, and (b) integrate certain materials and notices for enrollees (Barnette, 2022). The authorities granted through this regulation were also designed to help improve oversight of D-SNPs, which are specifically designed to provide targeted care and limit enrollment to dually eligible individuals. Recent changes to D-SNP regulations build on lessons learned in the Financial Alignment Initiative (CMS, 2024b) and emphasize the importance of care coordination for DE individuals. Through the CY 2025 MA and Part D Final Rule (89 FR 30448), CMS finalized another set of changes that will improve experiences and outcomes for DE individuals by increasing the percentage of DE MA enrollees who are in affiliated Medicaid managed care plans, as opposed to MA plans that differ from the enrollee's Medicaid plan (CMS, 2024a). Increasing the percentage of dually eligible MA enrollees who are in plans that also cover Medicaid will expand access to integrated materials, unified appeal processes across Medicare and Medicaid, and continued Medicare services during an appeal for those individuals (CMS, 2024a). States are also able to require plans to coordinate some care from the Medicaid side. Some states are implementing a requirement that people be enrolled in the same parent company for Medicare and Medicaid, , which is meant to remove barriers to care management for DE enrollees and improve communication. These changes also include ones designed to ensure that states have timely access to MA claims data for DE enrollees, which helps improve care coordination, coordination of benefits, and care transitions for these enrollees. The number of individuals in integrated care plans continues to grow, which also adds to the greater opportunity for dually eligible individuals to receive care coordination services. Another type of integrated care, Programs of All-Inclusive Care for the Elderly (CMS, 2024d), provides comprehensive medical and social care services to support elderly individuals living in the community, most of whom are DE.

Health care organizations might examine interprovider communication and follow-up processes to see if improvements can be made that would result in quality improvement for DE/LIS enrollees. DE/LIS enrollees appear to be at particularly high risk during the transitions surrounding hospitalizations, ED visits, and the period after discharge, so care coordination improvement efforts could be focused on those areas. To incentivize care coordination services, providers could bill for care coordination services, including Transitional Care Management Services (CMS, 2023a) during the 30-day period following a discharge, and, for DE/LIS enrollees with one or more chronic conditions, they could bill for Chronic Care Management Services (CMS, 2022).

Clinical Care Measures Included in This Report[8]

Prevention and Screening

- **Breast Cancer Screening**
- **Colorectal Cancer Screening**

Respiratory Conditions

- **Testing to Confirm COPD**
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Cardiovascular Conditions

- **Controlling High Blood Pressure**
- Continuous Beta-Blocker Treatment After a Heart Attack
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins

Diabetes

- 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
- Kidney Health Evaluation for Patients with Diabetes

Musculoskeletal Conditions

- **Osteoporosis Management in Women Who Had a Fracture**

Behavioral Health

- **Antidepressant Medication Management—Acute Phase Treatment**
- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Engagement of AOD Dependence Treatment

[8] This report considers all HEDIS measures that meet the measurement criteria and are not limited to the measures used in CMS Part C and D Star Ratings program. Measures shown in bold are included in the trend section of the report.

Medication Management and Care Coordination

- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Overuse and Appropriate Use of Medication

- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Chronic Renal Failure
- **Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia**
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults
- Avoiding Use of Opioids at High Dosage
- Avoiding Use of Opioids from Multiple Prescribers
- Avoiding Use of Opioids from Multiple Pharmacies

Access to and Availability of Care

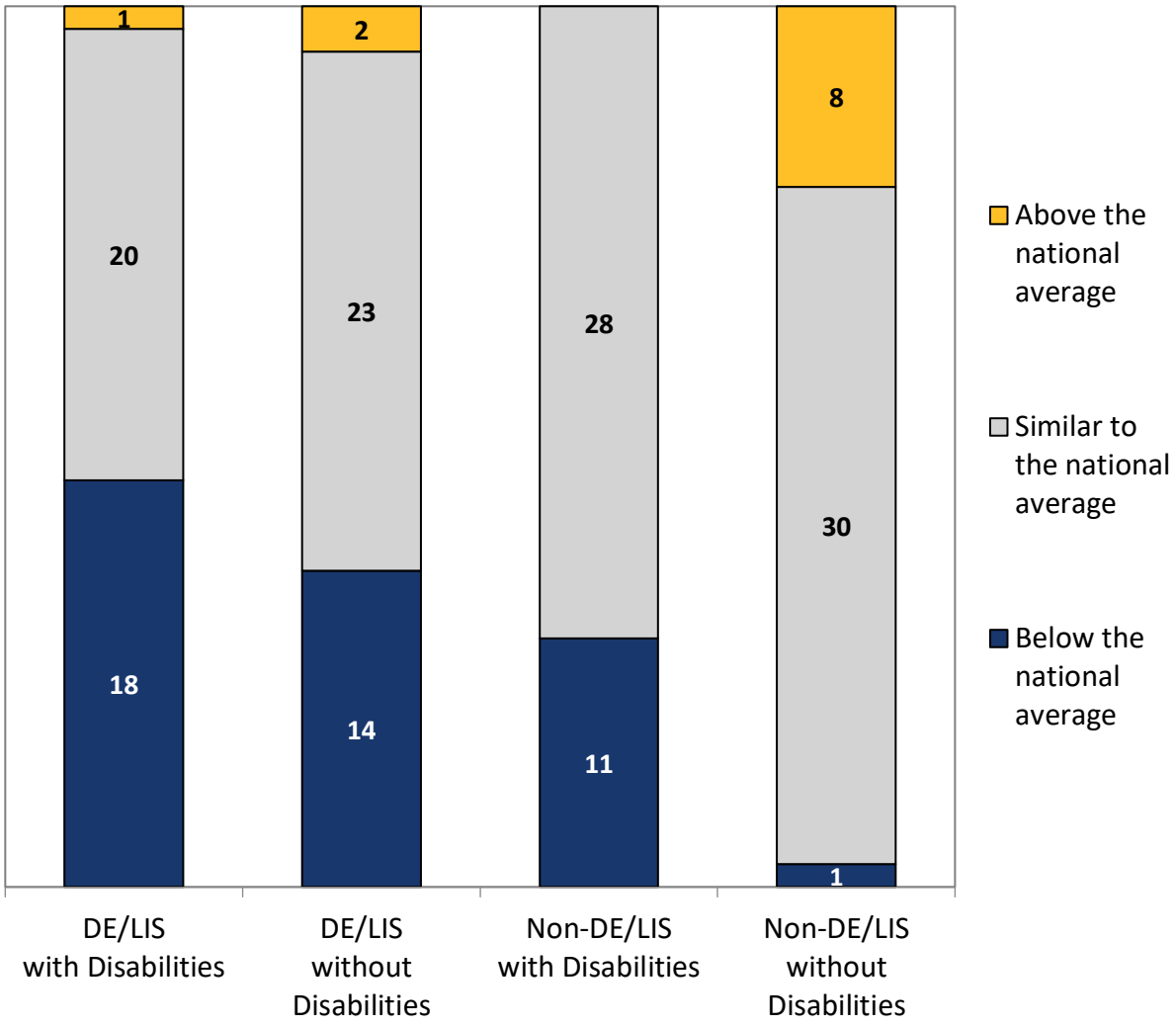
- Older Adults' Access to Preventive and Ambulatory Services

Abbreviations Used in This Report

AMI	acute myocardial infarction
AOD	alcohol and other drug
ASCVD	atherosclerotic cardiovascular disease
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
CY	contract year
DE	dually eligible for Medicare and Medicaid
DE/LIS	dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy
D-SNP	dual eligible special needs plans
ED	emergency department
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
LIS	Low-Income Subsidy
MA	Medicare Advantage
OMH	Office of Minority Health

Disparities in Care by DE/LIS and Disability Status: All Clinical Care Measures, Reporting Year 2022

Number of clinical care measures (of 39) for which members of groups defined by DE/LIS and disability status had results that were above, similar to, or below the national average in Reporting Year 2022



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2021 from MA plans nationwide.

NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Each group is compared with the national average for all MA enrollees.

- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points† on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points† on a 0–100 scale.

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

Results for DE/LIS MA Enrollees by Disability Status

DE/LIS MA enrollees with disabilities had results that were below the national average

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Kidney Health Evaluation in Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults

DE/LIS MA enrollees with disabilities had results that were above the national average

- Initiation of Alcohol and Other Drug (AOD) Dependence Treatment

DE/LIS MA enrollees without disabilities had results that were below the national average

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After Emergency Department (ED) Visit for Mental Illness (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults

DE/LIS MA enrollees without disabilities had results that were above the national average

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Diabetes

Results for Non-DE/LIS MA Enrollees by Disability Status

Non-DE/LIS MA enrollees with disabilities had results that were below the national average

- Breast Cancer Screening
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults
- Avoiding Use of Opioids at High Dosage

Non-DE/LIS MA enrollees without disabilities had results that were below the national average

- Initiation of AOD Dependence Treatment

Non-DE/LIS MA enrollees without disabilities had results that were above the national average

- Breast Cancer Screening
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Kidney Health Evaluation in Patients with Diabetes
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia
- Avoiding Use of Opioids at High Dosage

Overview of Appendices

Appendix A: Cross-Sectional Analysis of 2022 Data

Appendix A presents separate, unstacked bar charts for each clinical care measure. These charts show the percentage (and associated 95-percent confidence interval) of MA enrollees in each DE/LIS by disability status group whose care met the standard called for by the specific measure (e.g., a test or treatment) in Reporting Year 2022. These charts also indicate how each group's percentage compares with the national average for all MA enrollees. Unlike in the stacked bar chart that appears on page 12, which focuses on differences that are statistically significant and meet or exceed a magnitude threshold of 3 percentage points, in the unstacked bar charts all differences from the national average that are statistically significant (regardless of magnitude) are indicated through the use of symbols. In the unstacked bar charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically significant differences that are 3 points in magnitude or larger through the coloring of upward- and downward-pointing arrows that appear in the bars.[9] Dark blue arrows indicate statistically significant differences that are less than 3 points in magnitude; gold arrows indicate statistically significant differences that are 3 points in magnitude or larger.

Appendix B: Trends in Disparities, 2016–2022

For each of the selected clinical care measures, Appendix B first presents a line graph that shows how each DE/LIS and disability status group changed over time from 2016 to 2022, with the exception of 2020,[10] and then presents a paired bar chart showing scores for each DE/LIS by disability status group in 2016 and 2022. Accompanying each of the paired bar charts, is a table summarizing (1) group differences from the national average that existed in 2016, (2) group differences from the national average that remained in 2022 (which duplicates information presented in Appendix A), (3) how scores changed for each group over time, and (4) how scores changed over time relative to national average change. These summaries are based on statistical models that are described in Appendix C. In information conveyed about group differences from the national average that existed in 2016 and 2022—i.e., cross-sectional comparisons—differences that are not statistically significant or that are statistically significant but less than 3 points in magnitude are distinguished from differences that are both statistically significant and 3 points in magnitude or larger. In information conveyed about changes over time, only differences that are statistically significant and 1 point or larger are highlighted; differences over time that are not statistically significant or that are statistically significant but less than 1 point (before rounding) are treated as indicative of no change.

Appendix C: Data Sources and Methods

Appendix C contains detailed information on data sources and analytic methods.

[9] In some cases, confidence intervals for group averages are very narrow and thus difficult to see on these charts. In those instances, these symbols denoting statistically significant differences can be relied on to tell whether the confidence interval crosses the national average line.

[10] HEDIS clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

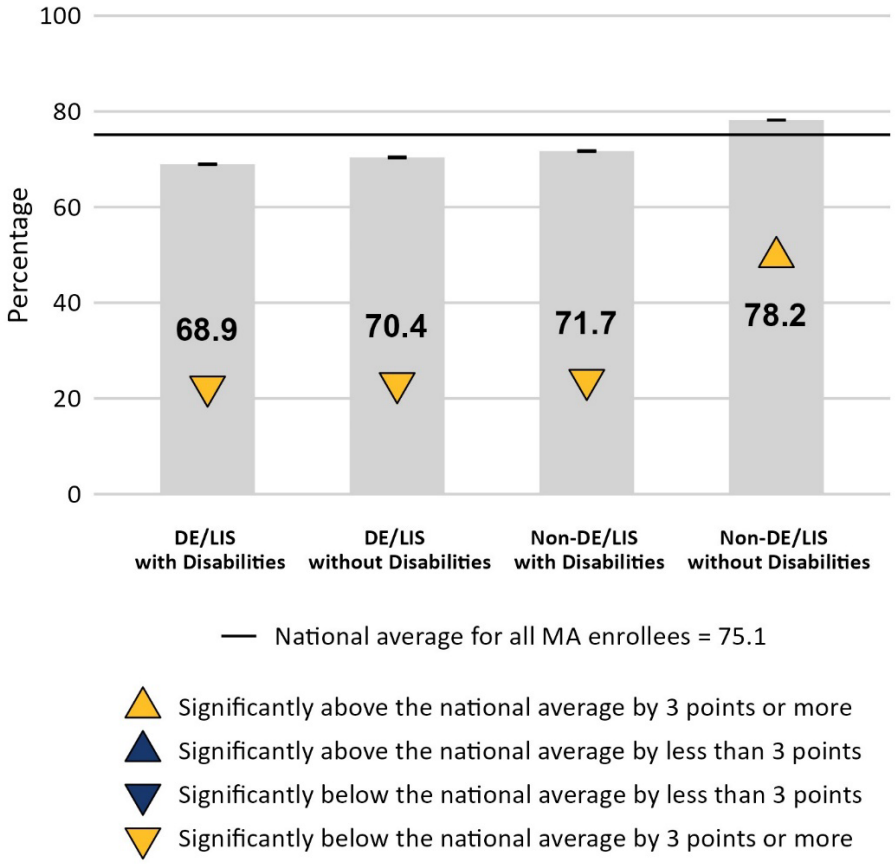
APPENDIX A

Cross-Sectional Analysis of 2022 Data

Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

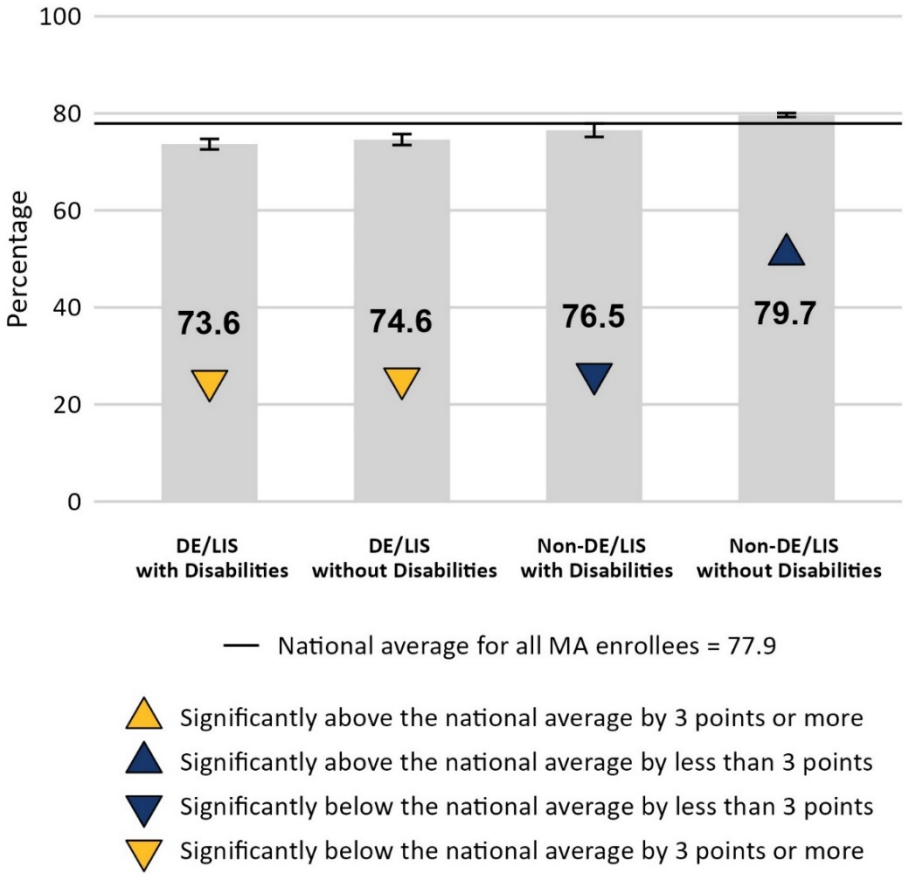
- The percentage of eligible[†] female DE/LIS MA enrollees with disabilities who were appropriately screened for breast cancer was **below**[‡] the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female DE/LIS MA enrollees without disabilities who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female non-DE/LIS MA enrollees with disabilities who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female non-DE/LIS MA enrollees without disabilities who were appropriately screened for breast cancer was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.

[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (specified at the top of the corresponding page).

[‡] Unlike in the summary chart presented on page 12, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are 3 or more points or less than 3 points.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

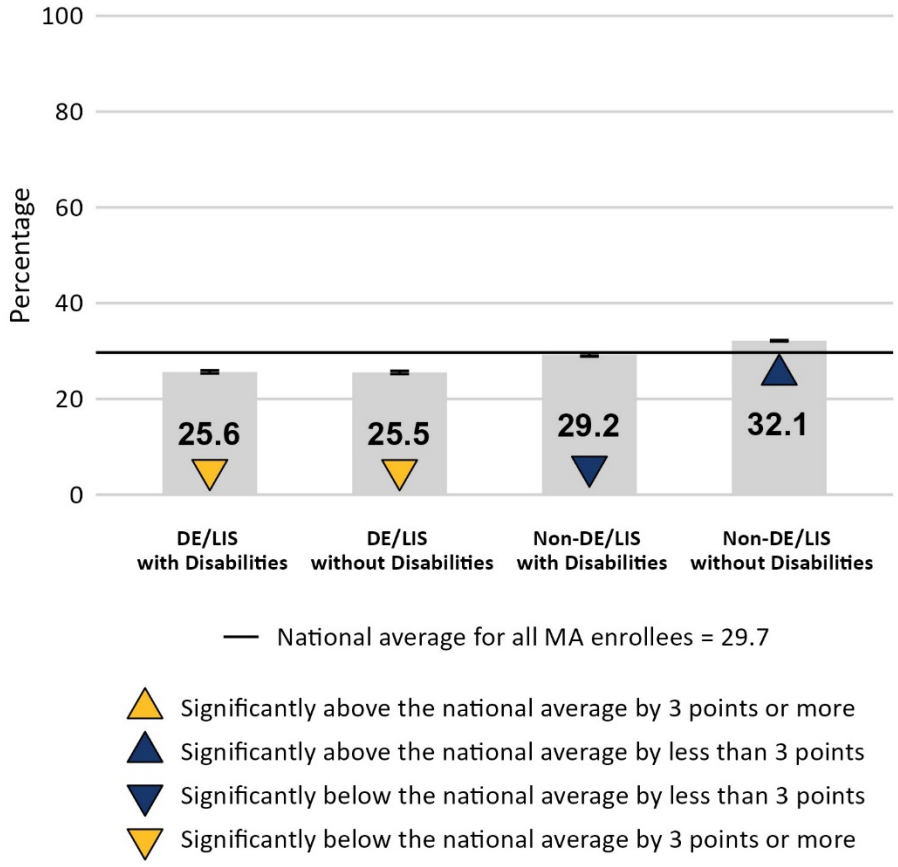
Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who were appropriately screened for colorectal cancer was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who were appropriately screened for colorectal cancer was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who were appropriately screened for colorectal cancer was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who were appropriately screened for colorectal cancer screening was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Respiratory Conditions

Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)

Percentage of MA 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 DE/LIS and disability status, Reporting Year 2022



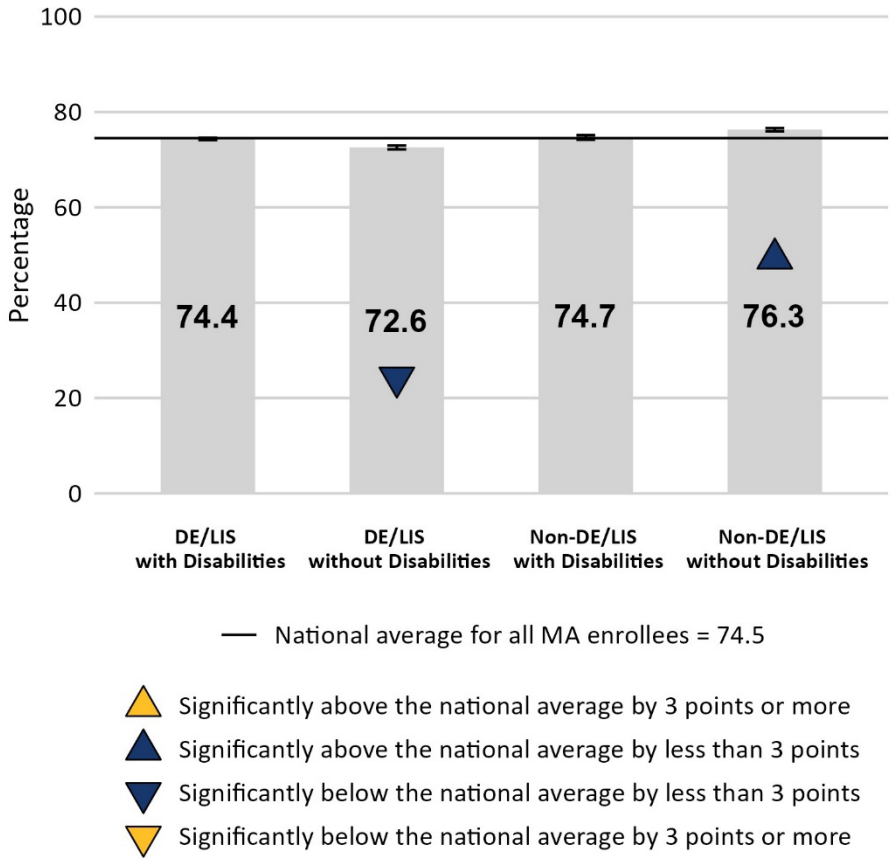
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by DE/LIS and disability status, Reporting Year 2022



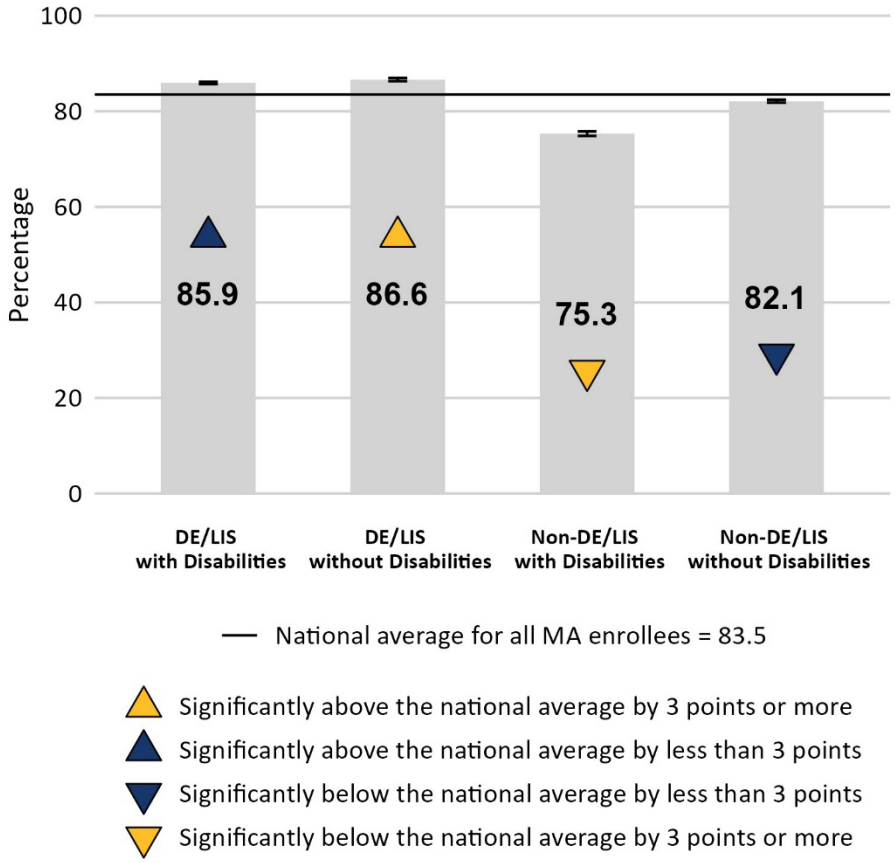
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible DE/LIS MA enrollees without disabilities who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

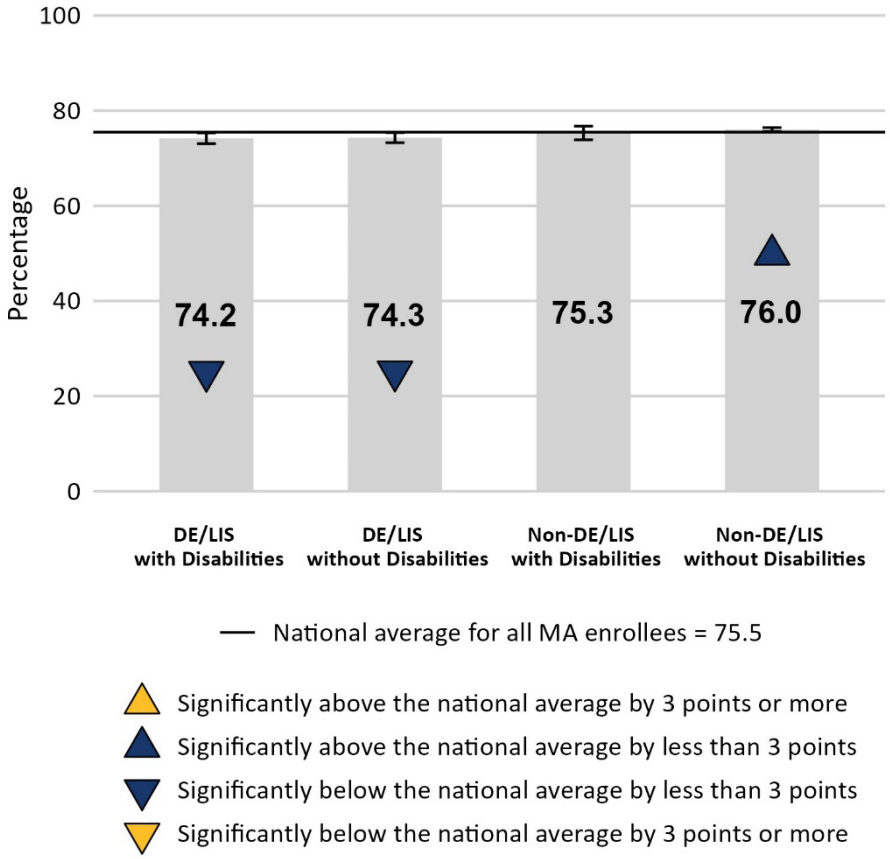
Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

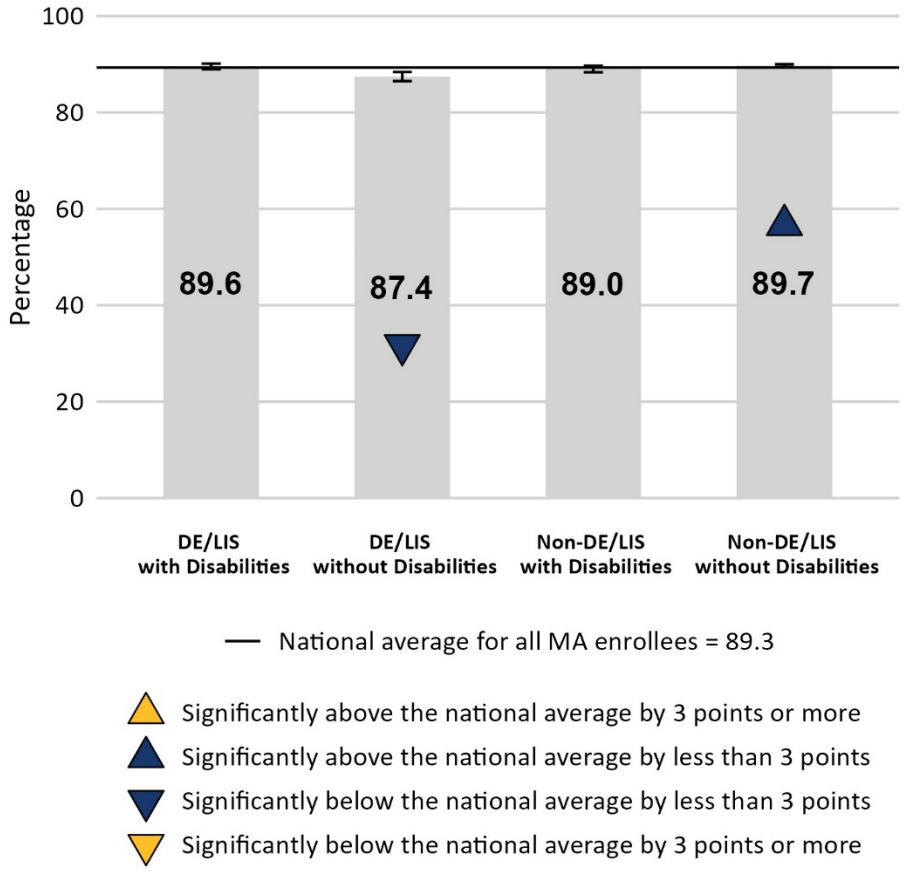
[†] Less than 140/90 for patients 18 to 59 years of age and for patients 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for patients 60 to 85 years of age without a diagnosis of diabetes.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who had their blood pressure adequately controlled was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by DE/LIS and disability status, Reporting Year 2022



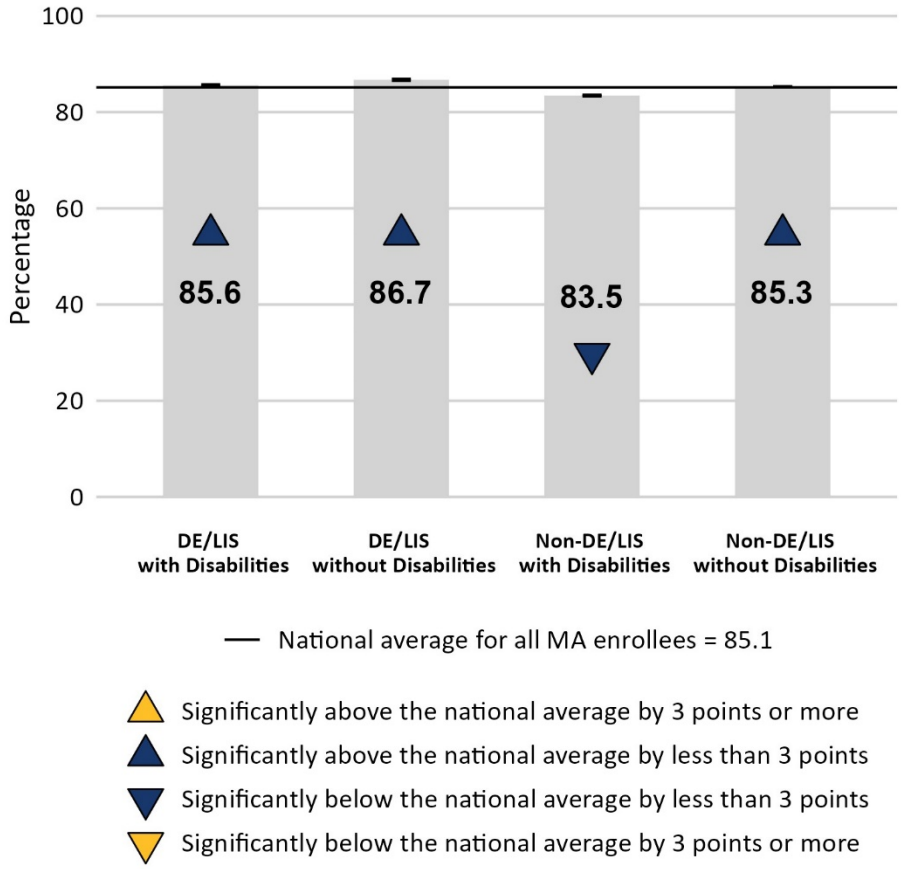
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who received continuous beta-blocker treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible DE/LIS MA enrollees without disabilities who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who received continuous beta-blocker treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who received continuous beta-blocker treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

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 with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by DE/LIS and disability status, Reporting Year 2022



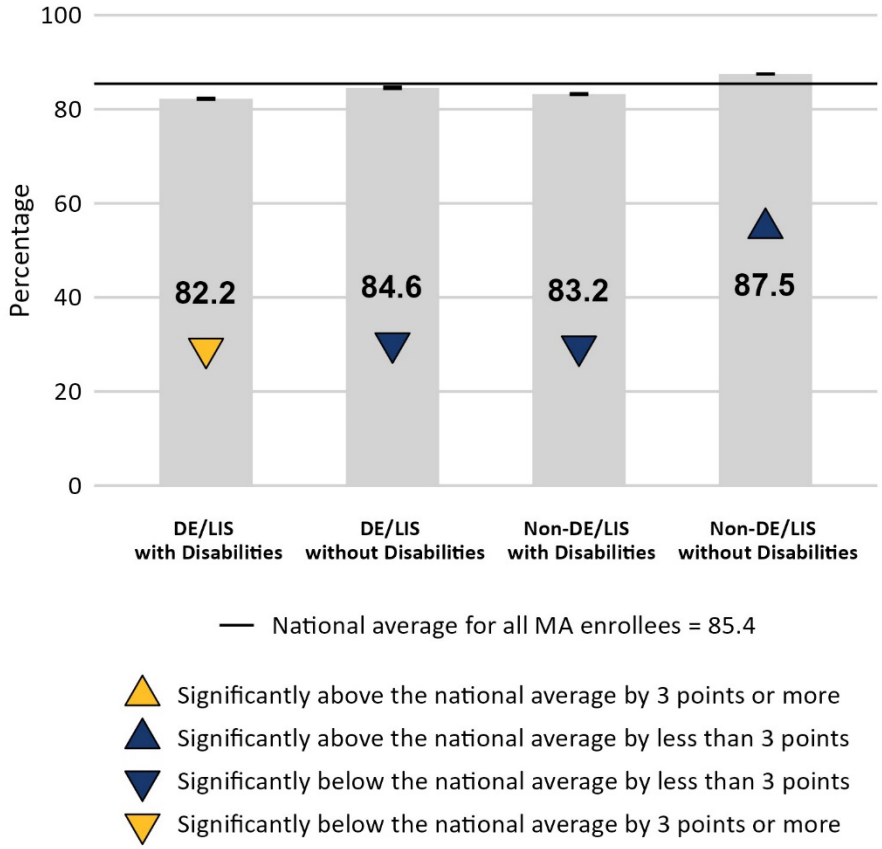
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities with clinical ASCVD who received statin therapy was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with clinical ASCVD who received statin therapy was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with clinical ASCVD who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with clinical ASCVD who received statin therapy was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

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 with clinical ASCVD 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 DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

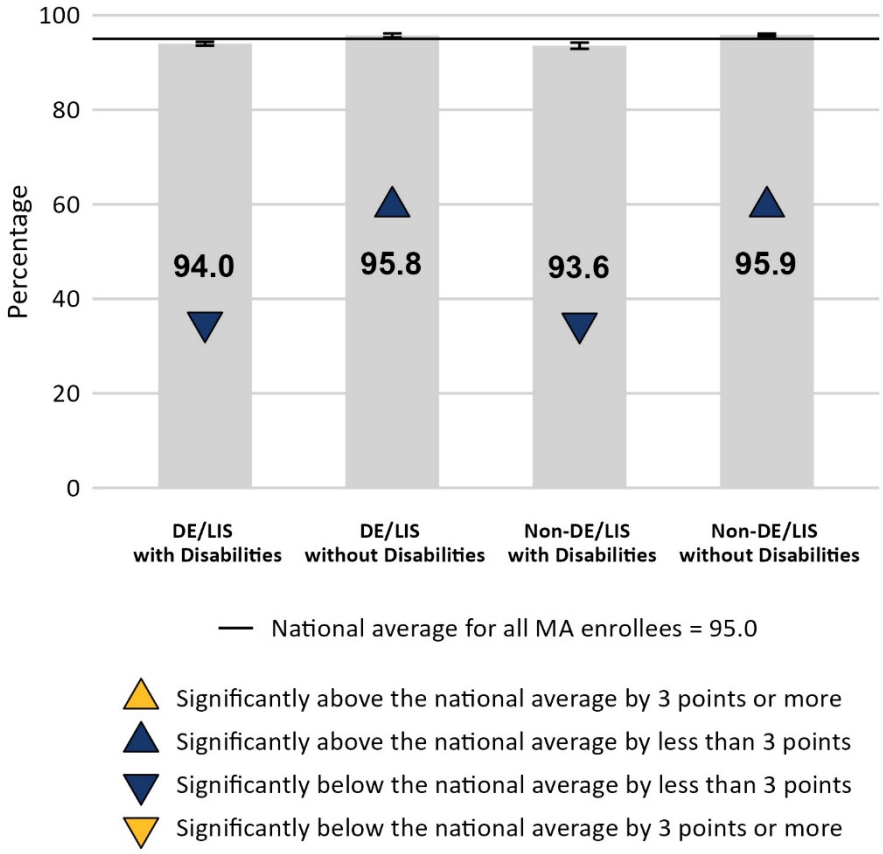
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with clinical ASCVD who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by DE/LIS and disability status, Reporting Year 2022



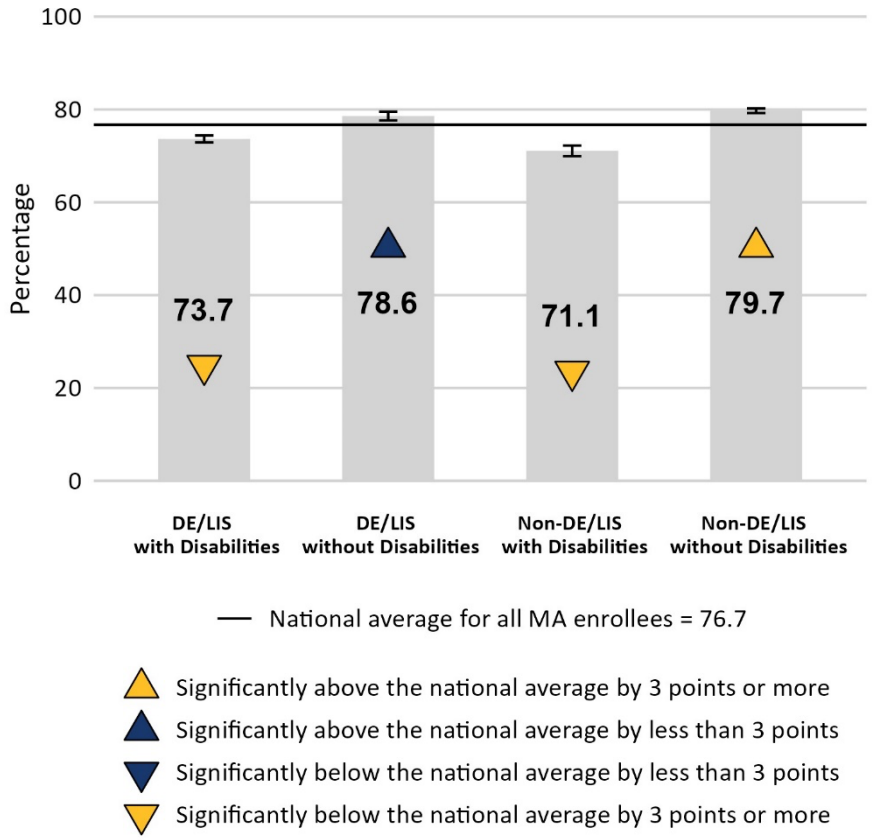
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had their blood sugar tested at least once in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had their blood sugar tested at least once in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had their blood sugar tested at least once in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had their blood sugar tested at least once in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

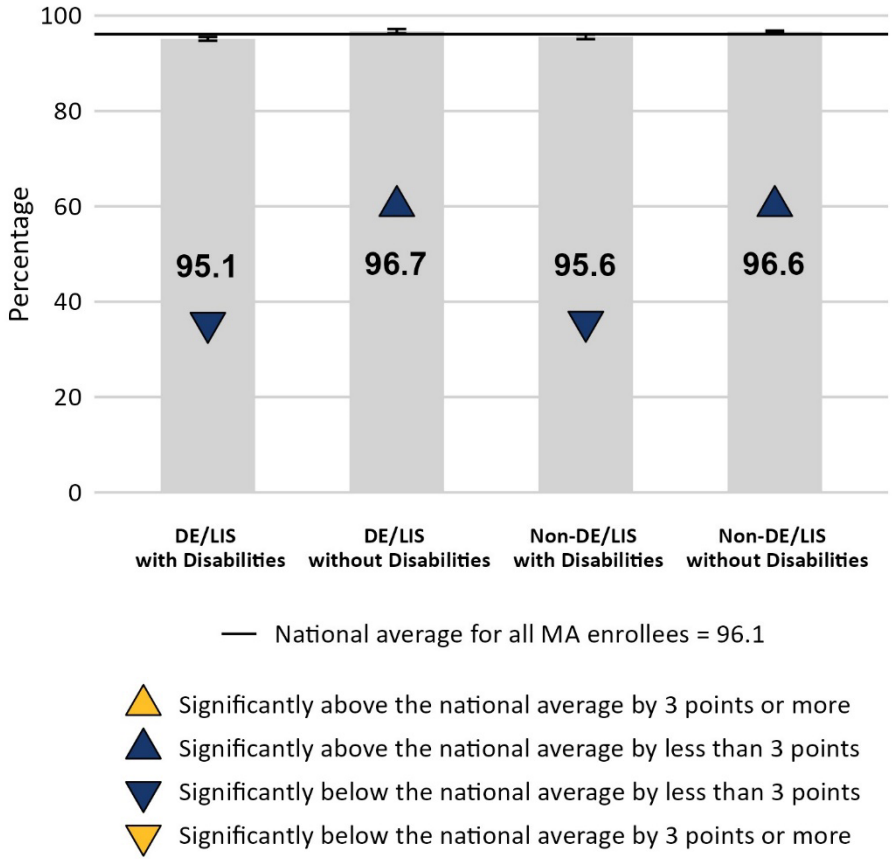
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had an eye exam in the past year was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.[†]
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had an eye exam in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had an eye exam in the past year was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had an eye exam in the past year was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.[†]

[†] Prior to rounding.

Diabetes Care—Kidney Disease Monitoring

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by DE/LIS and disability status, Reporting Year 2022



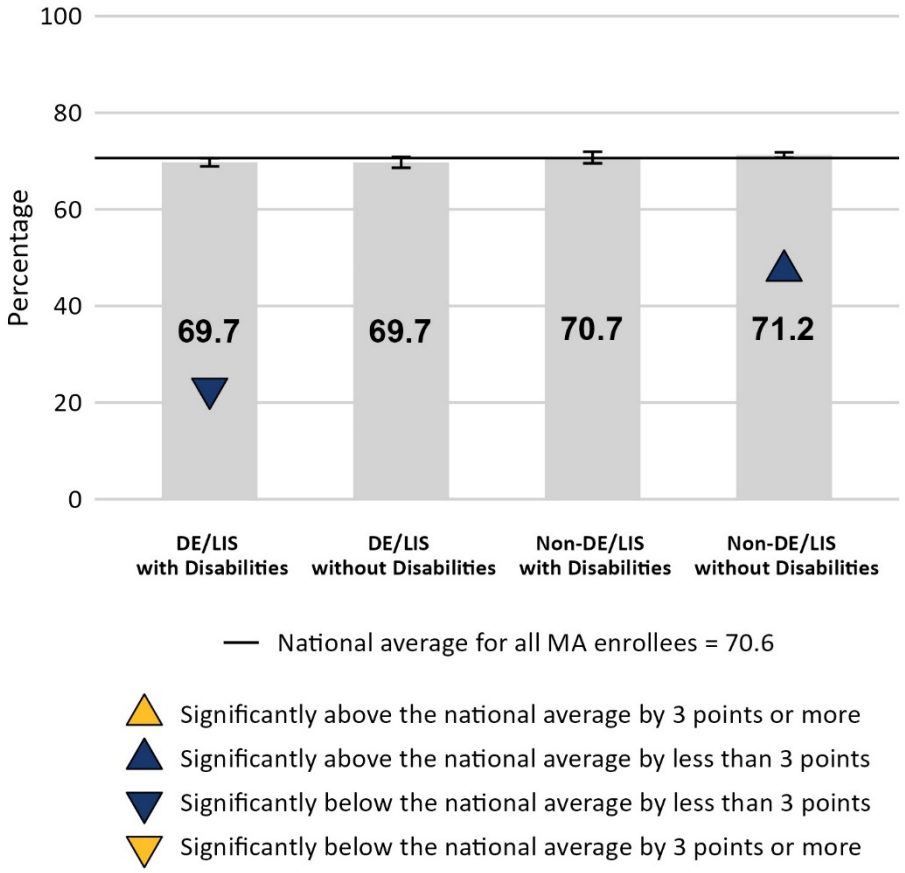
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had medical attention for nephropathy in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had medical attention for nephropathy in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had medical attention for nephropathy in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had medical attention for nephropathy in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by DE/LIS and disability status, Reporting Year 2022



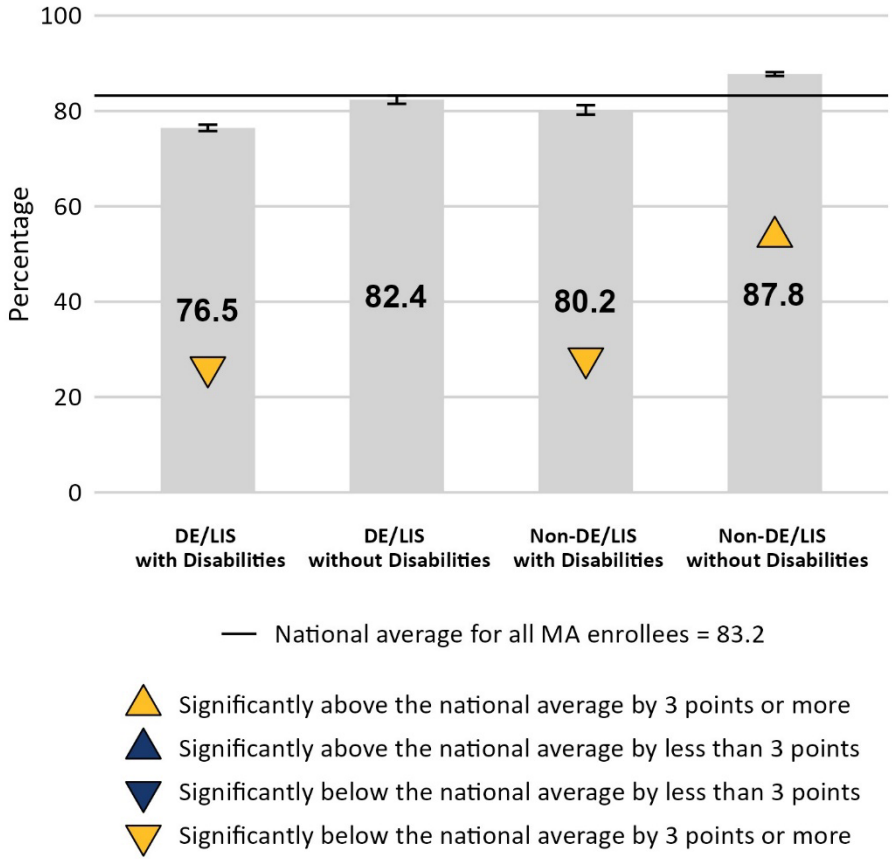
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had their blood pressure under control was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had their blood pressure under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

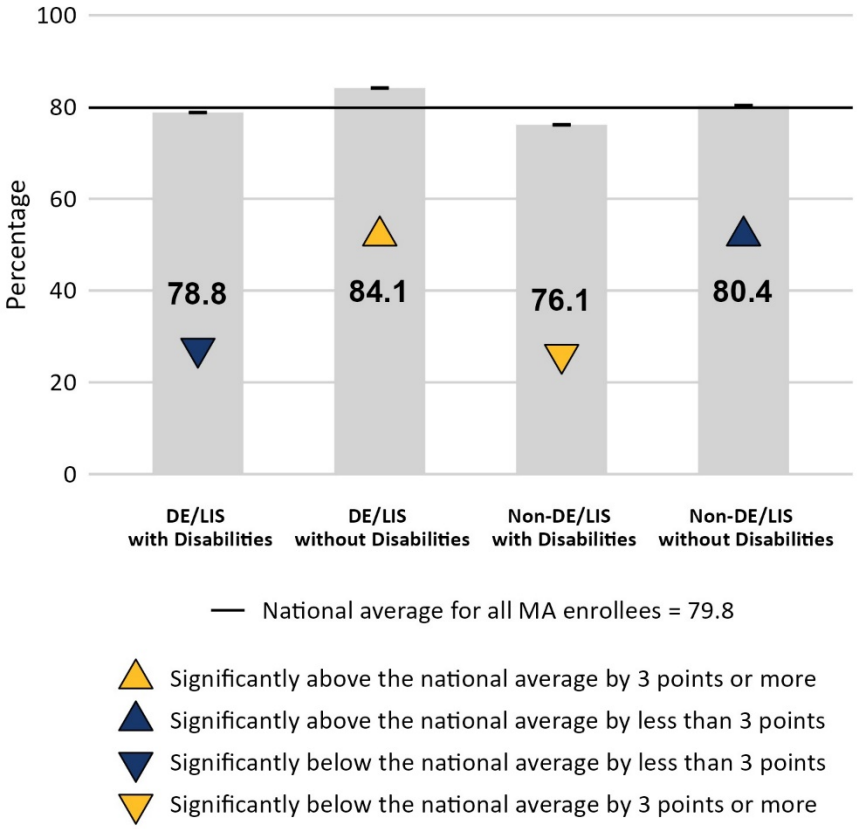
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had their blood sugar level under control was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.[†]
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had their blood sugar level under control was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.

[†] Prior to rounding.

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 DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

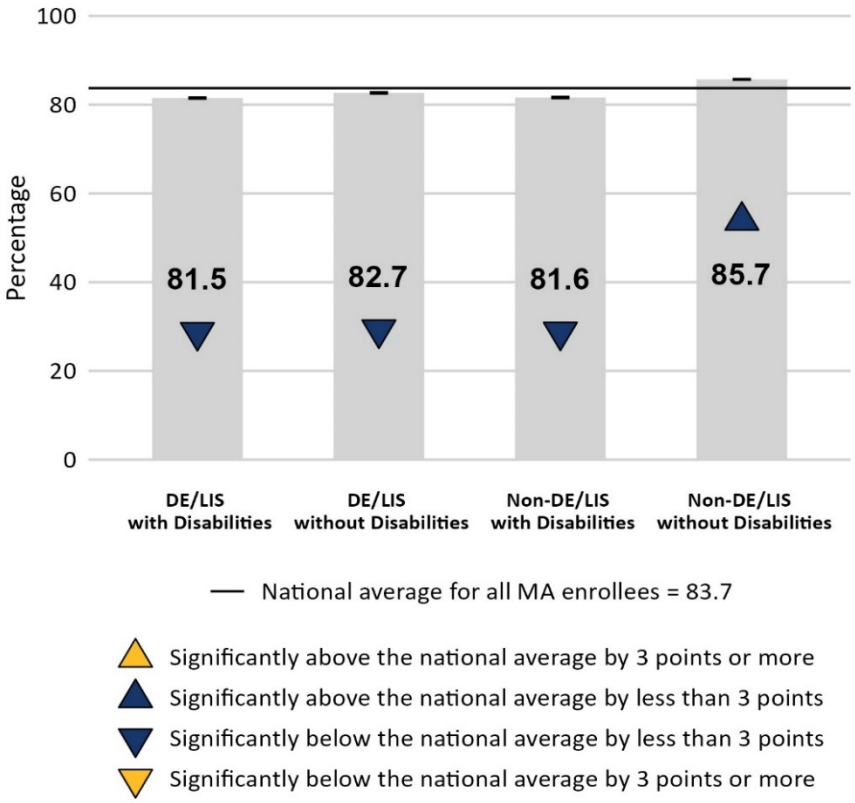
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who received statin therapy was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who received statin therapy was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Excludes those who also have clinical ASCVD.

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 DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

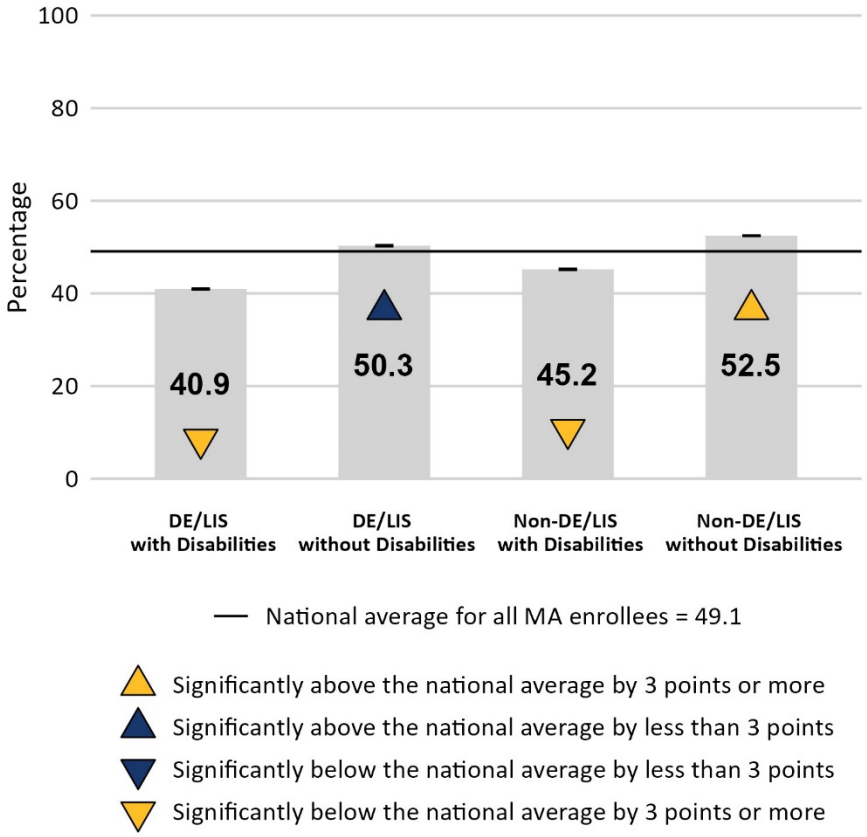
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Excludes those who also have clinical ASCVD.

Kidney Health Evaluation for Patients with Diabetes

Percentage of MA enrollees aged 18 to 85 years with diabetes (type 1 and type 2) who received an annual kidney health evaluation,† by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

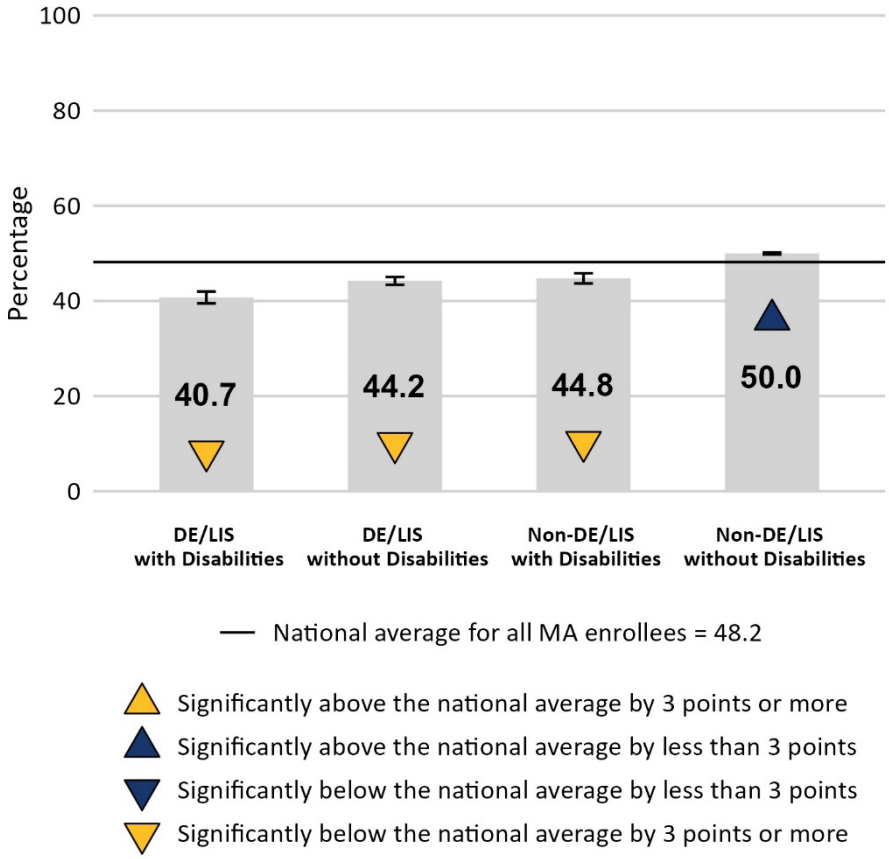
- The percentage of DE/LIS MA enrollees with disabilities with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with diabetes who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities with diabetes who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.

† Includes both an estimated glomerular filtration rate and a urine albumin-creatinine ratio.

Musculoskeletal Conditions

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 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 six months after the fracture, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

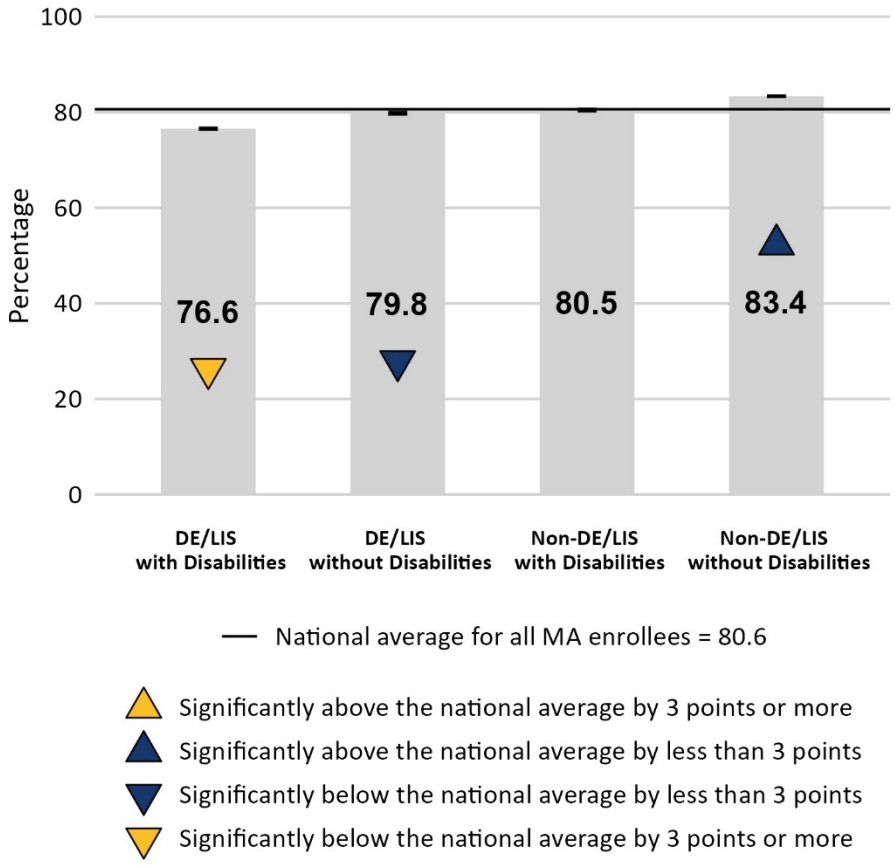
Disparities

- The percentage of eligible female DE/LIS MA enrollees with disabilities who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female DE/LIS MA enrollees without disabilities who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female non-DE/LIS MA enrollees with disabilities who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female non-DE/LIS MA enrollees without disabilities who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.

Behavioral Health

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by DE/LIS and disability status, Reporting Year 2022



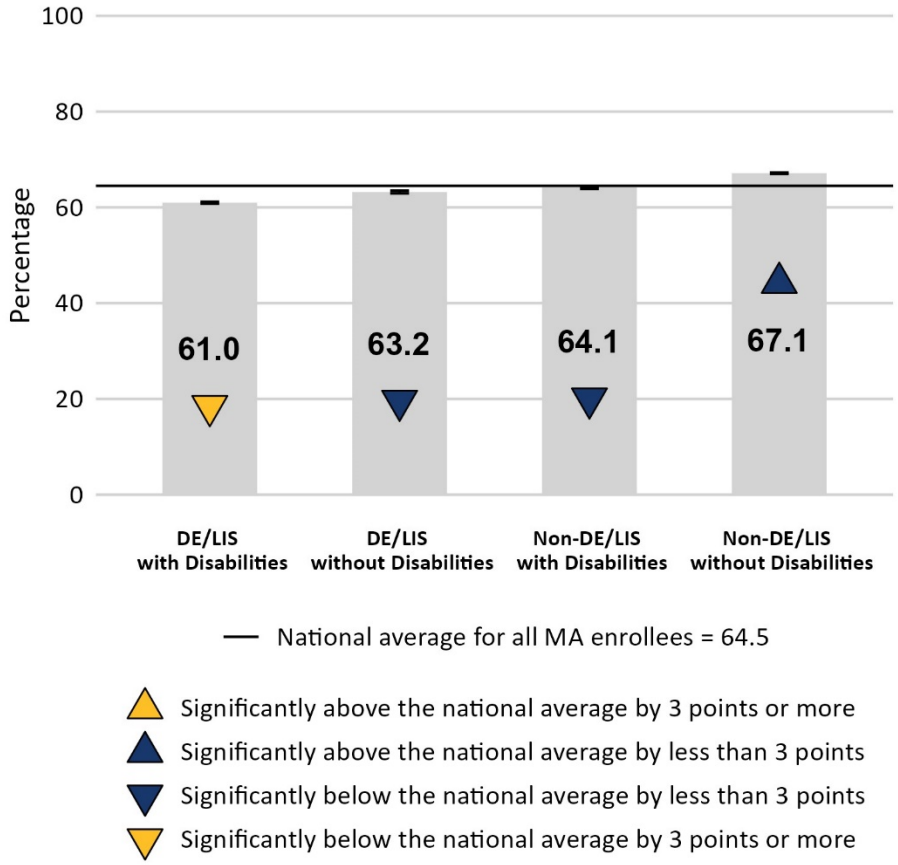
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by DE/LIS and disability status, Reporting Year 2022



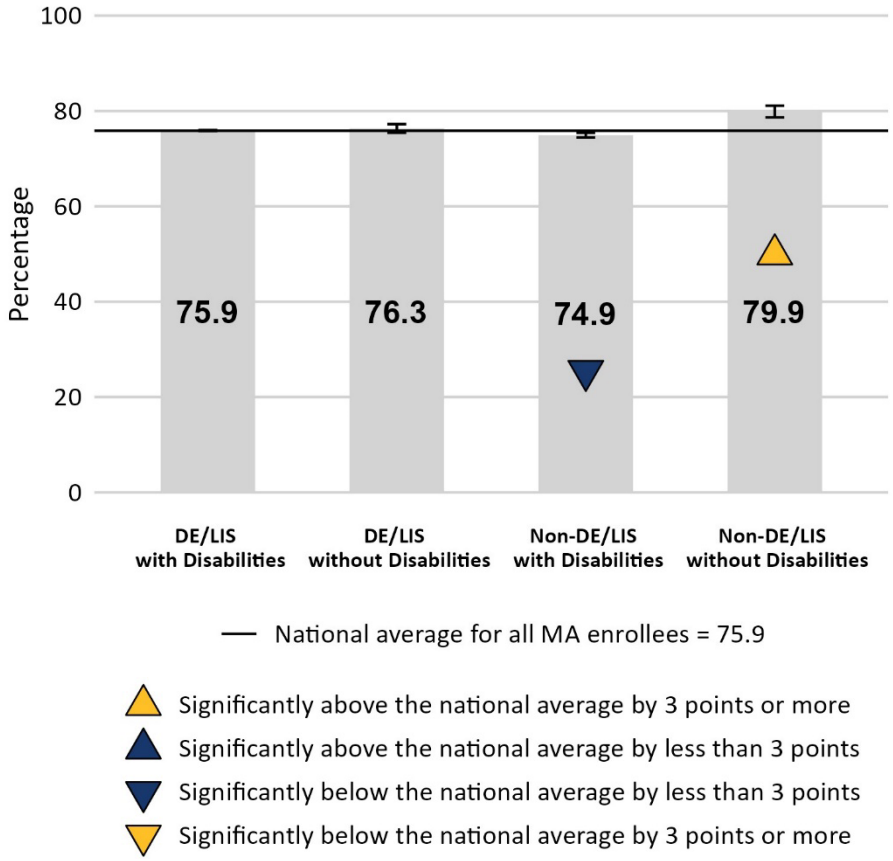
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Adherence to Antipsychotic Medications for People with Schizophrenia

Percentage of MA enrollees aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period, by DE/LIS and disability status, Reporting Year 2022



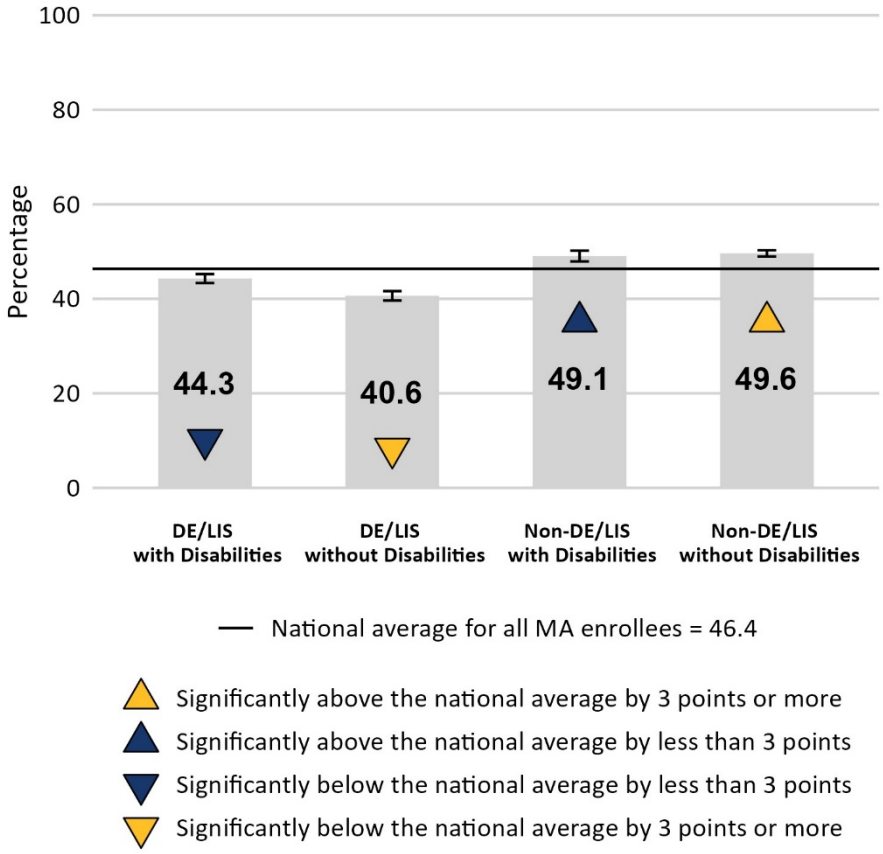
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all MA enrollees with schizophrenia or schizoaffective disorder.
- The percentage of eligible DE/LIS MA enrollees without disabilities with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all MA enrollees with schizophrenia or schizoaffective disorder.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **above** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points.

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

Percentage of MA enrollees aged 65 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 DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

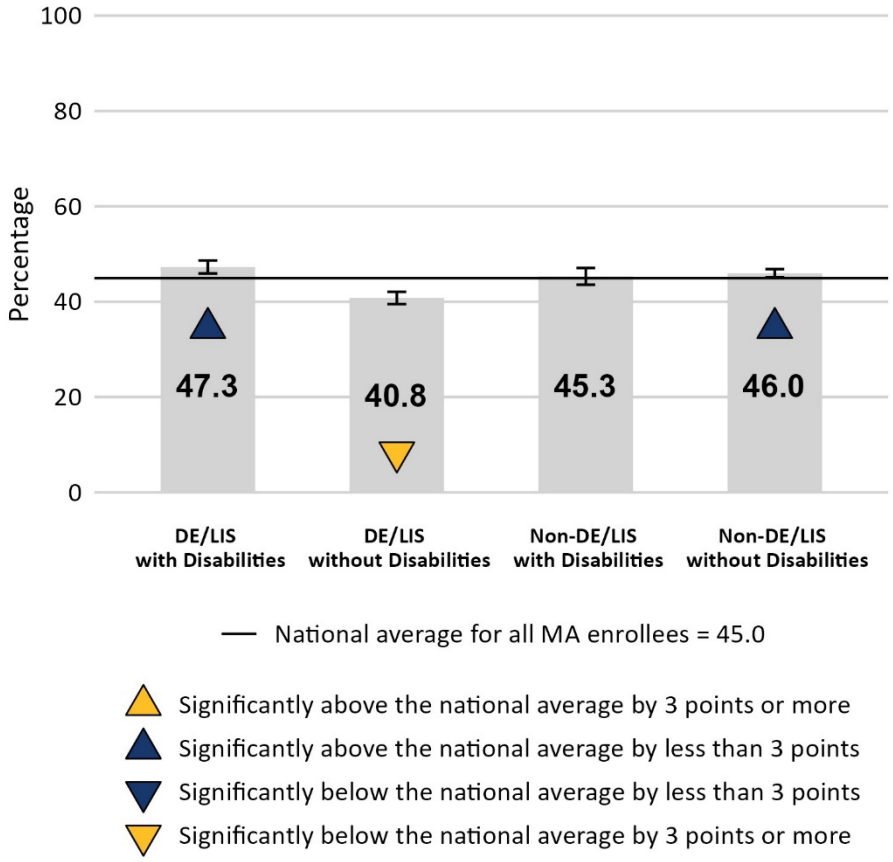
[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older[†] who had an ED visit for 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 the ED visit, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

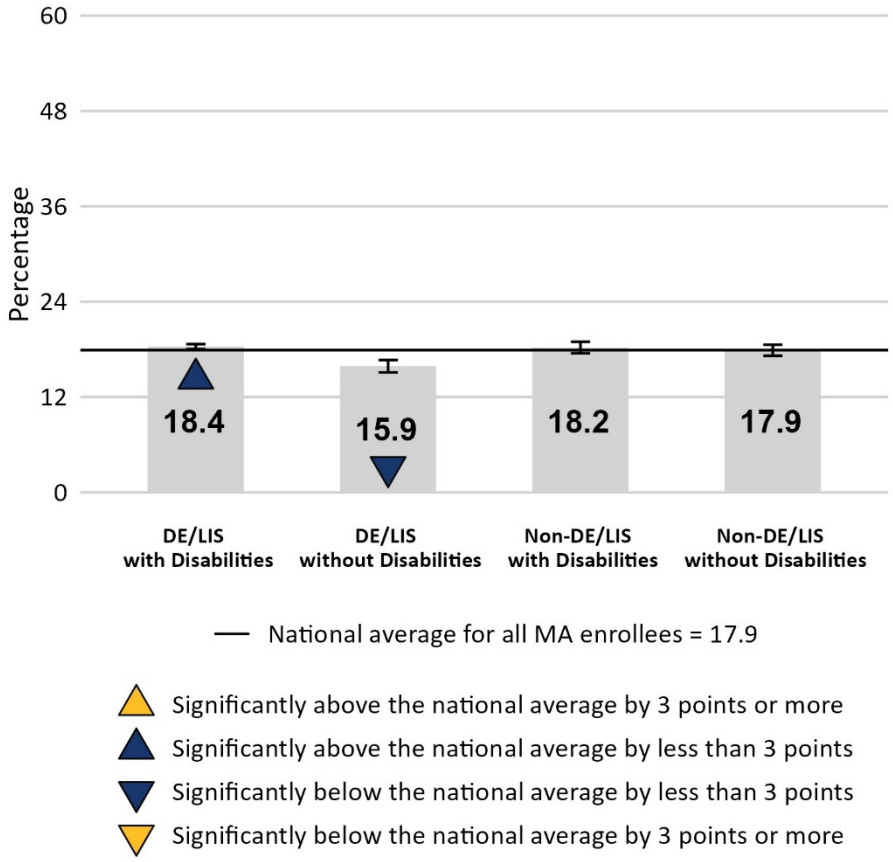
[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (within 30 days of discharge)

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

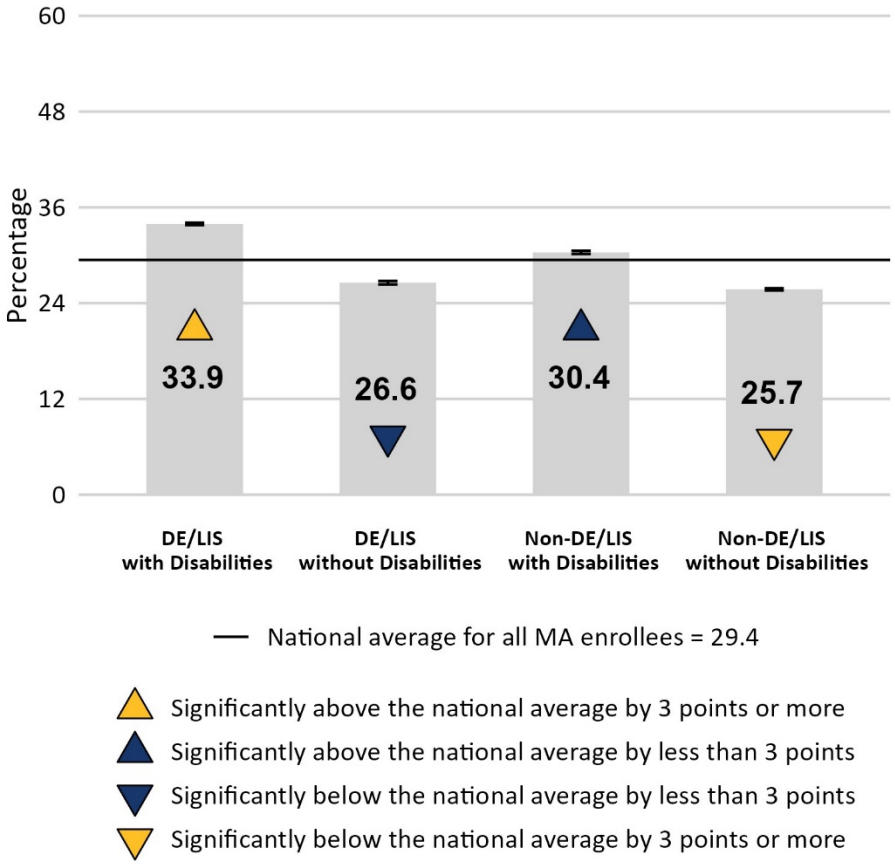
[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all eligible MA enrollees.

Initiation of Alcohol and Other Drug Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated[‡] treatment within 14 days of the diagnosis, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

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

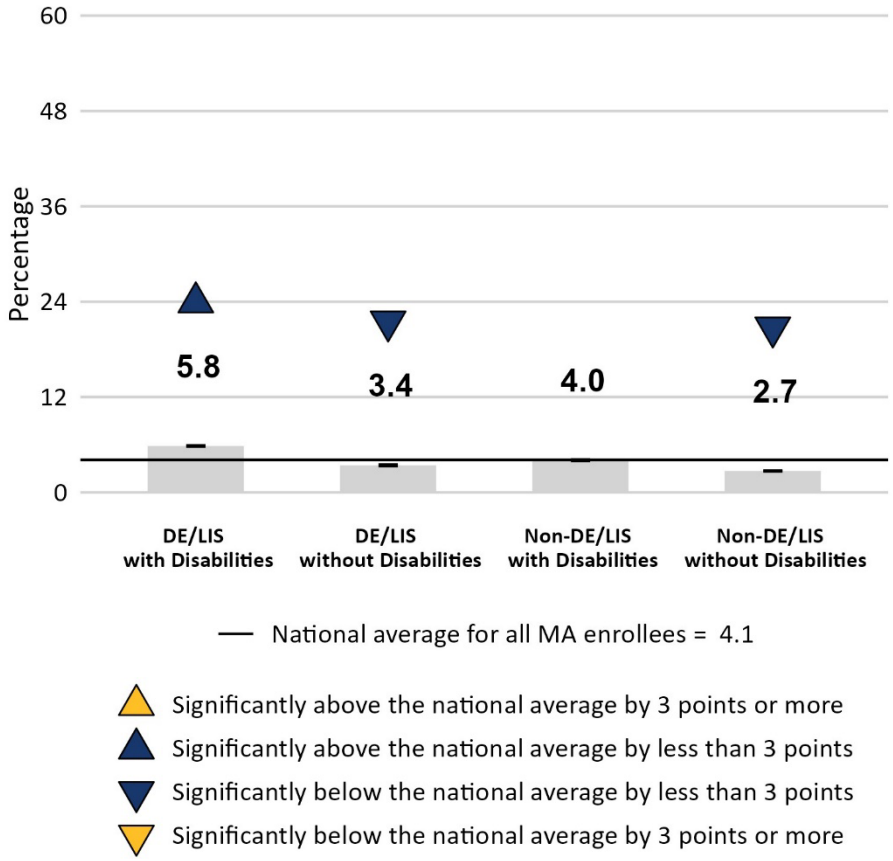
[‡] Initiation might occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Disparities

- The percentage of eligible DE/LIS MA enrollees with disabilities who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible DE/LIS MA enrollees without disabilities who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees with disabilities who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible non-DE/LIS MA enrollees without disabilities who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points.

Engagement of AOD Dependence Treatment

Percentage of MA 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 DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

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

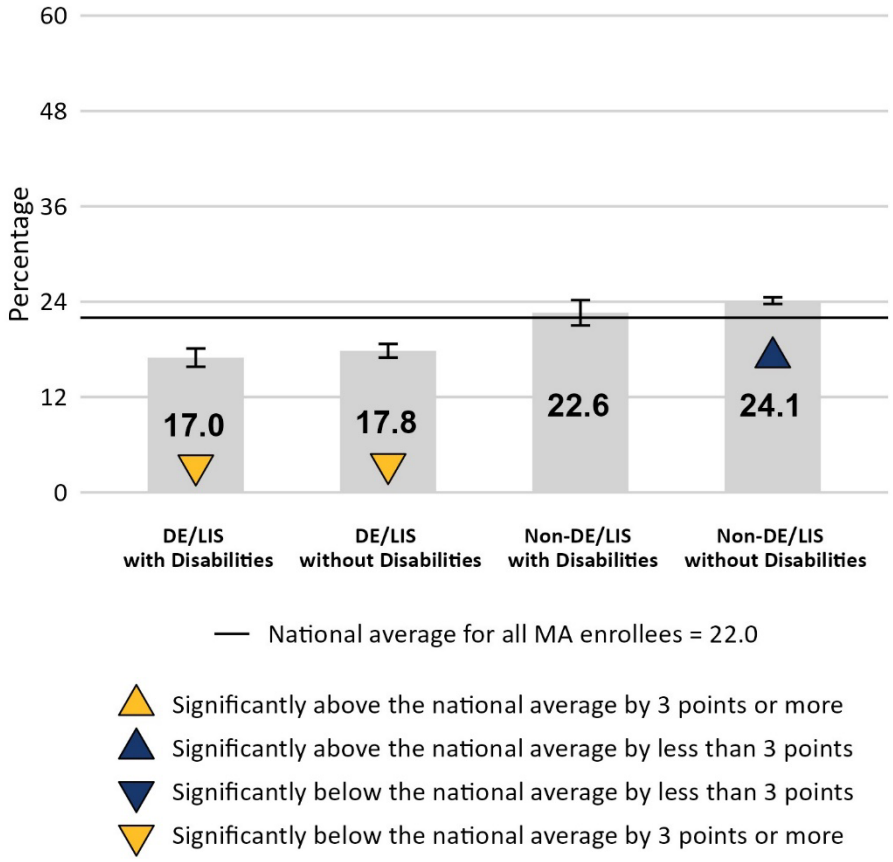
Disparities

- The percentage of DE/LIS MA enrollees with disabilities with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of non-DE/LIS MA enrollees without disabilities with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Medication Management and Care Coordination

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

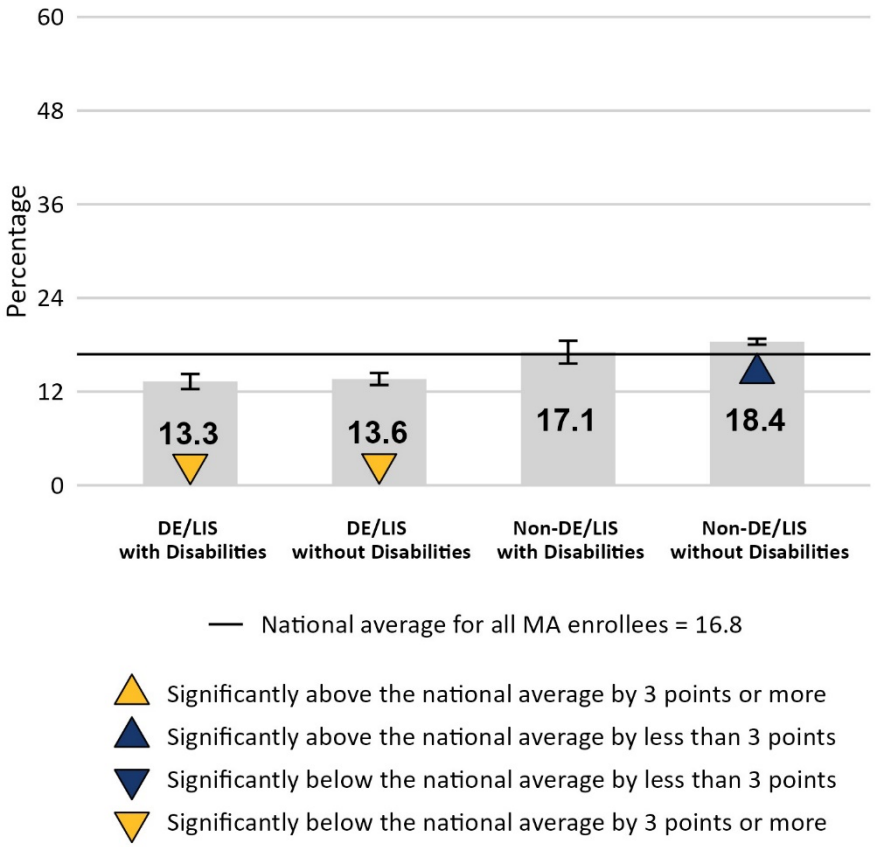
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

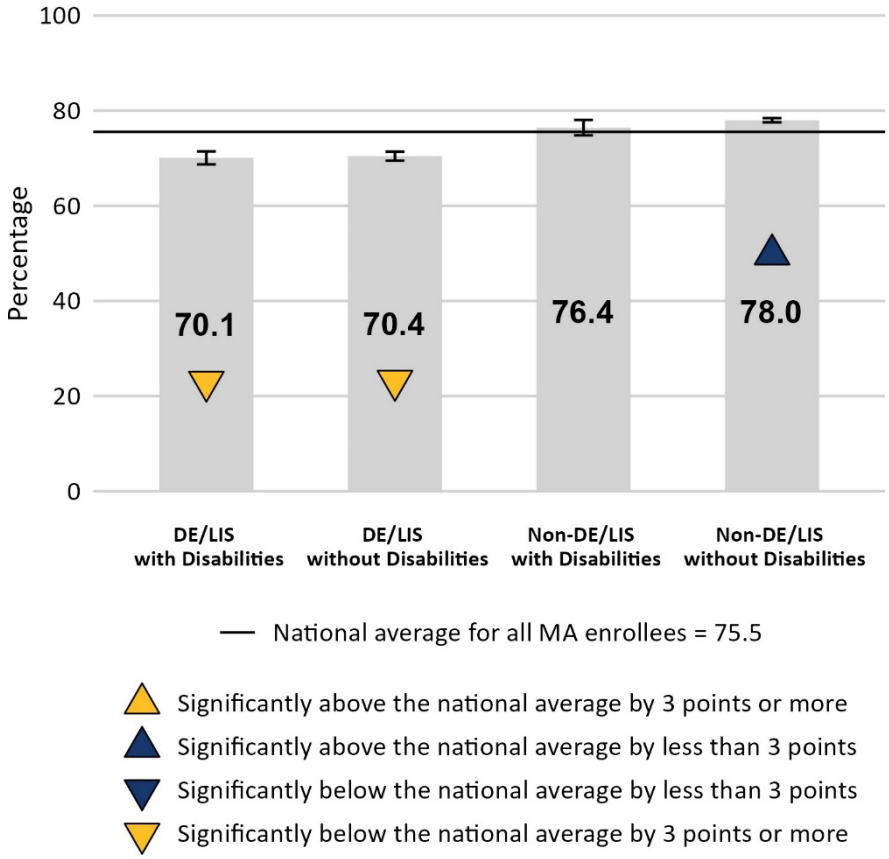
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

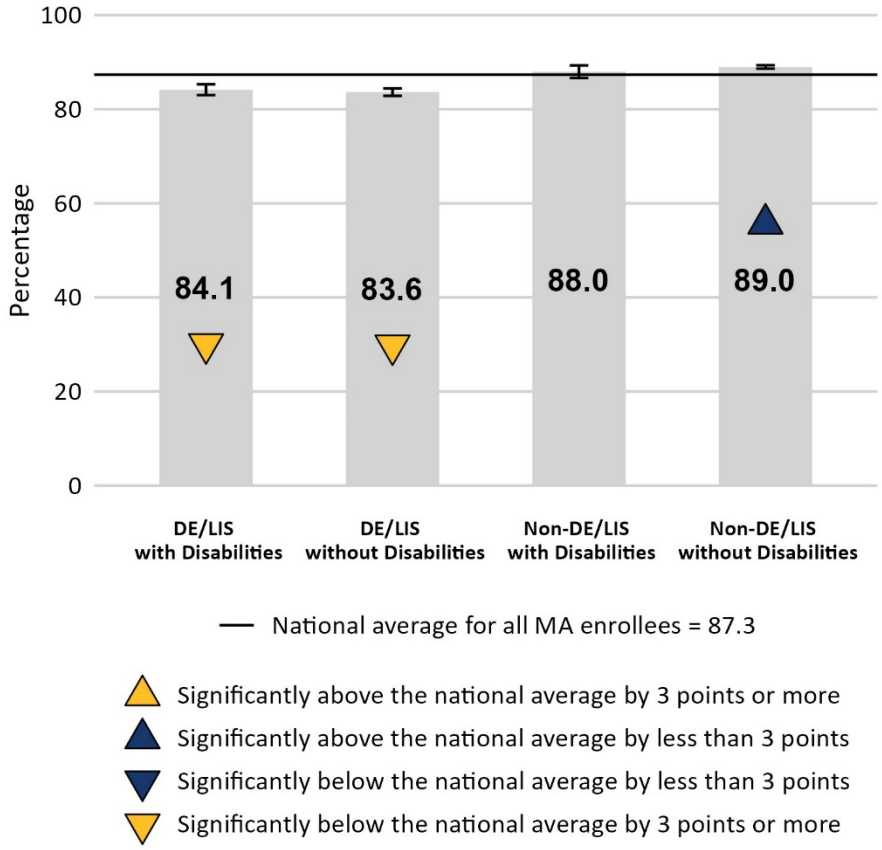
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth) was provided within 30 days of discharge, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

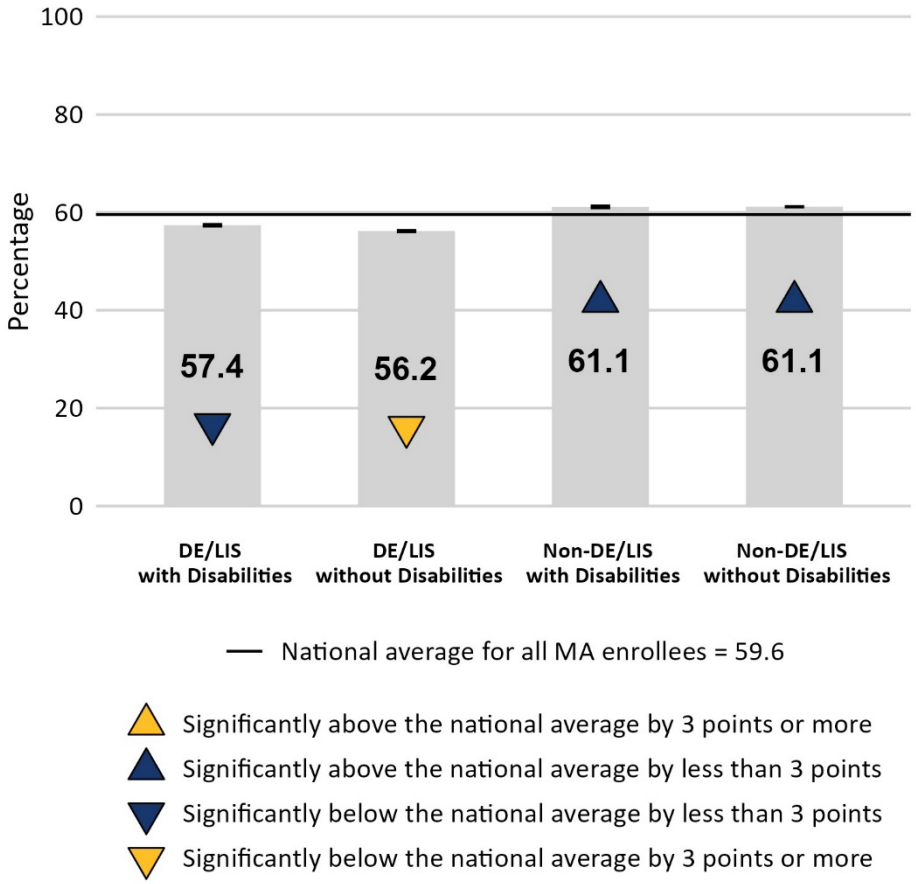
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions

Percentage of MA enrollees aged 65 years and older[†] with multiple high-risk chronic conditions[‡] who received follow-up care within seven days of an ED visit, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

[‡] Conditions include COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, AMI, atrial fibrillation, and stroke and transient ischemic attack.

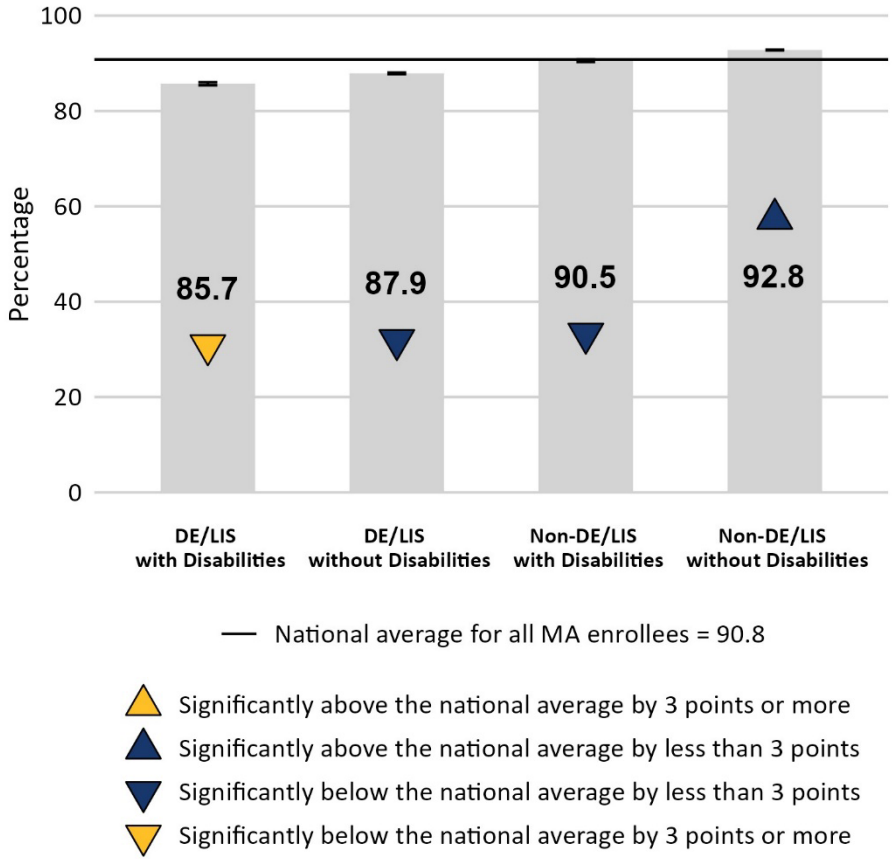
Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Overuse and Appropriate Use of Medication

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Chronic Renal Failure

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,[†] by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

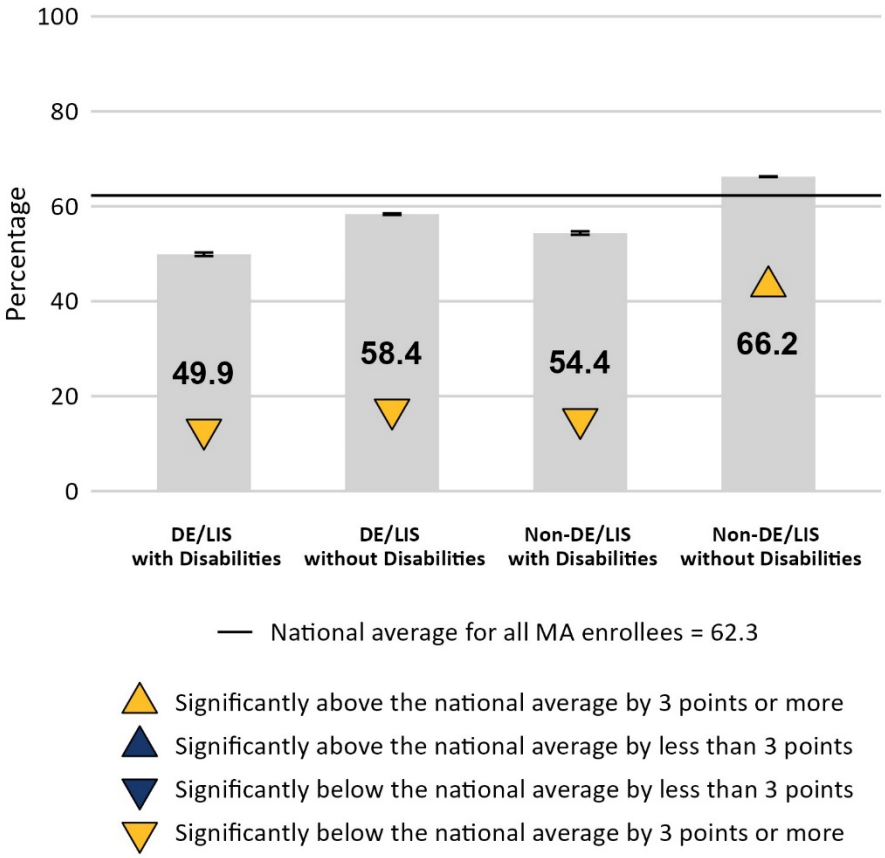
[†] This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) or nonaspirin NSAIDs.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

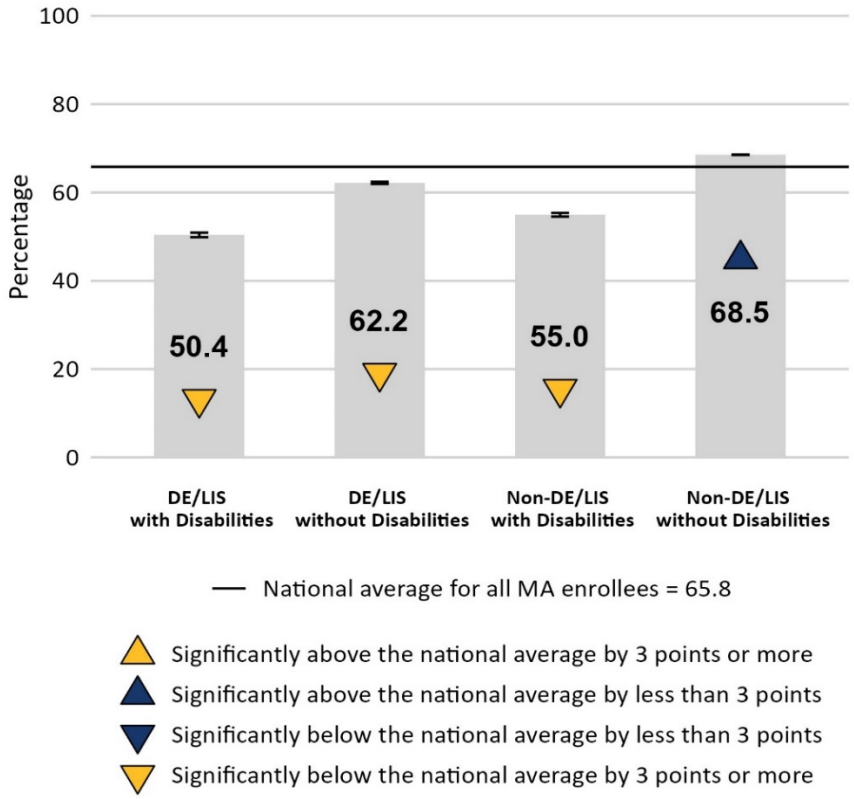
[†] This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,[†] by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

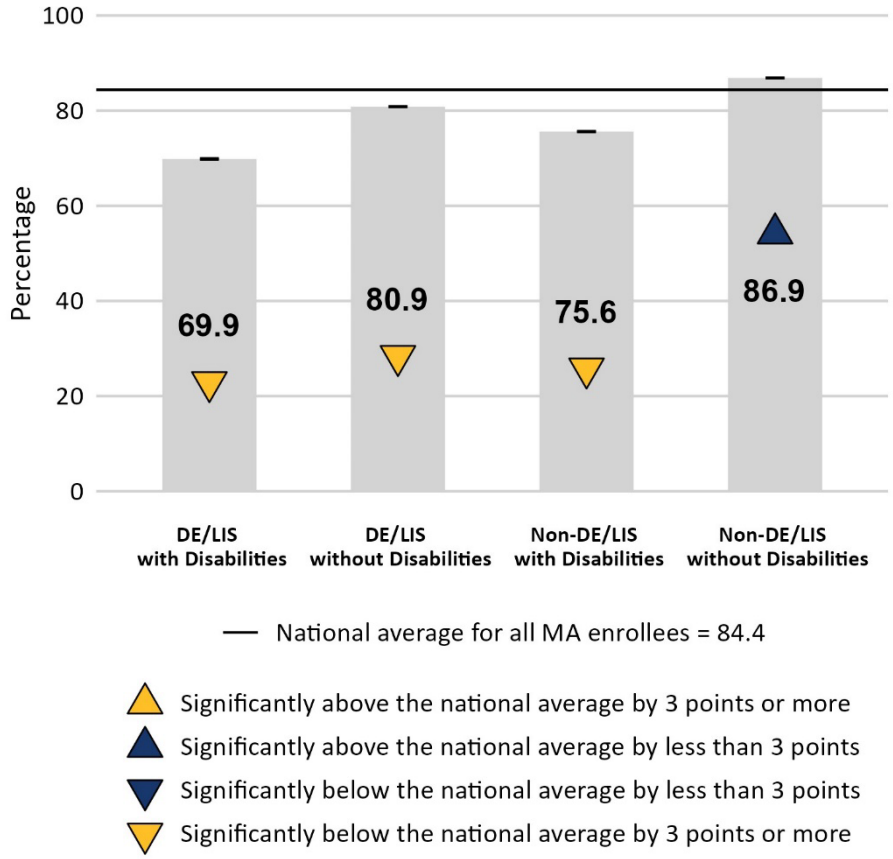
[†] This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Use of High-Risk Medications in Older Adults

Percentage of MA enrollees aged 65 years and older who were not prescribed two or more high-risk medications from the same drug class in the past year, by DE/LIS and disability status, Reporting Year 2022



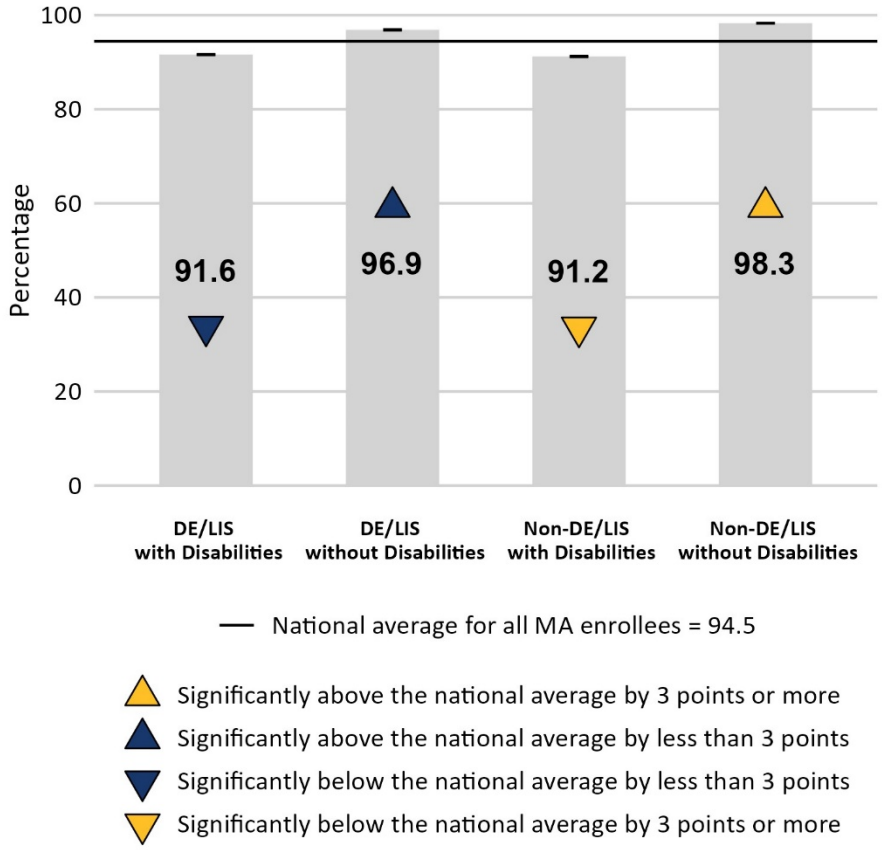
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of older adult DE/LIS MA enrollees with disabilities for whom use of high-risk medications was avoided was **below** the national average for all older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult DE/LIS MA enrollees without disabilities for whom use of high-risk medications was avoided was **below** the national average for all older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees with disabilities for whom use of high-risk medications was avoided was **below** the national average for all older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult non-DE/LIS MA enrollees without disabilities for whom use of high-risk medications was avoided was **above** the national average for all older adult MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage[†] for more than 14 days in the past year, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

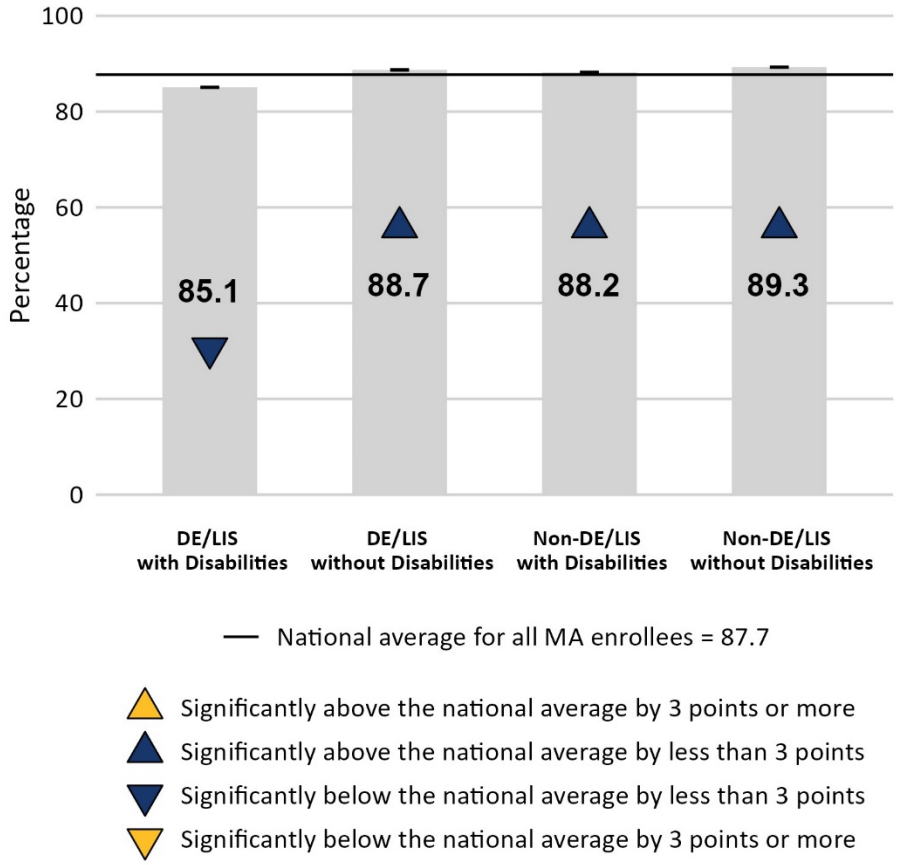
Disparities

- The percentage of DE/LIS MA enrollees with disabilities for whom use of opioids at a high dosage was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities for whom use of opioids at a high dosage was avoided was **below** the national average for all MA enrollees by more than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by more than 3 percentage points.

[†] Average morphine equivalent dose ≥ 90 mg.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by DE/LIS and disability status, Reporting Year 2022



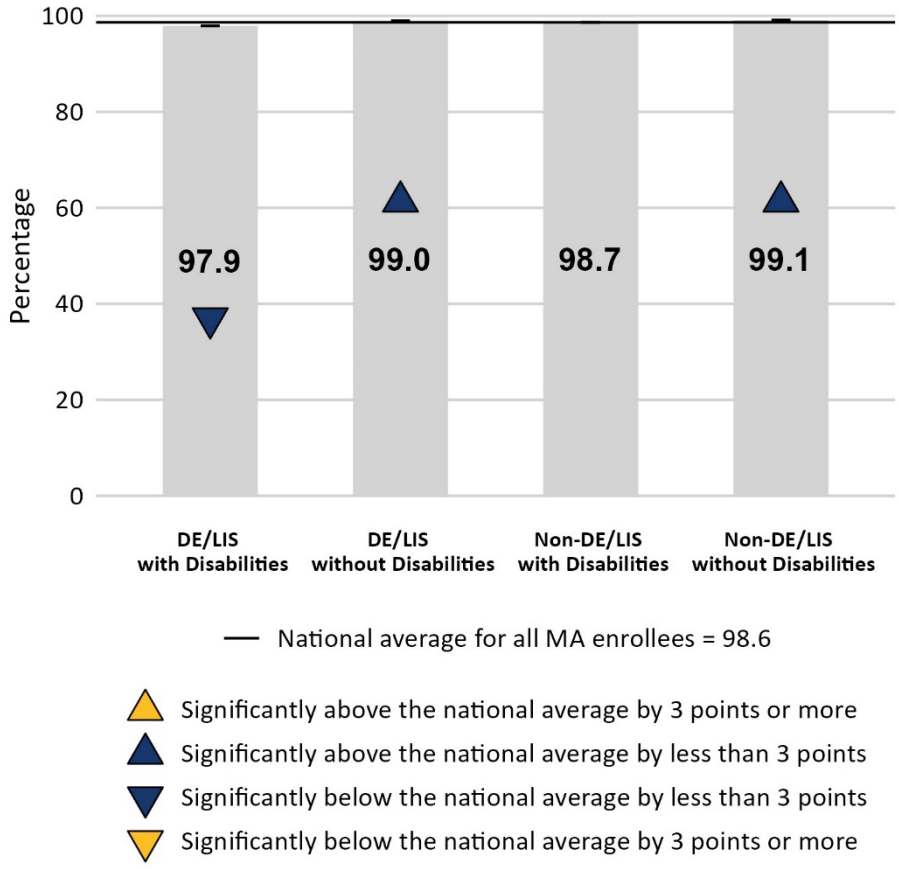
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities for whom use of opioids from multiple prescribers was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

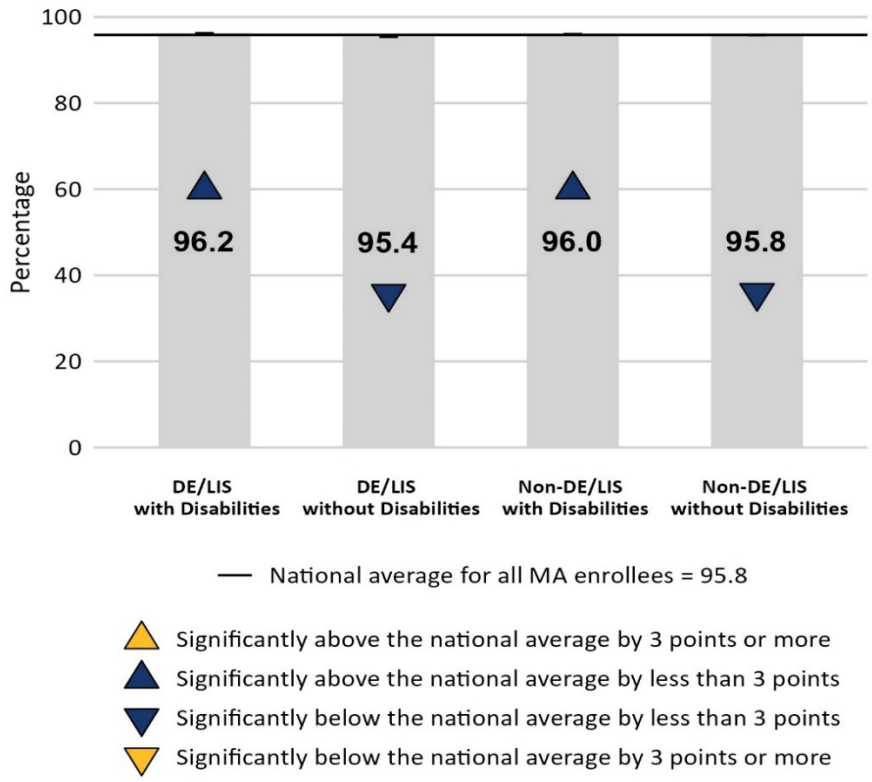
Disparities

- The percentage of DE/LIS MA enrollees with disabilities for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities for whom use of opioids from multiple pharmacies was avoided was **similar to** the national average for all MA enrollees.
- The percentage of non-DE/LIS MA enrollees without disabilities for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.

Access to and Availability of Care

Older Adults' Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 20 years and older who had an ambulatory or preventive care visit in the past year, by DE/LIS and disability status, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Disparities

- The percentage of DE/LIS MA enrollees with disabilities who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of DE/LIS MA enrollees without disabilities who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees with disabilities who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of non-DE/LIS MA enrollees without disabilities who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.[†]

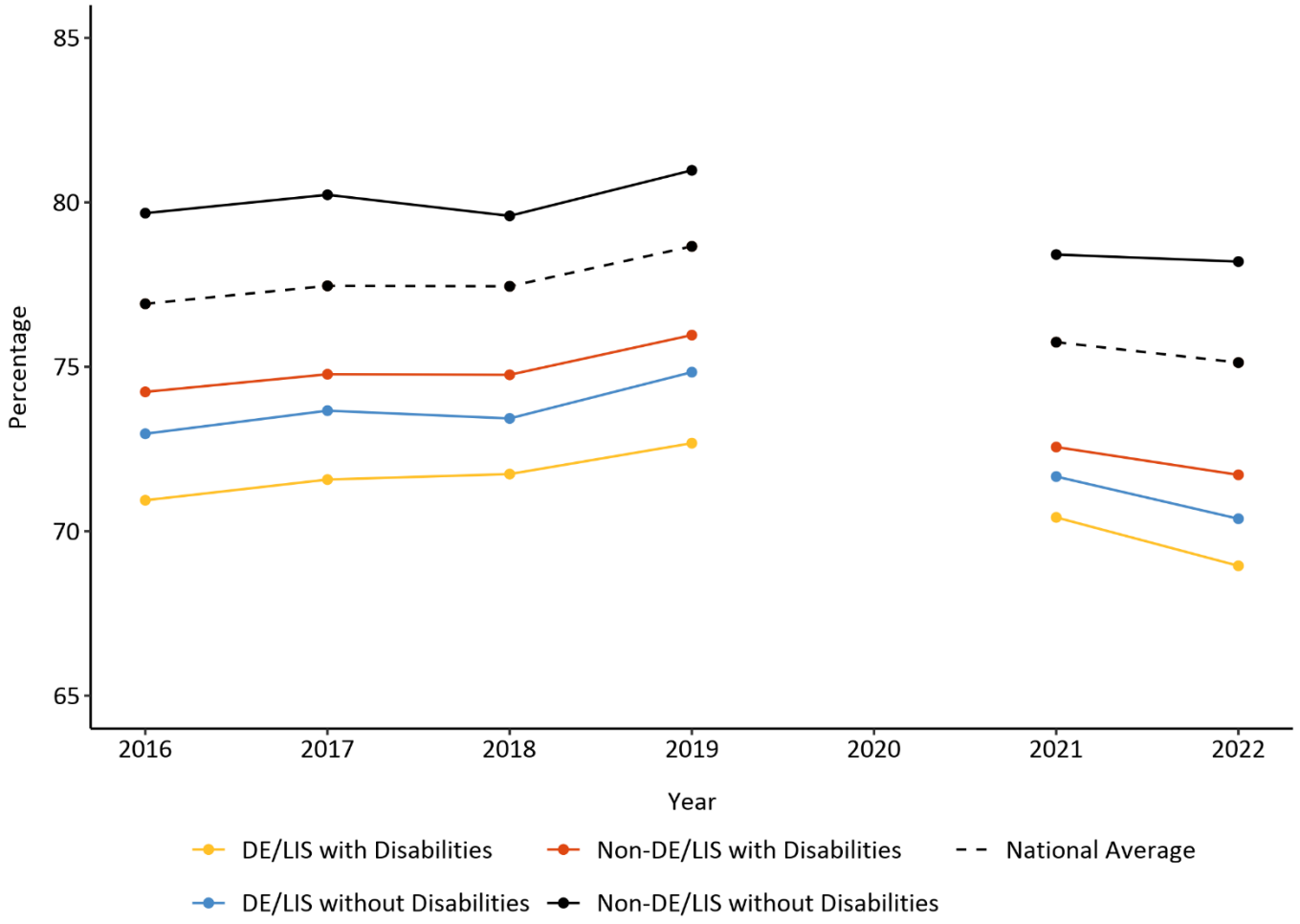
[†] Prior to rounding.

APPENDIX B

Trends in Disparities: 2016 to 2022

Breast Cancer Screening, 2016–2022

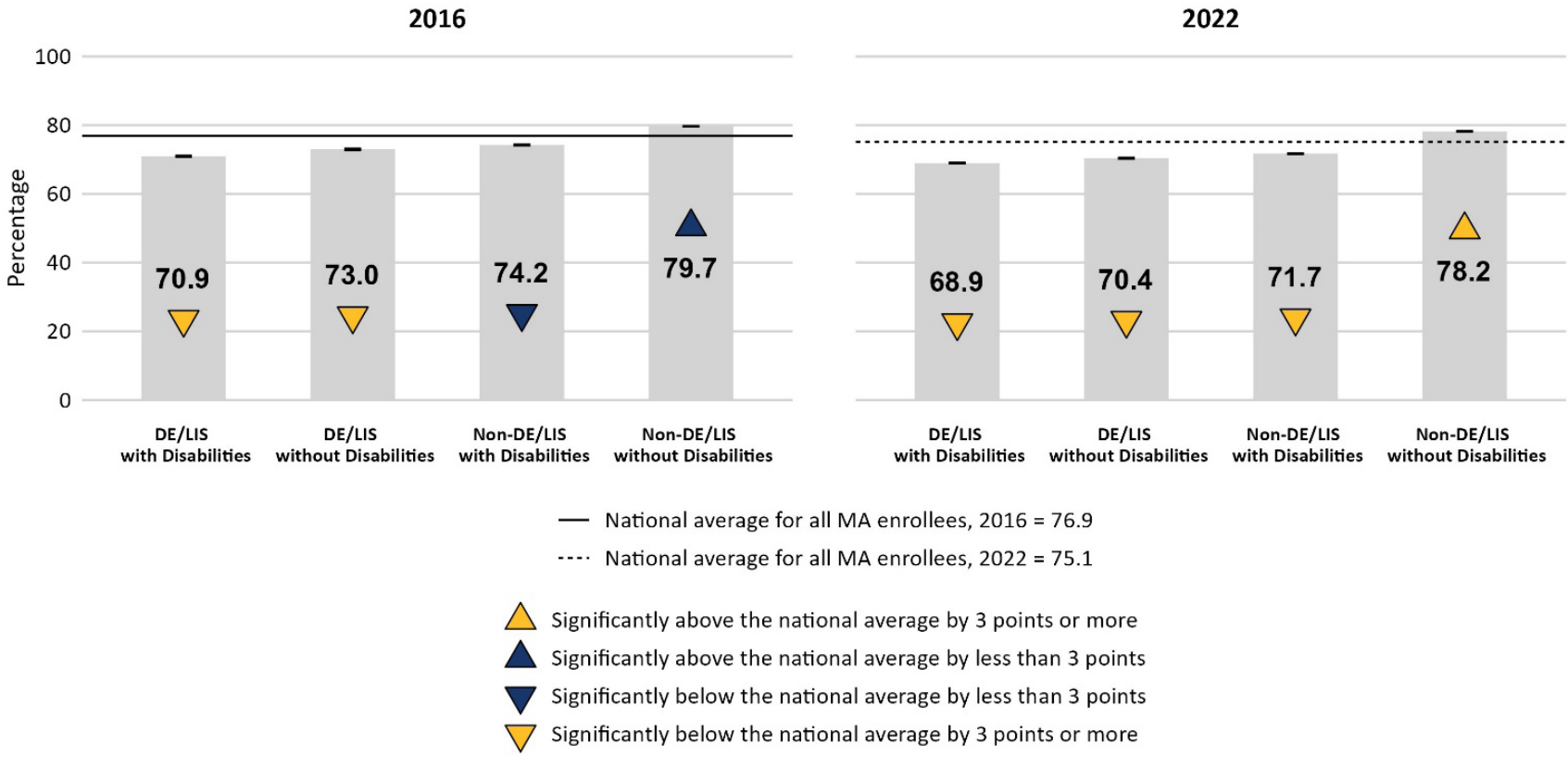
Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Breast Cancer Screening, 2016 and 2022

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Breast Cancer Screening, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016 to 2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	70.9 ▽	68.9 ▽	−2.0	Remained about the same
DE/LIS without disabilities	73.0 ▽	70.4 ▽	−2.6	Remained about the same
Non-DE/LIS with disabilities	74.2 ▼	71.7 ▽	−2.5	Remained about the same
Non-DE/LIS without disabilities	79.7 ▲	78.2 △	−1.5	Remained about the same
National average	76.9	75.1	−1.8	N/A

△ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

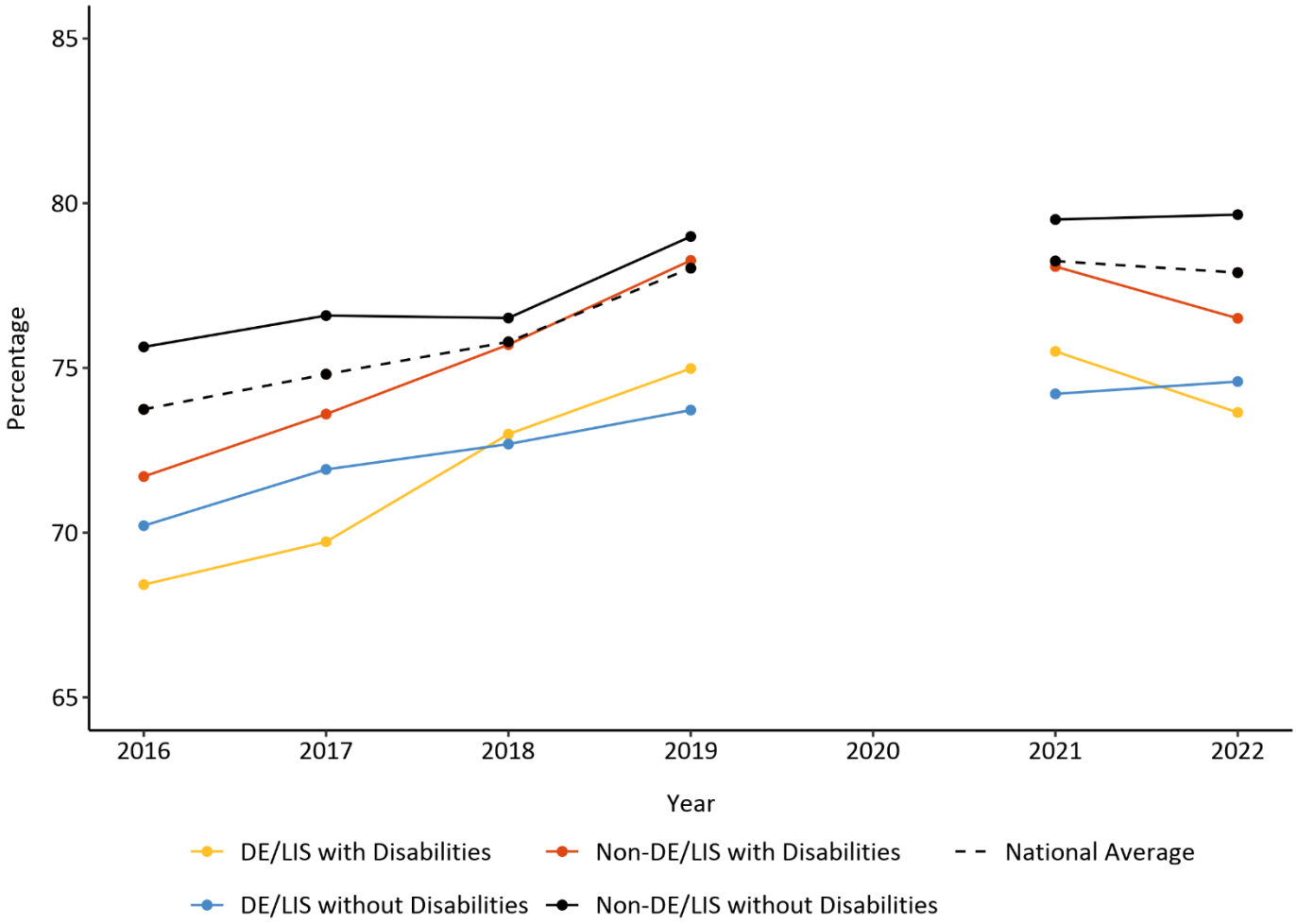
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores decreased for all groups from 2016 to 2022 in a manner that was comparable to the national average. As a result, gaps relative to the national average for DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, and non-DE/LIS MA enrollees with disabilities remained about the same in 2022 as in 2016, as did the advantage of non-DE/LIS MA enrollees without disabilities.

Colorectal Cancer Screening, 2016–2022

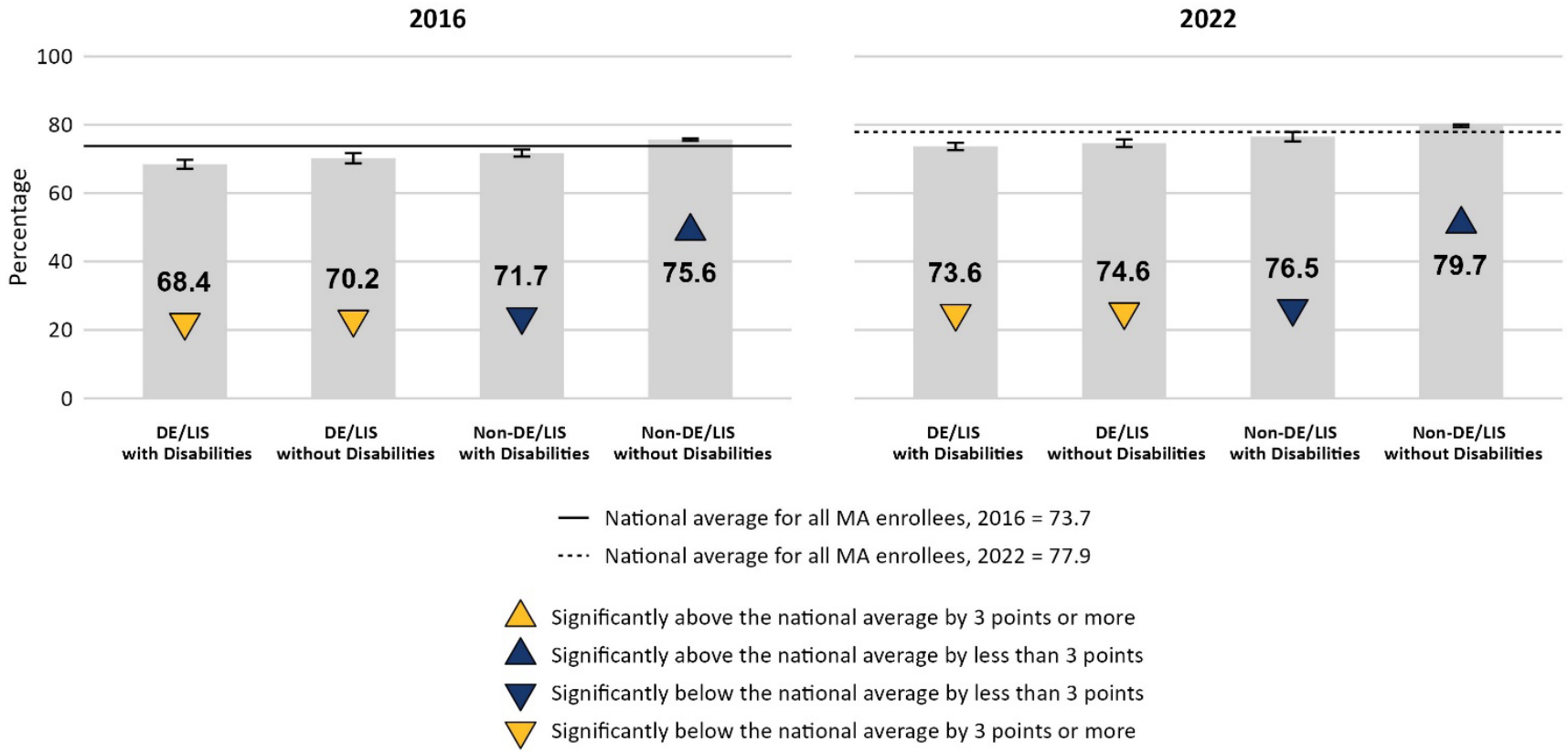
Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Colorectal Cancer Screening, 2016 and 2022

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Colorectal Cancer Screening, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	68.4 ▽	73.6 ▽	+5.2	Remained about the same
DE/LIS without disabilities	70.2 ▽	74.6 ▽	+4.4	Remained about the same
Non-DE/LIS with disabilities	71.7 ▼	76.5 ▼	+4.8	Remained about the same
Non-DE/LIS without disabilities	75.6 ▲	79.7 ▲	+4.0	Remained about the same
National average	73.7	77.9	+4.2	N/A

△ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

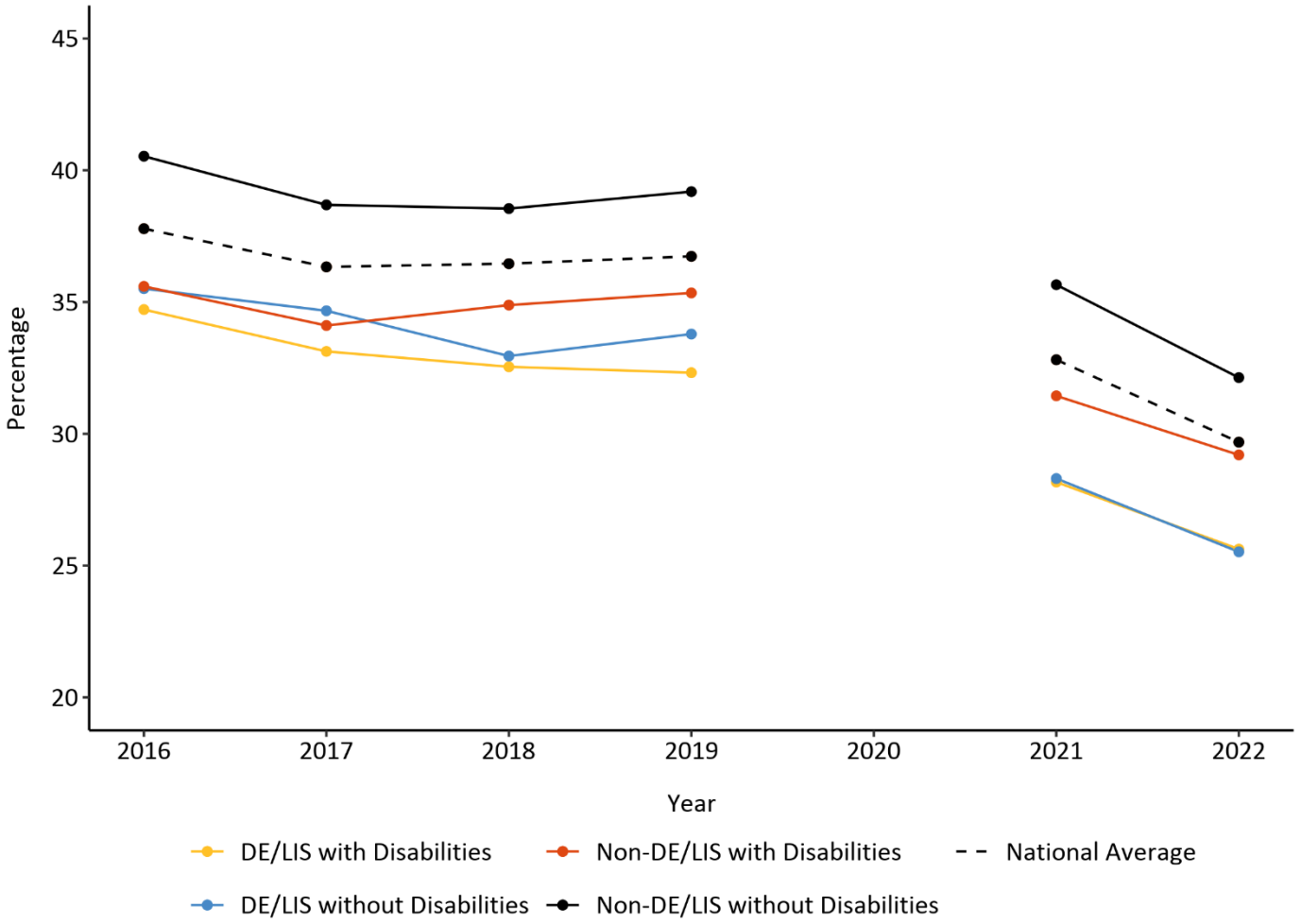
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022 in a manner that was comparable to the national average. As a result, gaps relative to the national average for DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, and non-DE/LIS MA enrollees with disabilities remained about the same in 2022 as in 2016, as did the advantage of non-DE/LIS MA enrollees without disabilities.

Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD), 2016–2022

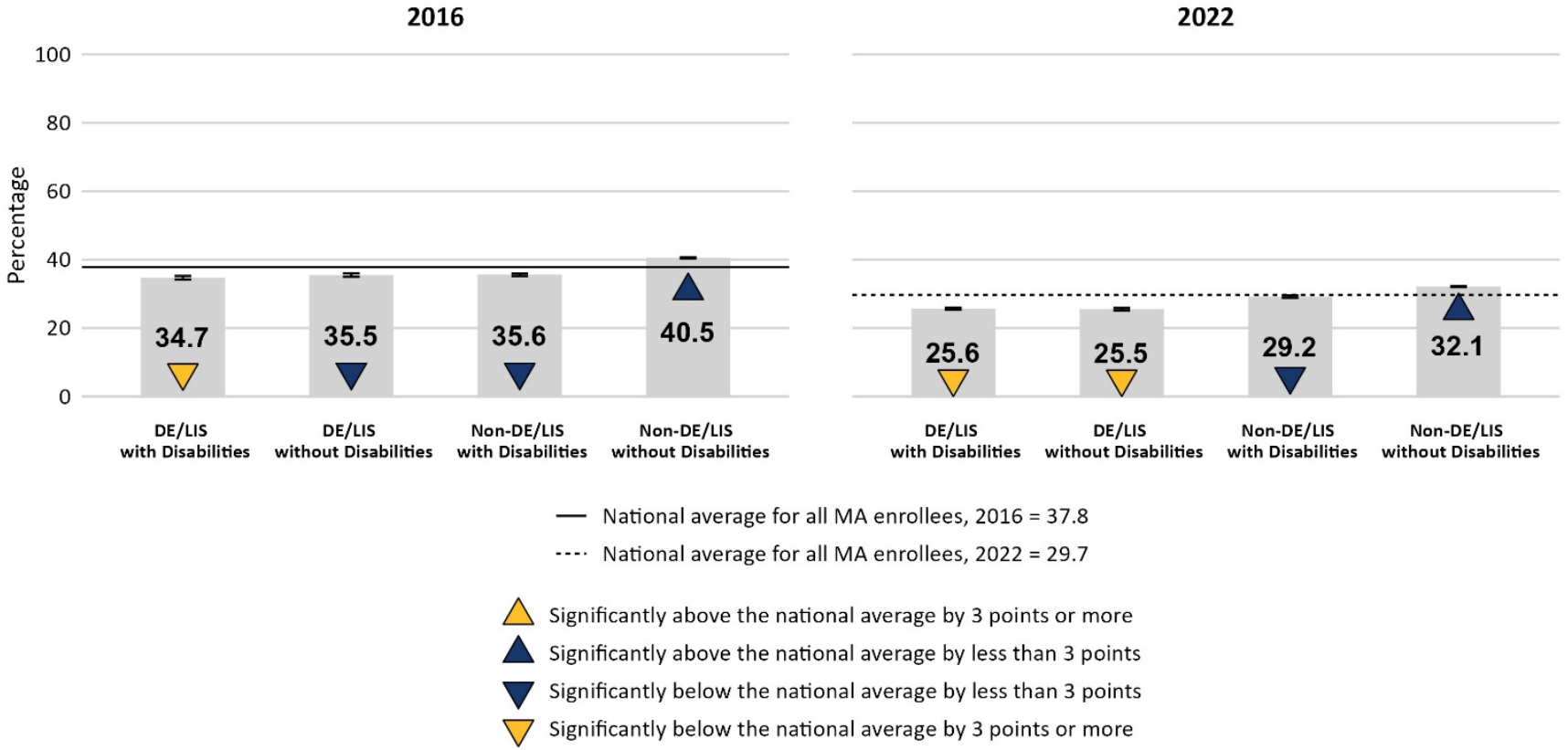
Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD), 2016 and 2022

Percentage of MA 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 DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD), 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	34.7 ▽	25.6 ▽	−9.1	Remained about the same
DE/LIS without disabilities	35.5 ▼	25.5 ▽	−10.0	-1.9
Non-DE/LIS with disabilities	35.6 ▼	29.2 ▼	−6.4	+1.7
Non-DE/LIS without disabilities	40.5 ▲	32.1 ▲	−8.4	Remained about the same
National average	37.8	29.7	−8.1	N/A

△ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

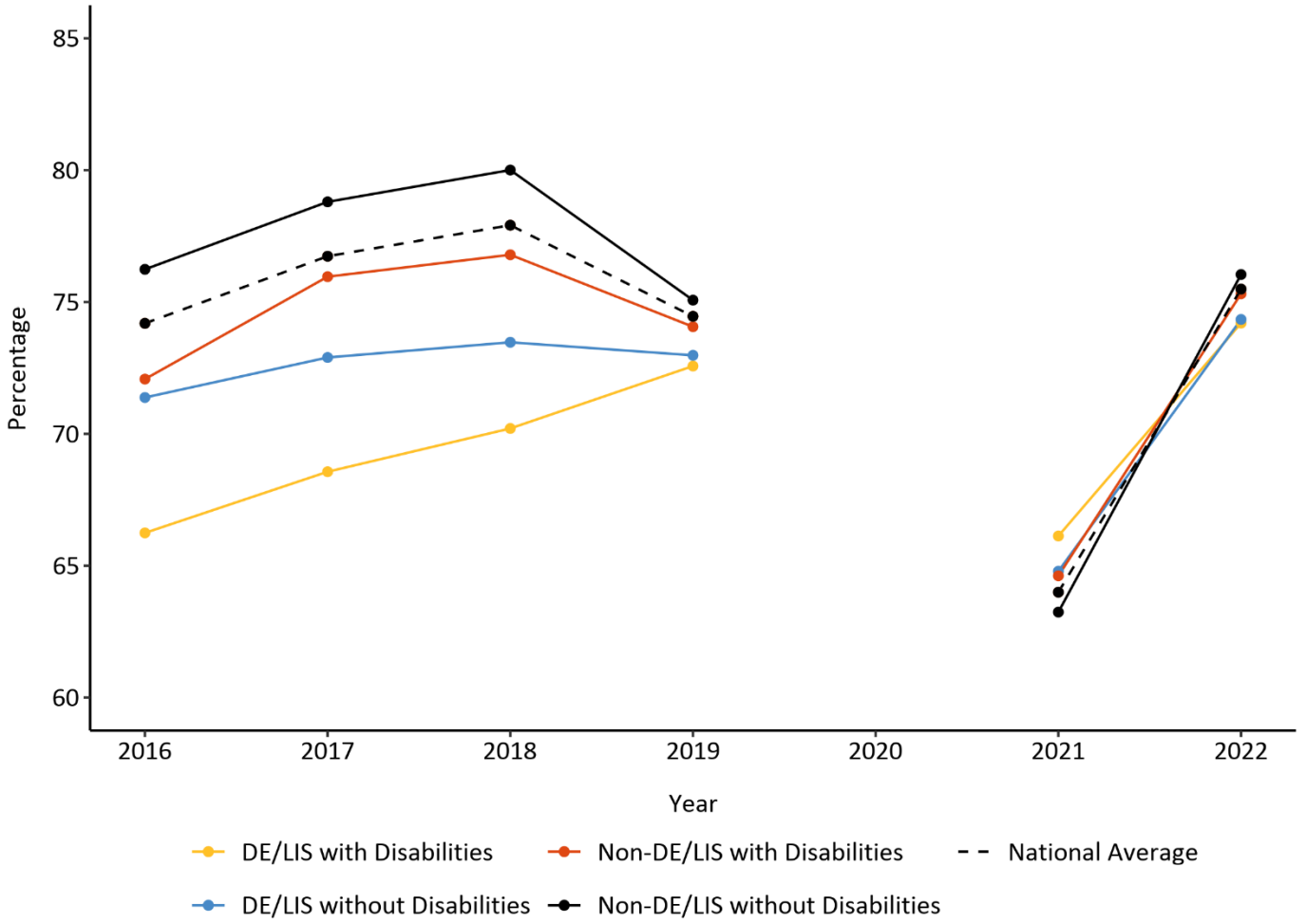
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, “remained about the same” is indicated.

Overall Summary: Scores decreased for all groups from 2016 to 2022. For DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees without disabilities, the decrease was comparable to the national average. As a result, an initial gap relative to the national average for DE/LIS MA enrollees with disabilities remained about the same in 2022, as did an initial advantage for non-DE/LIS MA enrollees without disabilities. For DE/LIS MA enrollees without disabilities, the decrease was greater than the national average, widening an initial gap for that group. For non-DE/LIS MA enrollees with disabilities, the decrease was less than the national average, shrinking an initial gap for that group.

Controlling High Blood Pressure, 2016–2022

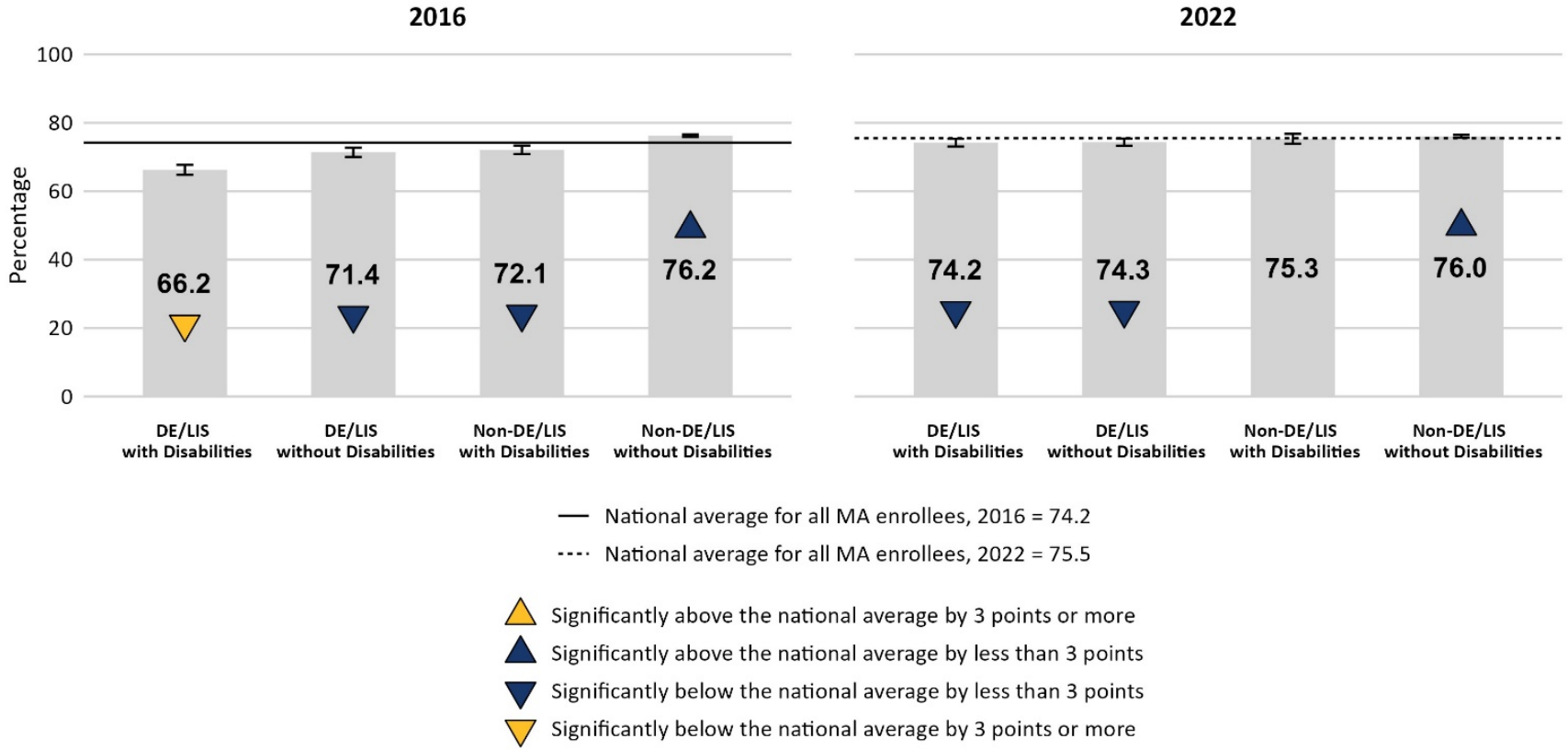
Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled during the past year, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Controlling High Blood Pressure, 2016 and 2022

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

[†] Less than 140/90 for patients 18 to 59 years of age and for patients 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for patients 60 to 85 years of age without a diagnosis of diabetes.

Controlling High Blood Pressure, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	66.2 ▼	74.2 ▼	+8.0	+6.7
DE/LIS without disabilities	71.4 ▼	74.3 ▼	+3.0	Remained about the same
Non-DE/LIS with disabilities	72.1 ▼	75.3	+3.2	+1.9
Non-DE/LIS without disabilities	76.2 ▲	76.0 ▲	Remained about the same	−1.5
National average	74.2	75.5	+1.3	N/A

▲ Significantly above the national average by 3 points or more

– ▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

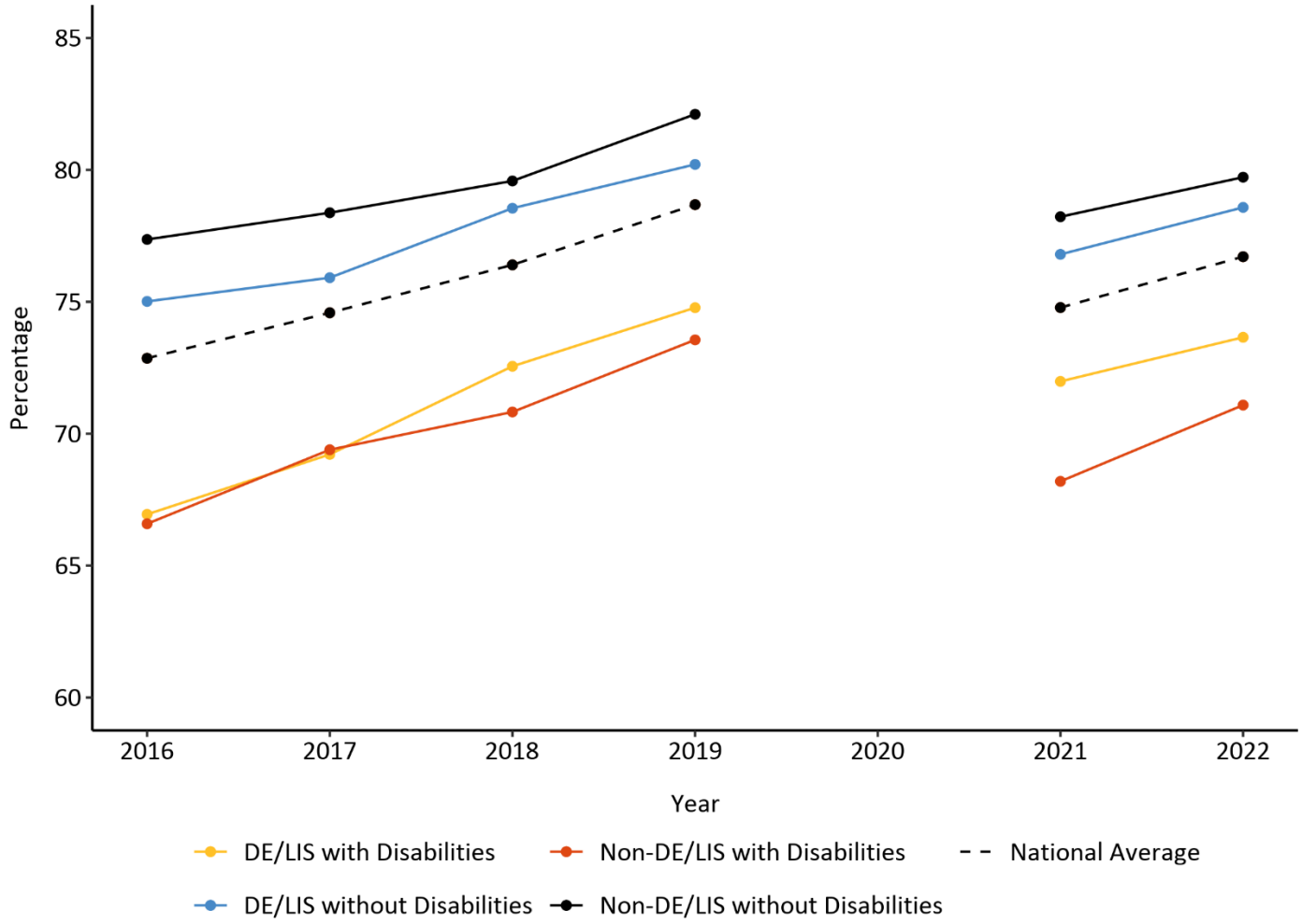
▼ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: For DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees with disabilities, scores increased from 2016 to 2022 in a way that was greater than the national average, shrinking initial gaps for these groups relative to the national average. The score for DE/LIS MA enrollees without disabilities also increased but in a way that was comparable to the national average, maintaining an initial gap for that group. The score for non-DE/LIS MA enrollees without disabilities was about the same in 2022 as in 2016, shrinking an initial advantage for that group.

Diabetes Care—Eye Exam, 2016–2022

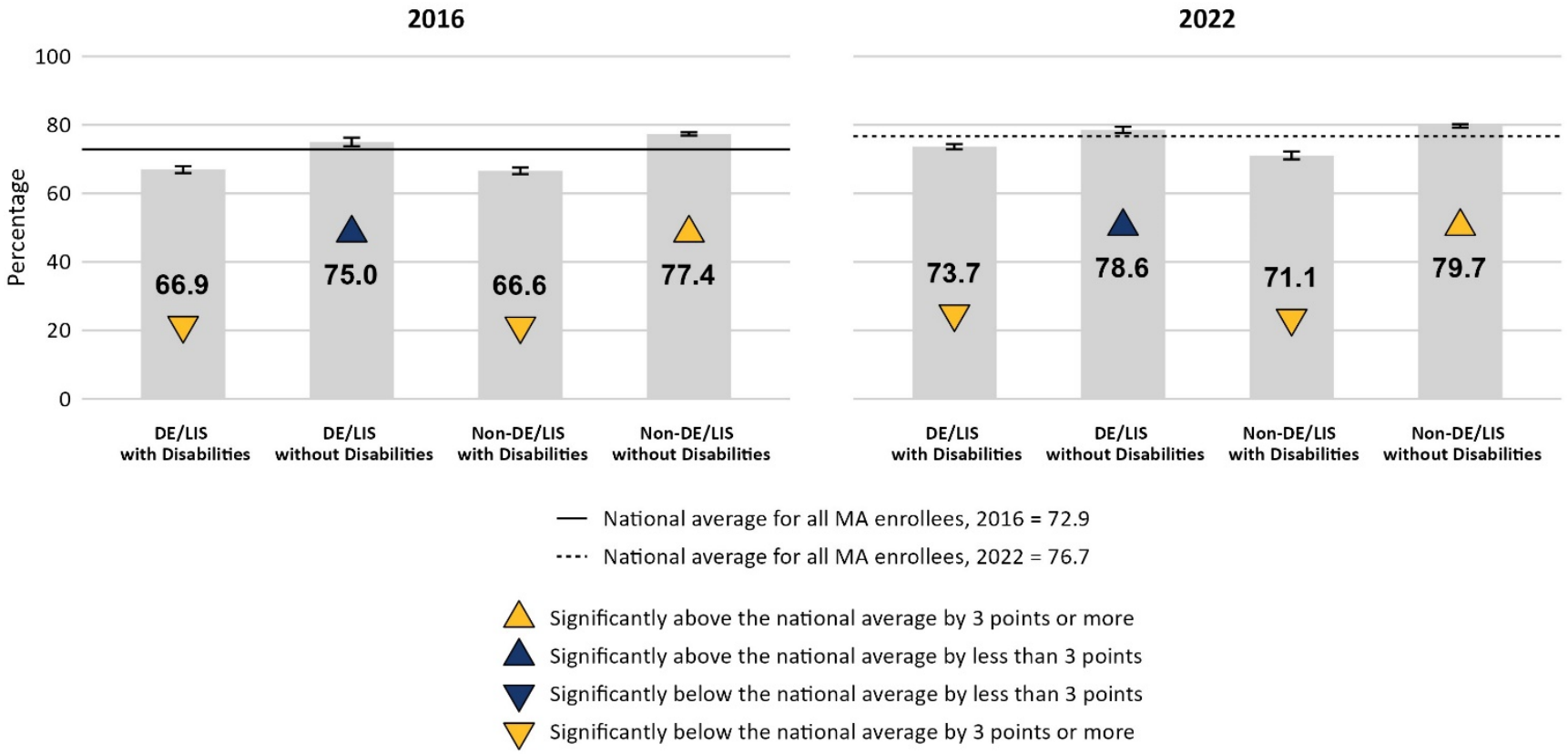
Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Diabetes Care—Eye Exam, 2016 and 2022

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Diabetes Care—Eye Exam, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	66.9 ▼	73.7 ▼	+6.7	+2.9
DE/LIS without disabilities	75.0 ▲	78.6 ▲	+3.6	Remained about the same
Non-DE/LIS with disabilities	66.6 ▼	71.1 ▼	+4.5	Remained about the same
Non-DE/LIS without disabilities	77.4 △	79.7 △	+2.4	−1.5
National average	72.9	76.7	+3.9	N/A

△ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

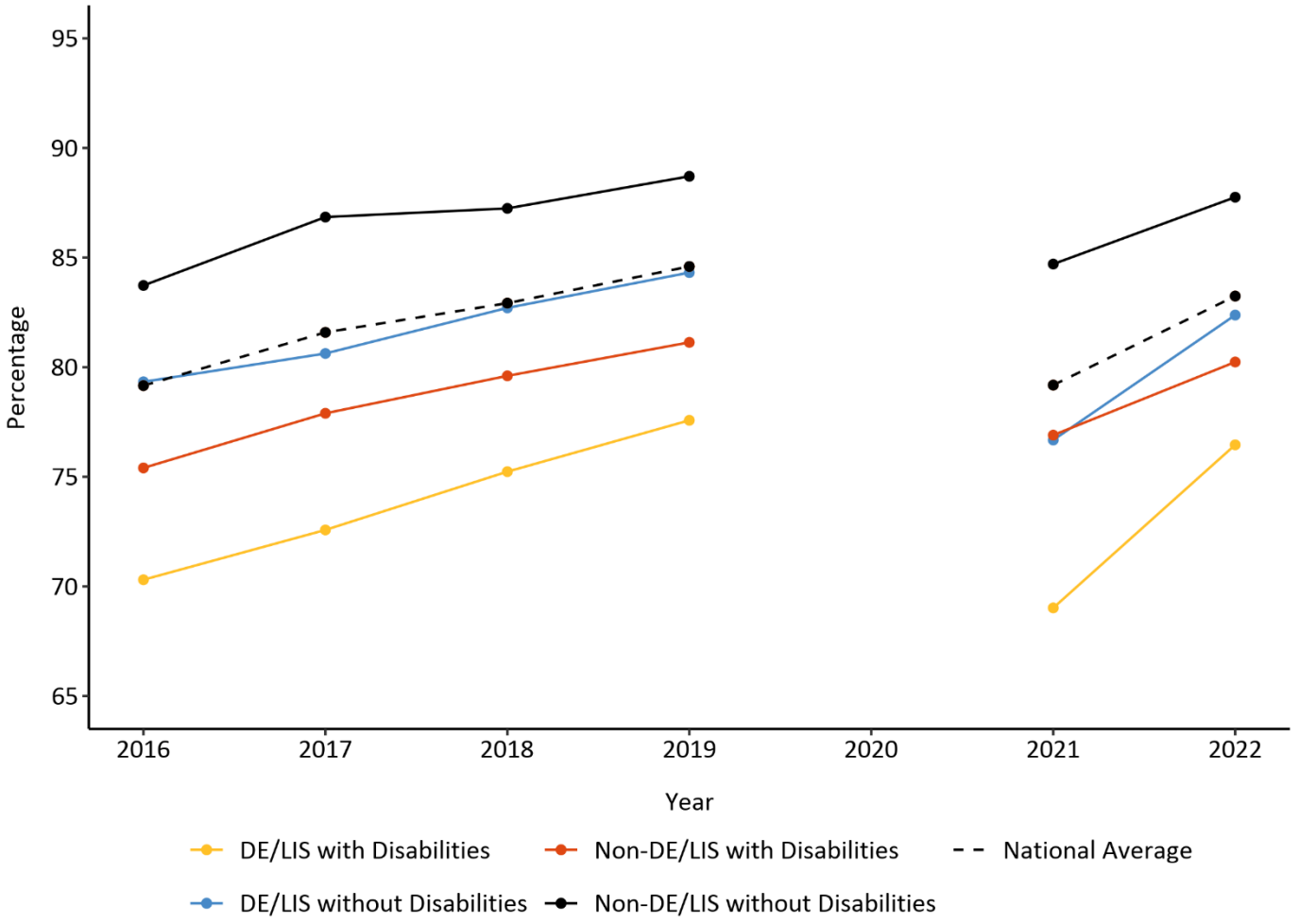
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022. For DE/LIS MA enrollees without disabilities and non-DE/LIS MA enrollees with disabilities, the increase was comparable to the national average. As a result, an initial advantage relative to the national average for DE/LIS MA enrollees without disabilities remained about the same in 2022, as did an initial gap for non-DE/LIS MA enrollees with disabilities. For DE/LIS MA enrollees with disabilities, the increase was greater than the national average, shrinking an initial gap for that group. For non-DE/LIS MA enrollees without disabilities, the increase was less than the national average, shrinking an initial gap for that group.

Diabetes Care—Blood Sugar Controlled, 2016–2022

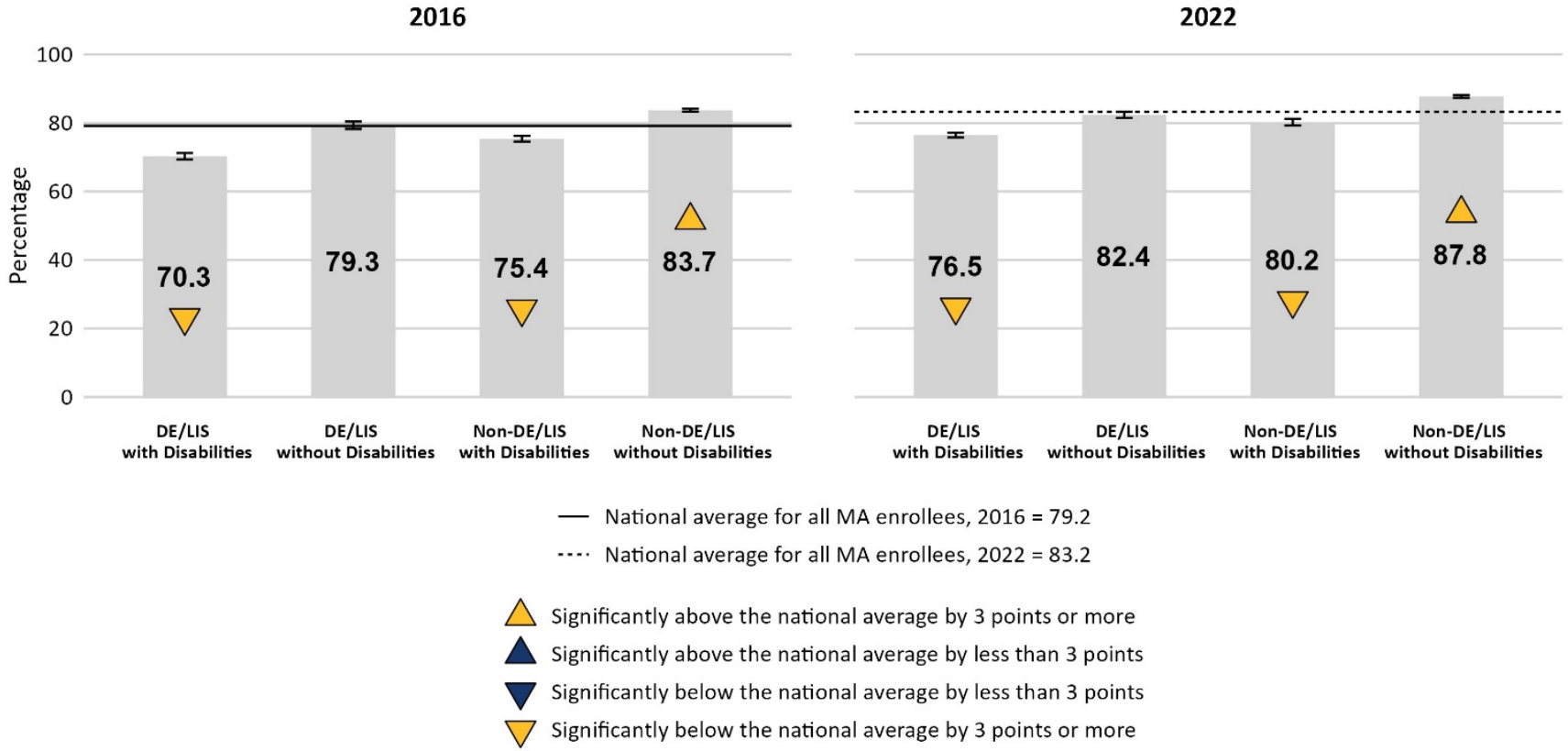
Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Diabetes Care—Blood Sugar Controlled, 2016 and 2022

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Diabetes Care—Blood Sugar Controlled, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	70.3 ▽	76.5 ▽	+6.2	Remained about the same
DE/LIS without disabilities	79.3	82.4 ▼	+3.0	Remained about the same
Non-DE/LIS with disabilities	75.4 ▽	80.2 ▽	+4.8	Remained about the same
Non-DE/LIS without disabilities	83.7 △	87.8 △	+4.0	Remained about the same
National average	79.2	83.2	+4.1	N/A

△ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

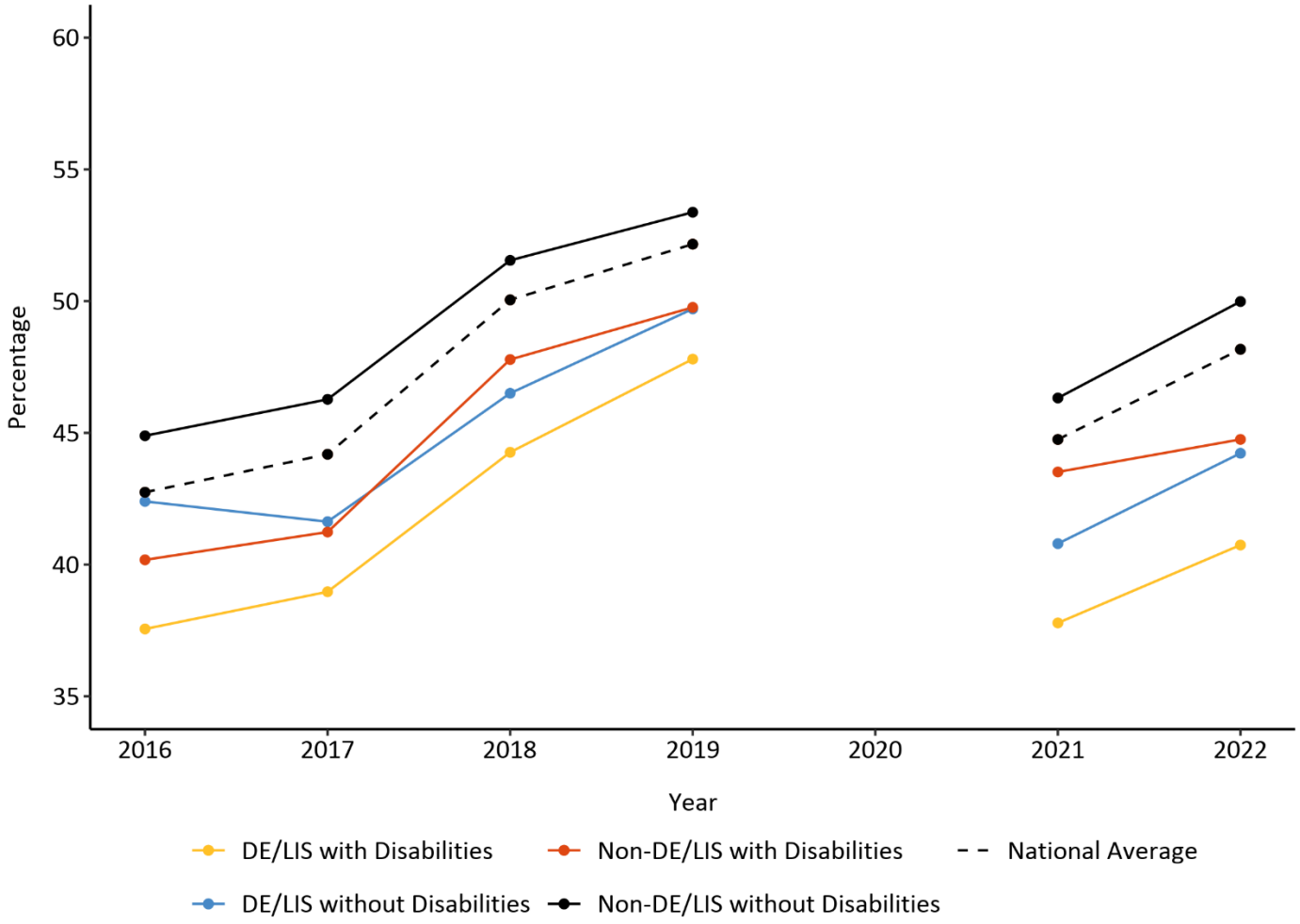
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022 in a manner that was comparable to the national average. As a result, gaps relative to the national average for DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees with disabilities remained about the same in 2022 as in 2016, as did the advantage of non-DE/LIS MA enrollees without disabilities.

Osteoporosis Management in Women Who Had a Fracture, 2016–2022

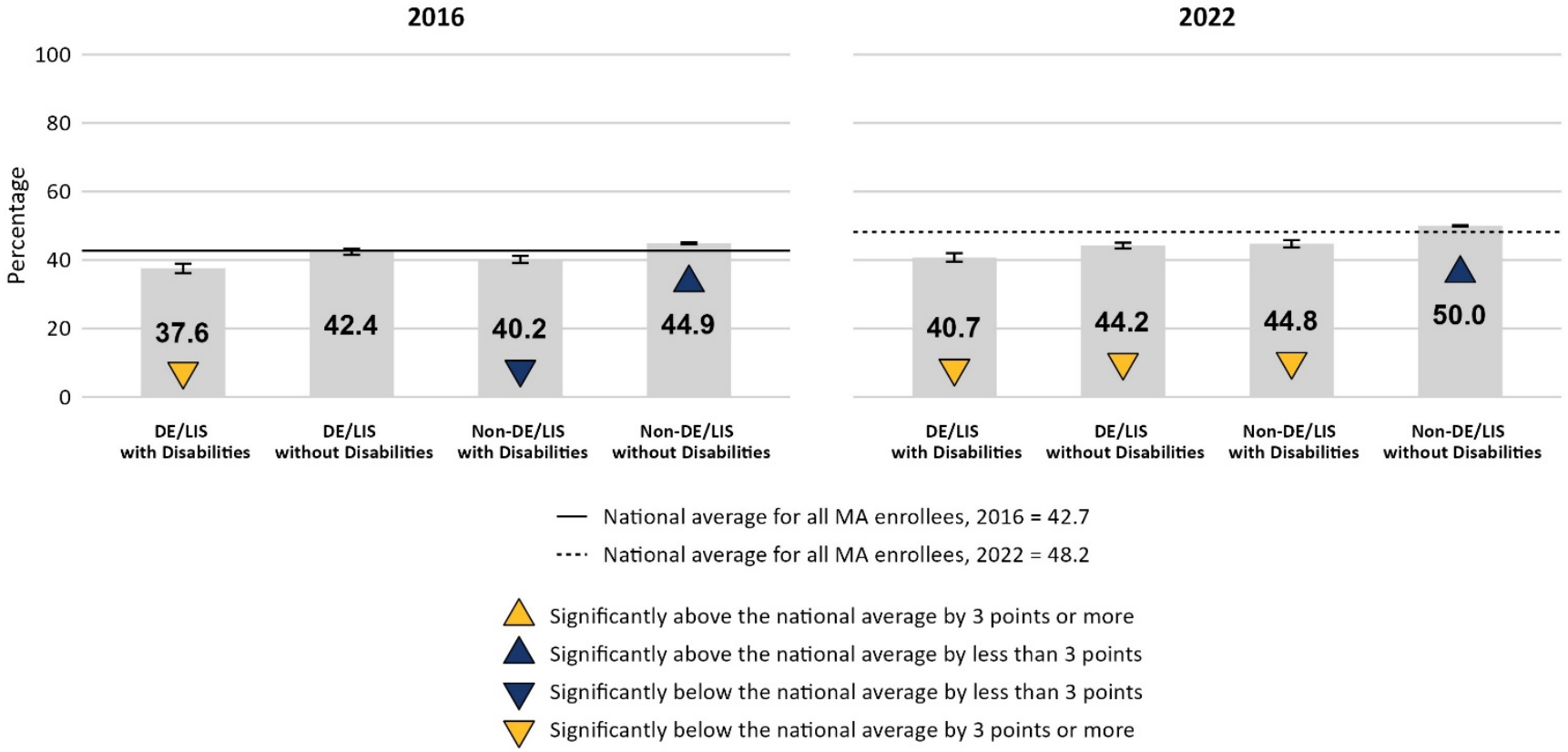
Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Osteoporosis Management in Women Who Had a Fracture, 2016 and 2022

Percentage of female MA enrollees aged 67 to 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 six months after the fracture, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Osteoporosis Management in Women Who Had a Fracture, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	37.6 ▽	40.7 ▽	+3.2	−2.2
DE/LIS without disabilities	42.4	44.2 ▽	+1.8	−3.6
Non-DE/LIS with disabilities	40.2 ▼	44.8 ▽	+4.6	Remained about the same
Non-DE/LIS without disabilities	44.9 ▲	50.0 ▲	+5.1	Remained about the same
National average	42.7	48.2	+5.4	N/A

– △ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

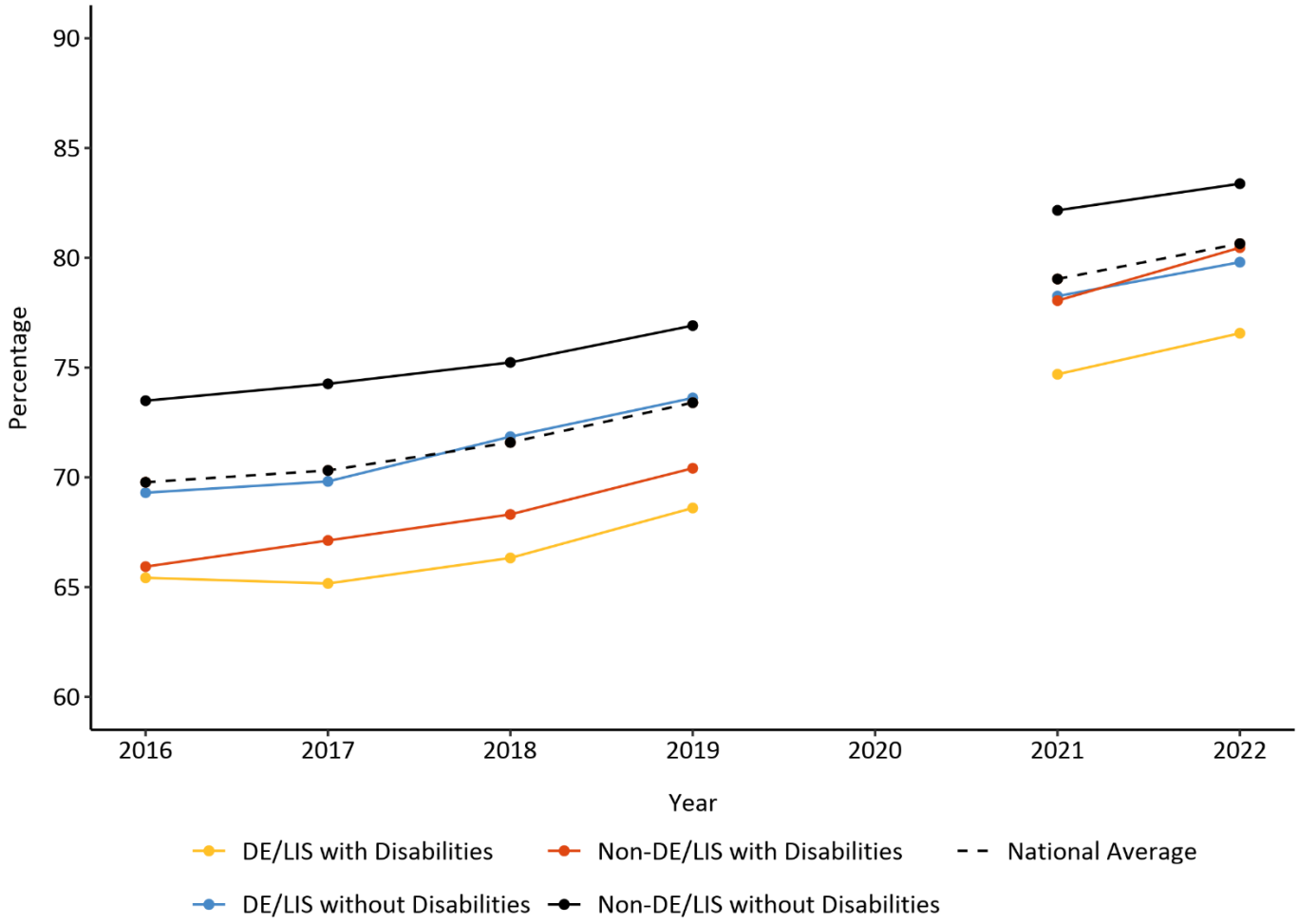
▽ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022. For non-DE/LIS MA enrollees with disabilities and non-DE/LIS MA enrollees without disabilities, the increase was comparable to the national average. As a result, an initial gap relative to the national average for non-DE/LIS MA enrollees with disabilities remained about the same in 2022, as did an initial advantage for non-DE/LIS MA enrollees without disabilities. For DE/LIS MA enrollees with disabilities and DE/LIS MA enrollees without disabilities, the increase was less than the national average, widening an initial gap for DE/LIS MA enrollees with disabilities and creating a gap for DE/LIS MA enrollees without disabilities.

Antidepressant Medication Management—Acute Phase Treatment, 2016–2022

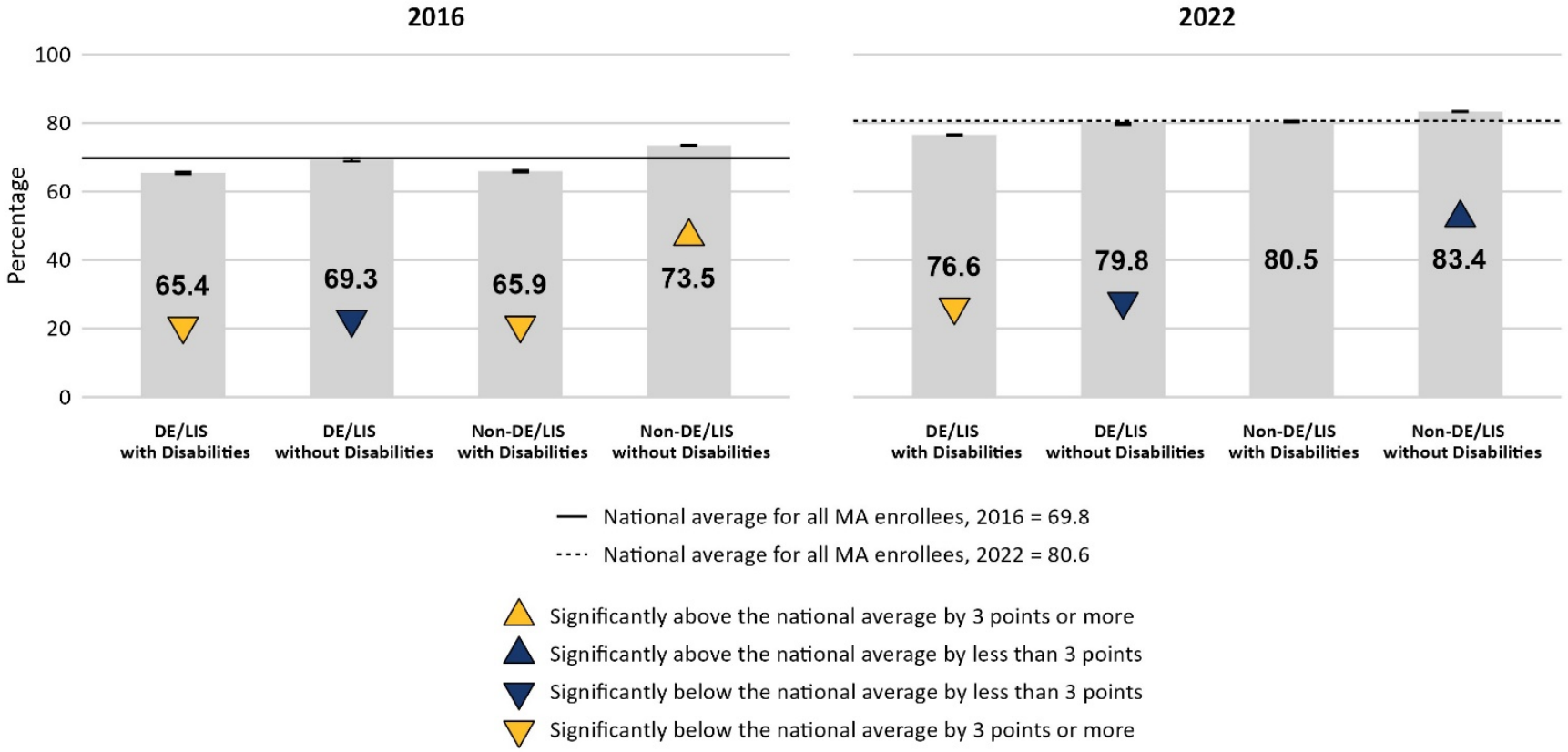
Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Antidepressant Medication Management—Acute Phase Treatment, 2016 and 2022

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

Antidepressant Medication Management—Acute Phase, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	65.4 ▼	76.6 ▼	+11.1	Remained about the same
DE/LIS without disabilities	69.3 ▼	79.8 ▼	+10.5	Remained about the same
Non-DE/LIS with disabilities	65.9 ▼	80.5	+14.5	+3.7
Non-DE/LIS without disabilities	73.5 ▲	83.4 ▲	+9.9	Remained about the same
National average	69.8	80.6	+10.9	N/A

▲ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

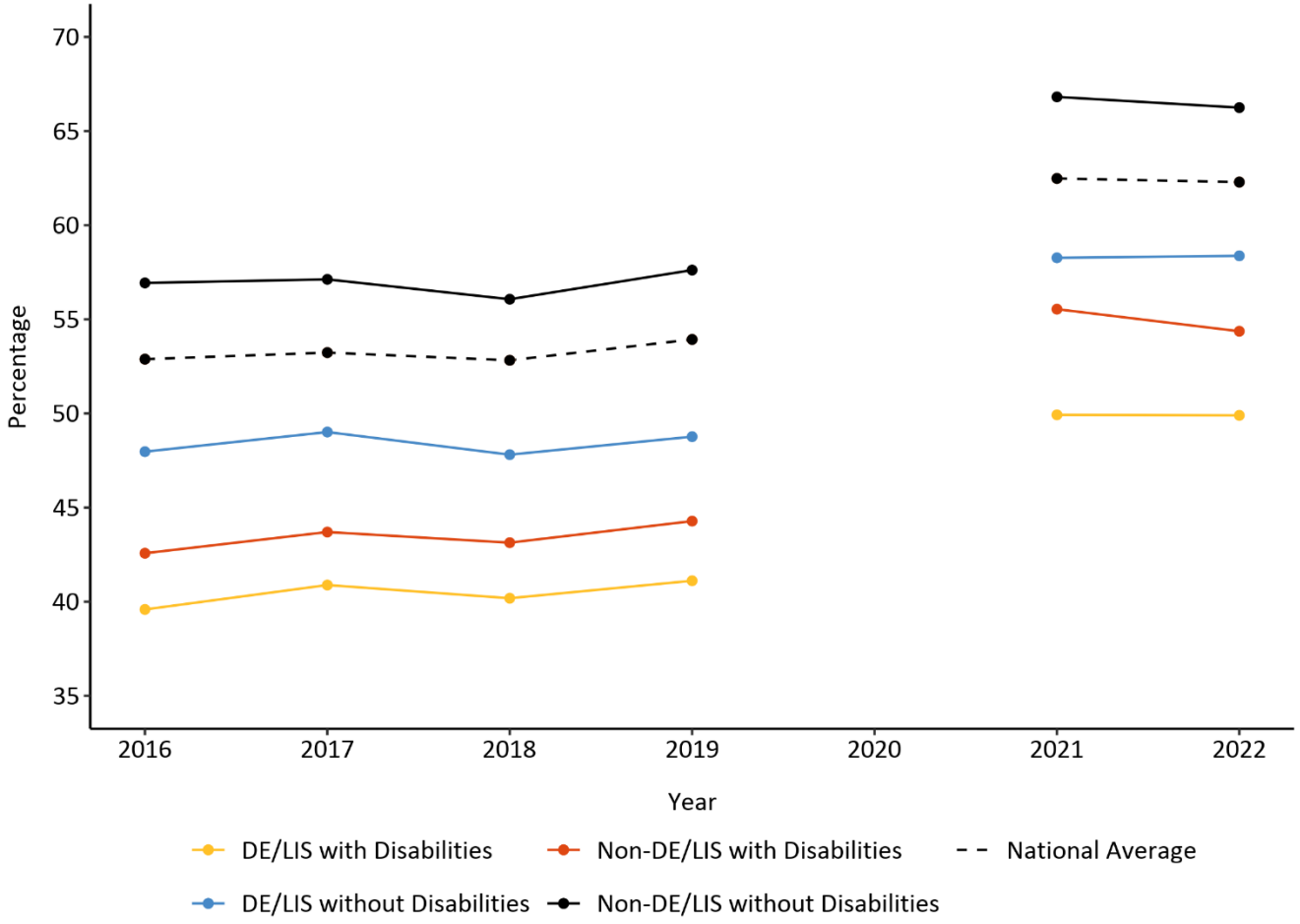
▼ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022. For DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, and non-DE/LIS MA enrollees without disabilities, the increase was comparable to the national average. As a result, initial gaps relative to the national average for DE/LIS MA enrollees with and without disabilities remained about the same in 2022, as did an initial advantage for non-DE/LIS MA enrollees without disabilities. For non-DE/LIS MA enrollees with disabilities, the increase was greater than the national average, eliminating an initial gap for that group.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia, 2016–2022

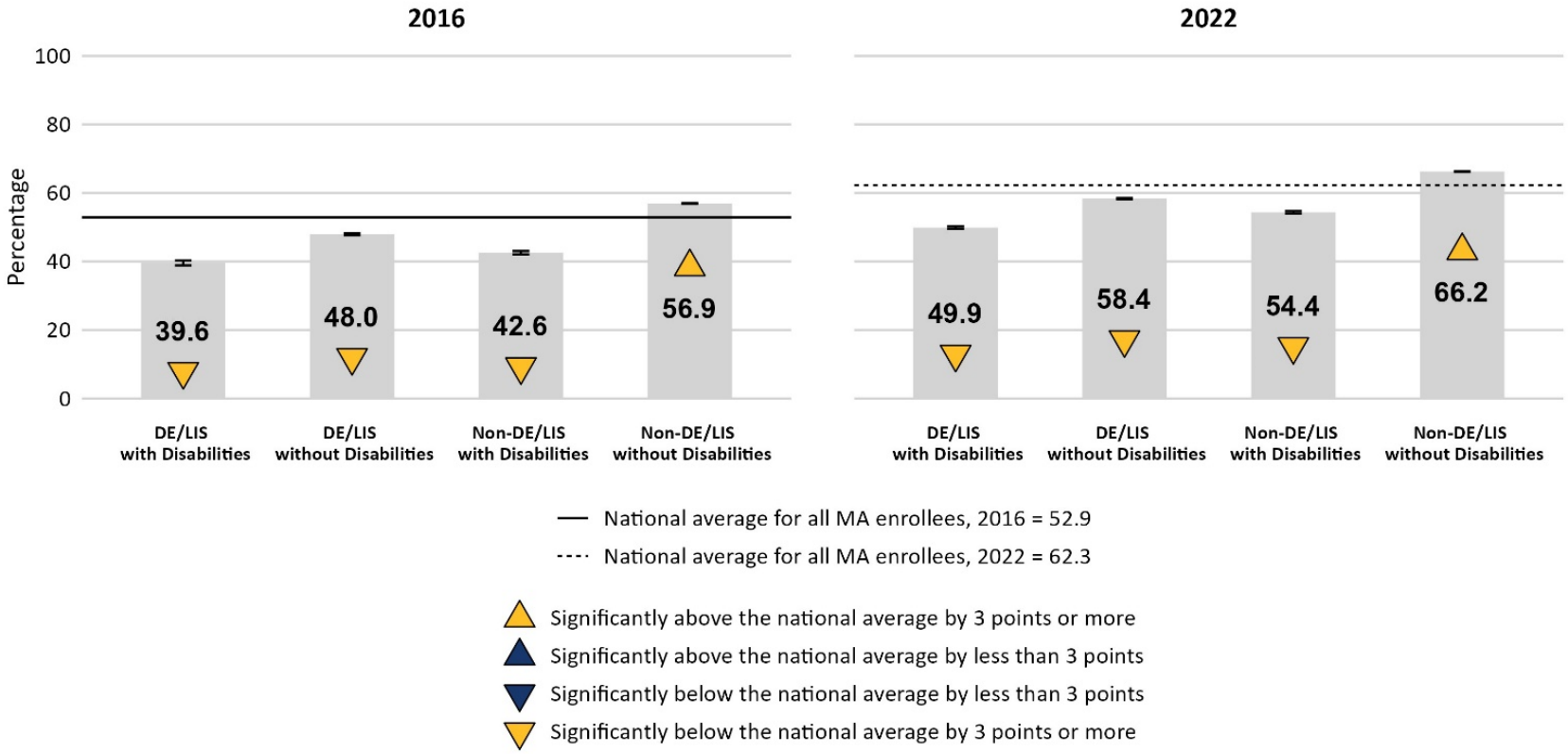
Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication, Reporting Years 2016–2022 trend, by DE/LIS and disability status



NOTE: Clinical quality data were not released for Reporting Year 2020 because of the COVID-19 pandemic.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia, 2016 and 2022

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by DE/LIS and disability status, in Reporting Years 2016 and 2022



SOURCE: Clinical quality data were collected in 2015 and 2021 from MA plans nationwide.
NOTES: DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia, 2016 and 2022

Summary of Findings

Group	2016 score	2022 score	Change, 2016–2022	Change in Difference Between This Group and the National Average, 2016–2022
DE/LIS with disabilities	39.6 ▼	49.9 ▼	+10.3	Remained about the same
DE/LIS without disabilities	48.0 ▼	58.4 ▼	+10.4	Remained about the same
Non-DE/LIS with disabilities	42.6 ▼	54.4 ▼	+11.8	+2.4
Non-DE/LIS without disabilities	56.9 ▲	66.2 ▲	+9.3	Remained about the same
National average	52.9	62.3	+9.4	N/A

▲ Significantly above the national average by 3 points or more

▲ Significantly above the national average by less than 3 points

▼ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

NOTES. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. N/A = Not applicable. Values are only shown in the last two columns if the change was statistically significant and 1 point or larger. Otherwise, "remained about the same" is indicated.

Overall Summary: Scores increased for all groups from 2016 to 2022. For DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, and non-DE/LIS MA enrollees without disabilities, the increase was comparable to the national average. As a result, initial gaps relative to the national average for DE/LIS MA enrollees with and without disabilities remained about the same in 2022, as did an initial advantage for non-DE/LIS MA enrollees without disabilities. For non-DE/LIS MA enrollees with disabilities, the increase was greater than the national average, shrinking an initial gap for that group.

APPENDIX C
Data Source and Methods

Healthcare Effectiveness Data and Information Set

HEDIS consists of more than 90 measures across six domains of care (National Committee for Quality Assurance, undated). These domains are effectiveness of care, access to and 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 the National Committee for Quality Assurance. HEDIS data are gathered via both surveys and medical charts and insurance claims or encounter data 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 CMS, or were deemed unsuitable for this application by CMS experts. In Reporting Year 2022, there were 713 MA contracts that supplied the 25,072,064 HEDIS measure records used for the part of this report that focuses on cross-sectional differences in 2022 data. Table 2 shows sample sizes and the distribution of the four DE/LIS by disability status groups on the 9 measures selected for the 2016–2022 trend analysis in Appendix B.

Reportability of Information

Most HEDIS measures are applicable to only a subset of the MA population. Sample size criteria were used to determine whether a score on a measure was reportable for a particular group. Scores based on 400 or more observations across all contracts were considered sufficiently precise for reporting. A sample size of 400 ensures that the margin of error for a dichotomous measure is no greater than 5 percent. All scores presented in this report are based on 400 or more observations.

Information on DE/LIS Status and Disability

Information on MA enrollees' DE/LIS and disability status was determined using CMS administrative data from March of the relevant data reporting year. For this report, all DE individuals (i.e., those who would be considered full-benefit, partial-benefit, and Qualified Medicare Beneficiaries) are included in the DE/LIS group. Information on disability status came from the Original Reason for Entitlement Code contained in the CMS-maintained Medicare Beneficiary Summary File. CMS obtains information on the reason for Medicare entitlement from the Social Security Administration and Railroad Retirement Board record systems. In this report, *people with disabilities* refers to people who had disability insurance benefits as their original reason for Medicare entitlement, while *people without disabilities* refers to people who had only old-age and survivors insurance or end-stage renal disease as their original reason for Medicare entitlement.

Analytic Approach: Cross-Sectional Analysis of 2022 Data

HEDIS scores for the four DE/LIS and disability status groups were estimated from logistic regression models. Four logistic regression models were run for each outcome; DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, non-DE/LIS MA enrollees with disabilities, and non-DE/LIS MA enrollees without disabilities successively served as the focal group.

Consistent with official scoring, none of the HEDIS measures reported were case mix–adjusted. That is, the sole predictor in these logistic regression models was an indicator of whether a person belonged to the focal DE/LIS and disability status group in each model. These models yielded estimates of each group's score in the form of a proportion and a statistical test of the difference between that score and

the score for all others; the statistical test is mathematically equivalent to the test of the difference of the group's score from the national average for all MA enrollees.[11]

To estimate the confidence interval for the difference between the score for one group and those not in that group, a linear regression that is otherwise similar to the logistic model described above (with the group identifier as the sole predictor) was run, retaining the standard error of the coefficient for the group identifier.[12] If a given group (A) makes up a proportion (*p*) of the whole, the difference of A from the overall mean is 1-*p* times as large as the difference of A from not-A. For example, if there were two groups of equal size and *p* equaled 0.5, each group would be half as far from the national average as from one another. To rescale the confidence interval so that it applies to the difference between the group and the national average, we simply multiply the confidence interval half-widths or standard errors by this same rescaling factor of 1-*p*, where *p* is the proportion of eligible MA enrollees in the focal group for a measure. The rescaled standard error or confidence interval half-width is then used to construct the confidence interval that corresponds to the difference of the focal group from the national average.

In comparisons of estimated scores with the national average, a difference is denoted as statistically significant if there is a less than 5-percent chance that the difference could have resulted because of sampling error alone. Differences that are statistically significant and 3 percentage points or greater are further denoted as practically significant. In the summary chart that appears on page 12, the focus is on practically significant differences. In the charts that present results on individual clinical care (HEDIS) measures in Appendix A, the focus is on statistically significant differences. In the chart symbols and the bullet-point summaries that appear below these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 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).

Analytic Approach: Trend Analysis, 2016 to 2022

For visualizing differences in how scores on the selected set of outcome measures changed over time for each DE/LIS and disability status group, line graphs were generated showing estimated scores for each group in Reporting Years 2016, 2017, 2018, 2019, 2021, and 2022 (data were not released for reporting in 2020 because of the COVID-19 pandemic). To construct these graphs, we ran one cross-sectional logistic model per year for each DE/LIS and disability status group and included an indicator for whether a person belonged to the focal group for the model.

We then ran a series of logistic models using Reporting Year 2016 and 2022 HEDIS data to estimate and test (1) change in measure scores over time for each DE/LIS and disability status group; (2) differences between each group and all others, cross-sectionally, in 2016 and 2022; and (3) differences in differences over time to look at whether each group changed differently from all others over time.

As with the cross-sectional analyses of 2022 data, four models were run for each outcome, with DE/LIS MA enrollees with disabilities, DE/LIS MA enrollees without disabilities, non-DE/LIS MA enrollees with

[11] An alternative would have been to run a single regression for each outcome and use linear contrasts to assess the difference of each group from the national average; for simplicity, we run multiple regressions testing each focal group separately.

[12] The estimates from this linear regression are essentially identical to those from the logistic regression, so the resulting confidence intervals are effectively consistent with the significance tests.

disabilities, and non-DE/LIS MA enrollees without disabilities successively serving as the focal group. For each model, predictors included (1) an indicator for 2022, which estimates the overall change in the outcome since 2016; (2) an indicator of whether a person belonged to the focal DE/LIS and disability status group, which indicates the difference between the score for the focal group and the score for all others in 2016; and (3) an interaction between 2022 and the group indicator, which indicates whether the score for the focal group changed differently over time compared with how the score changed for all others. Planned contrasts were conducted using these models to estimate change between 2016 and 2022 for the focal group and to estimate the difference between the score for the focal group and the score for all others in 2022.

Table 2. Sample Sizes and Distribution of DE/LIS and Disability Status Groups for Each Clinical Care Measure Included in the 2016–2022 Trend Analysis

Clinical Care Measure	*N*	DE/LIS with Disabilities (%)	DE/LIS without Disabilities (%)	Non-DE/LIS with Disabilities (%)	Non-DE/LIS without Disabilities (%)	Missing (%)
Breast Cancer Screening	22,944,835	12.3	9.0	14.3	60.3	4.1
Colorectal Cancer Screening	5,504,158	11.2	8.0	16.4	61.6	2.9
Testing to Confirm COPD	2,135,857	13.0	12.2	15.6	53.8	5.4
Controlling High Blood Pressure	4,563,571	10.7	10.7	13.6	61.9	3.0
Diabetes Care—Eye Exam	2,766,366	18.8	11.0	20.1	47.3	2.7
Diabetes Care—Blood Sugar Controlled	2,260,359	18.9	11.0	20.1	47.3	2.7
Osteoporosis Management in Women Who Had a Fracture	559,261	5.4	12.7	8.3	66.4	7.2
Antidepressant Medication Management—Acute Phase Treatment	2,904,404	20.9	13.3	19.2	41.7	4.9
Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia	4,617,893	4.9	20.9	6.9	61.1	6.2

NOTES. Sample sizes and distributions reflect data from Reporting Year 2016 to Reporting Year 2022, excluding Reporting Year 2020. Percentages are weighted for sampling. Sample sizes are unweighted. DE/LIS = dually eligible for Medicare and Medicaid or eligible for the Part D Low-Income Subsidy. Disability status is based on an MA enrollee's original reason for Medicare entitlement.

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