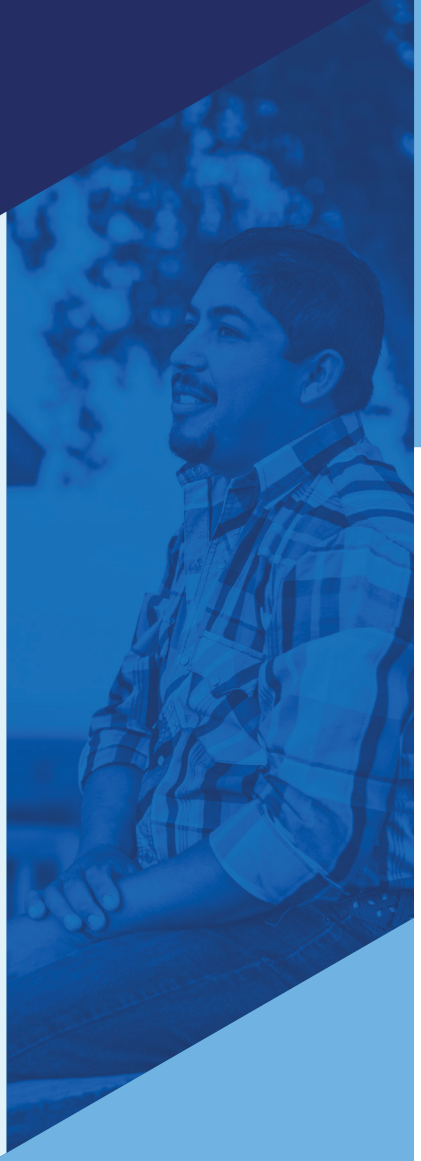

Rural-Urban Disparities in Health Care in Medicare

NOVEMBER 2024

IN COLLABORATION WITH
THE RAND CORPORATION

CMS

About This Report

This report presents summary information on the quality of health care received by people with Medicare nationwide. The report includes three sections, highlighting (1) rural-urban differences in health care experiences and clinical care, (2) how rural-urban differences in health care experiences and clinical care vary by race and ethnicity, and (3) historical trends in quality of care for rural and urban residents. The first two sections of the report focus on quality-of-care data reported in 2023. The section on trends in quality of care focuses on data reported from 2017 to 2023.

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Executive Summary

This report presents summary information on the quality of health care received by people with Medicare nationwide, highlighting (1) rural-urban differences in health care experiences and clinical care, (2) how rural-urban differences in health care experiences and clinical care vary by race and ethnicity, and (3) historical trends in quality of care for rural and urban residents. The first two sections of the report focus on quality-of-care data reported in 2023. The section on trends in quality of care focuses on data reported from 2017 to 2023.

The report is based on an analysis of two sources of information. The first source is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which are conducted annually by the Centers for Medicare & Medicaid Services (CMS) and focus on the health care experiences of people with Medicare across the country. These surveys of those with MA, Prescription Drug Plan (PDP), and Medicare FFS coverage also contain a patient-reported measure of having received a flu immunization in the past year. The second source of information is the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is composed of information collected from medical records and administrative data on the clinical quality of care that people receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease.

In all, seven CAHPS measures and 41 HEDIS measures were examined for Appendices A and B, focused on care reported in 2023. These measures were chosen based on their reliability and informativeness for comparing scores for rural and urban residents to the national average, and for comparing scores for racial and ethnic groups to the national average within rural and urban strata.

Only a subset of the measures included in the cross-sectional analysis of Reporting Year 2023 data were included in the trend analysis presented in Appendix C. To be eligible for inclusion, a measure had to exist and be specified consistently from Reporting Year 2017 to Reporting Year 2023 (CAHPS data were not collected and HEDIS clinical quality data were not released for Reporting Year 2020 due to the COVID-19 pandemic). From the 27 measures that met those criteria, 11 were chosen that provide broad representation of the areas of care covered by the full set and for which there were interesting patterns of differences over time. Trends on these measures may not be representative of the entire set of measures included in Appendices A and B.

Key Findings:

Rural-Urban Differences in Care Received in Reporting Year 2023

- Overall, MA enrollees living in rural areas had results that were below the national average for more than a third of all clinical care measures examined. This is considerably larger than the percentage of measures for which MA enrollees living in rural areas had below average results in Reporting Year 2022 data (presented in last year's edition of this report). As in Reporting Year 2022 data, MA enrollees living in urban areas had scores on clinical care measures in Reporting Year 2023 data that were nearly always similar to the national average.
- The largest deficits in clinical care for rural residents were for kidney health evaluation for patients with diabetes (a 15-percentage-point deficit for MA enrollees living in rural areas), avoidance of potential drug-disease interactions in both older patients with dementia (an 8-percentage-point deficit) and patients with a history of falls (a 5-percentage point deficit), osteoporosis screening in older women (a 7-percentage point deficit), and osteoporosis management in women who had a fracture (a 6-percentage-point deficit).

- This analysis also uncovered considerably lower rates of flu vaccination among rural versus urban residents in Reporting Year 2023 data. As it was in Reporting Year 2022 data, this disadvantage was observed among both MA enrollees and people with FFS coverage and was evident across racial and ethnic groups.
- Although there were no overall rural-urban differences in experiences with care that met the 3-point magnitude criterion used in this report, there was a consistent pattern of small statistically significant differences favoring rural residents. This pattern was also seen in Reporting Year 2022 CAHPS data.

Rural-Urban Differences in Care Received in Reporting Year 2023, by Race and Ethnicity

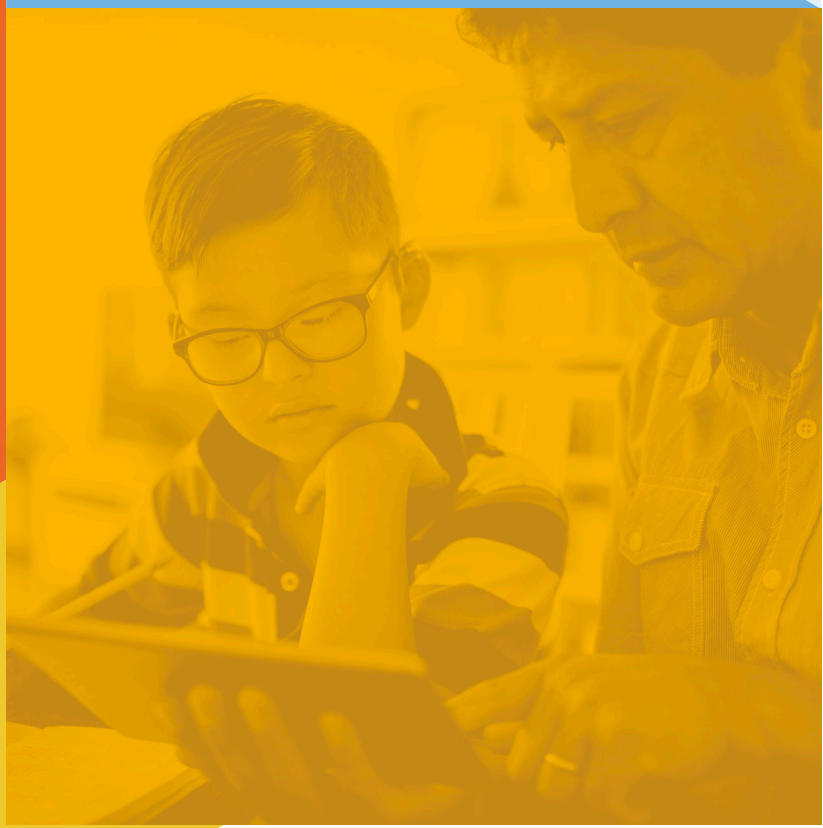
- The overall pattern of urban residents having Reporting Year 2023 scores on clinical care measures that were similar to the national average and rural residents often having scores that were below the national average was evident among all racial and ethnic groups except Hispanic MA enrollees. Whereas in urban areas Hispanic MA enrollees had results that were generally similar to the national average for all Hispanic MA enrollees, in rural areas they had results that were below the national average on nearly 40 percent of measures and above the national average on nearly a quarter of measures. This unique pattern of results for rural Hispanic MA enrollees was also seen in Reporting Year 2022 HEDIS data.
- A large portion of the below average results observed for rural Hispanic MA enrollees were in the area of behavioral health care. In particular, rural Hispanic MA enrollees had sizable deficits on 5 of the 8 behavioral health care measures examined for this report, including acute and continuing treatment of major depression with antidepressant medication (6- and 7-percentage point deficits), initiation of treatment for people with alcohol or other drug (AOD) dependence (a 10-percentage point deficit), and follow-up care for people seen in the emergency department for AOD dependence and mental illness (6-percentage point deficits in each case). This same pattern was seen in Reporting Year 2022 HEDIS data, indicating a persistent area of concern.

Trends in Quality of Care for Rural and Urban Residents, 2017–2023

- For 5 of the 10 HEDIS measures included in the trend analysis, scores increased for urban and rural residents from Reporting Year 2017 to Reporting Year 2023 but did so more for rural residents than for urban residents. As a result, in all of these cases initial advantages for MA enrollees living in urban areas (relative to the national average) remained about the same while initial gaps for MA enrollees living in rural areas shrank.
- For the other five HEDIS measures included in the analysis, scores either remained the same or increased similarly for rural and urban residents from Reporting Year 2017 to Reporting Year 2023, maintaining initial gaps for rural residents relative to the national average and initial advantages for urban residents relative to the national average.
- For the one CAHPS measure that was included in the trend analysis, Annual Flu Immunization, scores increased for MA enrollees in both urban and rural areas in a way that was comparable to the national average for all MA enrollees. As a result, an initial (i.e., Reporting Year 2017) advantage for MA enrollees living in urban areas remained about the same in Reporting Year 2023, as did an initial gap for MA enrollees living in rural areas. Scores on this measure also increased for people with FFS coverage living in urban and rural areas. However, whereas the increase for people with FFS coverage living in urban areas was comparable to the national average for all people with FFS coverage, the increase for people with FFS coverage living in

rural areas was less than the national average for all people with FFS coverage, resulting in a widening of an initial gap for people with FFS coverage living in rural areas.

Rural-Urban Disparities in Health Care in Medicare



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 equity in the delivery of care requires making comparisons of quality by personal characteristics of patients, such as rural or urban residence, race, and ethnicity. Prior studies have found higher rates of chronic illness and poorer overall health in rural communities compared with urban populations. One possible source of these differences in morbidity is disparate experiences with health care and differences in access to high-quality care between rural and urban areas (Meit et al., 2014). There is also evidence that the health care disadvantages faced by those living in rural areas are sometimes greater for racial and ethnic minorities than for those who are non-Hispanic White and that racial and ethnic disparities are sometimes greater in rural areas compared with urban areas (James et al., 2017; Probst et al., 2004). These gaps could occur because living in a rural area exacerbates exposure to unequal social conditions that foster disparities in health care (Caldwell et al., 2016).

In light of these prior findings, this report presents a variety of comparisons to provide a comprehensive understanding of the ways in which care differs by rurality, race and ethnicity, and the intersection of these characteristics. Appendix A compares quality of care for rural and urban residents to the national average for all people with the same type of Medicare coverage (i.e., the national average for people with that coverage type), either Medicare Advantage (MA) or Medicare Fee-for-Service (FFS).[1] Appendix A focuses on quality-of-care measures reported in 2023. In Appendix B, quality of care for rural and urban residents is compared with the national average for people of the same racial or ethnic group. Appendix B also focuses on quality-of-care measures reported in 2023 (hereafter Reporting Year 2023). Appendix C presents an analysis of historical trends in quality of care for rural and urban residents across a seven-year period, Reporting Years 2017–2023, with the exception of 2020 (measures were not released for reporting early in the coronavirus disease 2019 [COVID-19] pandemic).

These comparisons might be of interest to people with Medicare, MA organizations, Medicare Part D sponsors, and federal policymakers. This report is focused on differences at the national level. Interested readers can find information about health care quality for specific Medicare Advantage contracts (including Star Ratings) at Medicare.gov (Medicare.gov, undated) and information about racial and ethnic differences in health care quality within Medicare plans on the Stratified Reporting page at CMS.gov (CMS, 2024a).

Data Sources

The report is based on an analysis of two sources of information. The first source is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which are conducted annually by the Centers for Medicare & Medicaid Services (CMS) and focus on the health care experiences (e.g., ease of getting needed care, how well providers communicate, ease of getting needed

[1] People were classified as living in a rural or urban area according to the ZIP Code of their mailing address and the corresponding U.S. Census Bureau core-based statistical area (CBSA). CBSAs consist of the county or counties associated with at least one core urban area plus adjacent counties that have a high degree of social and economic integration with the core. Metropolitan statistical areas contain a core urban area with a population of 50,000 residents or more. Micropolitan statistical areas contain a core urban area with a population of at least 10,000 but less than 50,000 residents. For this report, anyone living in a metropolitan division or metropolitan statistical area was classified as an urban resident; anyone living in a micropolitan statistical area or outside a CBSA was classified as a rural resident.

prescription drugs) of people with Medicare across the country. These surveys of those with MA, Prescription Drug Plan (PDP), and Medicare FFS coverage also contain a patient-reported measure of having received a flu immunization in the past year. The second source of information is the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is composed of information collected from medical records and administrative data on the clinical quality of care that people receive for a variety of medical issues. 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 medications, and access to and availability of care. Data on these measures were gathered through medical records and insurance claims or encounter data for hospitalizations, medical office visits, and procedures (detailed information about these data can be found on the National Committee for Quality Assurance's HEDIS webpage [National Committee for Quality Assurance, undated]). A comprehensive list of the seven patient experience and 41 clinical care measures examined in Appendixes A and B is presented on pages 9–10. Scores on CAHPS measures are case mix–adjusted, as described in Appendix D. HEDIS measures are not case mix–adjusted.

A subset of the measures included in Appendixes A and B were selected for inclusion in the trend analysis presented in Appendix C. To be selected, a measure had to exist and be specified consistently from Reporting Year 2017 to Reporting Year 2023. From the 27 measures that met those criteria, 11 were chosen that provide broad representation of the areas of 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 rural-urban differences in scores or for which differences increased or decreased notably over time).

CAHPS surveys are administered to both MA enrollees and people with Medicare FFS and have protocols designed to promote comparability of experiences between the two populations (Orr et al., 2022).[2] In contrast, most of the HEDIS measures presented in this report are available only for those enrolled in MA plans. Thus, in this report, comparisons on CAHPS measures are presented for both MA enrollees and people with FFS coverage, while comparisons on HEDIS measures are presented only for MA enrollees.[3]

The CAHPS data presented in Appendixes A and B pertain to care experiences reported on the 2023 MA, FFS, and PDP CAHPS surveys, which were fielded from March to June 2023. Respondents were asked about care received in the six months prior to their completing the survey. HEDIS data reported in 2023 (Reporting Year 2023) were collected from MA plans throughout 2022 and thus correspond to care received from January to December 2022.[4]

Previous versions of this report, which are available on the Stratified Reporting page at CMS.gov (CMS, 2024a), presented information on the quality of care received by people with Medicare nationwide based on data reported in 2017, 2018, 2019, 2021, and 2022.[5] Because of the COVID-19 pandemic, the

[2] The MA CAHPS surveys are the source of data on all CAHPS measures for MA enrollees. For people with Medicare FFS coverage, the FFS CAHPS survey is the source of information on all CAHPS measures except ones pertaining to prescription drugs, which come from the PDP CAHPS survey.
[3] HEDIS data include the 50 states; Washington, D.C.; and U.S. territories, whereas the CAHPS data are limited to the 50 states; Washington, D.C.; and Puerto Rico.
[4] One measure reported here—Breast Cancer Screening—pertains to care received in the past two years.
[5] Some of the text in this report draws heavily—and sometimes verbatim—from language in these earlier reports.

CAHPS surveys were not fielded in 2020; likewise, HEDIS data were not released for reporting in that year.

The set of patient experience measures presented in this report is the same as the set reported on in the 2018–2023 reports (reporting 2017, 2018, 2019, 2021, and 2022 data). Two clinical care measures that were included in the 2023 report, Diabetes Care—Blood Sugar Testing and Diabetes Care—Kidney Disease Monitoring, were excluded from this report because they were retired from HEDIS effective Reporting Year 2023. Six clinical care measures are presented in this report for the first time: Initiation of Cardiac Rehabilitation, Engagement of Cardiac Rehabilitation, Kidney Disease Evaluation for Patients with Diabetes, Osteoporosis Screening in Older Women, Medication Adherence for People with Schizophrenia, and Pharmacotherapy for Opioid Use Disorder. The first five of these measures debuted in HEDIS Reporting Year 2022; the sixth debuted in HEDIS Reporting Year 2023.

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

Rural-Urban Disparities in Health Care in Medicare—Results Summary

With one exception, MA enrollees living in rural and urban areas had 2023 CAHPS survey scores that were similar to the national average for all MA enrollees (see Figure 1).[6] The exception pertained to the flu vaccination rate for rural MA enrollees, which was below the national average for all MA enrollees. This same pattern was evident among people with Medicare FFS coverage. These patterns were observed in Reporting Year 2022 CAHPS data (presented in the 2023 edition of this report).

Across 40 of 41 measures of clinical care (98 percent), MA enrollees living in urban areas had scores in Reporting Year 2023 data that were similar to the national average for all MA enrollees (see Figure 2). The exception pertained to a measure of kidney health evaluation for patients with diabetes, on which MA enrollees living in urban areas scored 3 percentage points above the national average for all MA enrollees. In contrast, MA enrollees living in rural areas had results that were below the national average for 14 of 41 measures (34 percent).[7] This number is considerably larger than the percentage of measures for which MA enrollees living in rural areas had below average results in Reporting Year 2022 data (21 percent). The largest deficits in clinical care for rural residents were for kidney health evaluation for patients with diabetes (a 15-percentage-point deficit for MA enrollees living in rural areas), avoidance of potential drug-disease interactions in both older patients with dementia (an 8-percentage-point deficit) and patients with a history of falls (a 5-percentage point deficit), osteoporosis screening in older women (a 7-percentage point deficit), and osteoporosis management in women who had a fracture (a 6-percentage point deficit).

[6] We characterize a score as *similar* to the national average if the difference is not statistically significant, falls below a magnitude threshold, or both. We describe scores as being above or below the national average if the difference is statistically significant and exceeds a magnitude threshold, as described in Appendix D.

[7] When only two groups are compared, scores for the larger group—here, MA enrollees living in urban areas—will always be closer to the overall (national) average than scores for the smaller group. This is because the larger group has a greater influence on the overall average. For example, if Group A consists of two-thirds of MA enrollees and Group B consists of one-third of MA enrollees, then the overall average will be half as far from Group A's score as from Group B's score.

Rural-Urban Disparities in Health Care in Medicare by Racial and Ethnic Group—Results Summary

With rare exceptions, the overall pattern of rural and urban residents having Reporting Year 2023 CAHPS scores that were similar to the national average generally held across racial and ethnic groups (see Figures 3 and 4). The exceptions pertained to Hispanic and Multiracial MA enrollees living in rural areas. Hispanic MA enrollees living in rural areas had CAHPS scores that were below the national average for all Hispanic MA enrollees on 2 of 7 measures (29 percent). Multiracial MA enrollees living in rural areas had scores that were above the national average for all Multiracial MA enrollees for 2 of 7 measures (29 percent) and below the national average for all Multiracial MA enrollees for 1 measure (14 percent).[8] In each case, their counterparts living in urban areas had scores that were consistently similar to the national average for their group. These findings for Multiracial MA enrollees were not observed in Reporting Year 2022 CAHPS data.

The overall pattern of urban residents having Reporting Year 2023 scores on clinical care measures that were similar to the national average and rural residents often having scores that were below the national average was evident among American Indian and Alaska Native (AI/AN), Asian American and Native Hawaiian or Pacific Islander (AA and NHPI), Black, and White MA enrollees (see Figure 5). A different pattern emerged among Hispanic MA enrollees.[9]

In urban areas, Hispanic MA enrollees had results that were below the national average for all Hispanic MA enrollees on 1 of 41 measures (2 percent) and above the national average for all Hispanic MA enrollees on 3 of 41 measures (10 percent). In rural areas, Hispanic MA enrollees had results that were below the national average on 16 of 41 clinical care measures (39 percent) and results that were above the national average on 12 of 41 measures (22 percent). The measures on which Hispanic MA enrollees living in rural areas had results that were below the national average pertained to care for patients with chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, depression, alcohol or other drug (AOD) abuse or dependence, kidney disease, dementia, a history of falls, and multiple chronic conditions; they also included measures of care coordination and avoidance of high-risk medications in older adults. The measures on which Hispanic MA enrollees living in rural areas had results that were above the national average pertained to care for patients with high blood pressure, diabetes, and osteoporosis (female enrollees); they also included measures of cancer screening, care coordination, and avoidance of overuse of opioids. This pattern of rural-urban differences among Hispanic MA enrollees is mainly similar to what was seen in Reporting Year 2022 data, although the percentage of measures on which Hispanic MA enrollees living in rural areas had below average results was notably larger in Reporting Year 2023 than in Reporting Year 2022.

Trends in Rural-Urban Disparities: 2017–2023—Results Summary

Because measures included in the trend analysis (Appendix C) were selected partly based on observed patterns of difference over time, findings for this set of measures may not generalize to the entire set of measures presented in Appendixes A and B.

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[8] For this report, non-Hispanic people who reported belonging to more than one racial group were classified as *Multiracial*.

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

All but one of the measures selected for the trend analysis were HEDIS measures. The one CAHPS measure that was included—and thus the only measure that pertains to both MA enrollees and people with FFS coverage—is the Annual Flu Immunization measure. On this measure, scores increased for MA enrollees in both urban and rural areas in a way that was comparable to the national average for all MA enrollees. As a result, an initial (i.e., Reporting Year 2017) advantage for MA enrollees living in urban areas (relative to the national average) remained about the same in Reporting Year 2023, as did an initial gap for MA enrollees living in rural areas. Scores on this measure also increased for people with FFS coverage living in urban and rural areas. However, whereas the increase for people with FFS coverage living in urban areas was comparable to the national average for all people with FFS coverage, the increase for people with FFS coverage living in rural areas was less than the national average for all people with FFS coverage. This resulted in a widening of an initial gap for people with FFS coverage living in rural areas.

For 4 of the 10 HEDIS measures included in the trend analysis, scores increased for urban and rural residents from Reporting Year 2017 to Reporting Year 2023 in a manner that was comparable to the national average. As a result, initial advantages relative to the national average for MA enrollees living in urban areas remained about the same in all cases, as did initial gaps for MA enrollees living in rural areas. The four measures for which this pattern was observed are Colorectal Cancer Screening, Controlling High Blood Pressure, Diabetes Care—Blood Sugar Controlled, and Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls.

For both urban and rural residents, scores on one HEDIS measure included in the trend analysis, Breast Cancer Screening, were about the same in Reporting Year 2023 as in Reporting Year 2017, maintaining a similar status quo. That is, an initial advantage relative to the national average for female MA enrollees living in urban areas remained about the same in Reporting Year 2023, as did an initial gap for female MA enrollees living in rural areas.

For the remaining 5 HEDIS measures included in the trend analysis, scores increased for urban and rural residents from Reporting Year 2017 to Reporting Year 2023 but did so more for rural residents than for urban residents. As a result, in all cases, initial advantages for MA enrollees living in urban areas (relative to the national average) remained about the same while initial gaps for MA enrollees living in rural areas shrank. The 5 measures on which this pattern was observed are Medication Adherence for Cardiovascular Disease—Statins, Diabetes Care—Blood Pressure Controlled, Osteoporosis Management in Women Who Had a Fracture, Antidepressant Medication Management-Acute Phase Treatment, and Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia.

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

Addressing Disparities in Flu Immunization Among Rural People with Medicare

Given the known disease burden of influenza (i.e., flu) (Centers for Disease Control and Prevention [CDC], 2023b), it is important that all individuals receive a strong recommendation for flu vaccination from their providers. Because individuals aged 65 years and older represent a large share of the Medicare population, it is relevant to note that the CDC preferentially recommend that people 65 years and older receive one of the following three flu vaccine options: the Fluzone High-Dose Quadrivalent inactivated flu vaccine, the Flublok Quadrivalent recombinant flu vaccine, and the Fluad Quadrivalent adjuvanted inactivated flu vaccine (CDC, 2023a). No such recommendation exists for people under the age of 65 years.

In Reporting Year 2023, there were considerably lower rates of annual flu vaccinations among rural residents compared to the national average. This disadvantage—which may reflect a more general vaccine hesitancy among rural residents (Kirzinger, Muñana, and Brodie, 2021)—was observed in both MA and FFS, and rural residents lagged behind the national average by 7 to 8 percentage points—a sizable gap—in both settings (see p. 28). In rural areas, Hispanic and White MA enrollees in particular had below average flu vaccination rates, while in FFS, all race and ethnicity groups in rural areas except for AA and NHPI enrollees were below the national average on this measure. This finding aligns with data from the CDC, which suggest that, in the United States, adults who are Black, AI/AN, and Hispanic disproportionately experience adverse flu-related outcomes, such as flu-related hospitalizations (CDC, 2022).

As shown in the trends section of this report (see Appendix C on pp. 192–197), rural-urban disparities in flu vaccination rates for both MA and FFS enrollees have been observed continually over the past six years. Notably, in FFS, improvement in the rate of flu vaccination for rural enrollees has not kept pace with national average improvement, resulting in a slightly widening urban-rural disparity on this measure.

CMS has several resources for enrollees and providers related to flu vaccination, including information about Medicare coverage of flu shots (CMS, 2024c). Provider resources include materials to encourage flu vaccination among Medicare enrollees, including a social media toolkit. To boost vaccination rates among people with Medicare overall, and particularly among rural residents, health care organizations might want to use this toolkit to share information about flu vaccination timing, morbidity and mortality associated with influenza, and the possibility of receiving a flu shot at the same time as other vaccinations (e.g., for COVID-19). Whenever possible, messaging around uptake of annual flu vaccines should be in multiple languages (e.g., English and Spanish) to ensure greatest reach.

Addressing Disparities in Diabetes Care Among Rural Medicare Advantage Enrollees

Diabetes is the eighth leading cause of death in the United States (Kochanek et al., 2024), and the prevalence of diagnosed diabetes increases with increasing rurality (Dugani et al., 2024). In Reporting Year 2023, significant disparities were noted for rural enrollees in each of the six clinical care measures related to diabetes care. Two of these measures, Diabetes Care—Eye Exam and Kidney Health Evaluation for Patients with Diabetes, were more than three percentage points below the national average for rural enrollees. Kidney Health Evaluation for Patients with Diabetes had the largest single disparity for all clinical care measures; for rural enrollees the measure was 15 percentage points below the national average.

CMS covers services to help prevent complications from diabetes and for all onset of diabetes among those with prediabetes (CMS, 2021b; CMS 2022). For example, Medicare enrollee cost-sharing for Part B- and D-covered insulin is now capped at $35 per month's supply of covered insulin (CMS, 2023a). CMS also covers self-management training for eligible enrollees and other resources for people living with diabetes (CMS, 2022) as well as for providers who treat their patients with this disease (CMS, 2023b). Likewise, the Agency for Healthcare Research and Quality has compiled information on a variety of evidence-based treatment practices and quality improvement strategies for providers treating individuals with diabetes (Agency for Healthcare Research and Quality, undated).

It is important that self-management training for diabetes is tailored appropriately to the settings in which individuals reside. For example, the accessibility of walking paths, roads with safe sidewalks,

grocery stores with affordable produce and other nutritious foods, and exercise facilities might be limited in more-rural areas (Hansen et al., 2015; Lenardson et al., 2015), which could complicate self-management strategies that hinge on these means of obtaining and maintaining a healthy weight and keeping physically active. There is therefore a need for strategies and interventions tailored to rural residents or residents of resource-limited areas so that self-management of diabetes through healthy eating and physical activity is achievable for all people regardless of where they live.

Addressing Disparities in Osteoporosis Care Among Rural Medicare Advantage Enrollees

Osteoporosis is a leading cause of morbidity and mortality among older adults in the United States, and it is associated with diminished quality of life, impaired mobility, and chronic pain (Leboime et al., 2010; Stanghelle et al., 2019). More than ten million people aged 50 and older in the United States have osteoporosis, the majority of whom are postmenopausal women (Sarafrazi et al., 2021).

In Reporting Year 2023, large disparities were observed for female rural residents enrolled in MA in both the diagnosis and treatment of osteoporosis. Women residing in rural areas were more than seven percentage points—a large gap—below the national average on both measures of osteoporosis clinical care analyzed for this report, Osteoporosis Screening in Older Women and Osteoporosis Management in Women Who Had a Fracture (see pp. 48–49). As shown in Appendix C, this large gap was evident in all racial and ethnic groups with reportable scores for rural and urban residents except for Hispanic MA enrollees (see pp. 143–146).

To minimize financial barriers to screening, Medicare reimburses routine bone mineral density testing every two years. As this analysis has shown, however, rates of screening remain low in the Medicare population, as do rates of treatment, and this is particularly the case for women living in rural areas. In 2021, CMS's Office of Minority Health released a data highlight that details osteoporosis disparities by race, ethnicity, and geography in the Medicare population and provides links to resources related to osteoporosis (CMS, 2021a).

It is recommended that women aged 65 and older and postmenopausal women under 65 years with known risk factors receive regular screening for osteoporosis (U.S. Preventive Task Force, 2018). Several barriers to providing osteoporosis screening and care have been identified, including lack of access to screening technologies and infusion centers for treatment (National Committee for Quality Assurance, 2022). This lack of access may be particularly salient in rural areas. To help overcome access barriers, providers—particularly those serving rural or geographically isolated populations—could consider leveraging telehealth technologies to conduct screenings and offer post-fracture management to people living in areas where care access is limited or otherwise challenging (Health Resources and Services Administration, 2023).

Patient Experience and Clinical Care Measures Included in This Report[10]

Patient Experience (CAHPS) Measures

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Doctors Who Communicate Well
- Care Coordination
- Getting Needed Prescription Drugs
- **Annual Flu Vaccine**[11]

Clinical Care (HEDIS) Measures

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**
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation

Diabetes

- Diabetes Care—Eye Exam
- **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

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

[11] The annual flu vaccine measure is collected via the CAHPS survey and is thus grouped with other CAHPS measures in this report.

Musculoskeletal Conditions

- Osteoporosis Screening in Older Women
- **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 People with Schizophrenia
- 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)
- 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

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 Medications

- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- **Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia**
- **Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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
- Pharmacotherapy for Opioid Use Disorder

Access to and Availability of Care

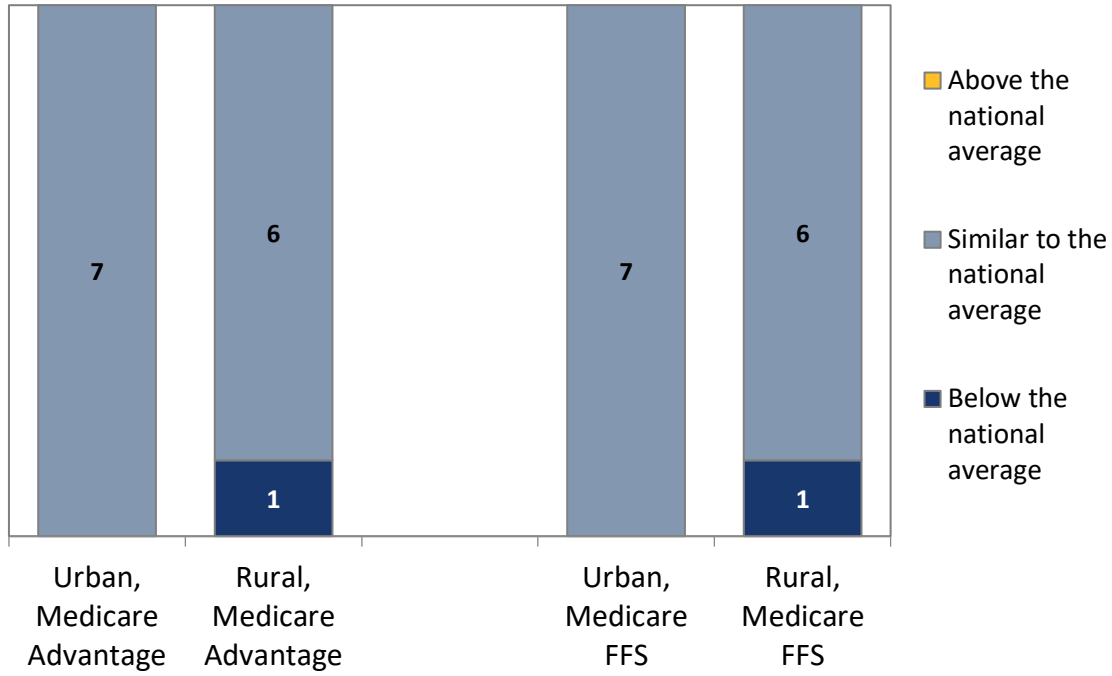
- Adult Access to Preventive and Ambulatory Services

Abbreviations Used in This Report

AA and NHPI	Asian American and Native Hawaiian or Pacific Islander
AI/AN	American Indian and Alaska Native
AMI	acute myocardial infarction
AOD	alcohol and other drug
ASCVD	atherosclerotic cardiovascular disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBSA	core-based statistical area
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease 2019
ED	emergency department
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
MA	Medicare Advantage
MBISG	Medicare Bayesian Improved Surname Geocoding
NSAID	nonsteroidal anti-inflammatory drug
PDP	prescription drug plan

Figure 1. Rural-Urban Disparities in Care: All Patient Experience Measures, Medicare Advantage and Medicare FFS

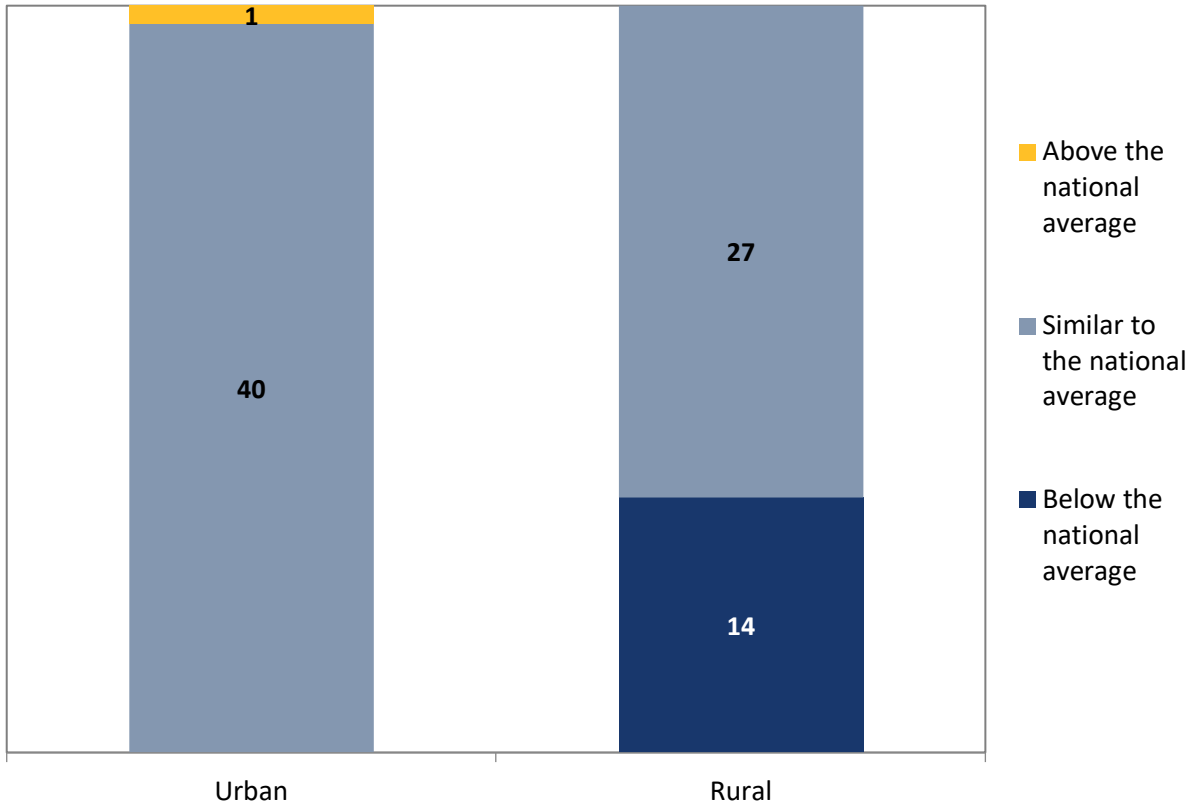
Number of patient experience measures (out of 7) for which rural and urban residents had results that were above, similar to, or below the national average in 2023



SOURCE: This chart summarizes data from all MA enrollees and people with Medicare FFS coverage nationwide who participated in the 2023 MA, FFS, and PDP CAHPS surveys.

Figure 2. Rural-Urban Disparities in Care: All Clinical Care Measures, Medicare Advantage

Number of clinical care measures (out of 41) for which rural and urban residents had results that were above, similar to, or below the national average for all MA enrollees in Reporting Year 2023

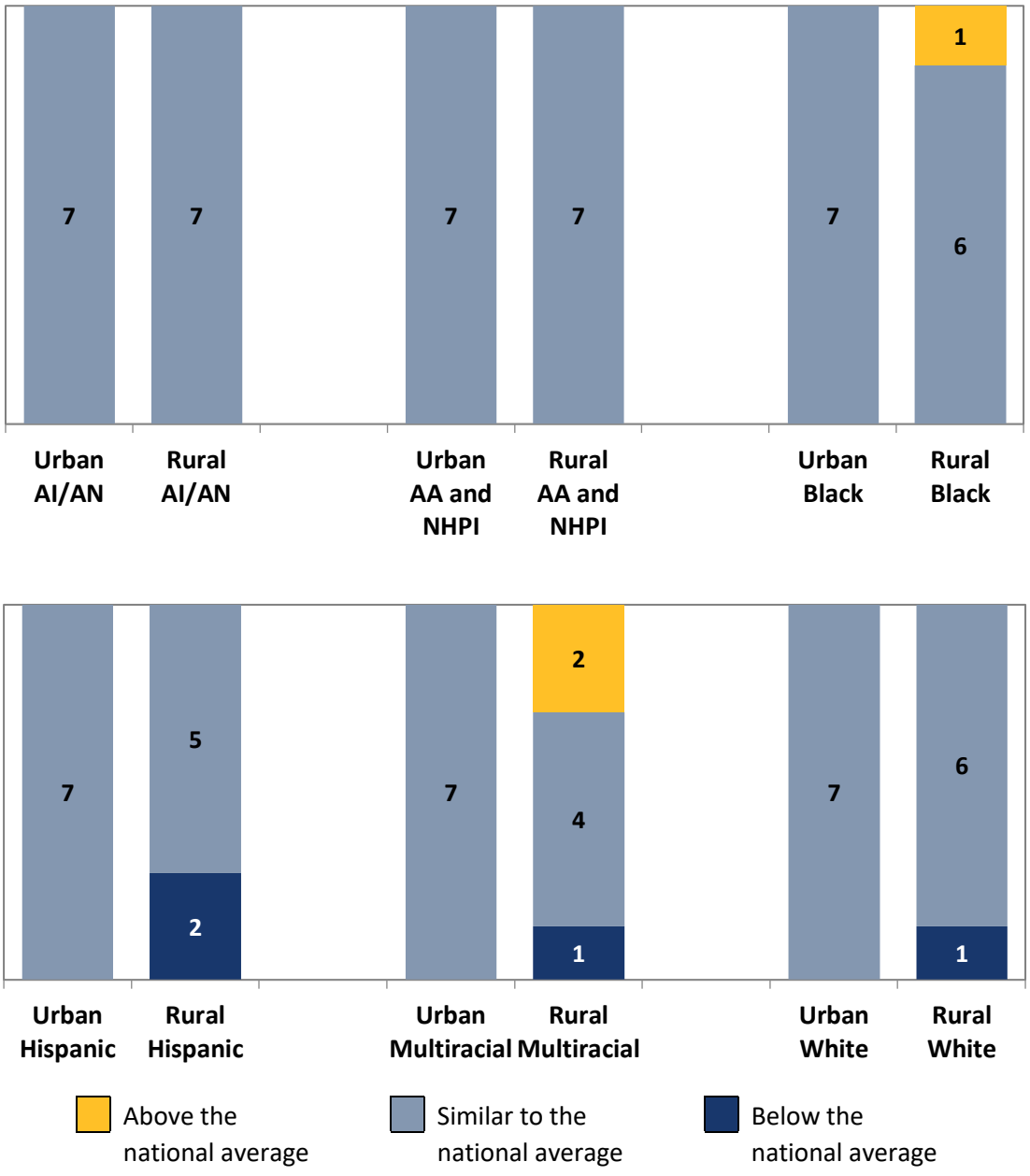


SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide and reported in 2023. Clinical quality data are not available for people with Medicare FFS coverage.

NOTE: When only two groups are compared, scores for the larger group—in this case, MA enrollees living in urban areas—will always be closer to the overall (national) average than scores for the smaller group.

Figure 3. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures, Medicare Advantage

Number of patient experience measures (out of 7) for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees <u>of the same race or ethnicity</u> in 2023

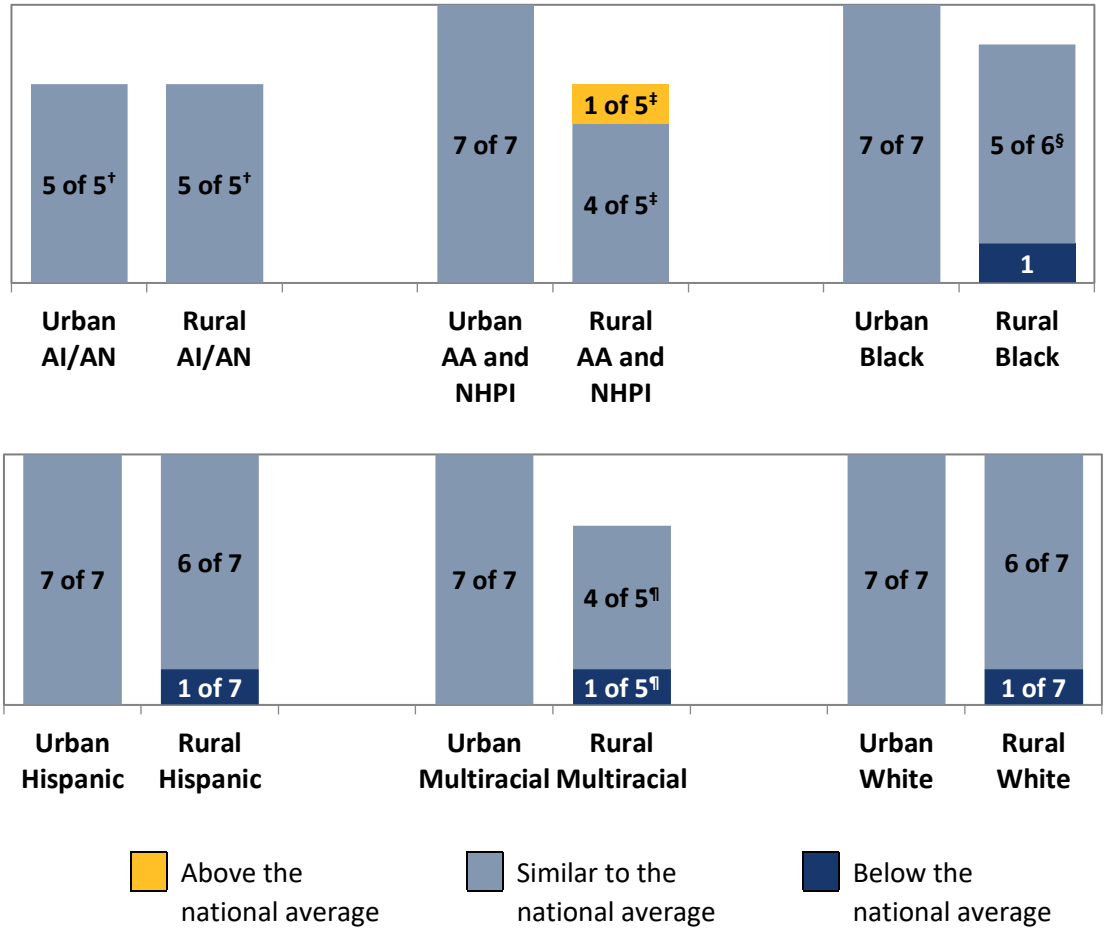


SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Figure 4. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures, Medicare FFS

Number of patient experience measures for which urban or rural residents with Medicare FFS coverage reported experiences that were above, similar to, or below the national average for all people with Medicare FFS coverage of the same race or ethnicity in 2023



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

† There were not enough data from AI/AN people with FFS coverage living in urban areas to compare these group to the national average for all AI/AN people with FFS coverage on two patient experience measures. There were also not enough data from AI/AN people with FFS coverage living in rural areas to compare this group to the national average for all AI/AN people with FFS coverage on the same two measures.

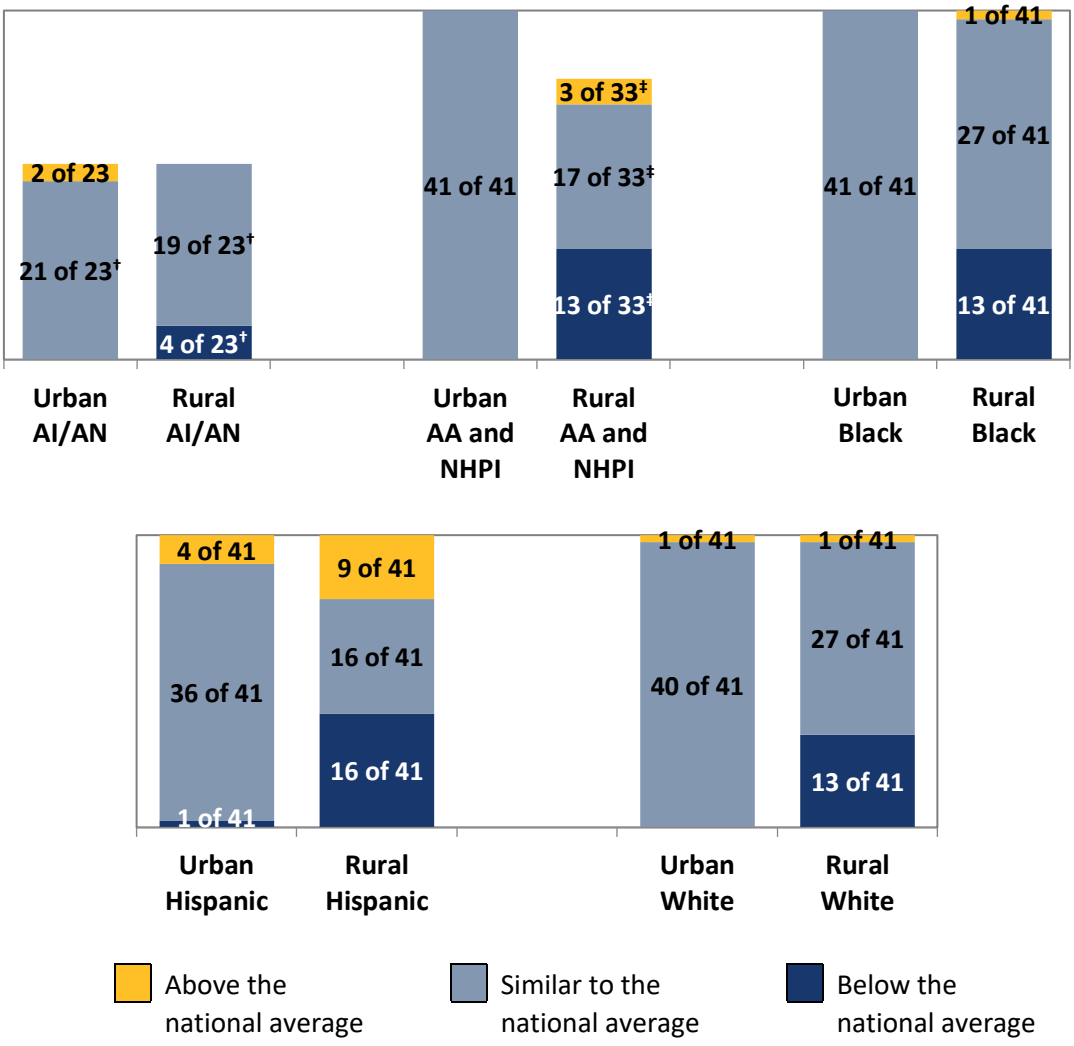
‡ There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare this group to the national average for all AA and NHPI people with FFS coverage on two patient experience measures.

§ There were not enough data from Black people with FFS coverage living in rural areas to compare this group to the national average for all Black people with FFS coverage on one patient experience measure.

¶ There were not enough data from Multiracial people with FFS coverage living in rural areas to compare this group to the national average for all Multiracial people with FFS coverage on two patient experience measures.

Figure 5. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Clinical Care Measures, Medicare Advantage

Number of clinical care measures for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. For reporting clinical care data stratified by race and ethnicity, racial and ethnic group membership is estimated using a method that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when their accuracy does not meet the standards described on p. 241. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.
† There were not enough data from AI/AN MA enrollees living in urban areas to compare this group to the national average for all AI/AN MA enrollees on 18 clinical care measures. There were also not enough data from AI/AN MA enrollees living in rural areas to compare this group to the national average for all AI/AN MA enrollees on the same 18 measures.
‡ There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group to the national average for all AA and NHPI MA enrollees on 8 clinical care measures.

Overview of Appendixes

Appendix A: Rural-Urban Disparities in Health Care in Medicare—Cross-Sectional Analysis of 2023 Data

Appendix A begins with a pair of stacked bar charts showing the number of patient experience measures for which rural and urban residents reported experiences of care that were above, similar to, or below the national average, separately for MA enrollees and people with FFS coverage. In these stacked bar charts, as in all stacked bar charts in this report, the focus is on practically significant differences (that is, differences that are statistically significant and exceed a magnitude threshold of 3 points). The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).[12] Following the pair of stacked bar charts are pairs of unstacked bar charts for each patient experience measure. These charts show the average scores (and associated 95-percent confidence intervals) for rural and urban residents on a 0–100 scale and indicate how each group's average score compares with the national average for people with the same Medicare coverage type (MA or FFS). The values presented in these charts represent the percentage of the best possible score for a measure. For example, consider a measure for which the best possible score is 4 and the worst possible score is 1. If a given group's score on that measure is 3.5, then that group's score on a 0–100 scale is ([3.5 − 1] / [4 − 1]) × 100 = 83.3. In the unstacked bar 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 through the coloring of upward- and downward-facing arrows that appear in the bars.[13] Blue arrows indicate statistically significant differences that are less than 3 points in magnitude; yellow arrows indicate statistically significant differences that are 3 points in magnitude or larger.

After the patient experience measures, Appendix A presents a stacked bar chart showing the number of clinical care measures for which rural and urban MA enrollees scored above, similar to, or below the national average for all MA enrollees (again, focusing on practically significant differences). Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure that show the percentages (and associated 95-percent confidence intervals) of rural and urban MA enrollees whose care met the standard called for by the specific measure (e.g., a test or treatment). In these unstacked bar 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 through the coloring of upward- and downward-facing arrows that appear in the bars, as described previously.

Appendix B: Rural-Urban Disparities in Health Care in Medicare by Racial and Ethnic Group—Cross-Sectional Analysis of 2023 Data

Appendix B provides detailed information on how rural and urban gaps in health care vary from one racial or ethnic group to another. The appendix begins with a stacked bar chart showing—separately for AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White MA enrollees—the number of patient experience measures for which rural and urban residents reported experiences of care that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity. Following

[12] The stacked bar charts that appear in Appendixes A and B duplicate charts that appear in the main report. In the appendixes, unlike in the main report, these stacked bar charts are followed directly by tables that detail the specific measures for each group represented in the figure that had scores that were 3 or more points above or below the relevant benchmark.

[13] 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.

these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show—separately for AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White MA enrollees—the average scores for rural and urban residents on a 0–100 scale and indicate how each group's average score compares with the national average for all MA enrollees of the same race or ethnicity. Comparable information on the patient experiences of rural and urban residents of different racial and ethnic backgrounds is then presented for people with FFS coverage. After the patient experience data, Appendix B presents a set of stacked bar charts showing, separately for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees, the number of clinical care measures for which rural and urban residents had results that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity. Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure that show, separately for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees, the percentages of rural and urban residents whose care met the standard called for by the specific measure.

Appendix C: Trends in Rural-Urban Disparities: 2017-2023

For each of the selected clinical care measures (including the measure of flu immunization that is included on the CAHPS surveys), Appendix C first presents a line graph that shows how scores for rural and urban areas changed over time from 2017 to 2023, with the exception of 2020,[14] and then presents a paired bar chart showing scores for rural and urban residents in 2017 and 2023. Accompanying each of the paired bar charts is a table summarizing (1) group differences from the national average that existed in 2017, (2) group differences from the national average that remained in 2023 (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 D. In information conveyed about group differences from the national average that existed in 2017 and 2023 (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 D: Data Sources and Methods

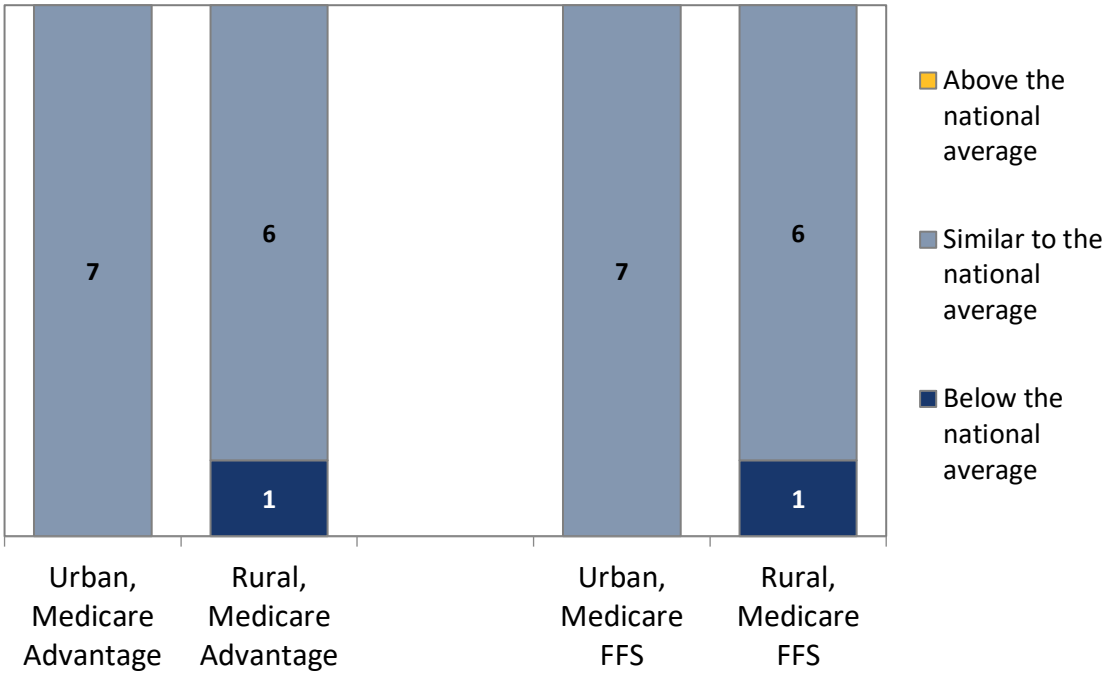
Appendix D contains detailed information on data sources and analytic methods.

[14] HEDIS clinical quality data were not released for Reporting Year 2020 due to the COVID-19 pandemic.

Appendix A: Rural-Urban Disparities in Health Care Medicare—Cross-Sectional Analysis of 2023 Data

Rural-Urban Disparities in Care: All Patient Experience Measures, Medicare Advantage and Medicare FFS

Number of patient experience measures (out of 7) for which rural and urban residents had results that were above, similar to, or below the national average in 2023



SOURCE: This chart summarizes data from all MA enrollees and people with Medicare FFS coverage nationwide who participated in the 2023 MA, FFS, and PDP CAHPS surveys.

Rural and urban residents enrolled in MA were compared with the national average for all MA enrollees. Rural and urban residents with Medicare FFS coverage were compared with the national average for all people with Medicare FFS coverage.

- **Above the national average** = The group had results that were 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 had results that were 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 had results that were below the national average. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

MA enrollees living in rural areas had results that were below the national average
• Annual Flu Vaccine

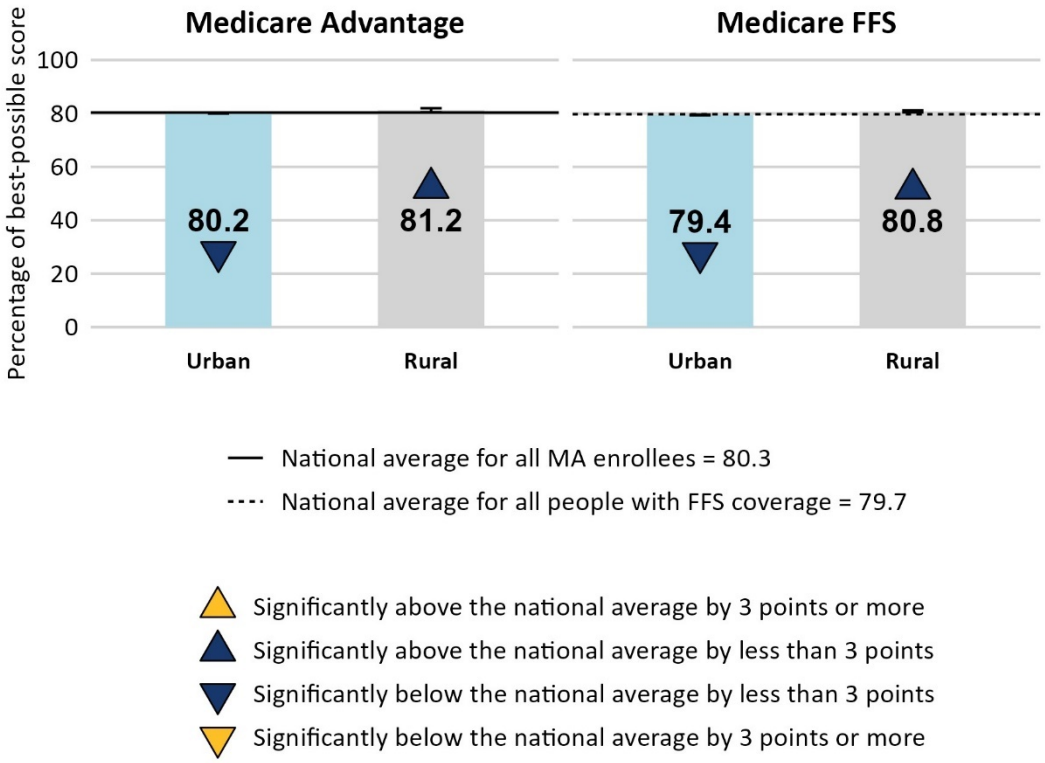
People with FFS coverage living in rural areas had results that were below the national average
• Annual Flu Vaccine

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

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

Disparities

- MA enrollees living in urban areas reported experiences with getting needed care that were **below**[‡] the national average for all MA enrollees by less than 3 points on a 0–100 scale. MA enrollees living in rural areas reported experiences with getting needed care that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

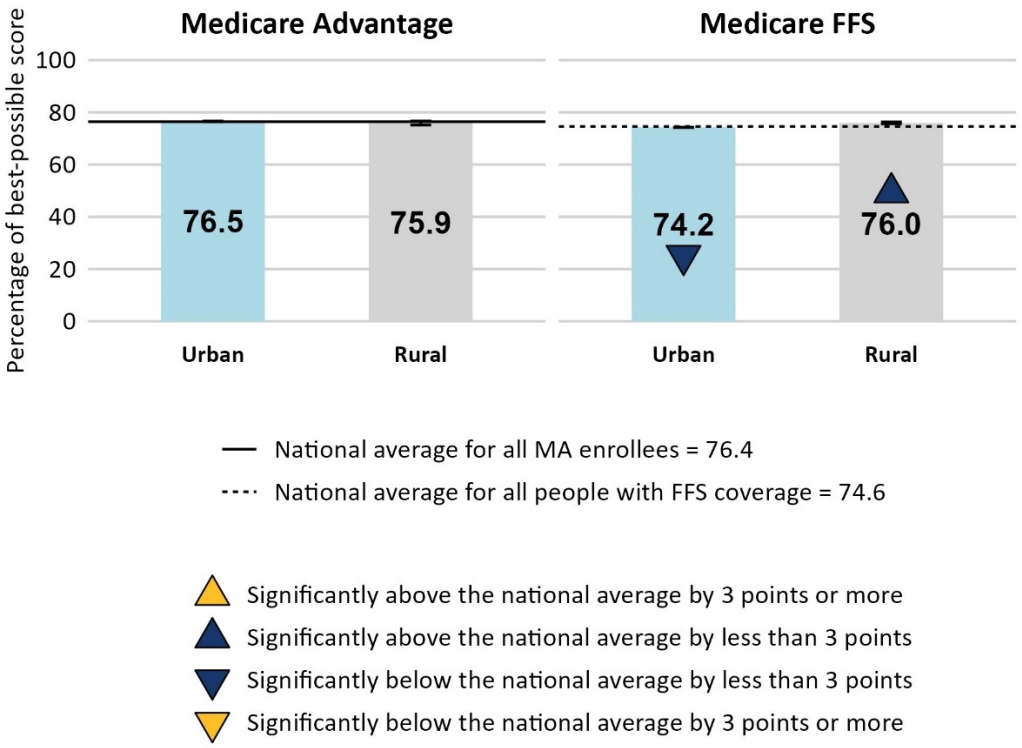
- People with FFS coverage living in urban areas reported experiences with getting needed care that were **below** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale. People with FFS coverage living in rural areas reported experiences with getting needed care that were **above** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale.

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

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

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

Disparities

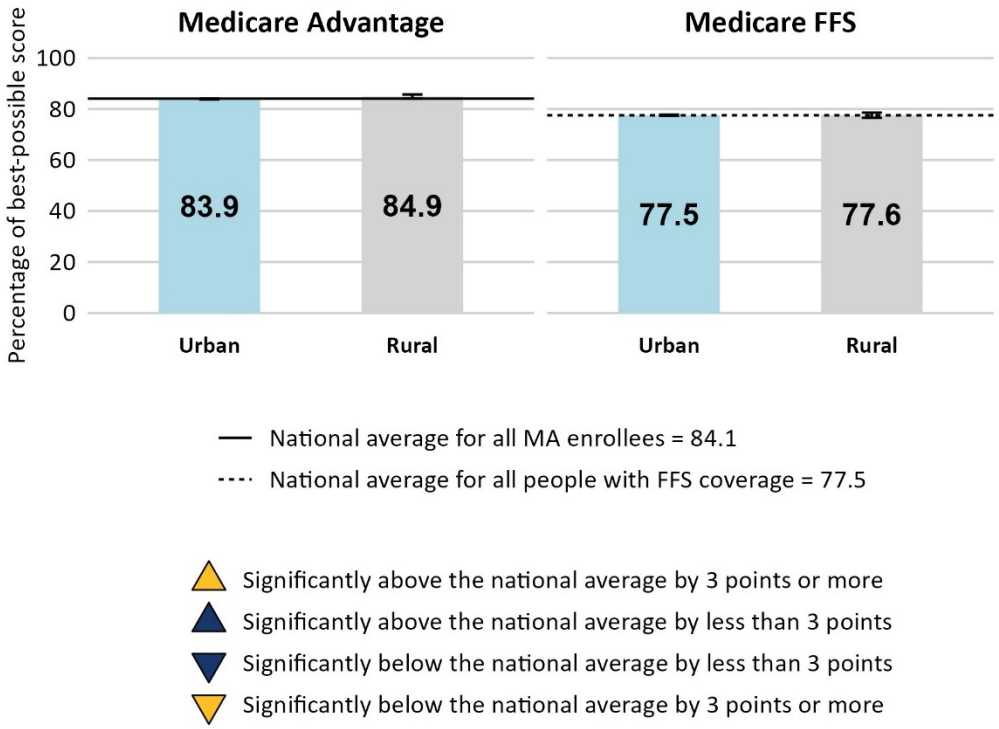
- MA enrollees living in urban areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.

- People with FFS coverage living in urban areas reported experiences with getting appointments and care quickly that were **below** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale. People with FFS coverage living in rural areas reported experiences with getting appointments and care quickly that were **above** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale.

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

Disparities

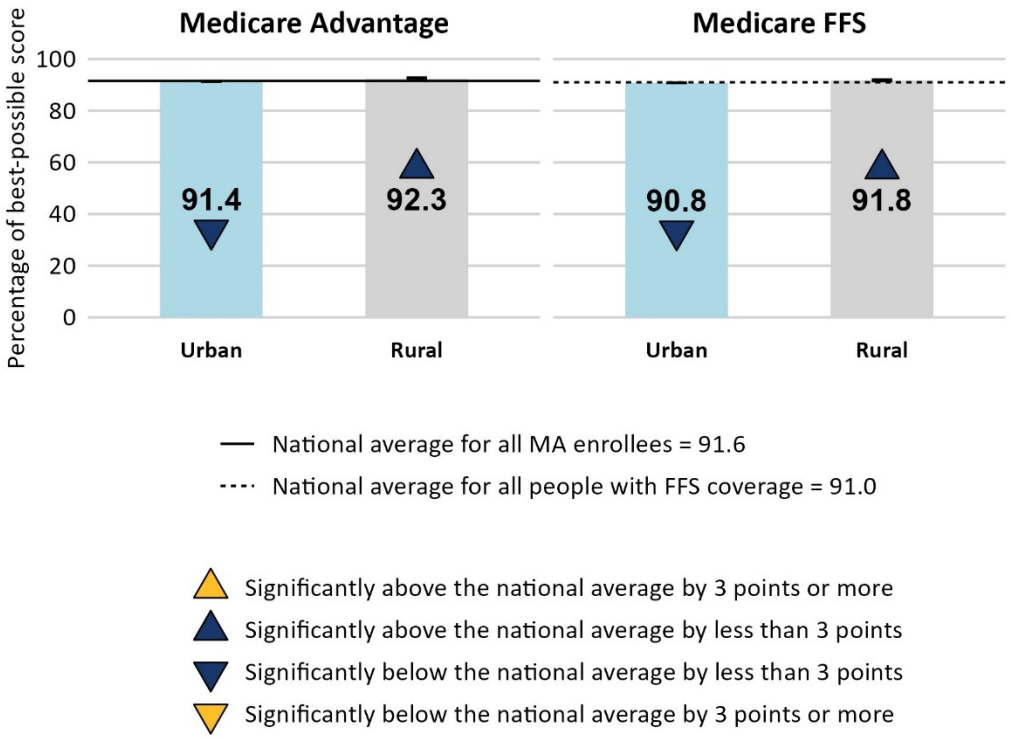
- MA enrollees living in urban areas reported experiences with customer service that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with customer service that were **similar to** the national average for all MA enrollees.

- People with FFS coverage living in urban areas reported experiences with customer service that were **similar to** the national average for all people with FFS coverage. People with FFS coverage living in rural areas reported experiences with customer service that were **similar to** the national average for all people with FFS coverage.

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

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

Disparities

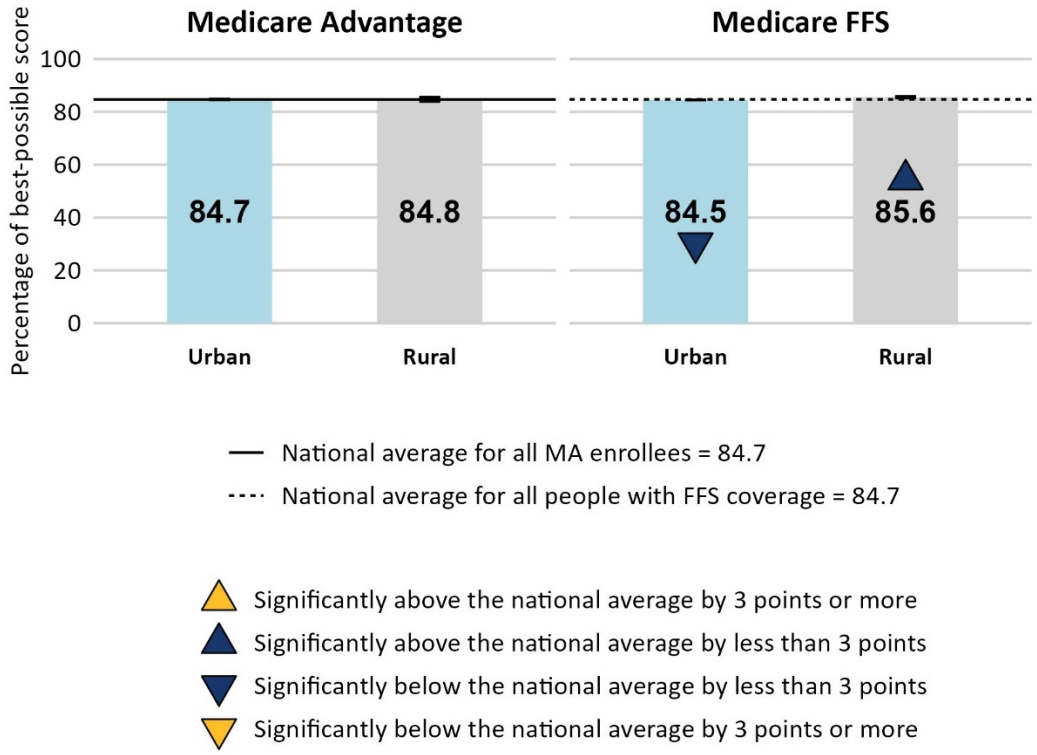
- MA enrollees living in urban areas reported experiences with doctor communication that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale. MA enrollees living in rural areas reported experiences with doctor communication that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

- People with FFS coverage living in urban areas reported experiences with doctor communication that were **below** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale. People with FFS coverage living in rural areas reported experiences with doctor communication that were **above** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale.

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

Disparities

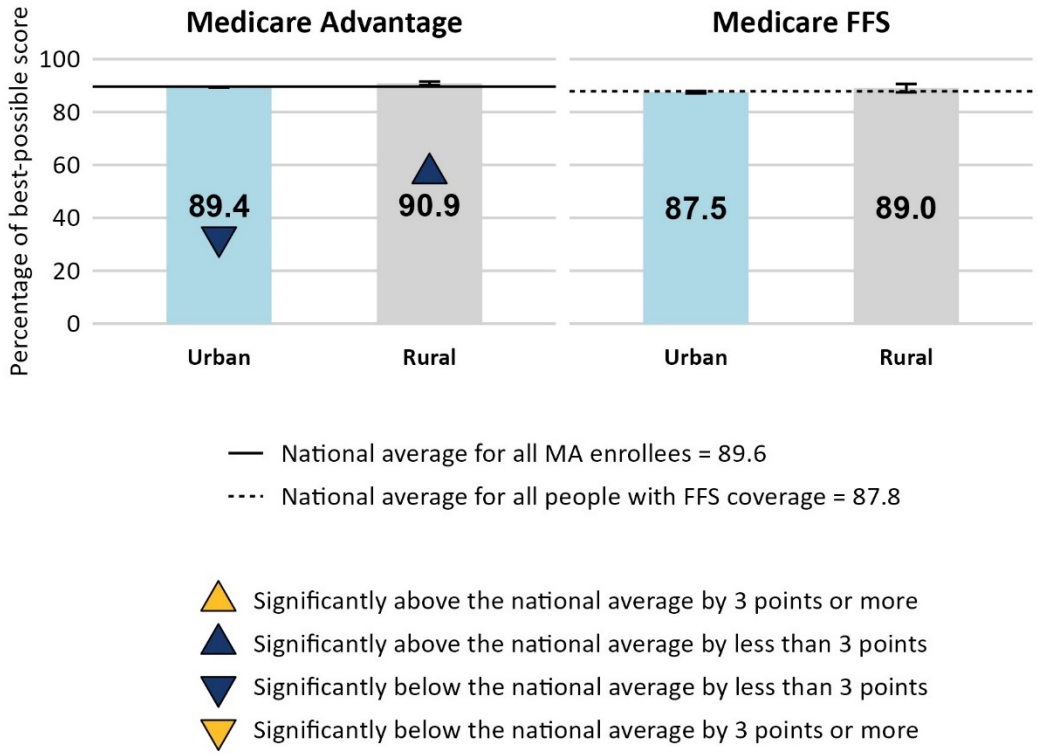
- MA enrollees living in urban areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees.

- People with FFS coverage living in urban areas reported experiences with care coordination that were **below** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale. People with FFS coverage living in rural areas reported experiences with care coordination that were **above** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale.

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,[†] by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and PDP CAHPS surveys.

Disparities

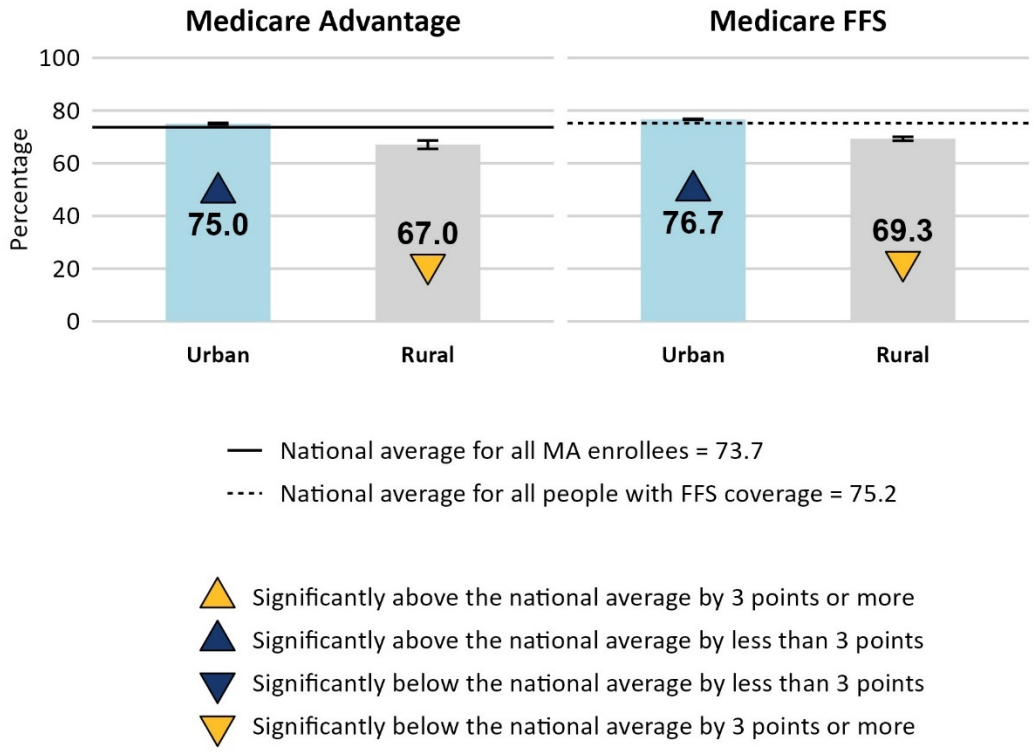
- MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale. MA enrollees living in rural areas reported experiences with getting needed prescription drugs that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

- People with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all people with FFS coverage. People with FFS coverage living in rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all people with FFS coverage.

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

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by geography within coverage type, 2023



SOURCE: Data are from the 2023 MA and FFS CAHPS surveys.

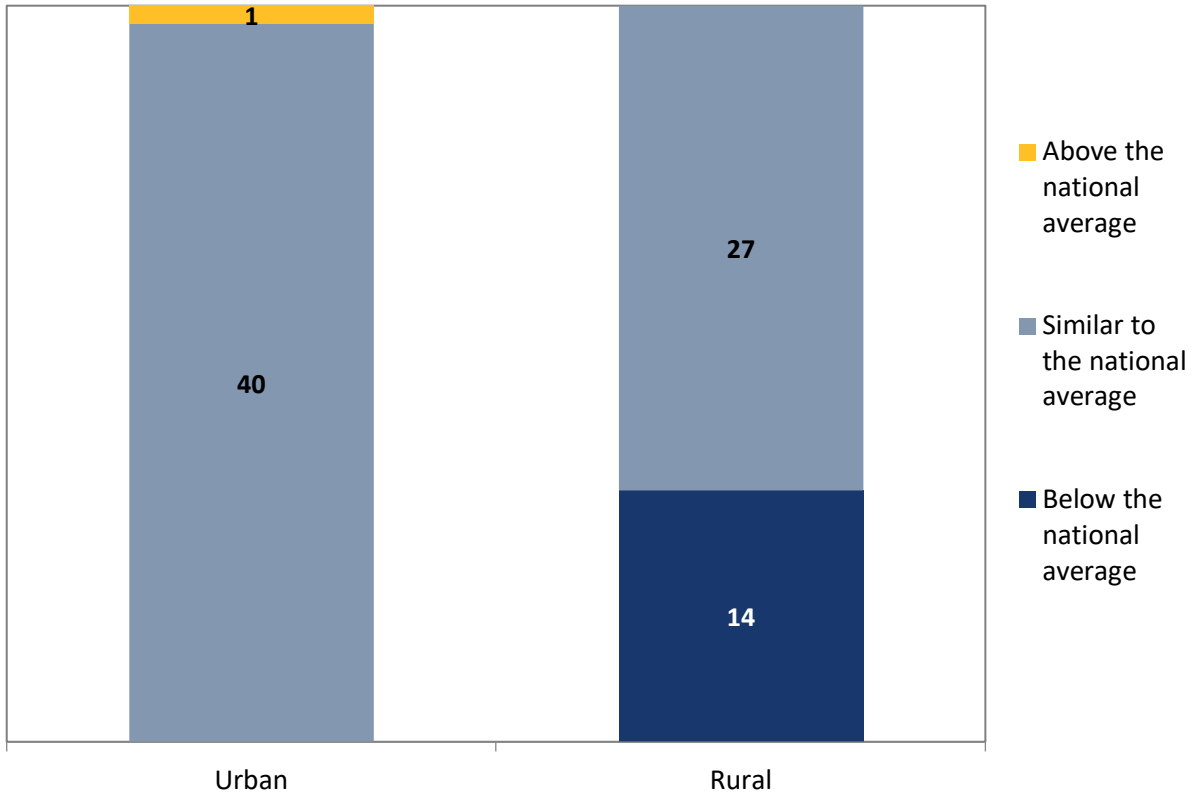
Disparities

- The percentage of MA enrollees living in urban areas who received the flu vaccination was **above** the national average for all MA enrollees by less than 3 percentage points. The percentage of MA enrollees living in rural areas who received the flu vaccination was **below** the national average for all MA enrollees by more than 3 percentage points.

- The percentage of people with FFS coverage living in urban areas who received the flu vaccination was **above** the national average for all people with FFS coverage by less than 3 percentage points. The percentage of people with FFS coverage living in rural areas who received the flu vaccination was **below** the national average for all people with FFS coverage by more than 3 percentage points.

Rural-Urban Disparities in Care: All Clinical Care Measures, Medicare Advantage

Number of clinical care measures (out of 41) for which rural and urban residents had results that were above, similar to, or below the national average for all MA enrollees in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide and reported in 2023. Clinical quality data are not available for people with Medicare FFS coverage.

NOTE: When only two groups are compared, scores for the larger group—in this case, MA enrollees living in urban areas—will always be closer to the overall (national) average than scores for the smaller group.

Rural and urban residents enrolled in MA were compared with the national average for all MA enrollees.

- **Above the national average** = The group had results that were 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 had results that were 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 had results that were 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).

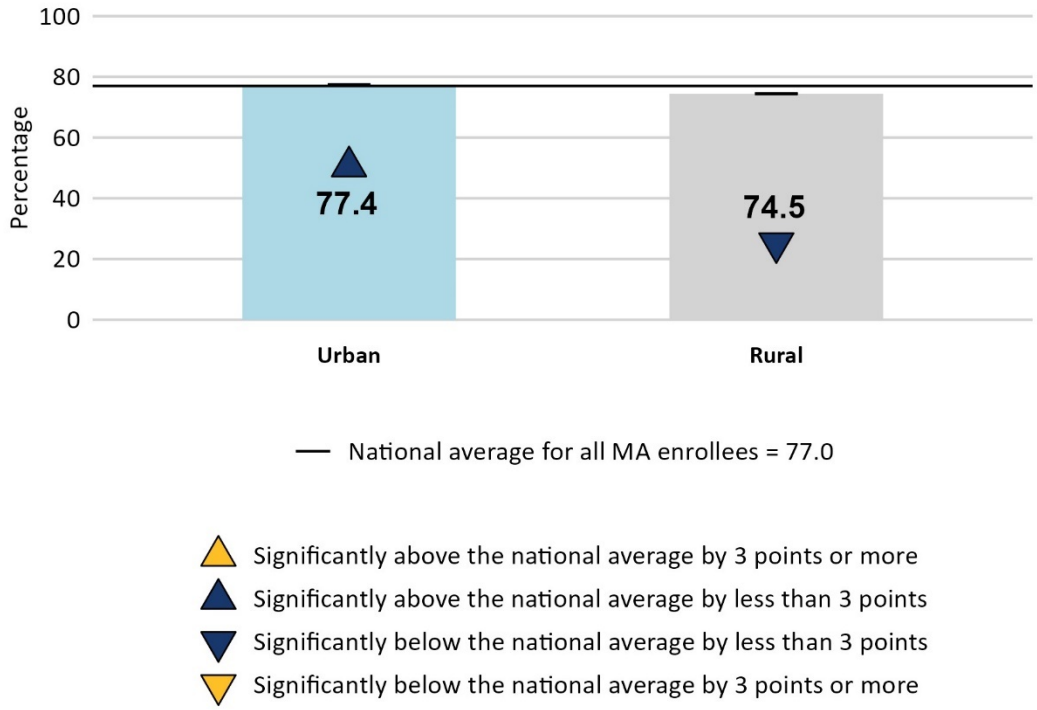
MA enrollees living in urban areas had results that were above the national average
• Kidney Health Evaluation for Patients with Diabetes

MA enrollees living in rural areas had results that were below the national average
• Colorectal Cancer Screening • Diabetes Care—Eye Exam • Kidney Health Evaluation for Patients with Diabetes • Osteoporosis Screening in Older Women • Osteoporosis Management in Women Who Had a Fracture • 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) • Transitions of Care—Notification of Inpatient Admission • Transitions of Care—Receipt of Discharge Information • Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls • Avoiding Use of High-Risk Medications in Older Adults

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible[†] female MA enrollees living in urban areas who were appropriately screened for breast cancer was **above**[‡] the national average for all eligible female MA enrollees by less than 3 percentage points.

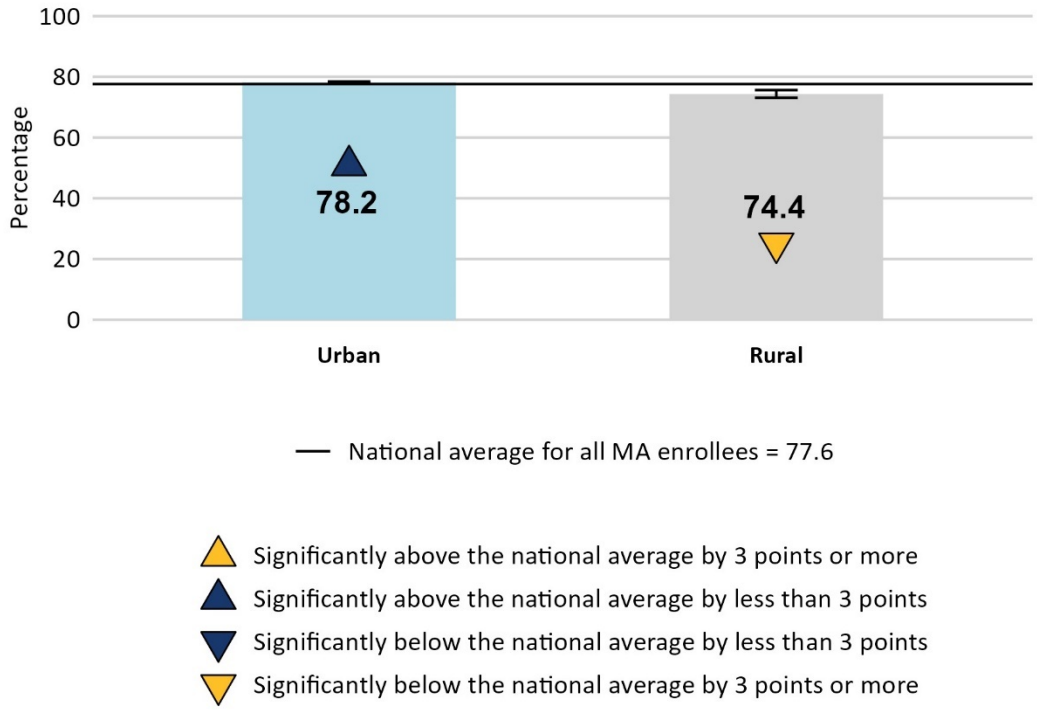
- The percentage of eligible female MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.

[†] 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 (which are specified at the top of the corresponding page).

[‡] Unlike on the preceding two pages, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

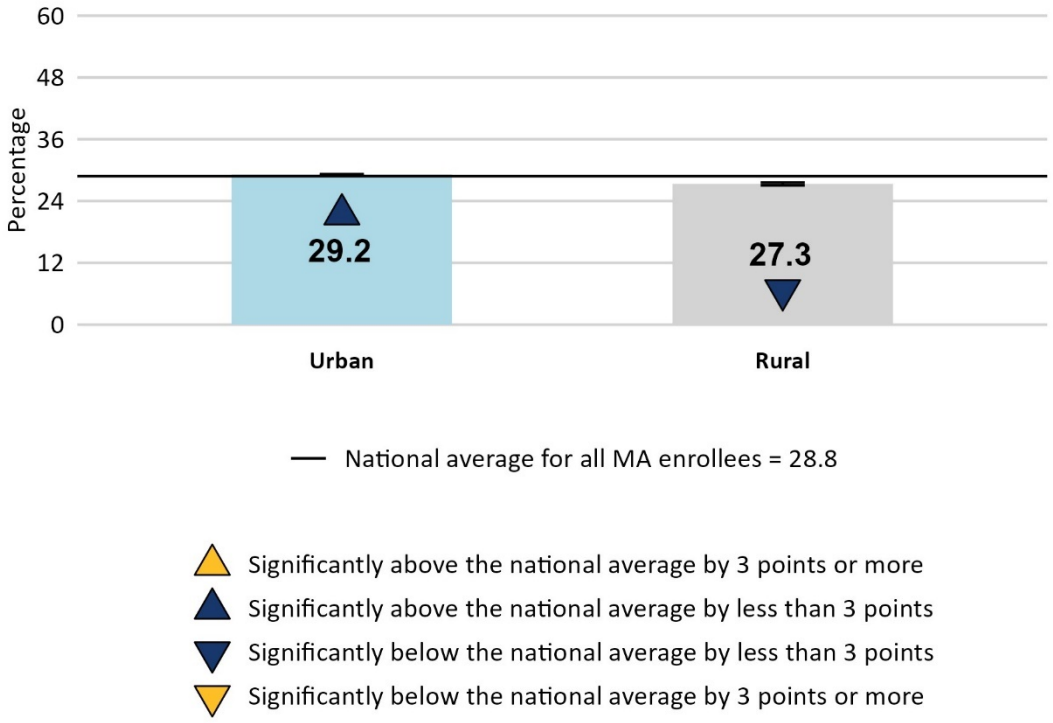
- The percentage of eligible MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

- The percentage of eligible MA enrollees living in rural areas who were appropriately screened for colorectal cancer was **below** the national average for all eligible MA enrollees by more than 3 percentage points.

Clinical Care: 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

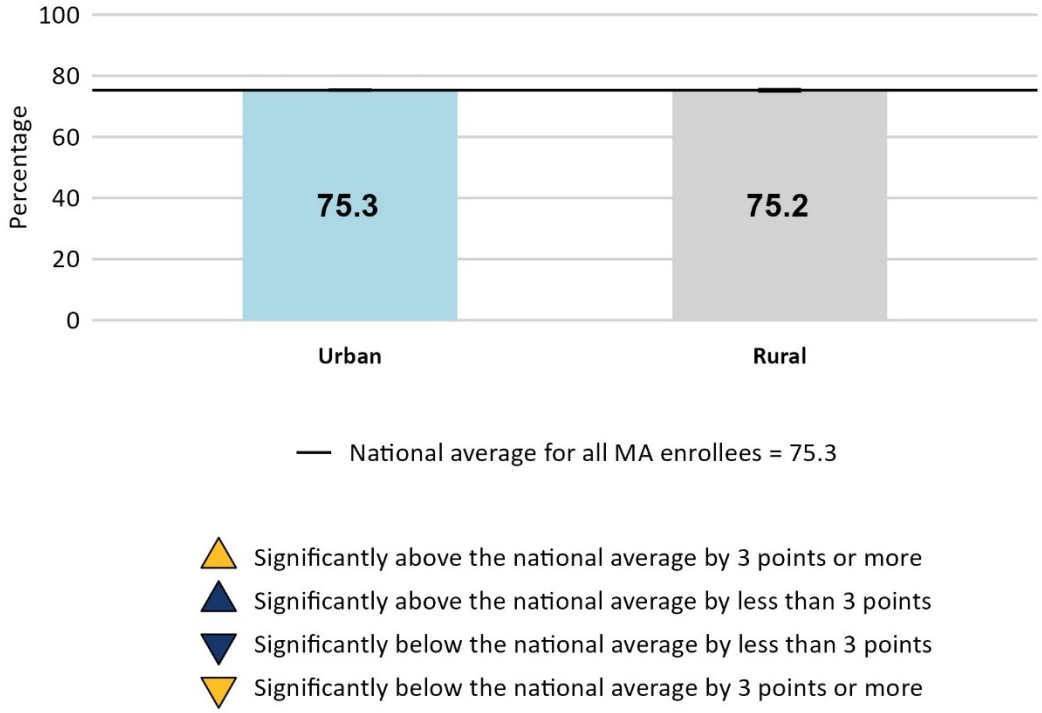
Disparities

- The percentage of eligible MA enrollees living in urban areas 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.

- The percentage of eligible MA enrollees living in rural areas 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.

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 geography, Reporting Year 2023



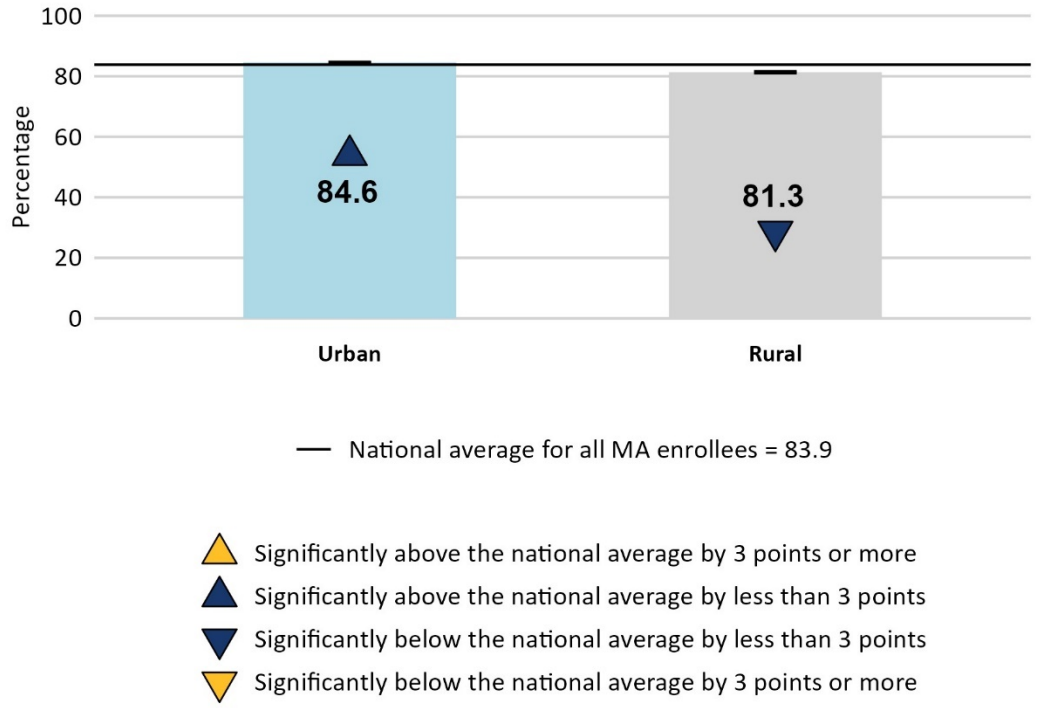
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible MA enrollees living in urban areas 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 MA enrollees living in rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

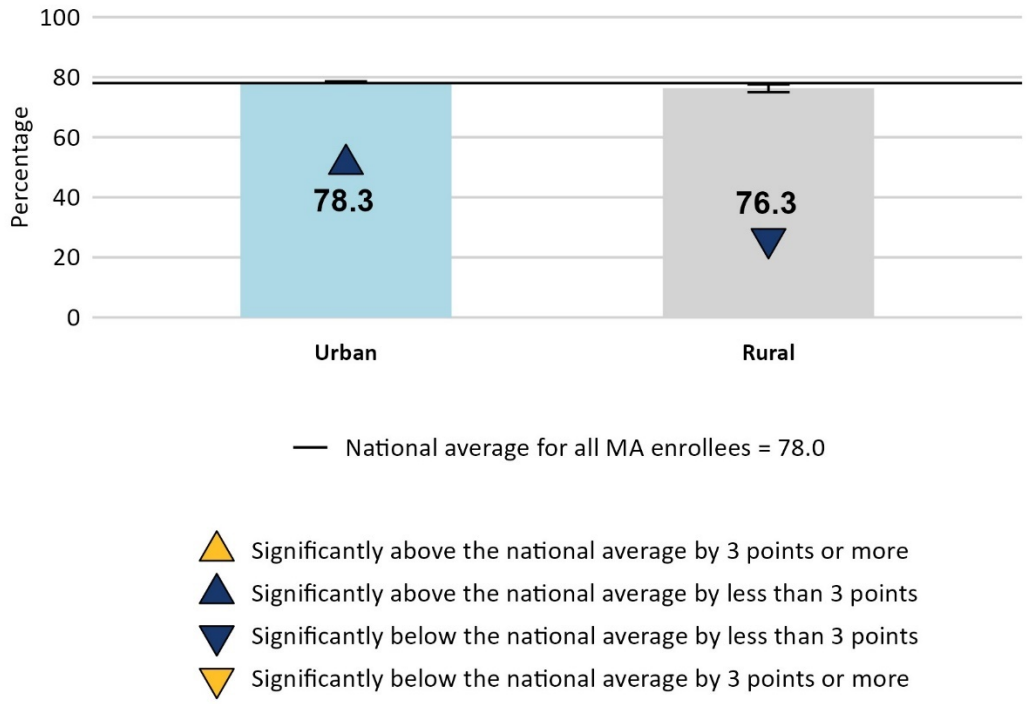
- The percentage of eligible MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

- The percentage of eligible MA enrollees living in rural areas 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.

Clinical Care: 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

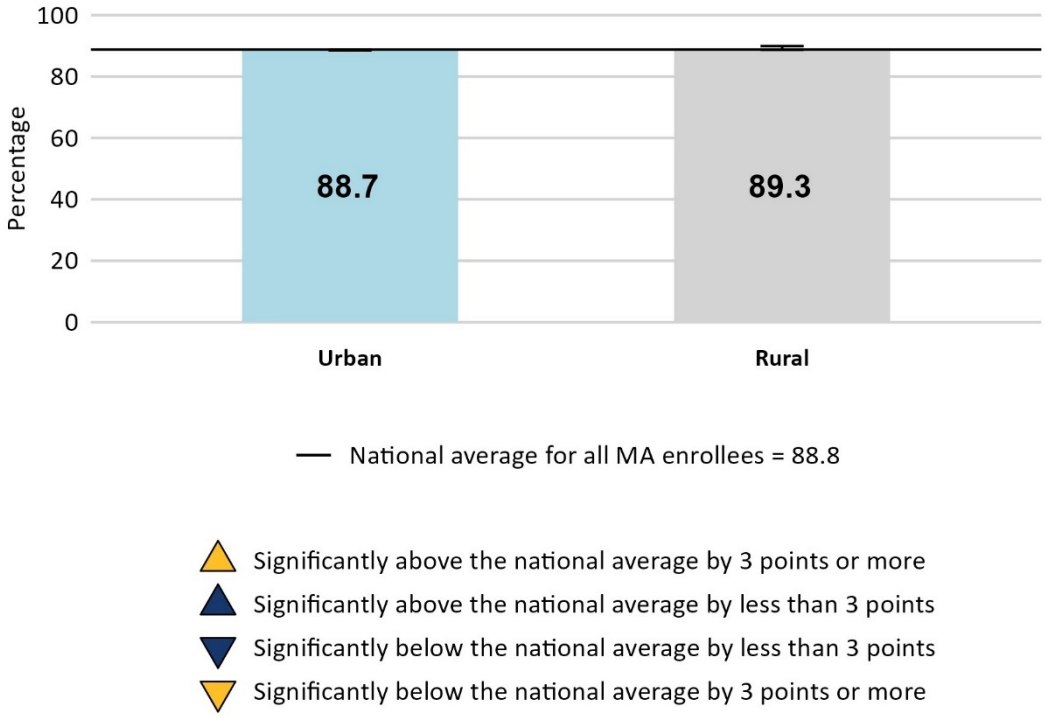
Disparities

- The percentage of eligible MA enrollees living in urban areas who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible MA enrollees living in rural areas who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] 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.

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 geography, Reporting Year 2023



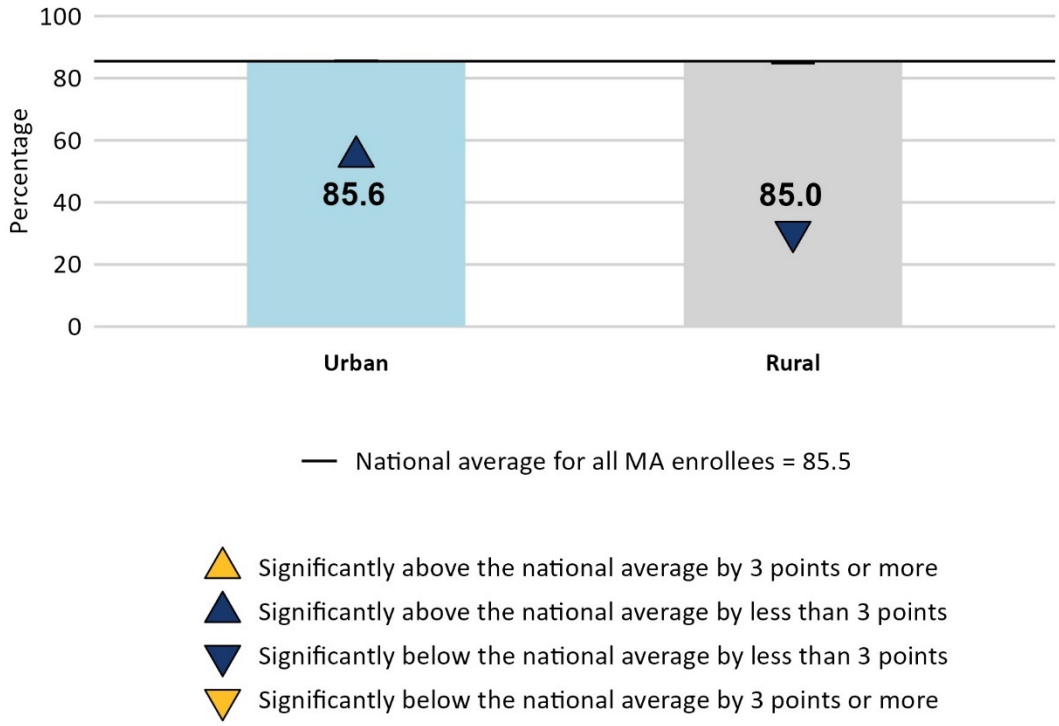
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of MA enrollees living in urban areas who received continuous beta-blocker treatment after a heart attack was **similar to** the national average for all eligible MA enrollees.
- The percentage of MA enrollees living in rural areas who received continuous beta-blocker treatment after a heart attack was **similar to** the national average for all eligible MA enrollees.

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 geography, Reporting Year 2023



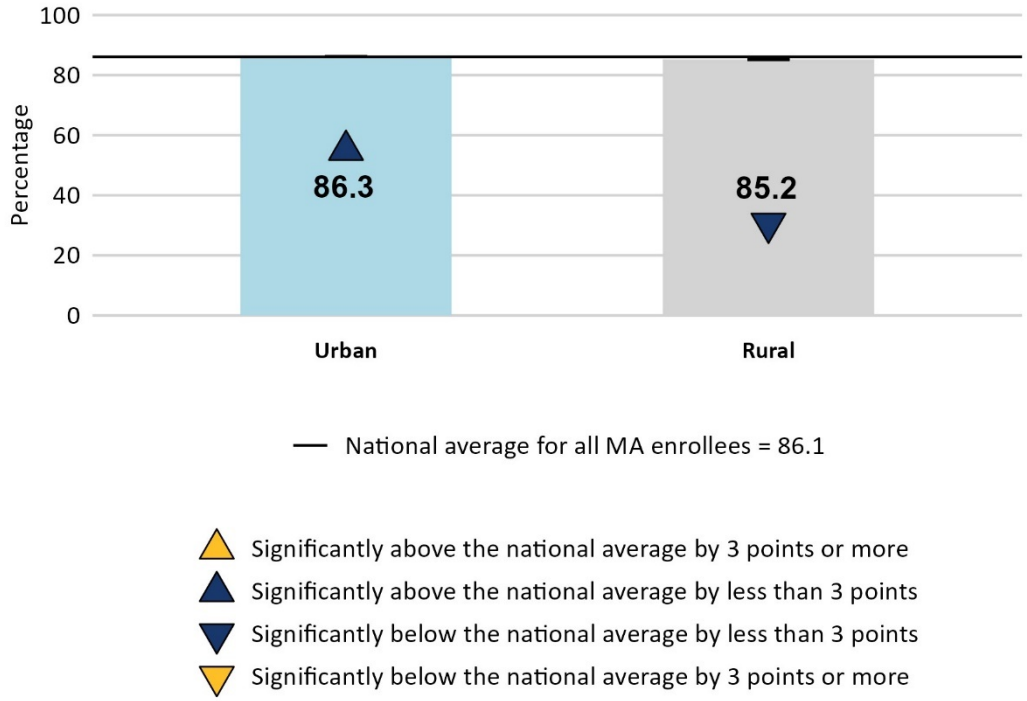
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **above** the national average for all MA enrollees with ASCVD by less than 3 percentage points.
- The percentage of MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **below** the national average for all MA enrollees with 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 who remained on the medication for at least 80 percent of the treatment period, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

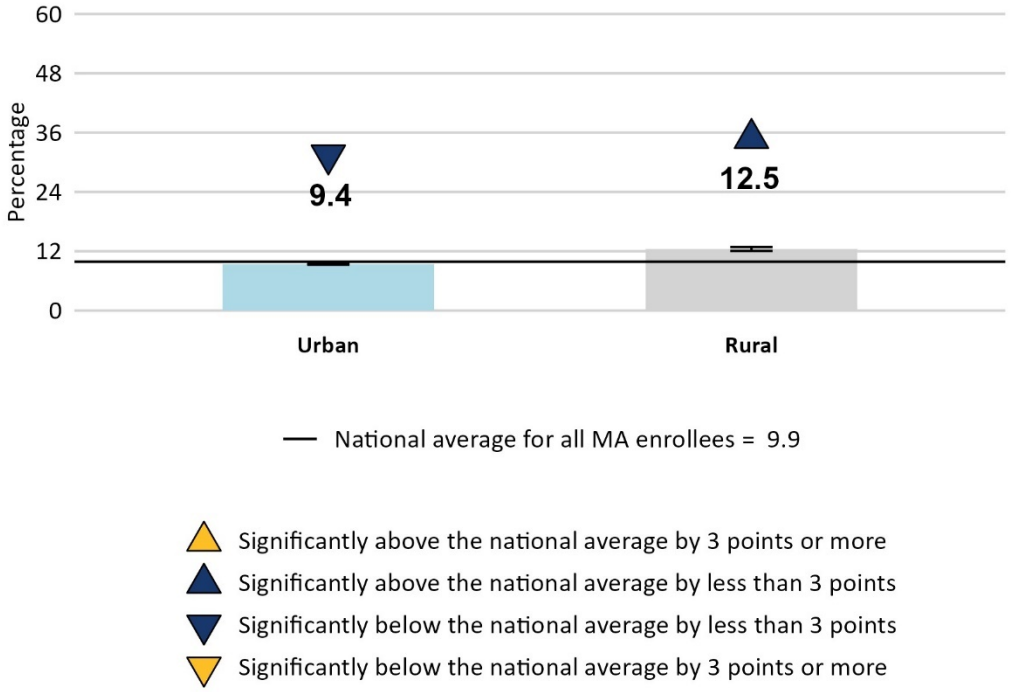
Disparities

- The percentage of MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

- The percentage of MA enrollees with clinical ASCVD living in rural areas who had proper statin medication adherence was **below** the national average for all MA enrollees with ASCVD by less than 3 percentage points.

Initiation of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older[†] who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

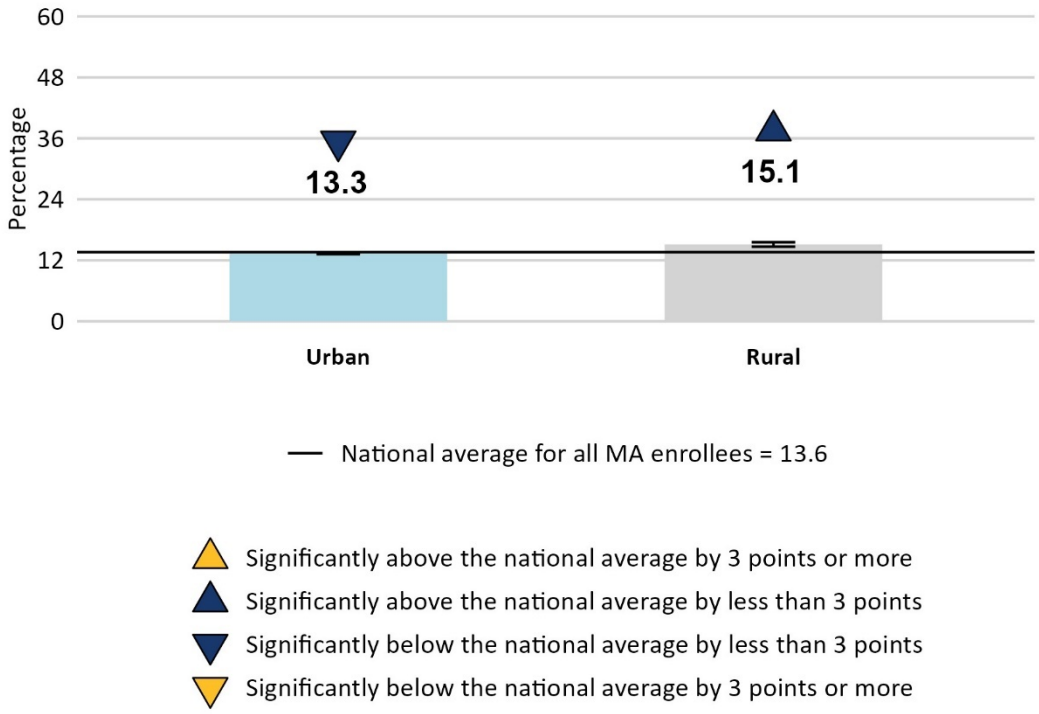
- The percentage of MA enrollees living in urban areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

- The percentage of MA enrollees living in rural areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

[†] 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.

Engagement of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older[†] who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of MA enrollees living in urban areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

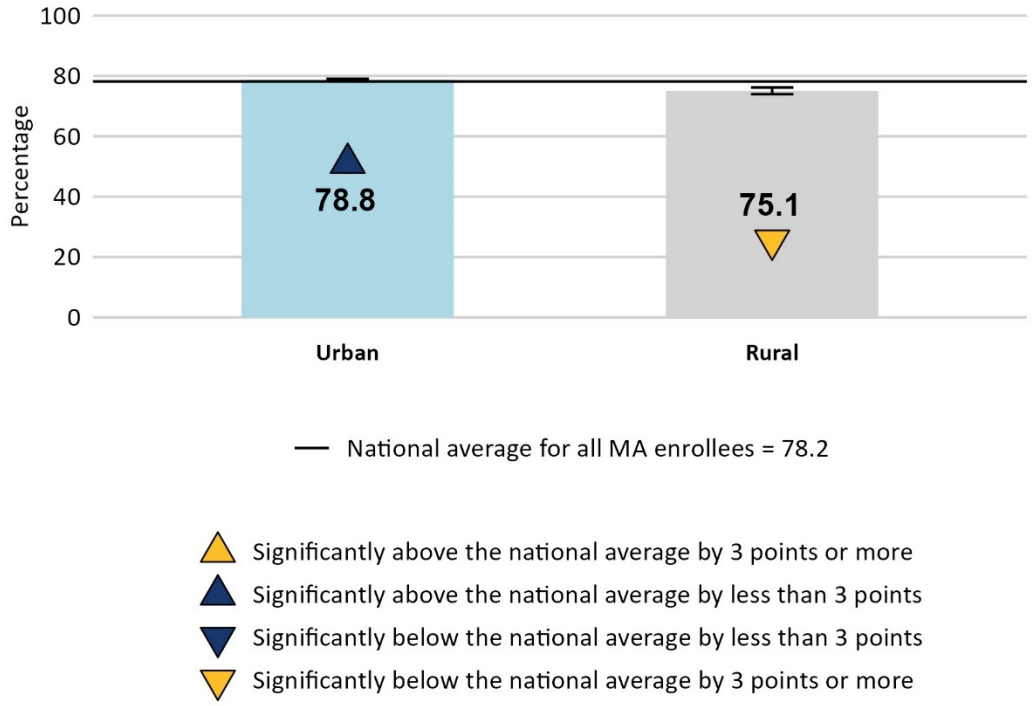
- The percentage of MA enrollees living in rural areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

[†] 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.

Clinical Care: Diabetes

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 geography, Reporting Year 2023



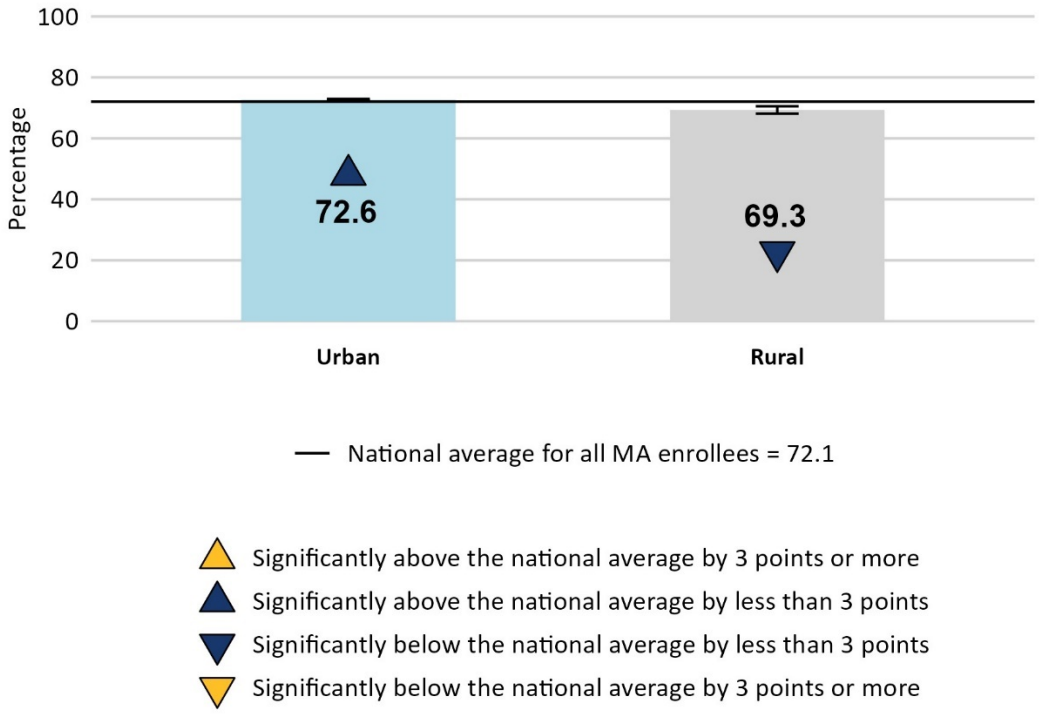
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of MA enrollees with diabetes living in urban areas 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 MA enrollees with diabetes living in rural areas 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

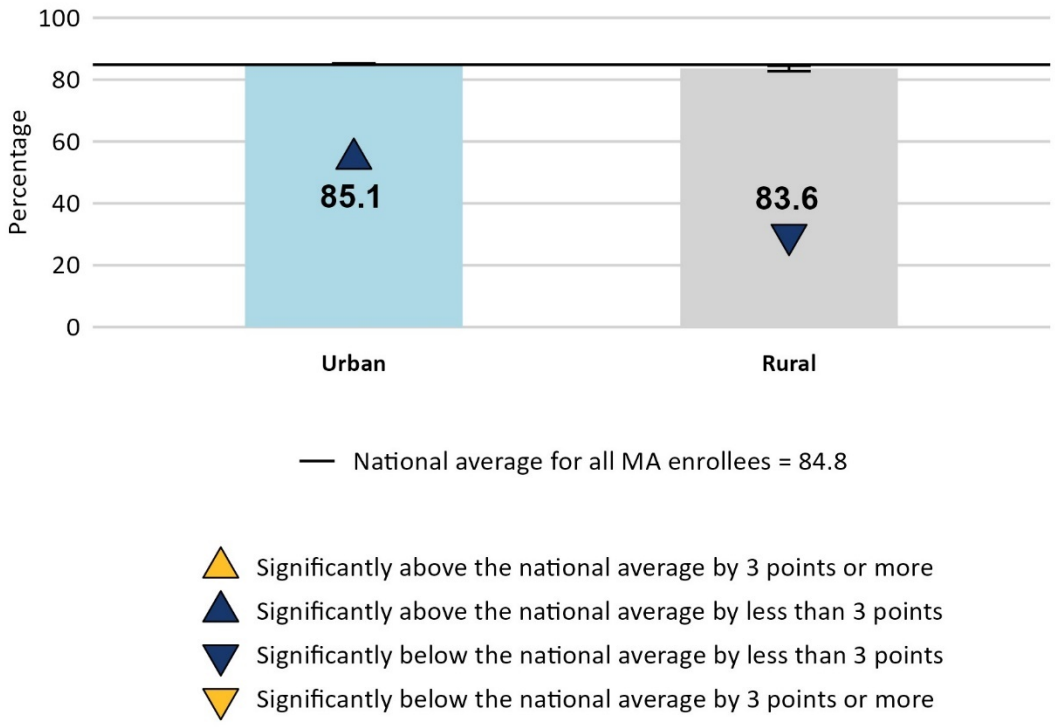
Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had their blood pressure under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

- The percentage of MA enrollees with diabetes living in rural areas who had their blood pressure under control was **below** 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

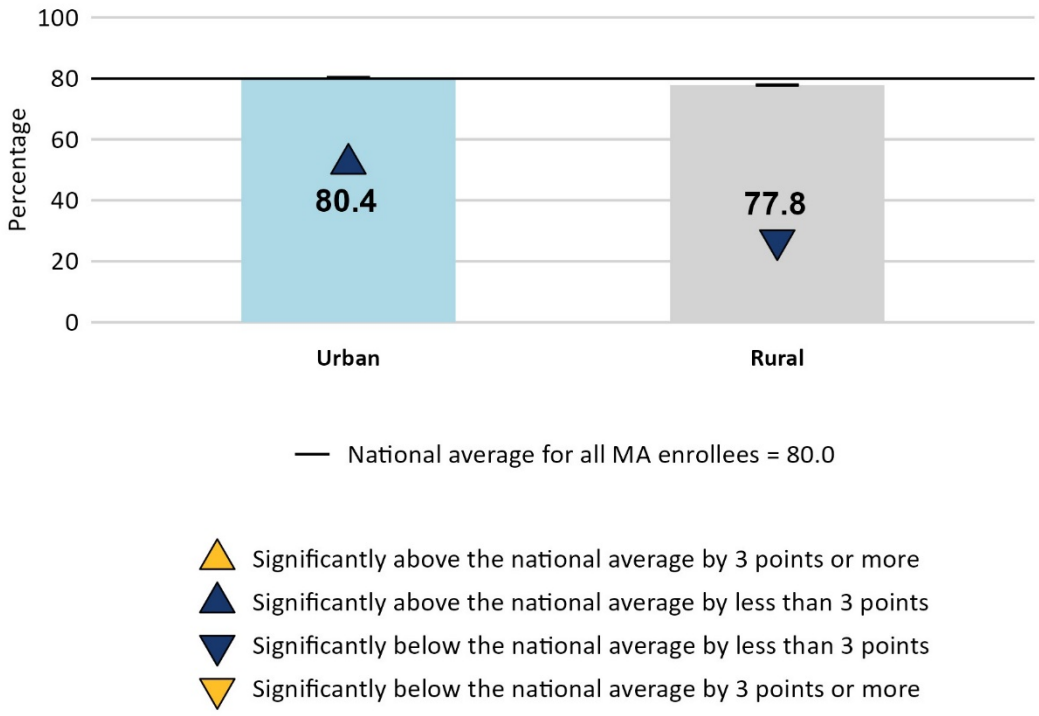
Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had their blood sugar level under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

- The percentage of MA enrollees with diabetes living in rural areas who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

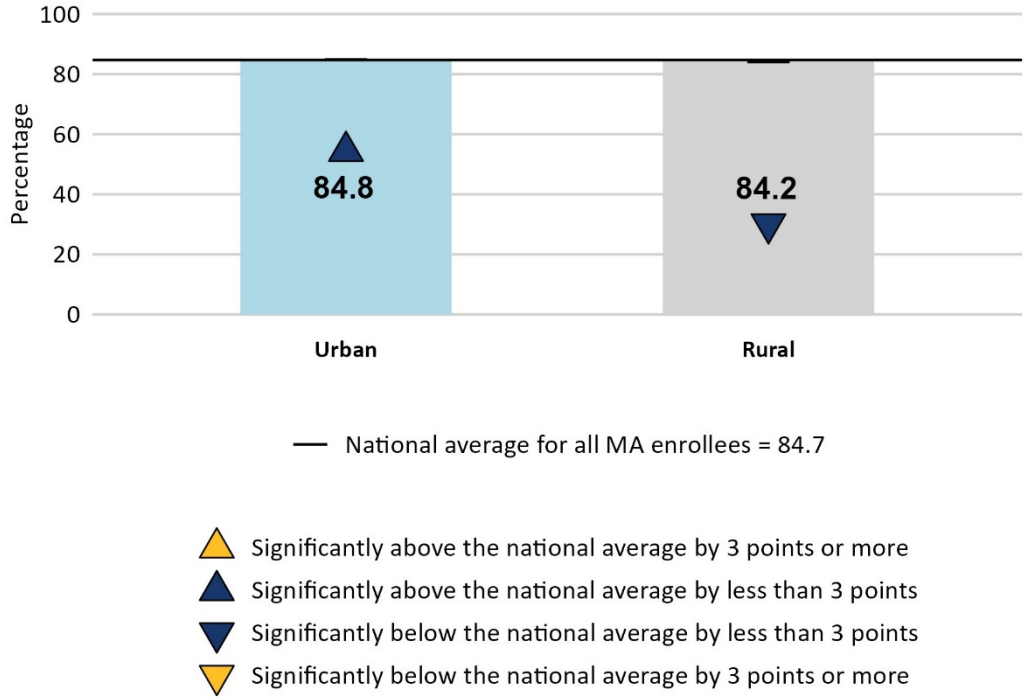
Disparities

- The percentage of MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of MA enrollees with diabetes living in rural areas who received statin therapy was **below** 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

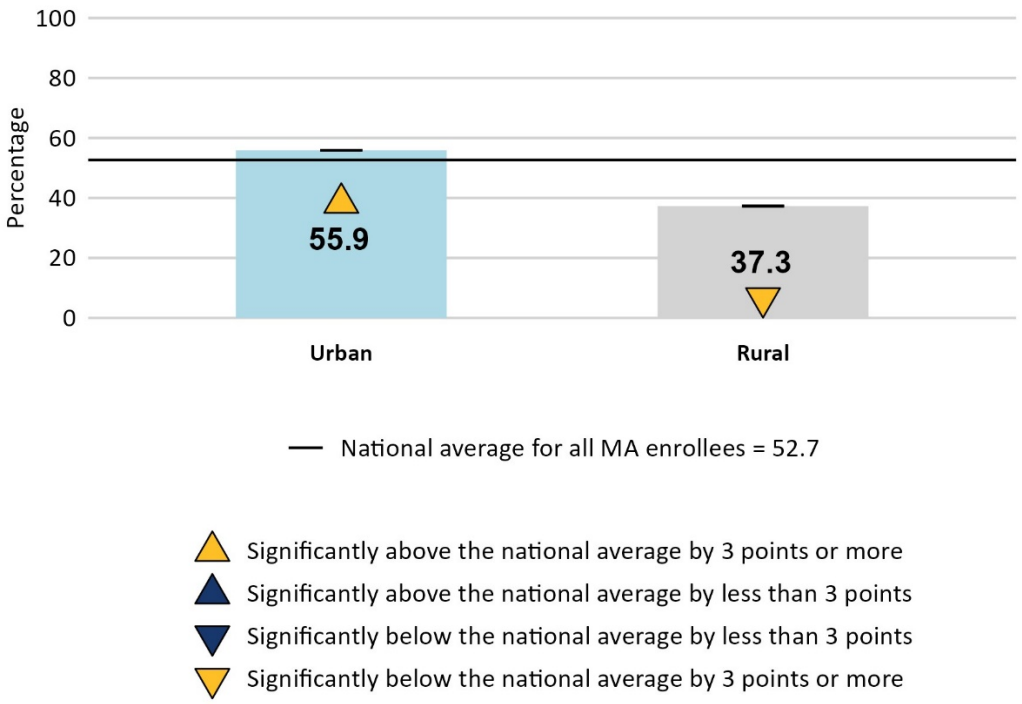
Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **below** 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

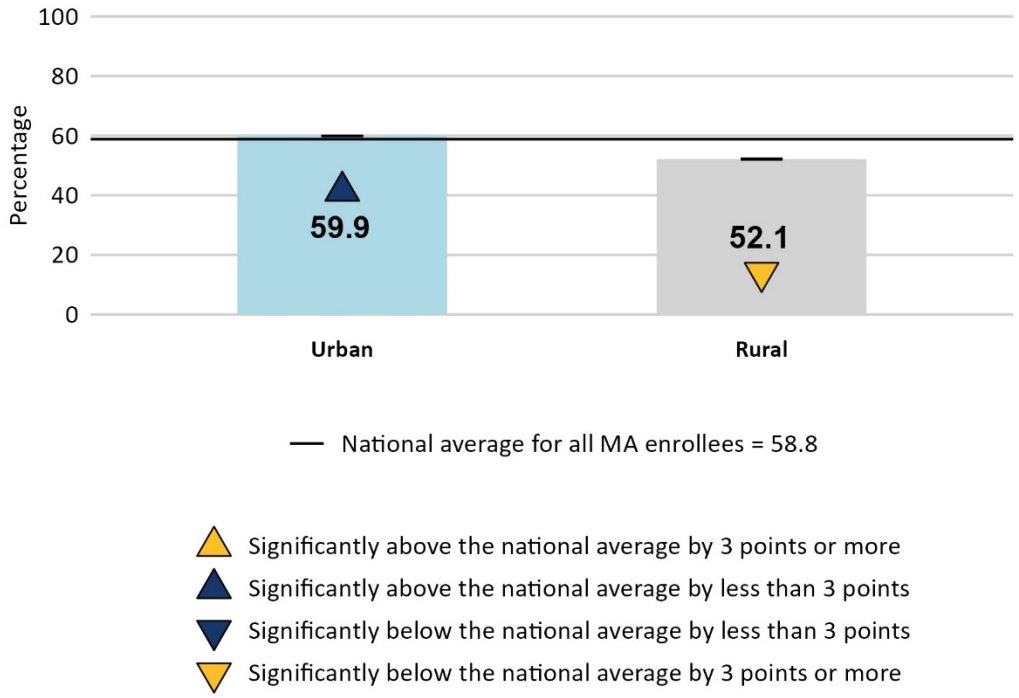
- The percentage of MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** 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.

Clinical Care: Musculoskeletal Conditions

Osteoporosis Screening in Older Women

Percentage of female MA enrollees aged 65 to 75 years who had appropriate screening for osteoporosis, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

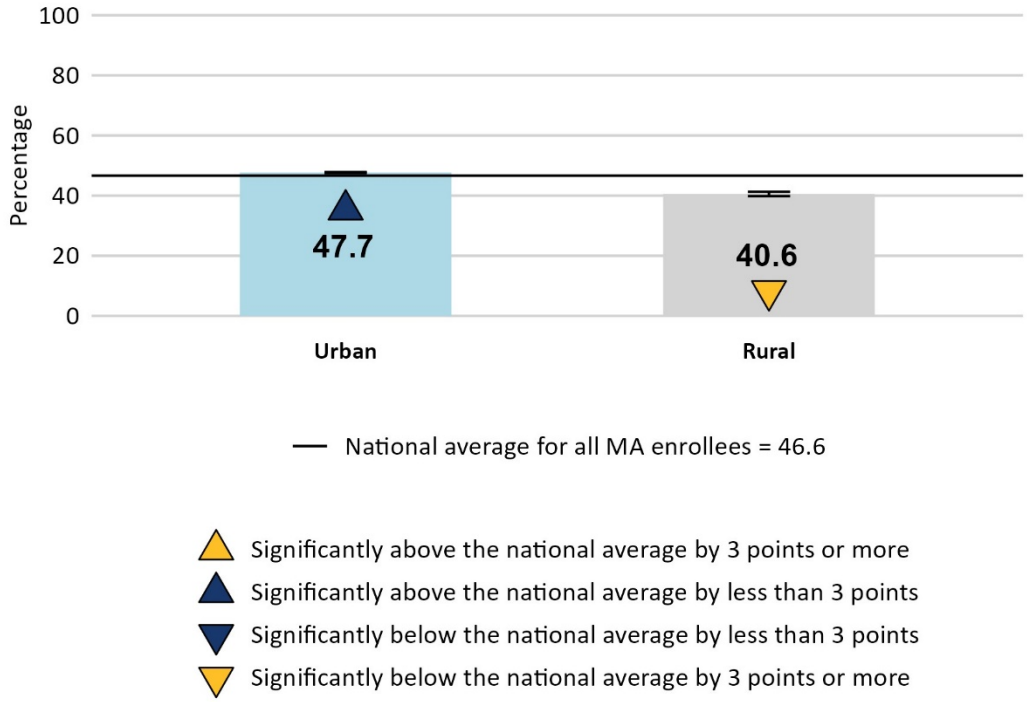
Disparities

- The percentage of eligible female MA enrollees living in urban areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.

- The percentage of eligible female MA enrollees living in rural areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

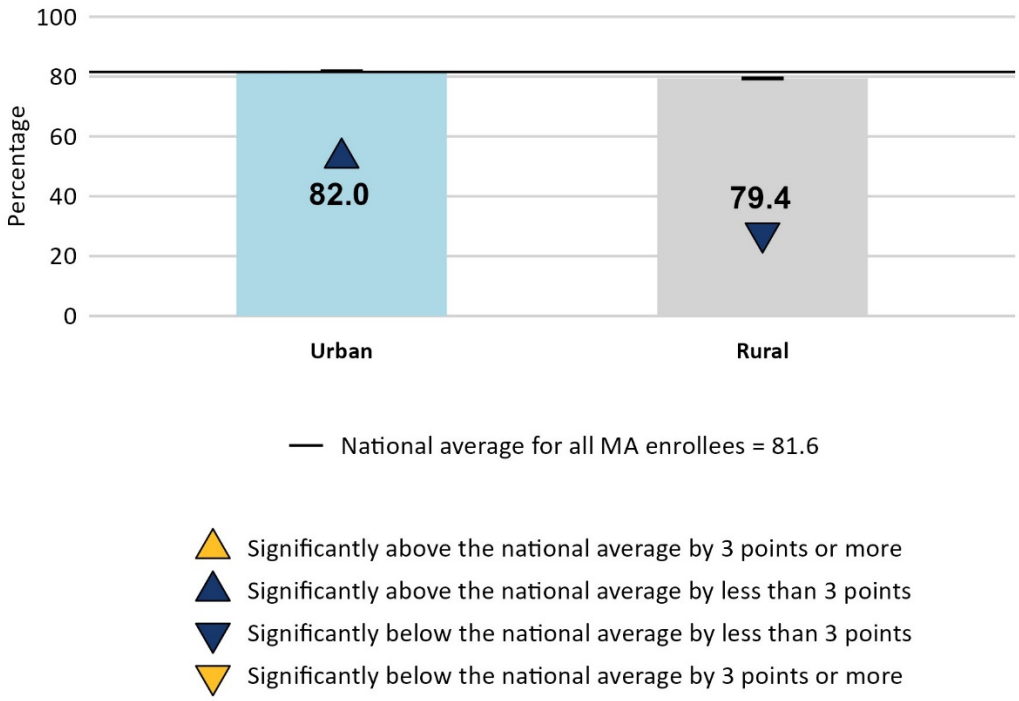
- The percentage of eligible female MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.

- The percentage of eligible female MA enrollees living in rural areas 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.

Clinical Care: 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 geography, Reporting Year 2023



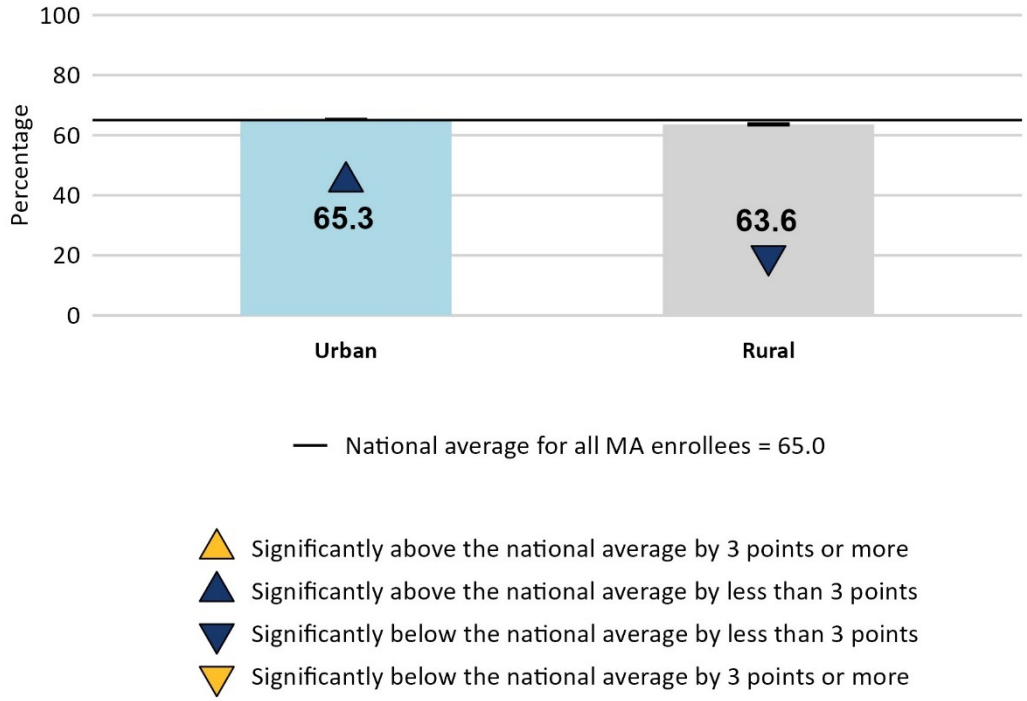
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible MA enrollees living in urban areas 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.
- The percentage of eligible MA enrollees living in rural areas 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.

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 the medication for at least 180 days, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

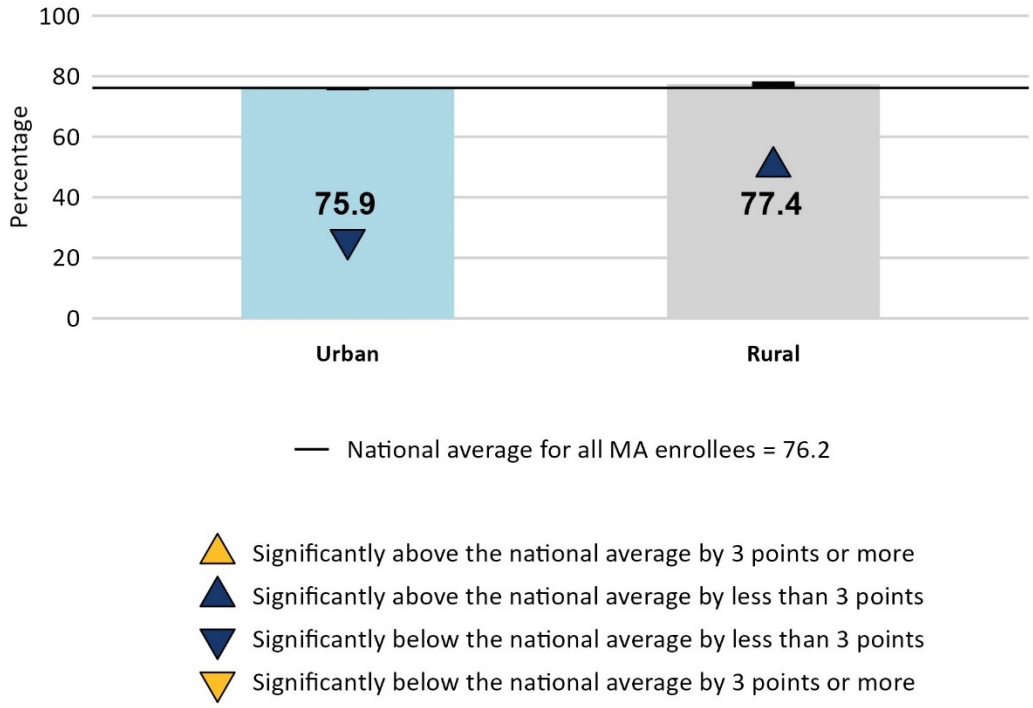
Disparities

- The percentage of eligible MA enrollees living in urban areas 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.

- The percentage of eligible MA enrollees living in rural areas 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

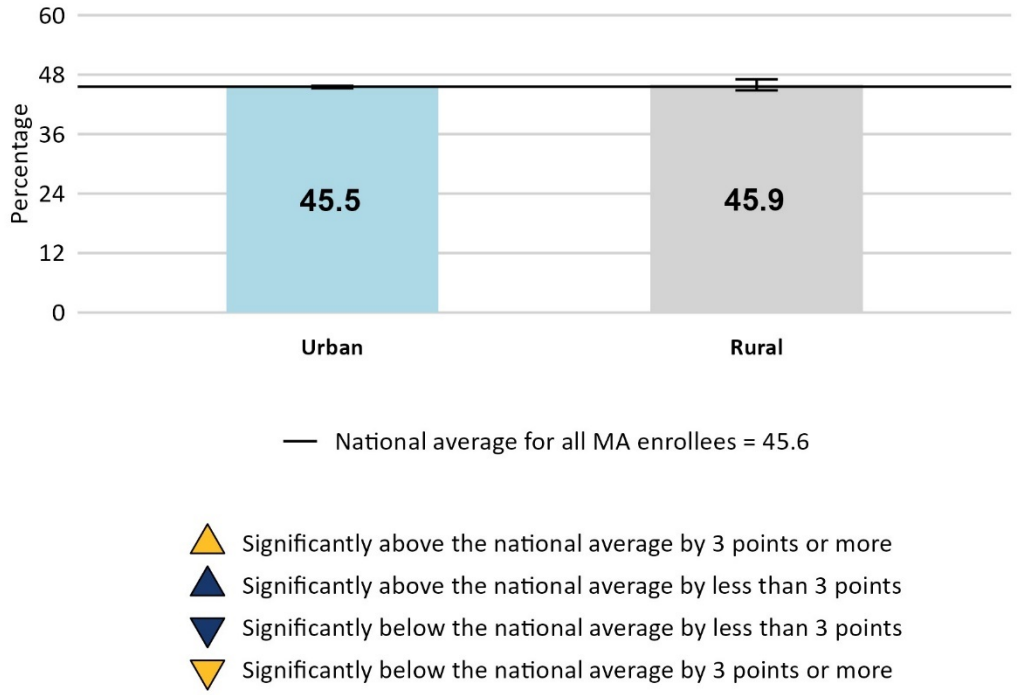
Disparities

- The percentage of MA enrollees with schizophrenia or schizoaffective disorder living in urban areas 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 eligible MA enrollees by less than 3 percentage points.

- The percentage of MA enrollees with schizophrenia or schizoaffective disorder living in rural areas 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 eligible MA enrollees by less 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

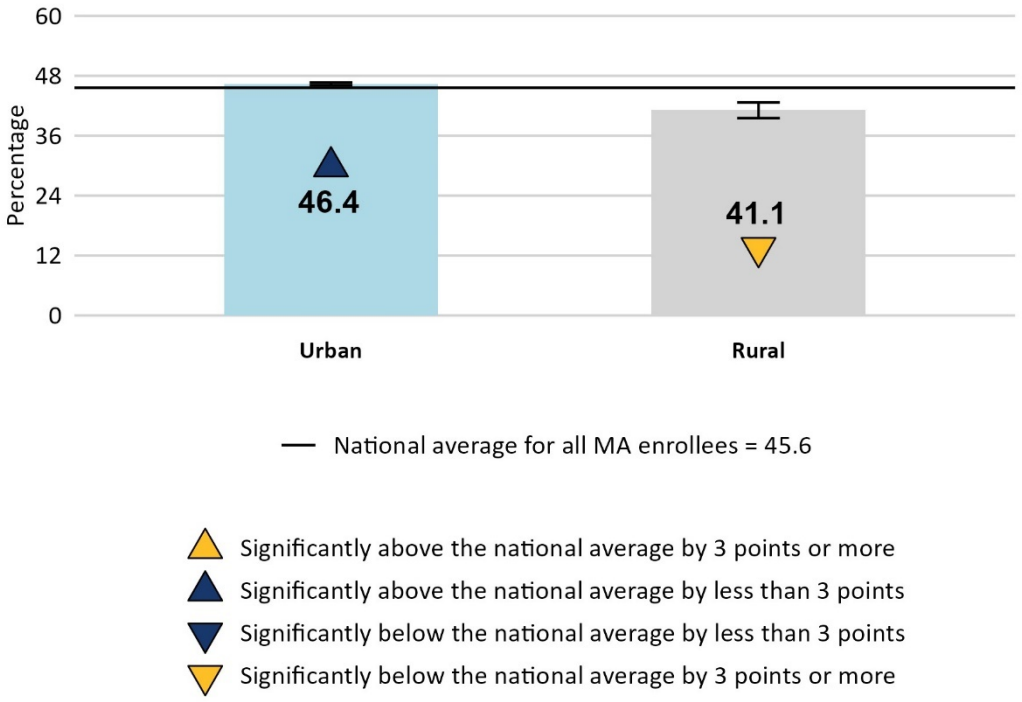
- The percentage of MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible MA enrollees.

- The percentage of MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible MA enrollees.

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

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

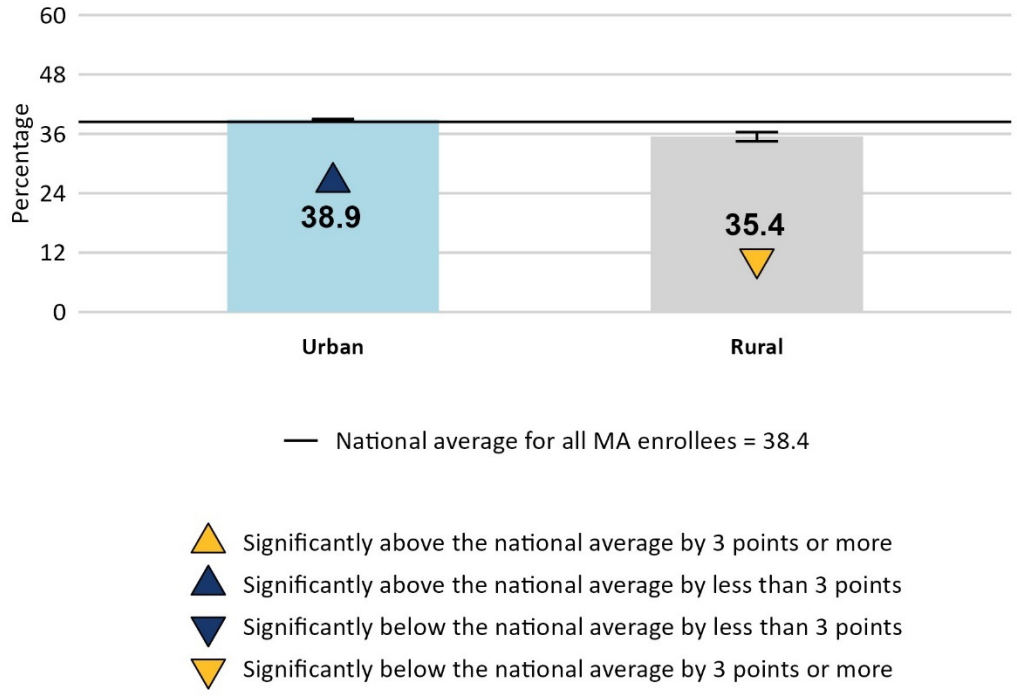
- The percentage of MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

- The percentage of MA enrollees living in rural areas 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 MA enrollees by more than 3 percentage points.

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

Follow-Up After ED Visit for 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of MA enrollees living in urban areas 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.

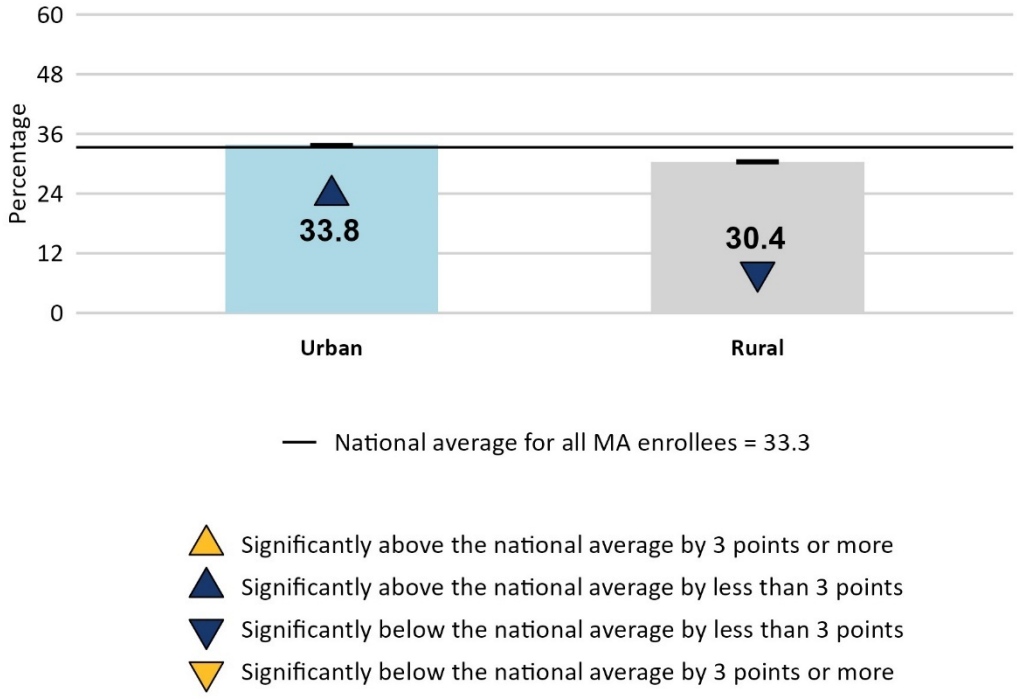
- The percentage of MA enrollees living in rural areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points. [‡]

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

[‡] Prior to rounding.

Initiation of AOD 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of MA enrollees living in urban areas 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.

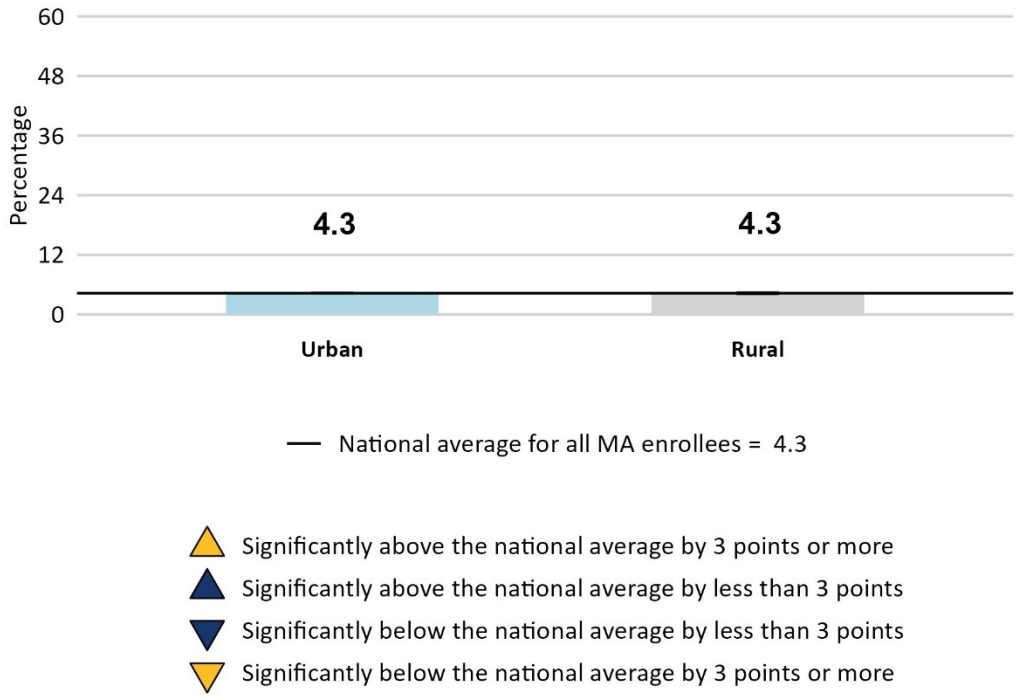
- The percentage of MA enrollees living in rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

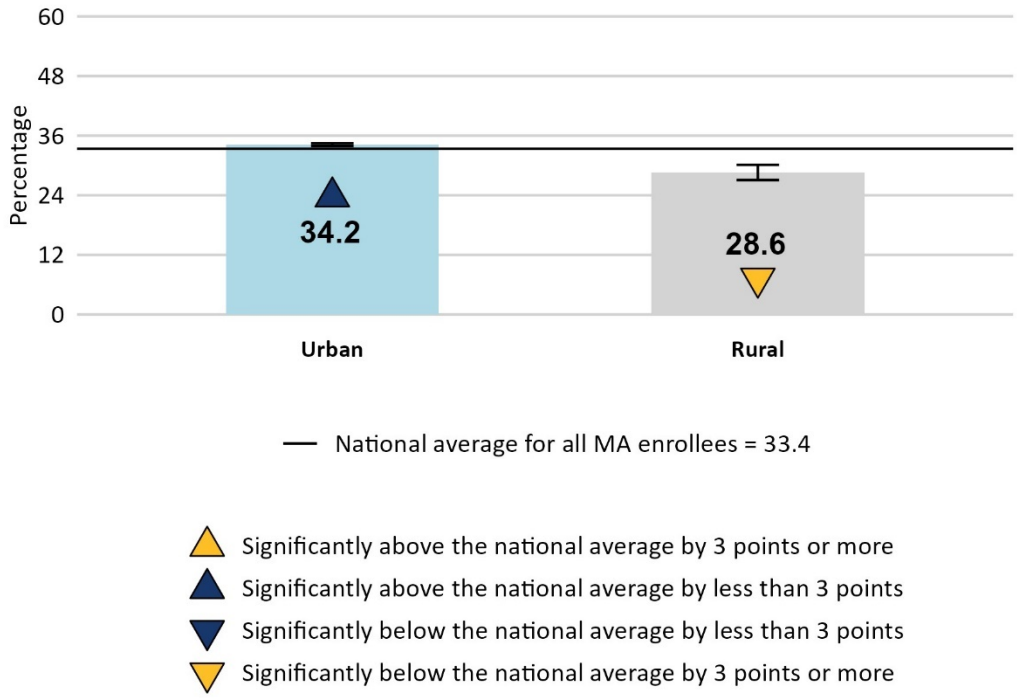
- The percentage of MA enrollees with a new episode of AOD dependence living in urban areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of MA enrollees with a new episode of AOD dependence living in rural areas 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.

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

Clinical Care: 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

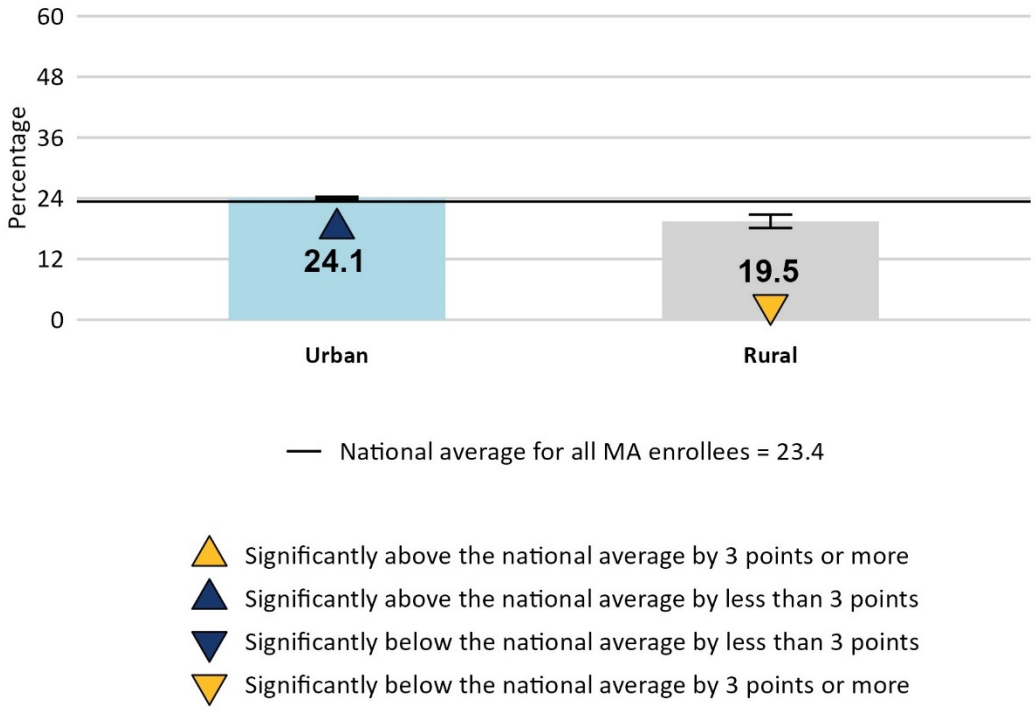
- The percentage of MA enrollees living in urban areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

- The percentage of MA enrollees living in rural areas 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 MA enrollees by more than 3 percentage points.

[†] 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

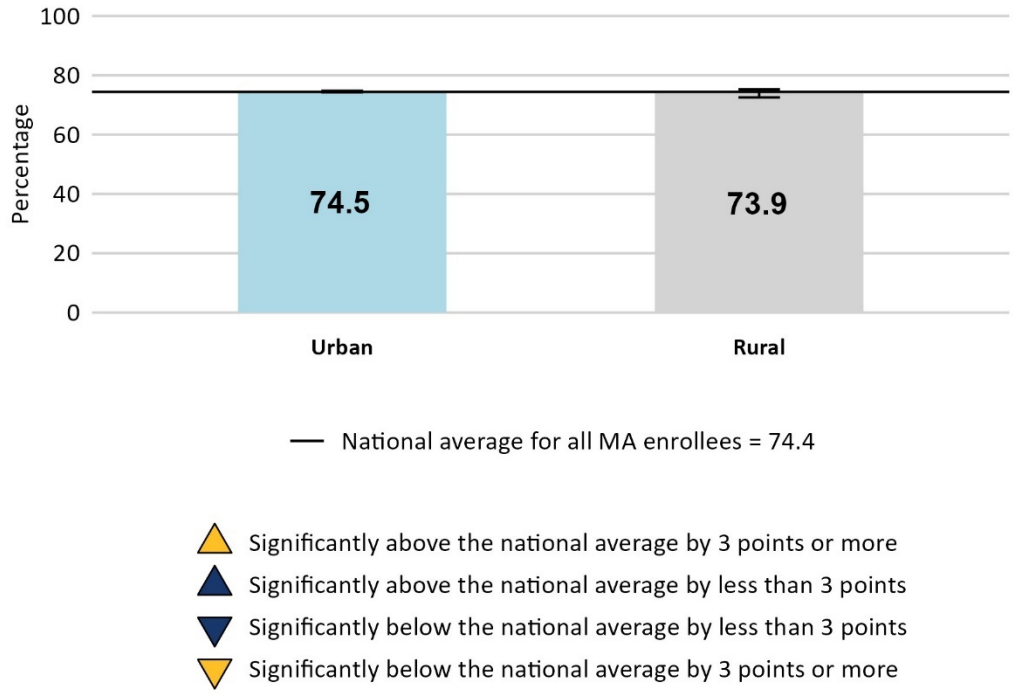
Disparities

- The percentage of MA enrollees living in urban areas 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 MA enrollees by less than 3 percentage points.
- The percentage of MA enrollees living in rural areas 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 MA enrollees by more than 3 percentage points.

[†] 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

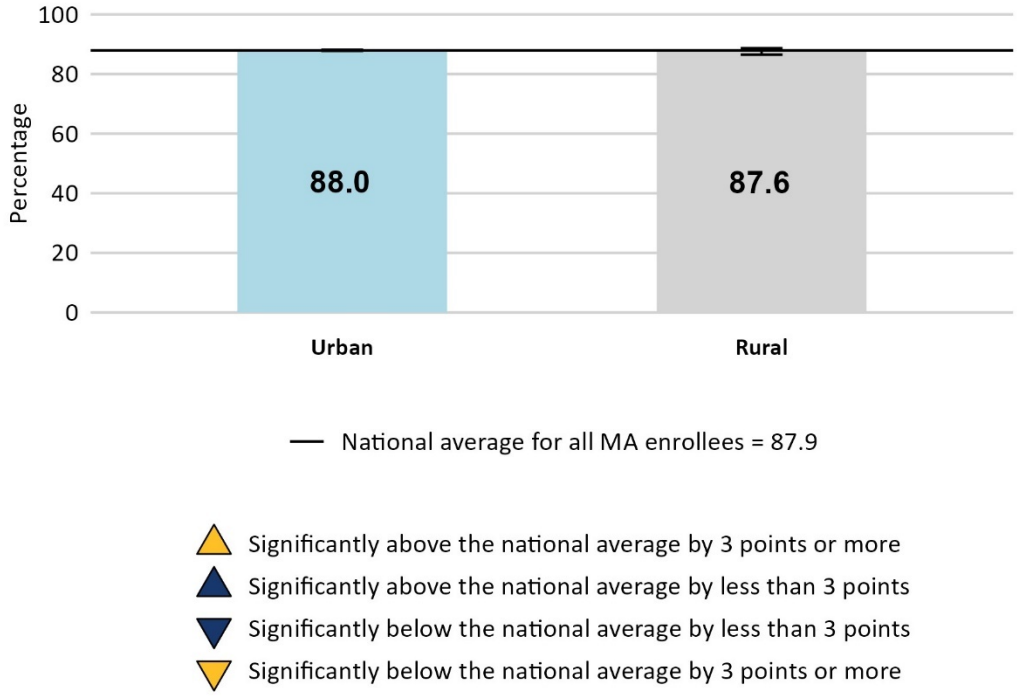
Disparities

- The percentage of MA enrollees living in urban areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees.
- The percentage of MA enrollees living in rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees.

[†] 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.

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

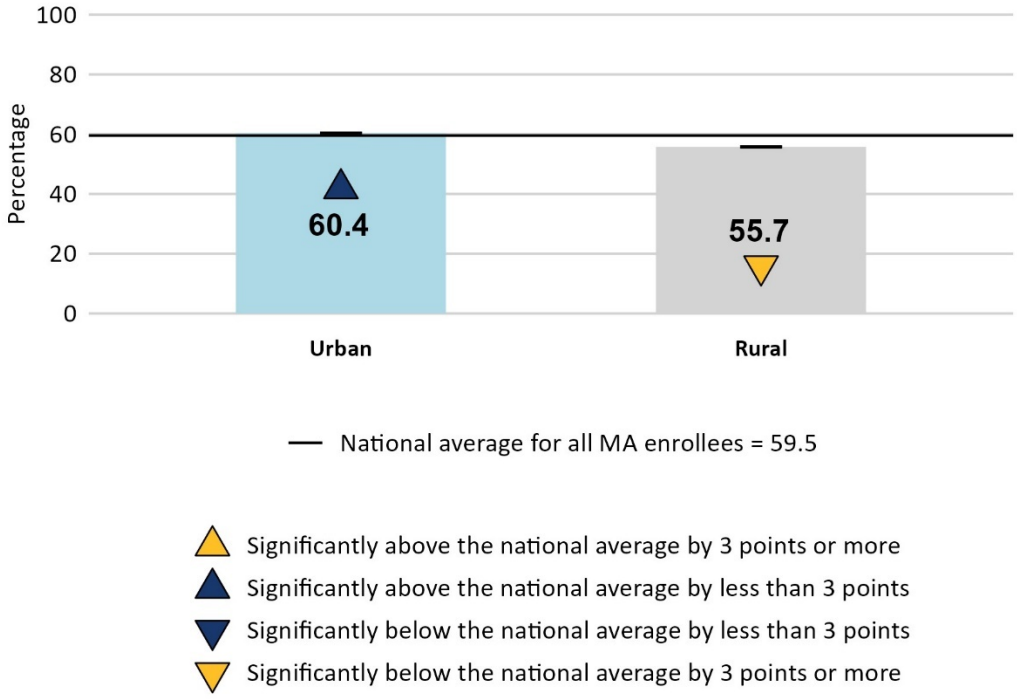
Disparities

- The percentage of MA enrollees living in urban areas 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 MA enrollees.
- The percentage of MA enrollees living in rural areas 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 MA enrollees.

[†] 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.

Follow-Up After ED Visit for People with High-Risk Multiple 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

- The percentage of MA enrollees with multiple high-risk chronic conditions living in rural areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible MA enrollees by more than 3 percentage points.

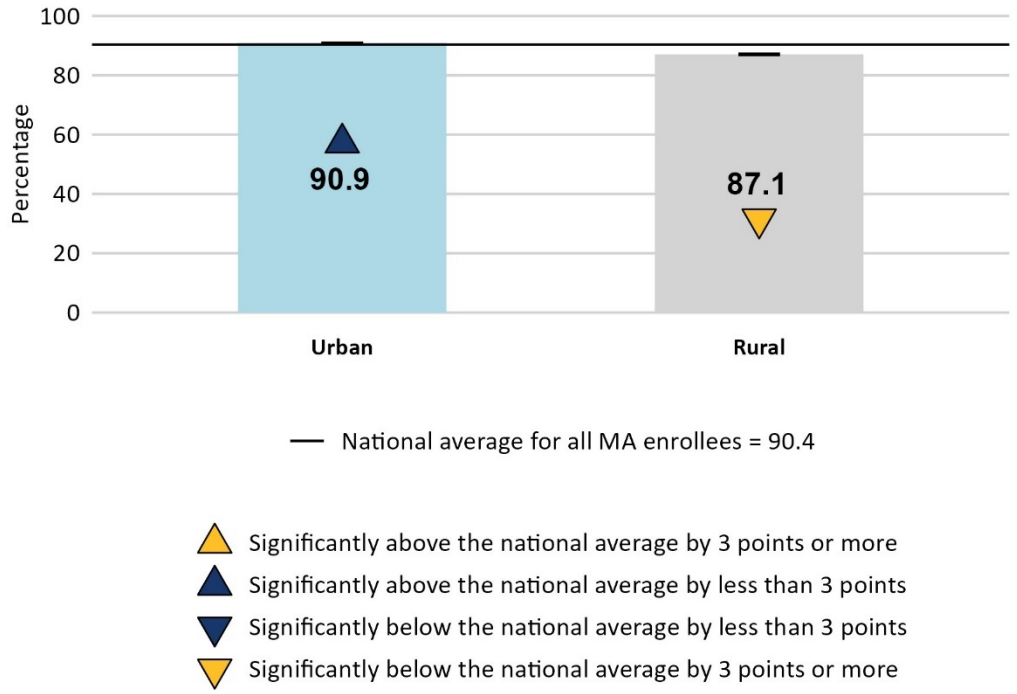
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

[‡] 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.

Clinical Care: Overuse and Appropriate Use of Medications

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

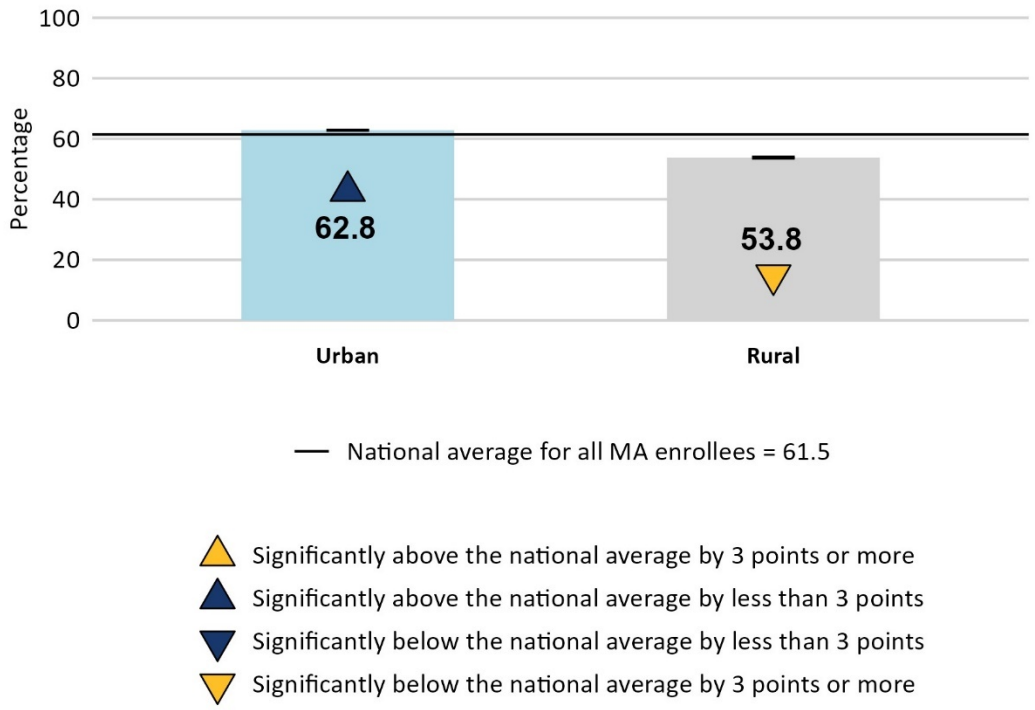
Disparities

- The percentage of older adult MA enrollees with chronic renal failure living in urban areas 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.
- The percentage of older adult MA enrollees with chronic renal failure living in rural areas 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.

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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

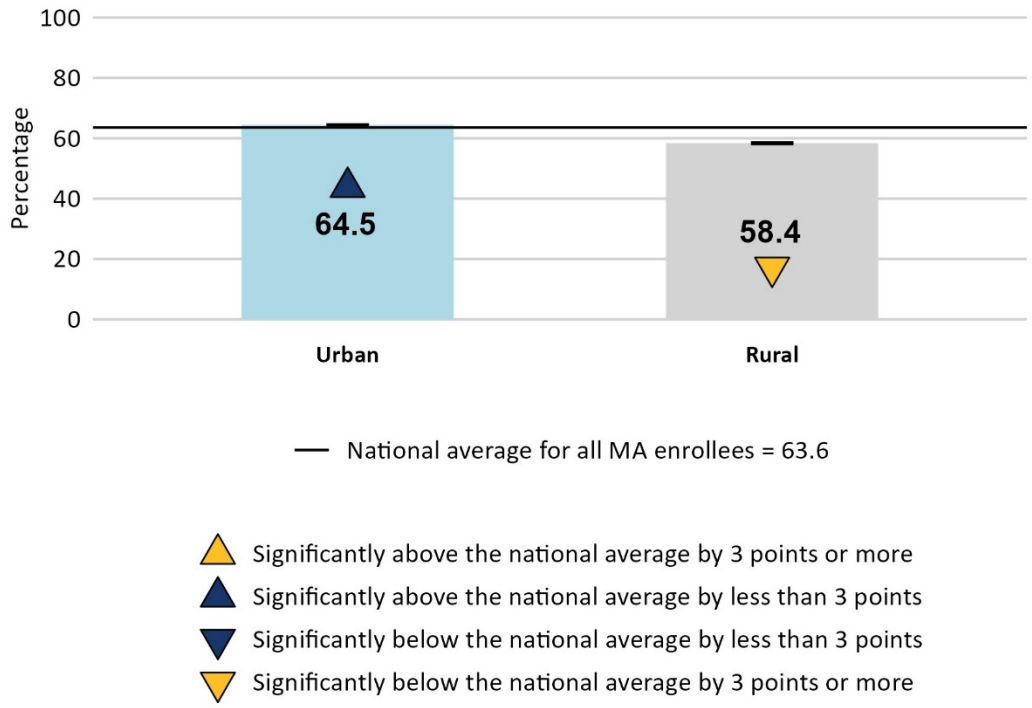
- The percentage of older adult MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

- The percentage of older adult MA enrollees with dementia living in rural areas 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.

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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

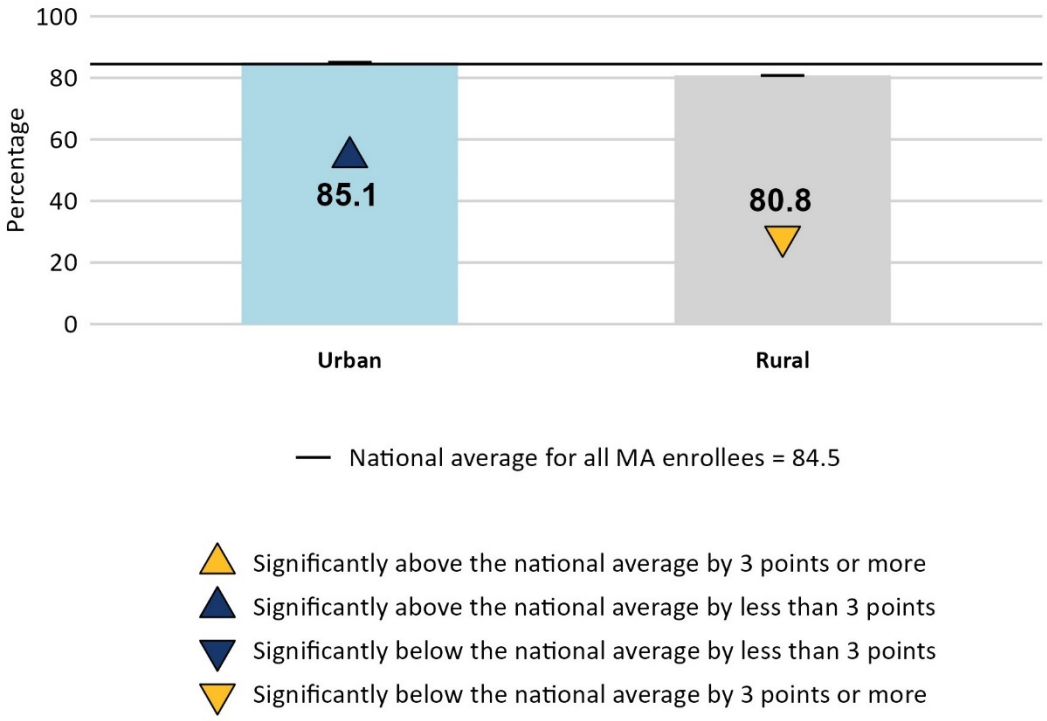
- The percentage of older adult MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

- The percentage of older adult MA enrollees with a history of falls living in rural areas 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.

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

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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

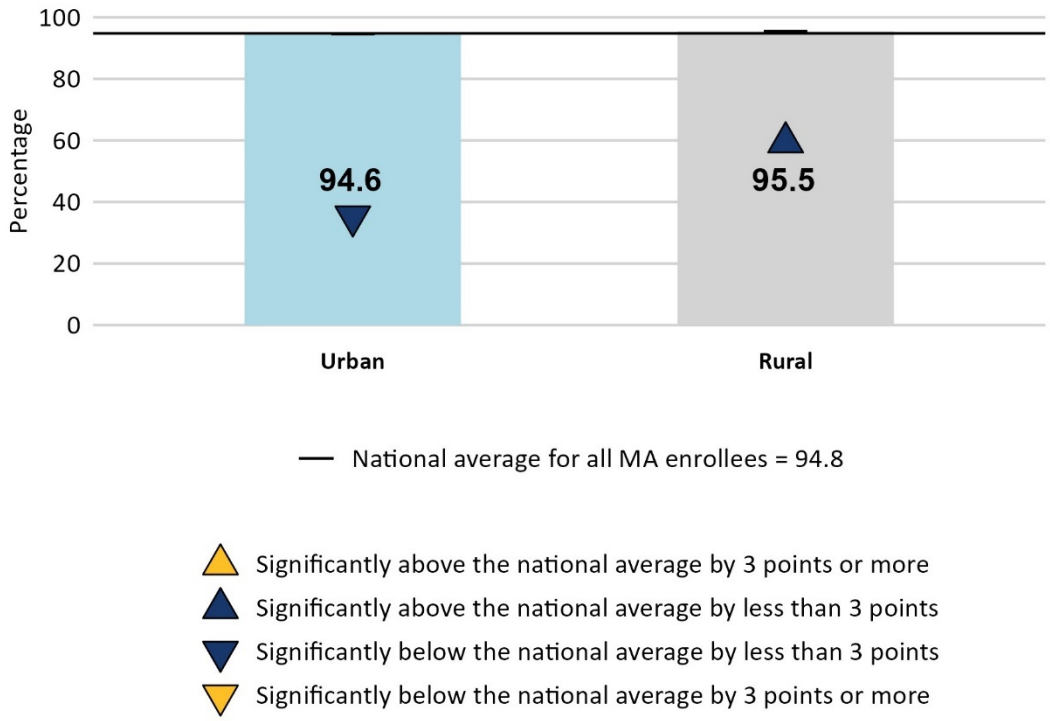
Disparities

- The percentage of older adult MA enrollees living in urban areas for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

- The percentage of older adult MA enrollees living in rural areas for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult MA enrollees by more 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

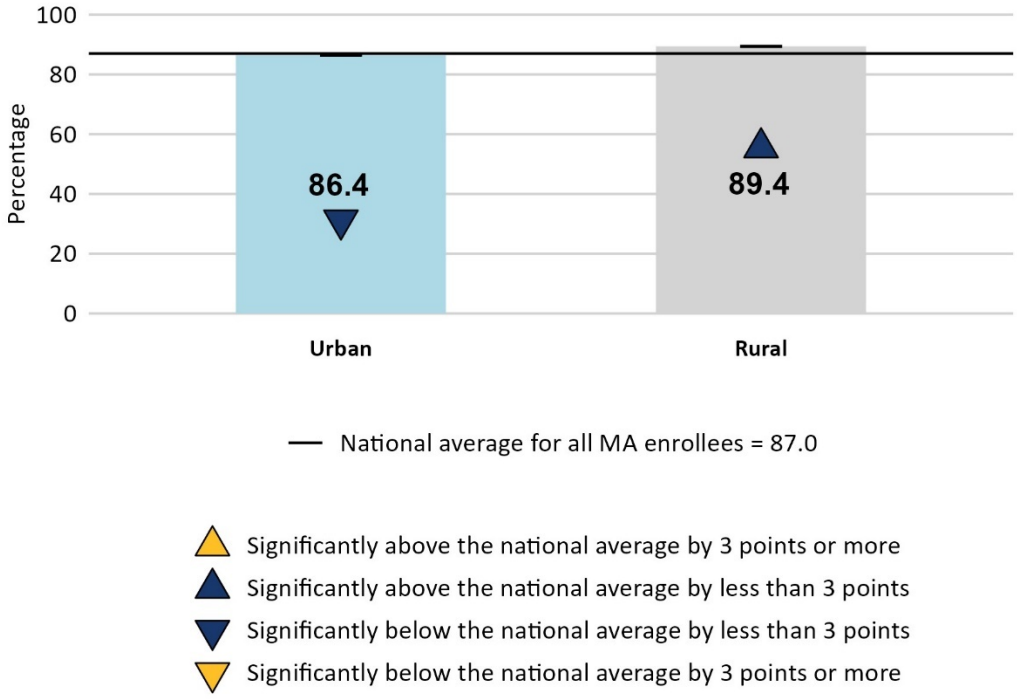
Disparities

- The percentage of MA enrollees living in urban areas 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 MA enrollees living in rural areas 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.

[†] 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

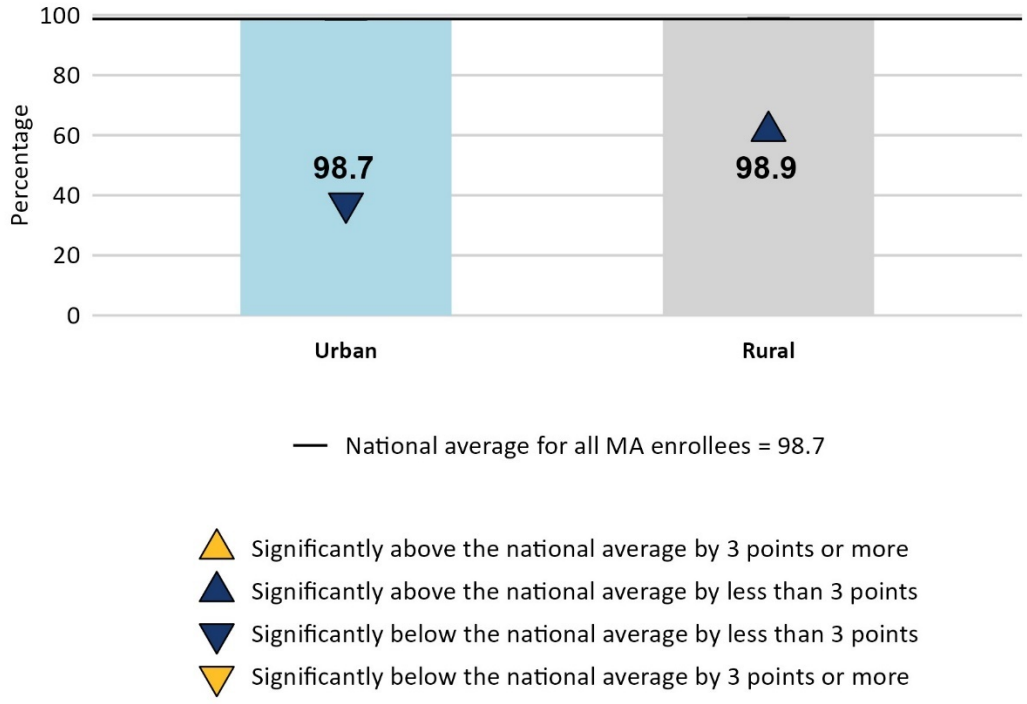
Disparities

- The percentage of MA enrollees living in urban areas 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 MA enrollees living in rural areas 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 geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

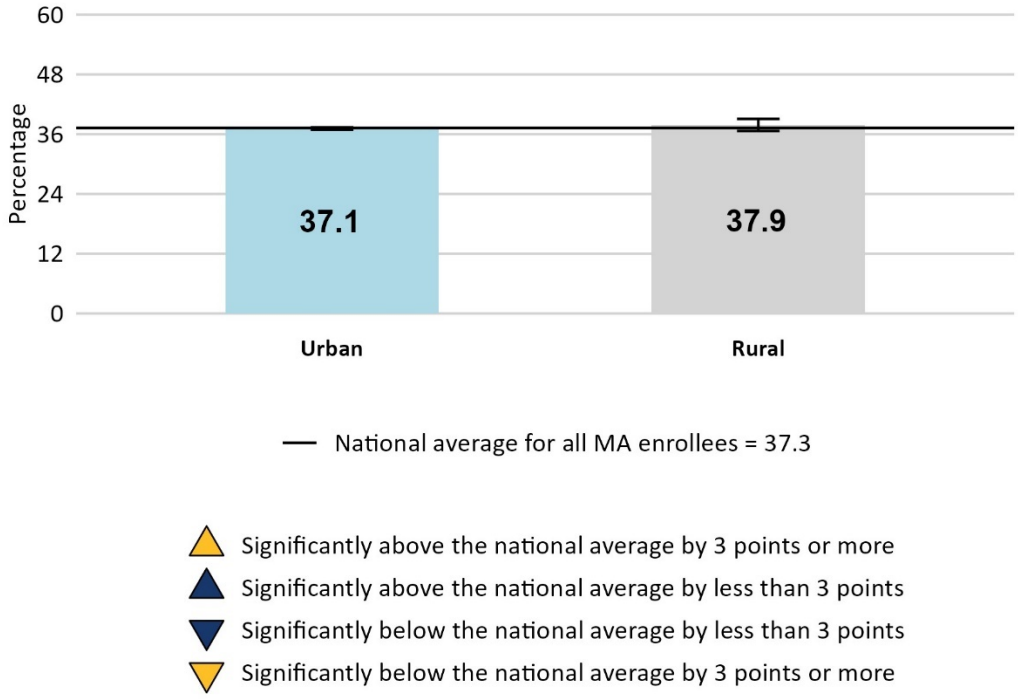
- The percentage of MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average[†] for all MA enrollees by less than 3 percentage points.

- The percentage of MA enrollees living in rural areas 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.

[†] Prior to rounding.

Pharmacotherapy for Opioid Use Disorder

Percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees aged 18 years and older[†] that continued for at least 180 days, by geography, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees living in urban areas that continued for at least 180 days was **similar to** the national average for all MA enrollees.

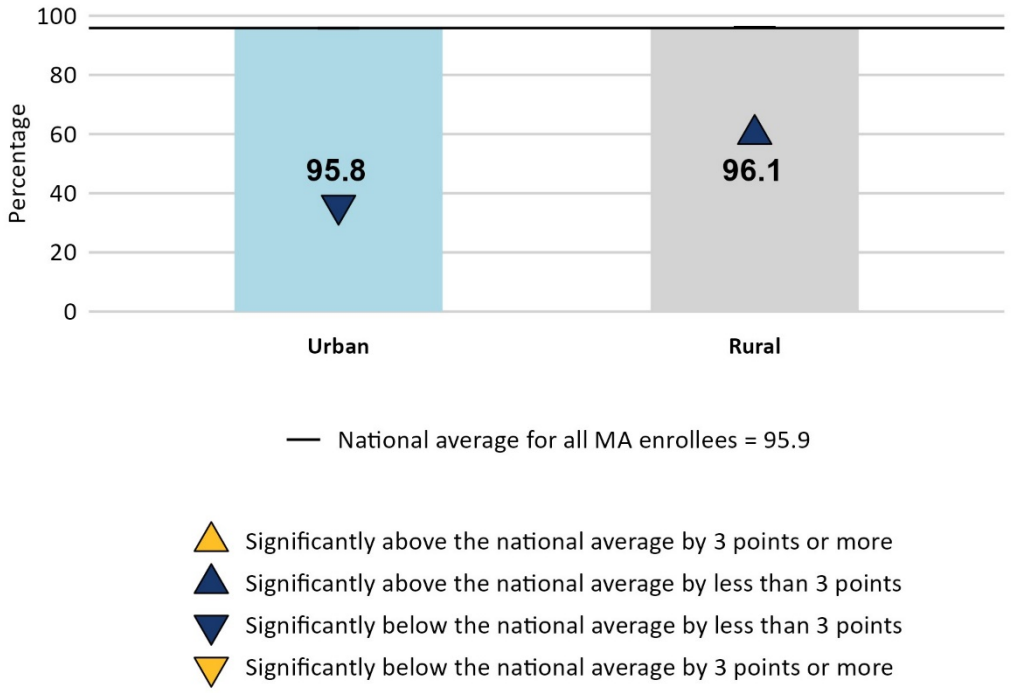
- The percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees living in rural areas that continued for at least 180 days was **similar to** the national average for all MA enrollees.

[†] Although the lower-bound age cutoff for this HEDIS measure is 16 years old, the data used in this report are limited to adults.

Clinical Care: Access to and Availability of Care

Adult 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 geography, Reporting Year 2023



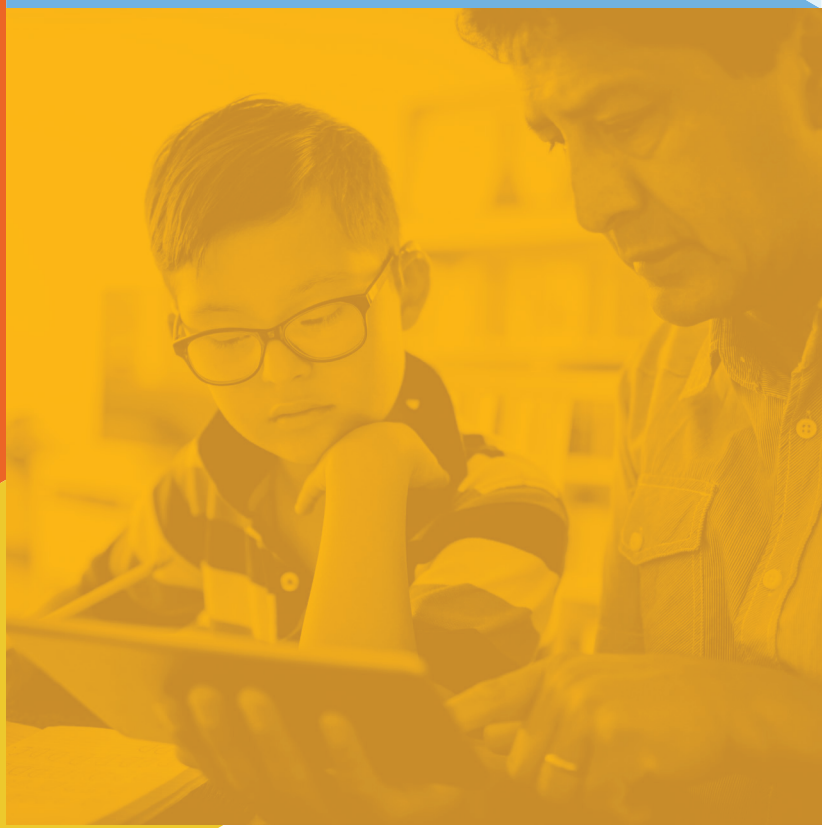
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of MA enrollees living in urban areas 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.

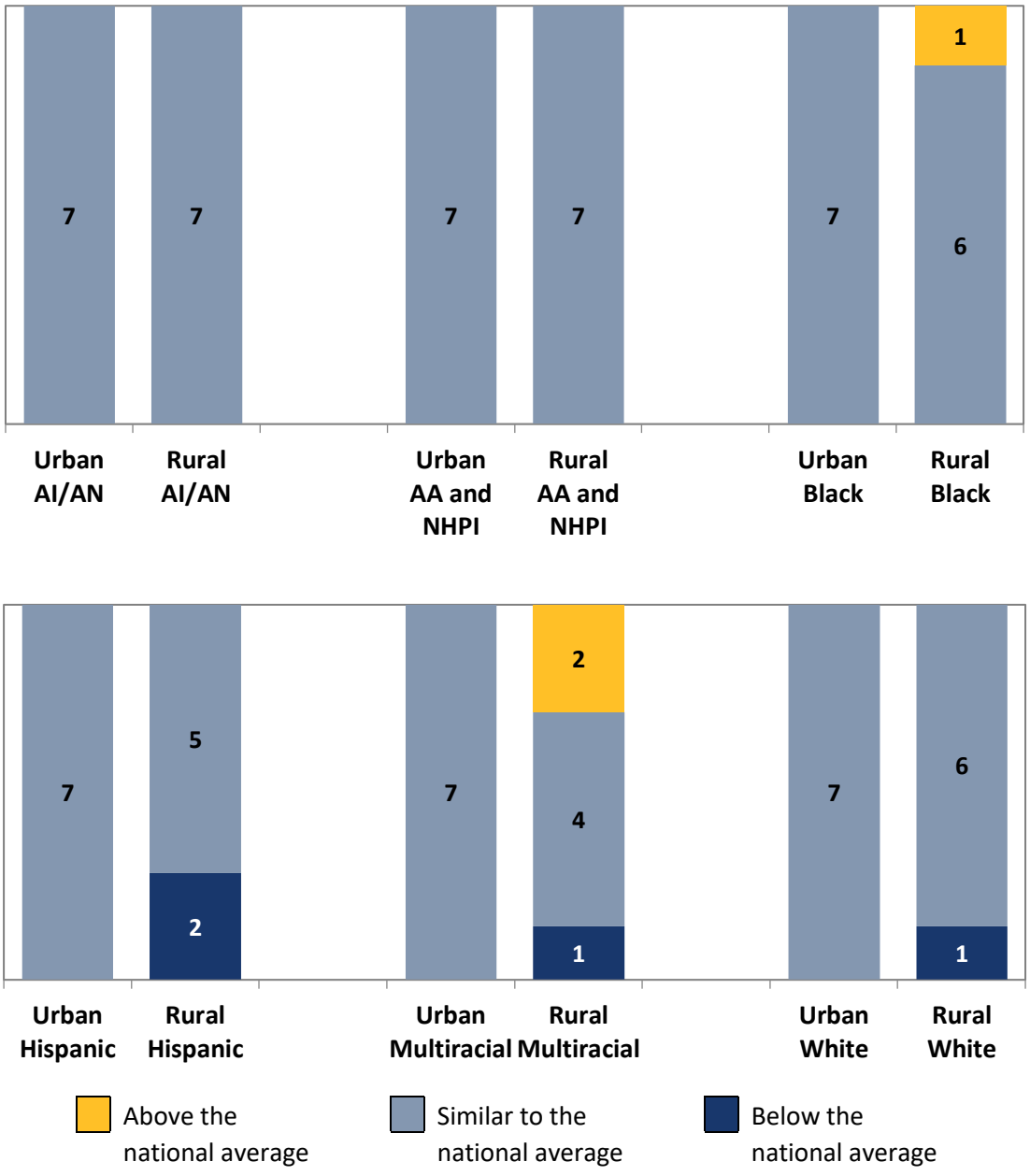
- The percentage of MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.

Appendix B: Rural-Urban Disparities in Health Care in Medicare by Racial and Ethnic Group—Cross-Sectional Analysis of 2023 Data



Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures, Medicare Advantage

Number of patient experience measures (out of 7) for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees <u>of the same race or ethnicity</u> in 2023



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Rural and urban residents enrolled in MA were compared with the national average for all MA enrollees of the same race or ethnicity.

- **Above the national average** = Rural or urban residents had results that were above the national average for the racial or ethnic group. 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** = Rural and urban residents had results that were similar to the national average for the racial or ethnic group. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = Rural or urban residents had results that were below the national average for the racial or ethnic group. The difference is statistically significant and equal to or larger than 3 points† on a 0–100 scale.

Black MA enrollees living in rural areas had results that were above the national average for all Black MA enrollees
• Getting Needed Care

Hispanic MA enrollees living in rural areas had results that were below the national average for all Hispanic MA enrollees
• Getting Appointments and Care Quickly • Annual Flu Vaccine

Multiracial MA enrollees living in rural areas had results that were above the national average for all Multiracial MA enrollees
• Getting Needed Care • Getting Needed Prescription Drugs

Multiracial MA enrollees living in rural areas had results that were below the national average for all Multiracial MA enrollees
• Customer Service

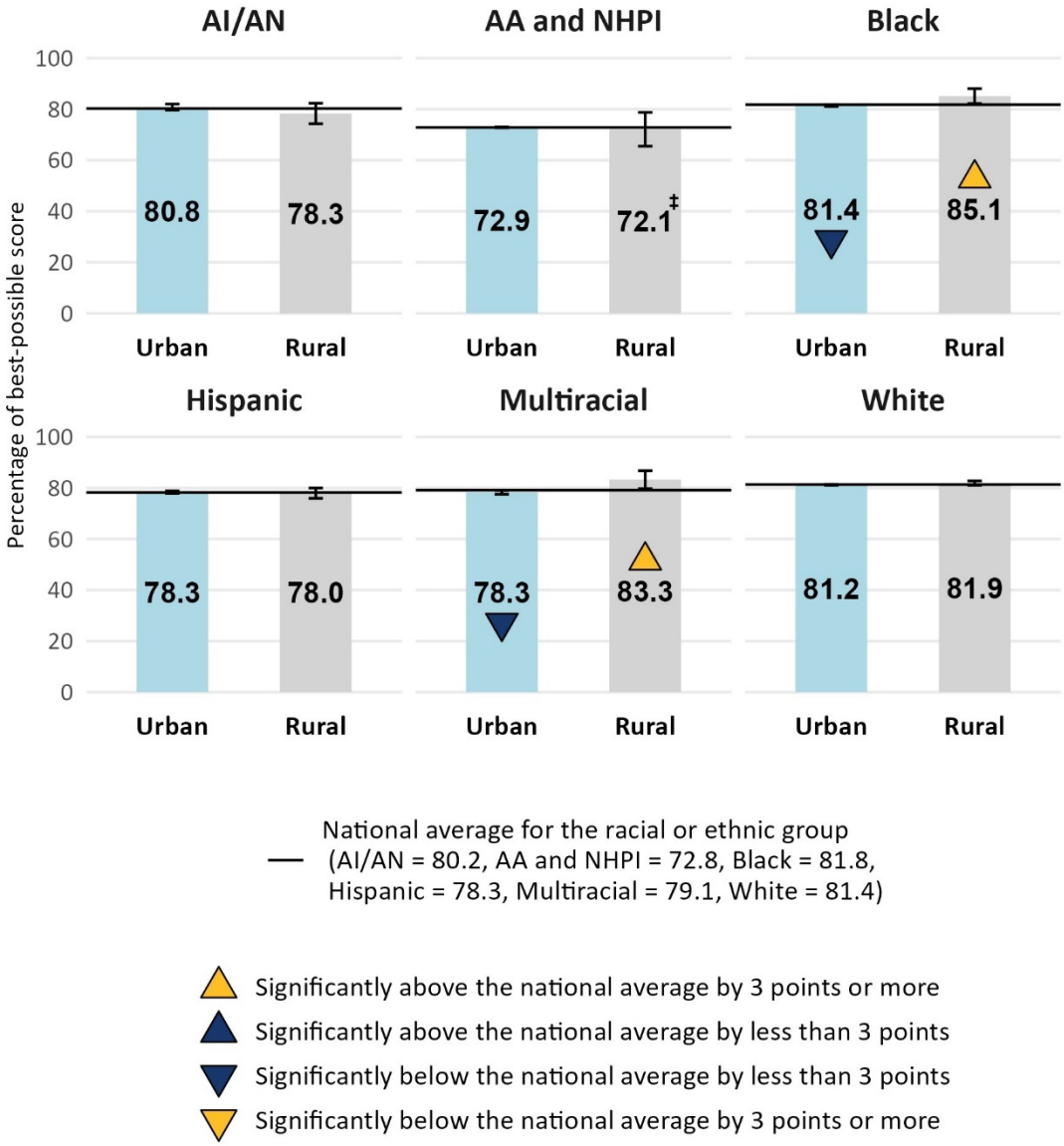
White MA enrollees living in rural areas had results that were below the national average for all White MA enrollees
• Annual Flu Vaccine

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

Patient Experience: Medicare Advantage

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban areas reported experiences with getting needed care that were **below**[§] the national average for all Black MA enrollees by less than 3 points on a 0–100 scale. Black MA enrollees living in rural areas reported experiences with getting needed care that were **above** the national average for all Black MA enrollees by more than 3 points on a 0–100 scale.

- Hispanic MA enrollees living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Hispanic MA enrollees.

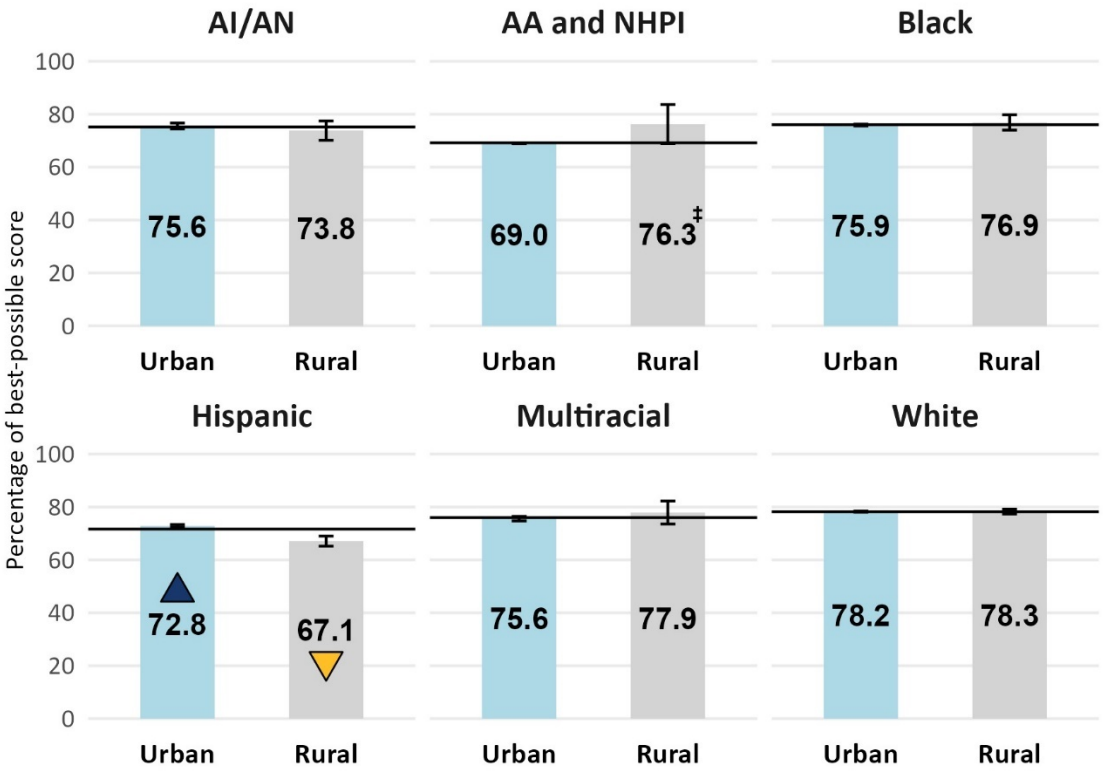
- Multiracial MA enrollees living in urban areas reported experiences with getting needed care that were **below** the national average for all Multiracial MA enrollees by less than 3 points on a 0–100 scale. Black MA enrollees living in rural areas reported experiences with getting needed care that were **above** the national average for all Black MA enrollees by more than 3 points on a 0–100 scale.

- White MA enrollees living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all White MA enrollees.

[§] Unlike on pp. 73–74, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all Black MA enrollees.

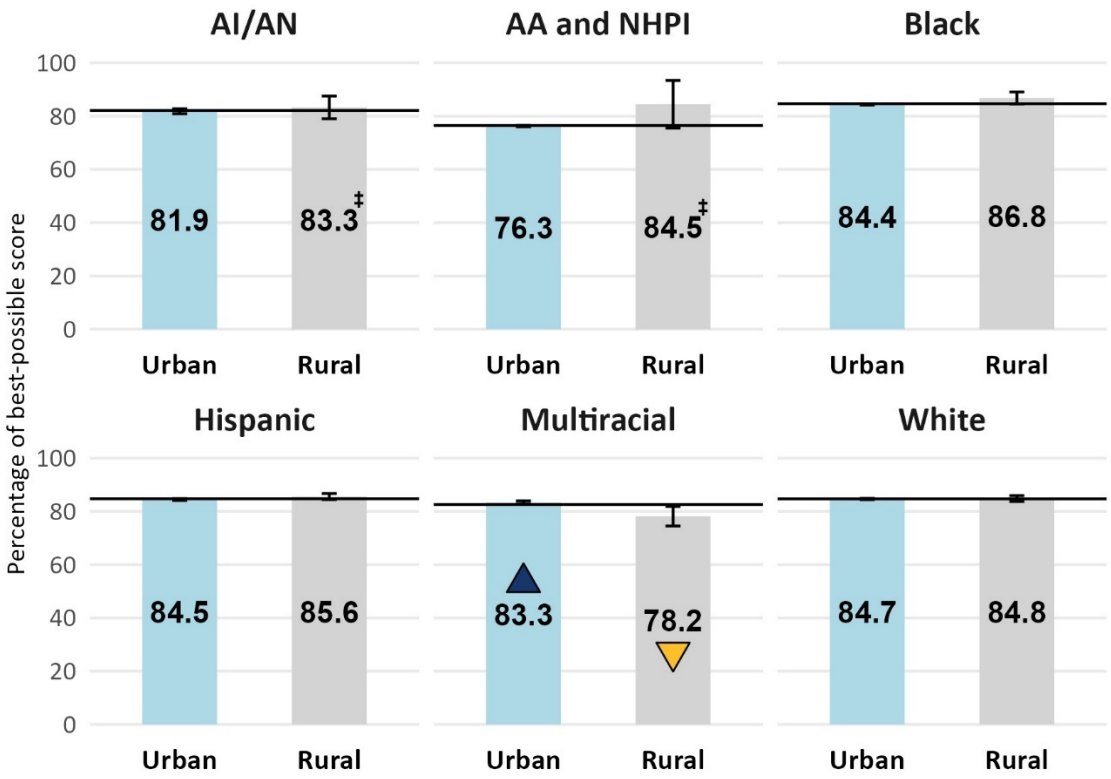
- Hispanic MA enrollees living in urban areas reported experiences with getting appointments and care quickly that were **above** the national average for all Hispanic MA enrollees by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with getting appointments and care quickly that were **below** the national average for all Hispanic MA enrollees by more than 3 points on a 0–100 scale.

- Multiracial MA enrollees living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all Multiracial MA enrollees.

- White MA enrollees living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all White MA enrollees.

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Black MA enrollees.

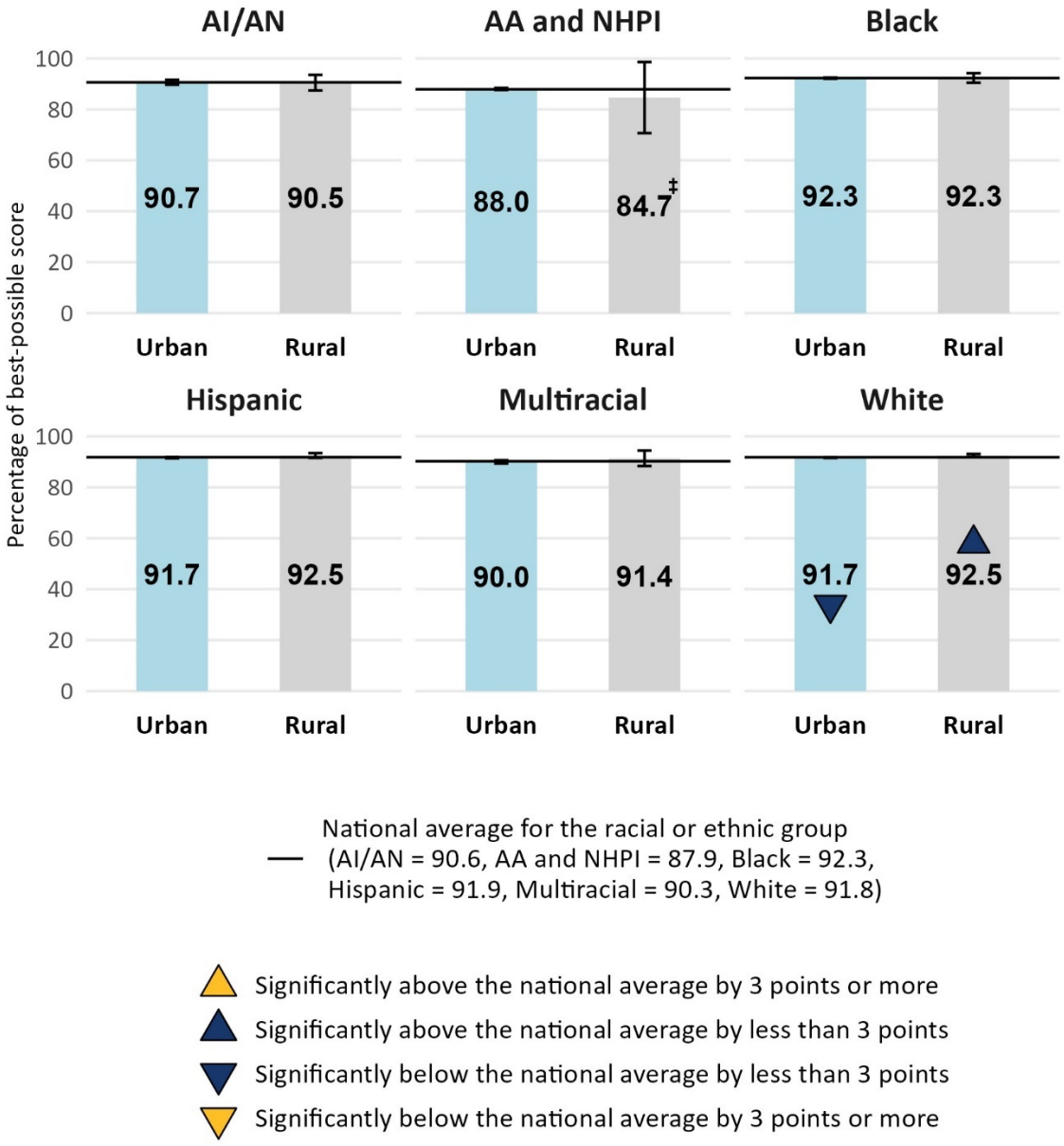
- Hispanic MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Hispanic MA enrollees.

- Multiracial MA enrollees living in urban areas reported experiences with customer service that were **above** the national average for all Multiracial MA enrollees by less than 3 points on a 0–100 scale. Multiracial MA enrollees living in rural areas reported experiences with customer service that were **below** the national average for all Multiracial MA enrollees by more than 3 points on a 0–100 scale.

- White MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all White MA enrollees.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Black MA enrollees.

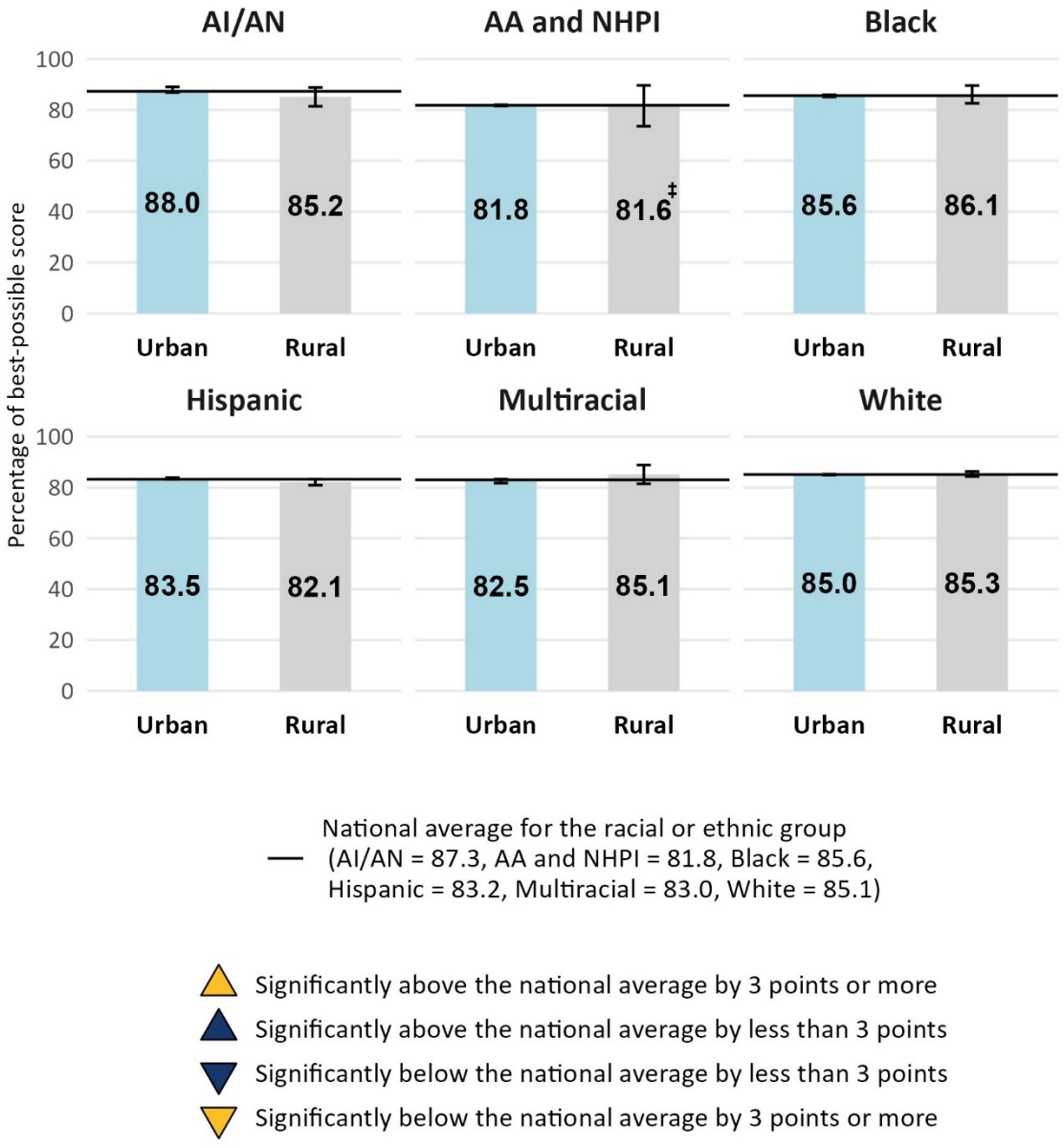
- Hispanic MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Hispanic MA enrollees.

- Multiracial MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Multiracial MA enrollees.

- White MA enrollees living in urban areas reported experiences with doctor communication that were **below** the national average for all White MA enrollees by less than 3 points on a 0–100 scale. White MA enrollees living in rural areas reported experiences with doctor communication that were **above** the national average for all White MA enrollees by less than 3 points on a 0–100 scale.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Black MA enrollees.

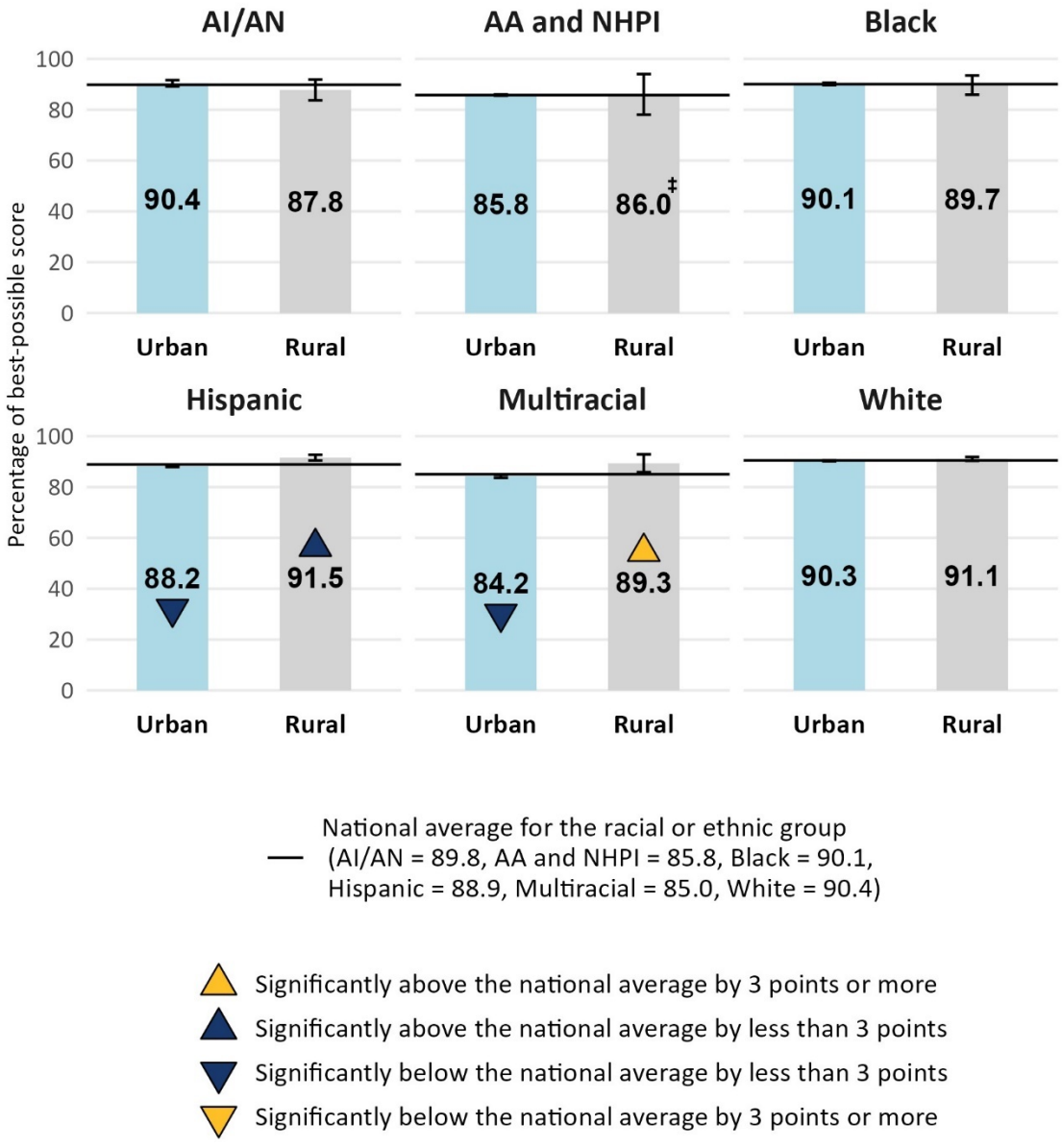
- Hispanic MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Hispanic MA enrollees.

- Multiracial MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Multiracial MA enrollees.

- White MA enrollees living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all White MA enrollees.

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plans,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN MA enrollees living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all AI/AN MA enrollees.

- AA and NHPI MA enrollees living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all AA and NHPI MA enrollees.

- Black MA enrollees living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all Black MA enrollees.

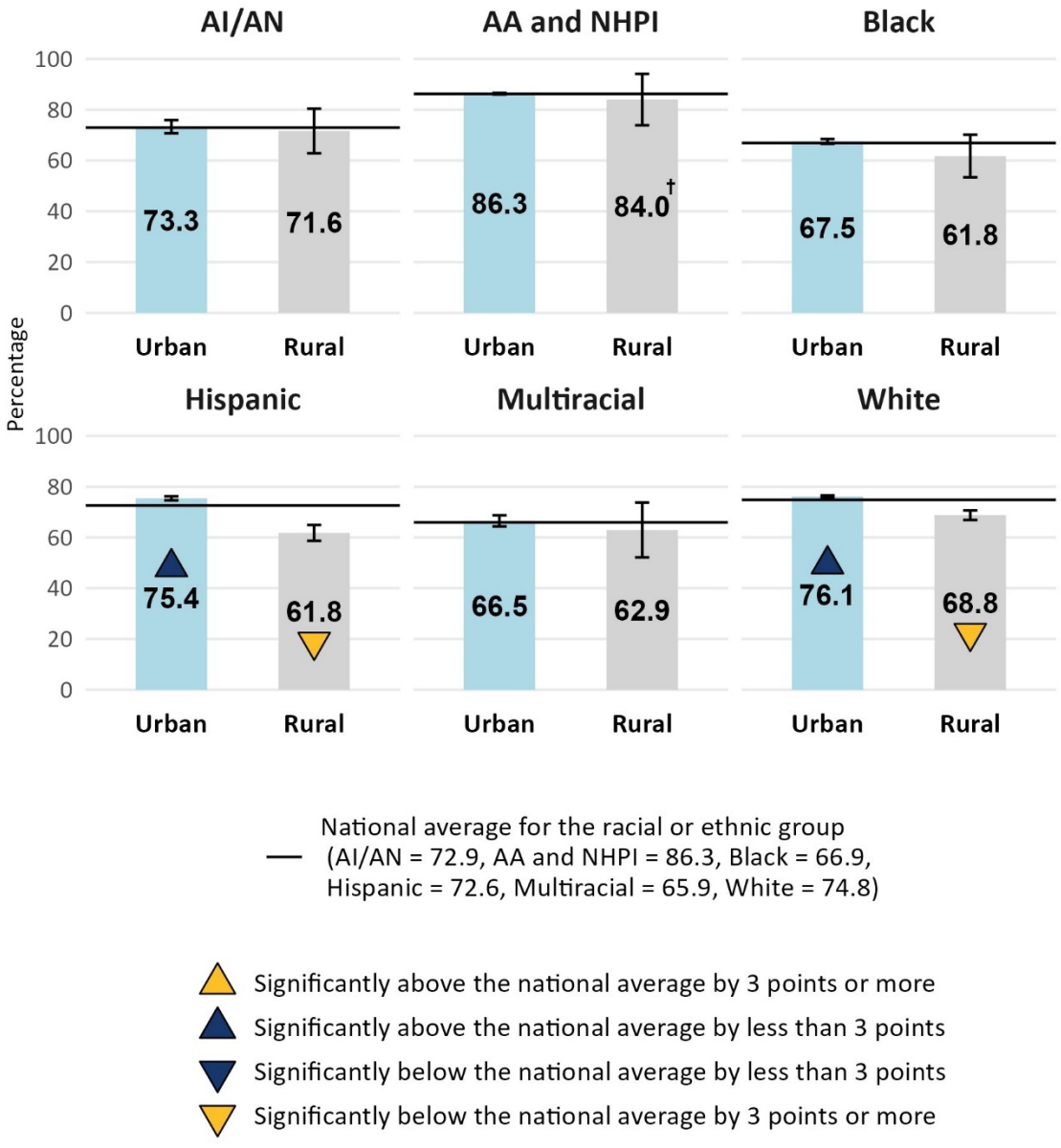
- Hispanic MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all Hispanic MA enrollees by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with getting needed prescription drugs that were **above** the national average for all Hispanic MA enrollees by less than 3 points on a 0–100 scale.

- Multiracial MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all Multiracial MA enrollees by less than 3 points on a 0–100 scale. Multiracial MA enrollees living in rural areas reported experiences with getting needed prescription drugs that were **above** the national average for all Multiracial MA enrollees by more than 3 points on a 0–100 scale.

- White MA enrollees living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all White MA enrollees.

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of AI/AN MA enrollees living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all AI/AN MA enrollees.

- The percentages of AA and NHPI MA enrollees living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all AA and NHPI MA enrollees.

- The percentages of Black MA enrollees living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all Black MA enrollees.

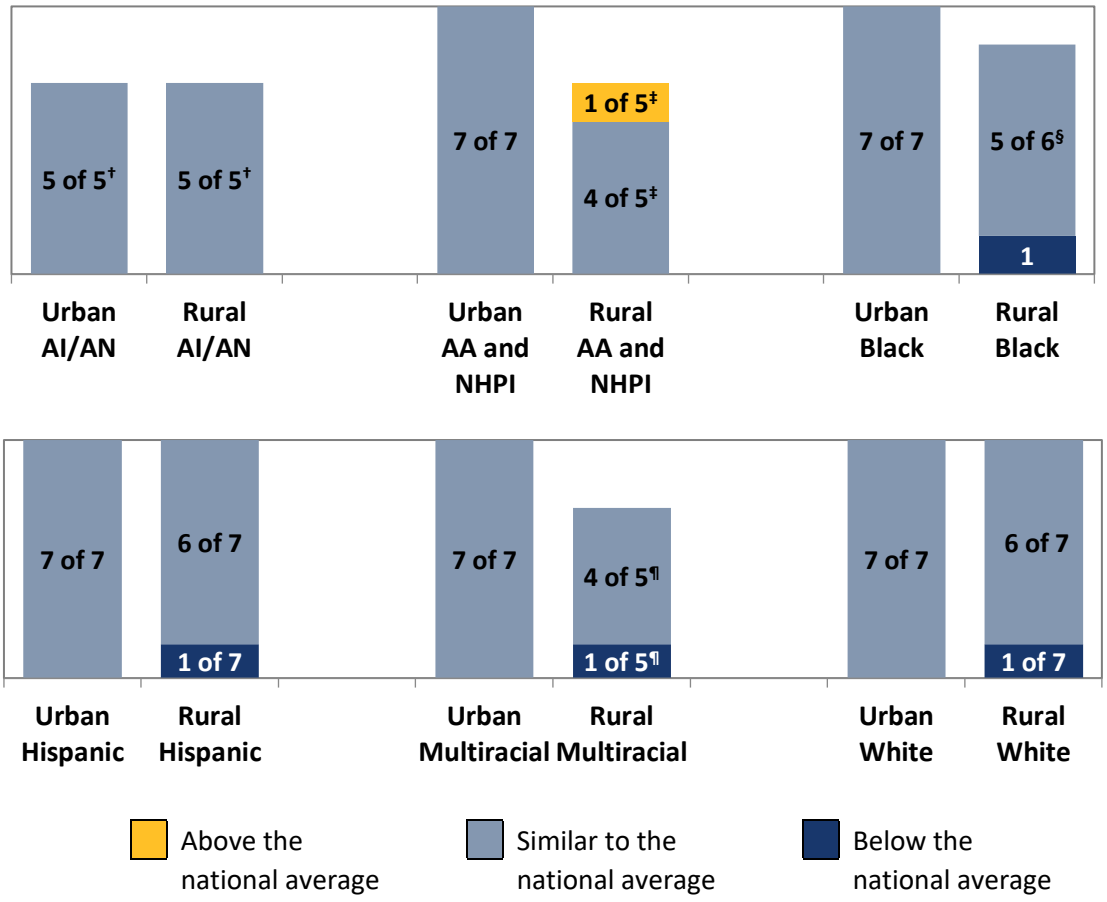
- The percentage of Hispanic MA enrollees living in urban areas who received the flu vaccine was **above** the national average for all Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who received the flu vaccine was **below** the national average for all Hispanic MA enrollees by more than 3 percentage points.

- The percentages of Multiracial MA enrollees living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all Multiracial MA enrollees.

- The percentage of White MA enrollees living in urban areas who received the flu vaccine was **above** the national average for all White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who received the flu vaccine was **below** the national average for all White MA enrollees by more than 3 percentage points.

Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures, Medicare FFS

Number of patient experience measures for which urban or rural residents with Medicare FFS coverage had results that were above, similar to, or below the national average for all people with Medicare FFS coverage of the same race or ethnicity in 2023



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2023 FFS and PDP CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

† There were not enough data from AI/AN people with FFS coverage living in urban areas to compare this group to the national average for all AI/AN people with FFS coverage on two patient experience measures. There were also not enough data from AI/AN people with FFS coverage living in rural areas to compare this group to the national average for all AI/AN people with FFS coverage on the same two measures.

‡ There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare this group to the national average for all AA and NHPI people with FFS coverage on two patient experience measures.

§ There were not enough data from Black people with FFS coverage living in rural areas to compare this group to the national average for all Black people with FFS coverage on one patient experience measure.

¶ There were not enough data from Multiracial people with FFS coverage living in rural areas to compare this group to the national average for all Multiracial people with FFS coverage on two patient experience measures.

Rural and urban residents with Medicare FFS coverage were compared with the national average for all people with Medicare FFS coverage of the same racial or ethnic group.

- **Above the national average** = Rural or urban residents had results that were above the national average for the racial or ethnic group. 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** = Rural or urban residents had results that were similar to the national average for the racial or ethnic group. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = Rural or urban residents had results that were below the national average for the racial or ethnic group. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

AA and NHPI people with FFS coverage living in rural areas had results that were above the national average for all AA and NHPI people with FFS coverage
• Getting Appointments and Care Quickly

Black people with FFS coverage living in rural areas had results that were below the national average for all Black people with FFS coverage
• Annual Flu Vaccine

Hispanic people with FFS coverage living in rural areas had results that were below the national average for all Hispanic people with FFS coverage
• Annual Flu Vaccine

Multiracial people with FFS coverage living in rural areas had results that were below the national average for all Multiracial people with FFS coverage
• Annual Flu Vaccine

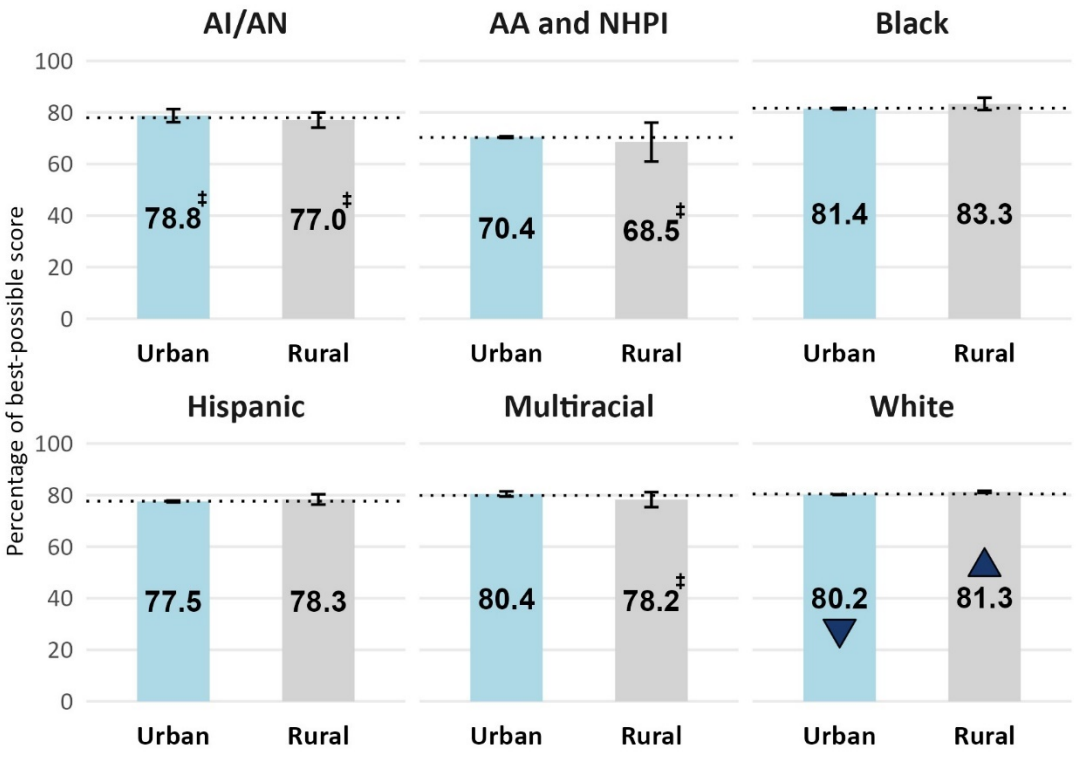
White people with FFS coverage living in rural areas had results that were below the national average for all White people with FFS coverage
• Annual Flu Vaccine

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

Patient Experience: Medicare FFS

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 FFS CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all AI/AN people with FFS coverage.

- AA and NHPI people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all AA and NHPI people with FFS coverage.

- Black people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Black people with FFS coverage.

- Hispanic people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Hispanic people with FFS coverage.

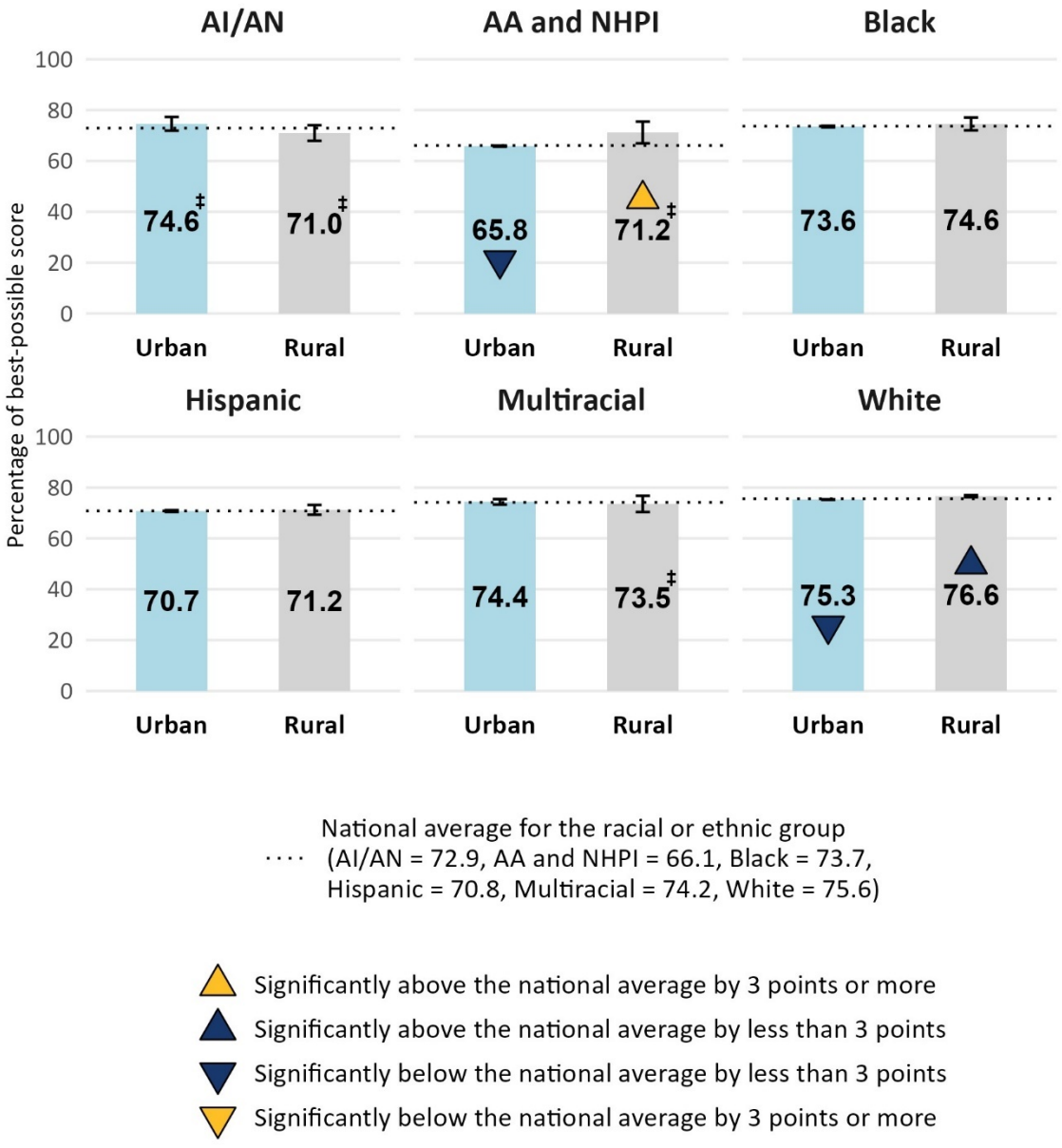
- Multiracial people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Multiracial people with FFS coverage.

- White people with FFS coverage living in urban areas reported experiences with getting needed care that were **below**[§] the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale. White people with FFS coverage living in rural areas reported experiences with getting needed care that were **above** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale.

[§] Unlike on pp. 89–90, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 FFS CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN people with FFS coverage living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all AI/AN people with FFS coverage.

- AA and NHPI people with FFS coverage living in urban areas reported experiences with getting appointments and care quickly that were **below** the national average for all AA and NHPI people with FFS coverage by less than 3 points on a 0–100 scale. AA and NHPI people with FFS coverage living in rural areas reported experiences with getting appointments and care quickly that were **above** the national average for all AA and NHPI people with FFS coverage by more than 3 points on a 0–100 scale.

- Black people with FFS coverage living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all Black people with FFS coverage.

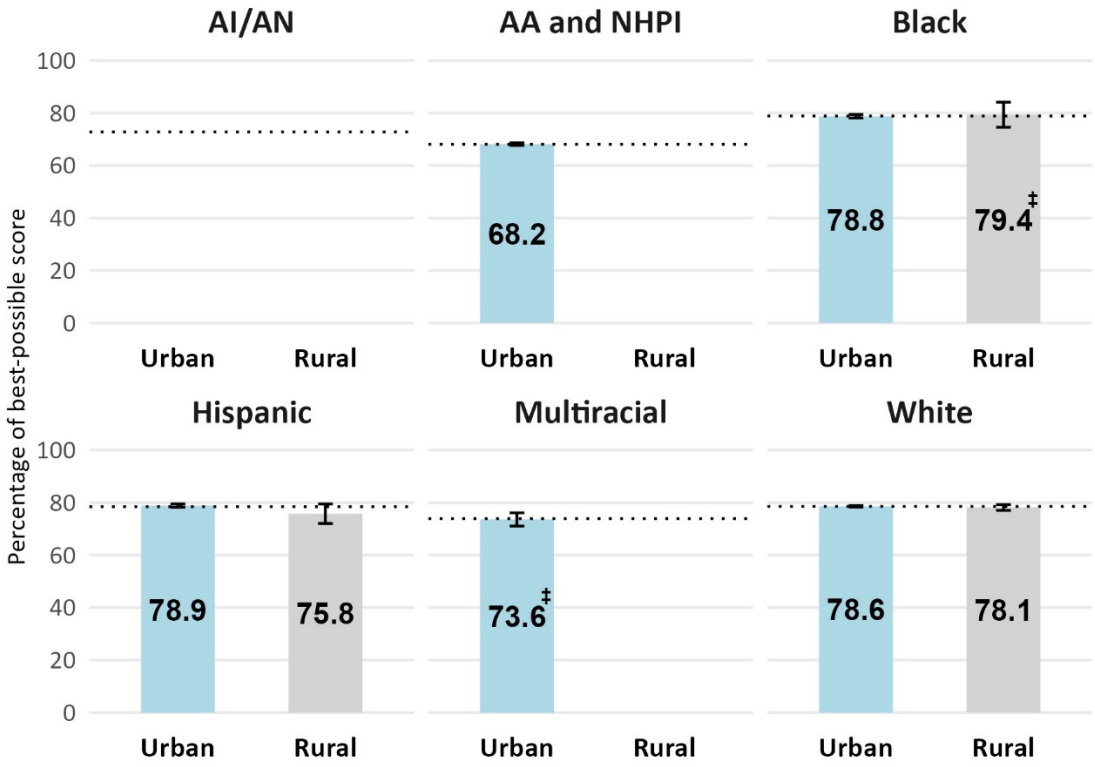
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all Hispanic people with FFS coverage.

- Multiracial people with FFS coverage living in urban and rural areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all Multiracial people with FFS coverage.

- White people with FFS coverage living in urban areas reported experiences with getting appointments and care quickly that were **below** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale. White people with FFS coverage living in rural areas reported experiences with getting appointments and care quickly that were **above** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale.

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by geography within racial and ethnic group, 2023



···· National average for the racial or ethnic group (AI/AN = 72.8, AA and NHPI = 68.1, Black = 78.9, Hispanic = 78.4, Multiracial = 73.9, White = 78.5)

▲ 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

SOURCE: Data are from the 2023 FFS CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- There were not enough data from AI/AN people with FFS coverage living in urban or rural areas to compare the scores for these groups to the national average for all AI/AN people with FFS coverage on experiences with customer service.

- AA and NHPI people with FFS coverage living in urban areas reported experiences with customer service that were **similar to** the national average for all AA and NHPI people with FFS coverage. There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare this group to the national average for all AA and NHPI people with FFS coverage on experiences with customer service.

- Black people with FFS coverage living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Black people with FFS coverage.

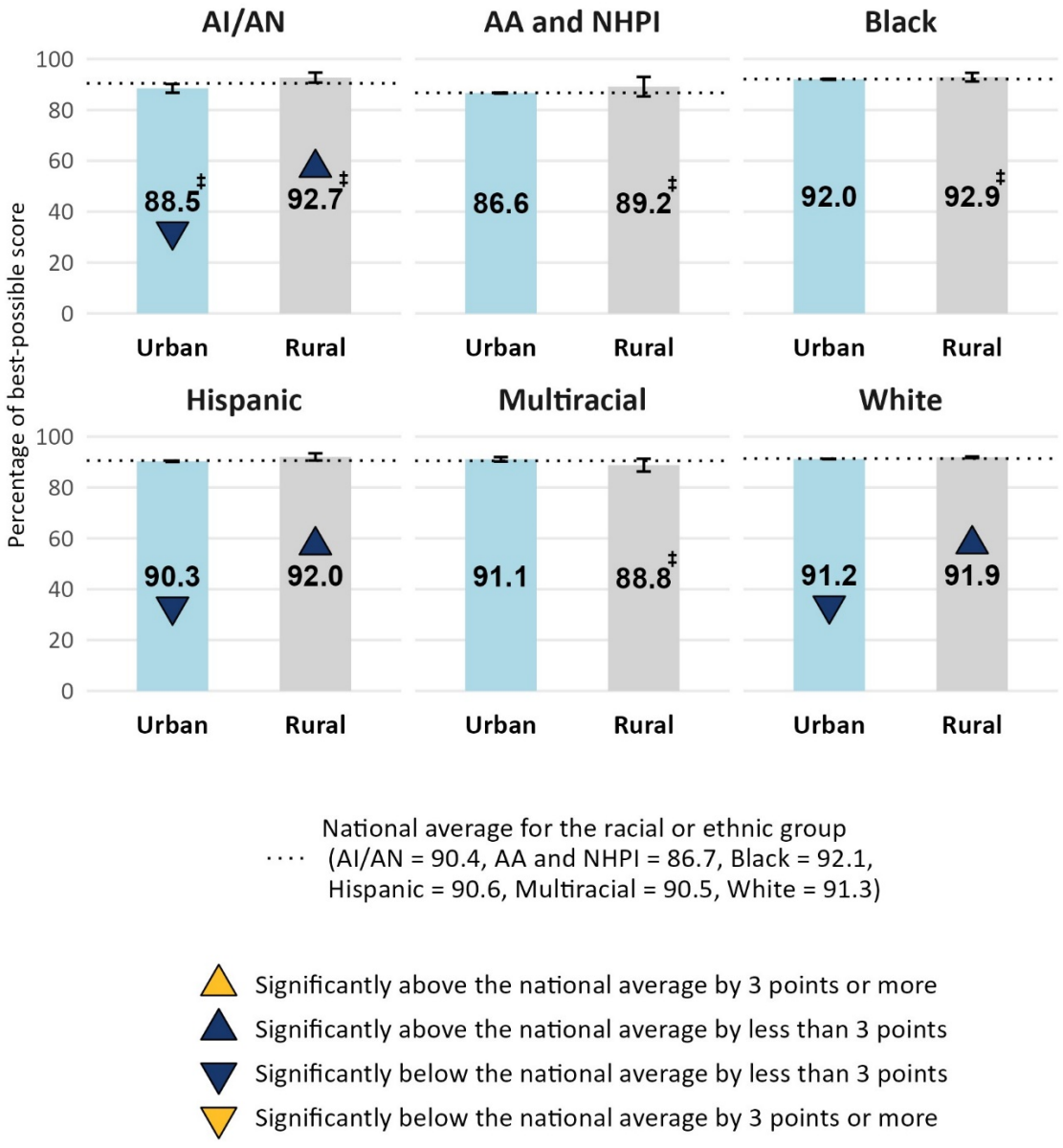
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Hispanic people with FFS coverage.

- Multiracial people with FFS coverage living in urban areas reported experiences with customer service that were **similar to** the national average for all Multiracial people with FFS coverage. There were not enough data from Multiracial people with FFS coverage living in rural areas to compare this group to the national average for all Multiracial people with FFS coverage on experiences with customer service.

- White people with FFS coverage living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all White people with FFS coverage.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 FFS CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN people with FFS coverage living in urban areas reported experiences with doctor communication that were **below** the national average for all AI/AN people with FFS coverage by less than 3 points on a 0–100 scale. AI/AN people with FFS coverage living in rural areas reported experiences with doctor communication that were **above** the national average for all AI/AN people with FFS coverage by less than 3 points on a 0–100 scale.

- AA and NHPI people with FFS coverage living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all AA and NHPI people with FFS coverage.

- Black people with FFS coverage living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Black people with FFS coverage.

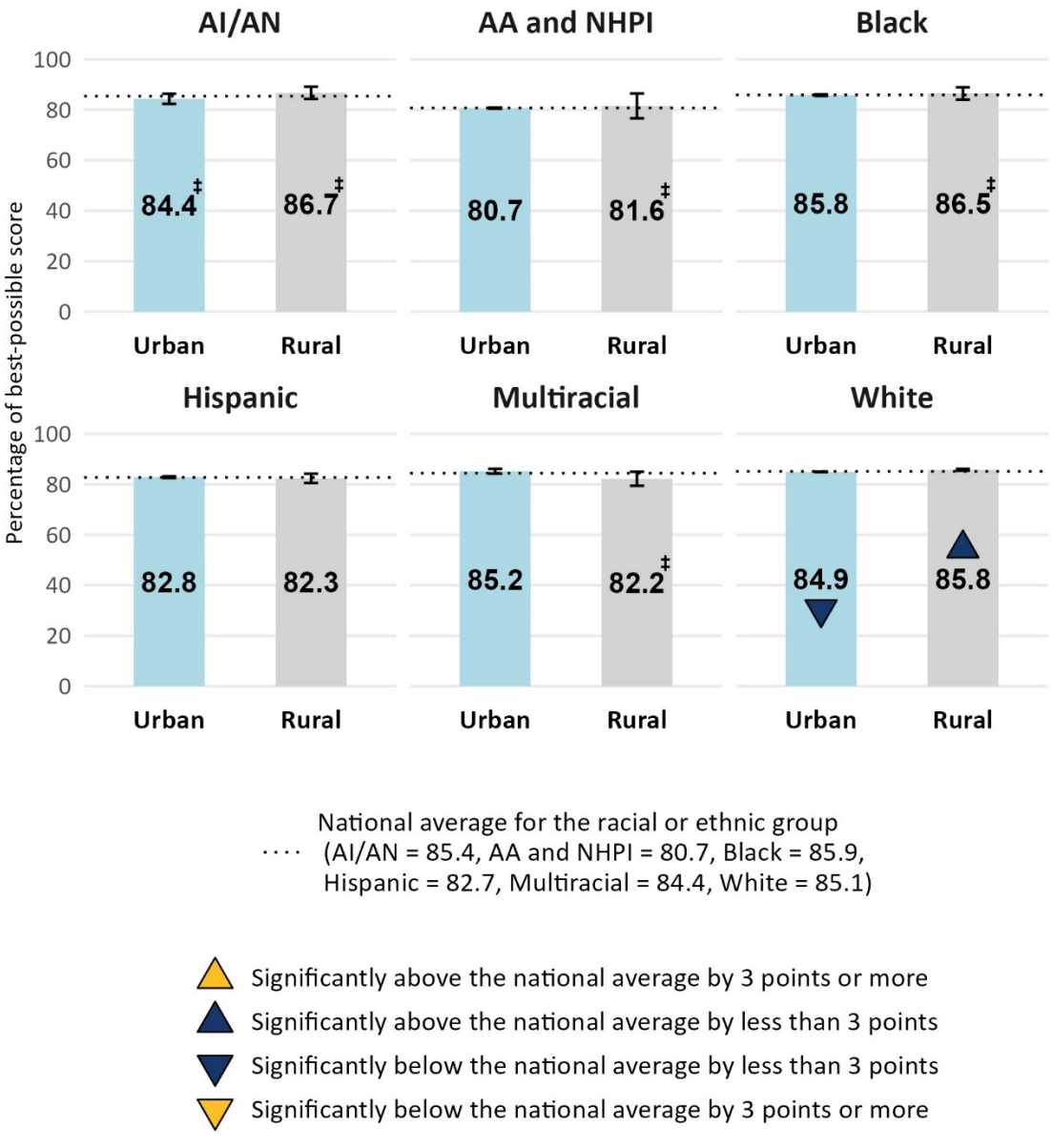
- Hispanic people with FFS coverage living in urban areas reported experiences with doctor communication that were **below** the national average for all Hispanic people with FFS coverage by less than 3 points on a 0–100 scale. Hispanic people with FFS coverage living in rural areas reported experiences with doctor communication that were **above** the national average for all Hispanic people with FFS coverage by less than 3 points on a 0–100 scale.

- Multiracial people with FFS coverage living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Multiracial people with FFS coverage.

- White people with FFS coverage living in urban areas reported experiences with doctor communication that were **below** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale. White people with FFS coverage living in rural areas reported experiences with doctor communication that were **above** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 FFS CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- AI/AN people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all AI/AN people with FFS coverage.

- AA and NHPI people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all AA and NHPI people with FFS coverage.

- Black people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Black people with FFS coverage.

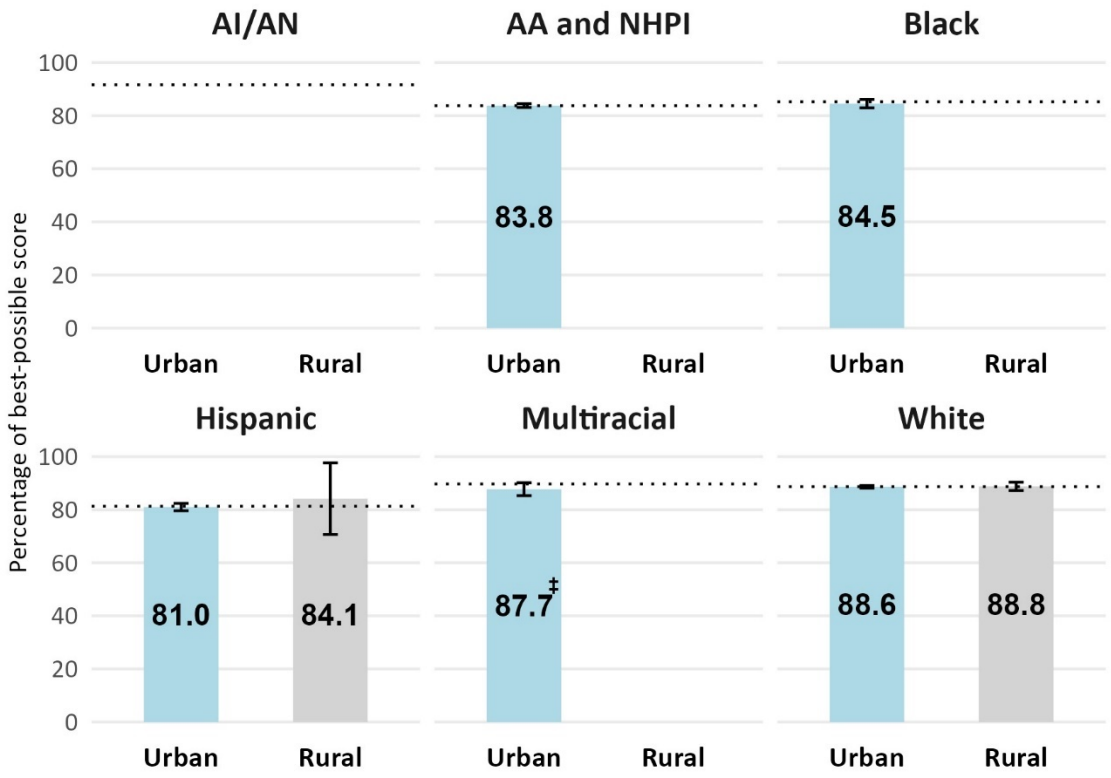
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Hispanic people with FFS coverage.

- Multiracial people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Multiracial people with FFS coverage.

- White people with FFS coverage living in urban areas reported experiences with care coordination that were **below** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale. White people with FFS coverage living in rural areas reported experiences with care coordination that were **above** the national average for all White people with FFS coverage by less than 3 points on a 0–100 scale.

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,[†] by geography within racial and ethnic group, 2023



···· National average for the racial or ethnic group (AI/AN = 91.7, AA and NHPI = 83.7, Black = 85.3, Hispanic = 81.3, Multiracial = 89.7, White = 88.7)

▲ 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

SOURCE: Data are from the 2023 PDP CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- There were not enough data from AI/AN people with FFS coverage living in urban or rural areas to compare the score for these groups to the national average for all AI/AN people with FFS coverage on experiences with getting needed prescription drugs.

- AA and NHPI people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **similar** the national average for all AA and NHPI people with FFS coverage. There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare this group to the national average for all AA and NHPI people with FFS coverage on experiences with getting needed prescription drugs.

- Black people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all Black people with FFS coverage. There were not enough data from Black people with FFS coverage living in rural areas to compare this group to the national average for all Black people with FFS coverage on experiences with getting needed prescription drugs.

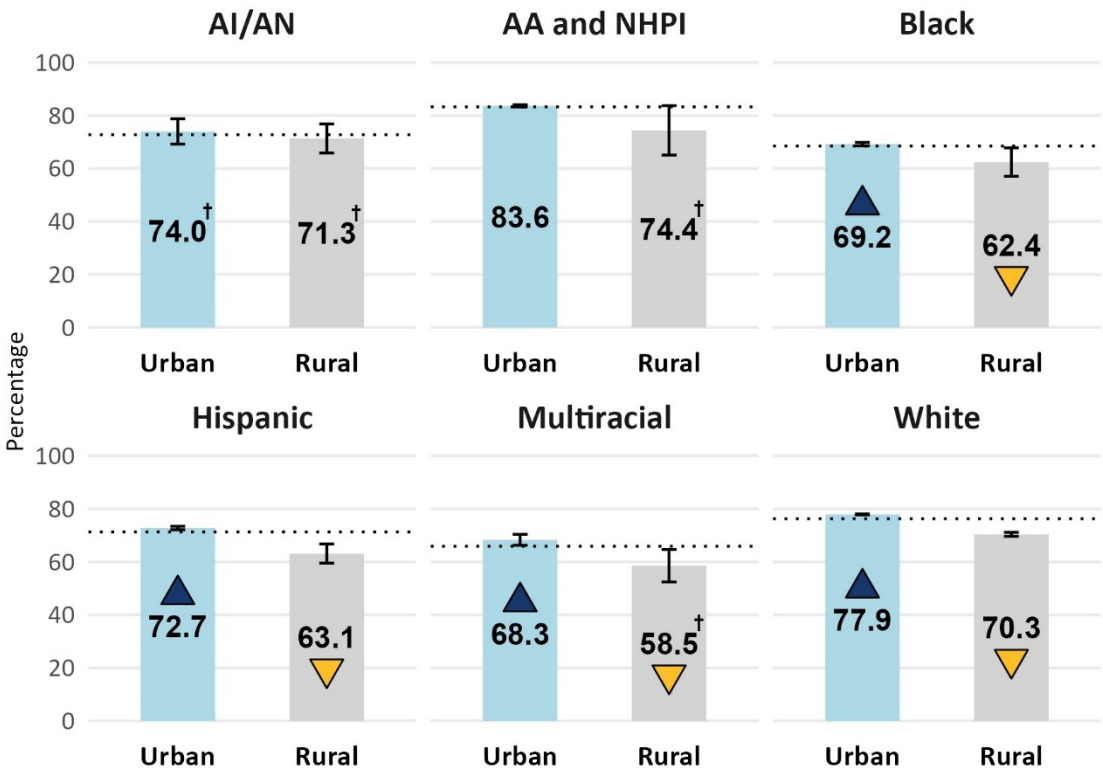
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all Hispanic people with FFS coverage.

- Multiracial people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all Multiracial people with FFS coverage. There were not enough data from Multiracial people with FFS coverage living in rural areas to compare this group to the national average for all Multiracial people with FFS coverage on experiences with getting needed prescription drugs.

- White people with FFS coverage living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all White people with FFS coverage.

Annual Flu Vaccine

Percentage of people with FFS coverage who got a vaccine (flu shot), by geography within racial and ethnic group, 2023



SOURCE: Data are from the 2023 FFS CAHPS survey.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of AI/AN people with FFS coverage living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all AI/AN people with FFS coverage.

- The percentages of AA and NHPI people with FFS coverage living in urban and rural areas who received the flu vaccine were each **similar to** the national average for all AA and NHPI people with FFS coverage.

- The percentage of Black people with FFS coverage living in urban areas who received the flu vaccine was **above** the national average for all Black people with FFS coverage by less than 3 percentage points. The percentage of Black people with FFS coverage living in rural areas who received the flu vaccine was **below** the national average for all Black people with FFS coverage by more than 3 percentage points.

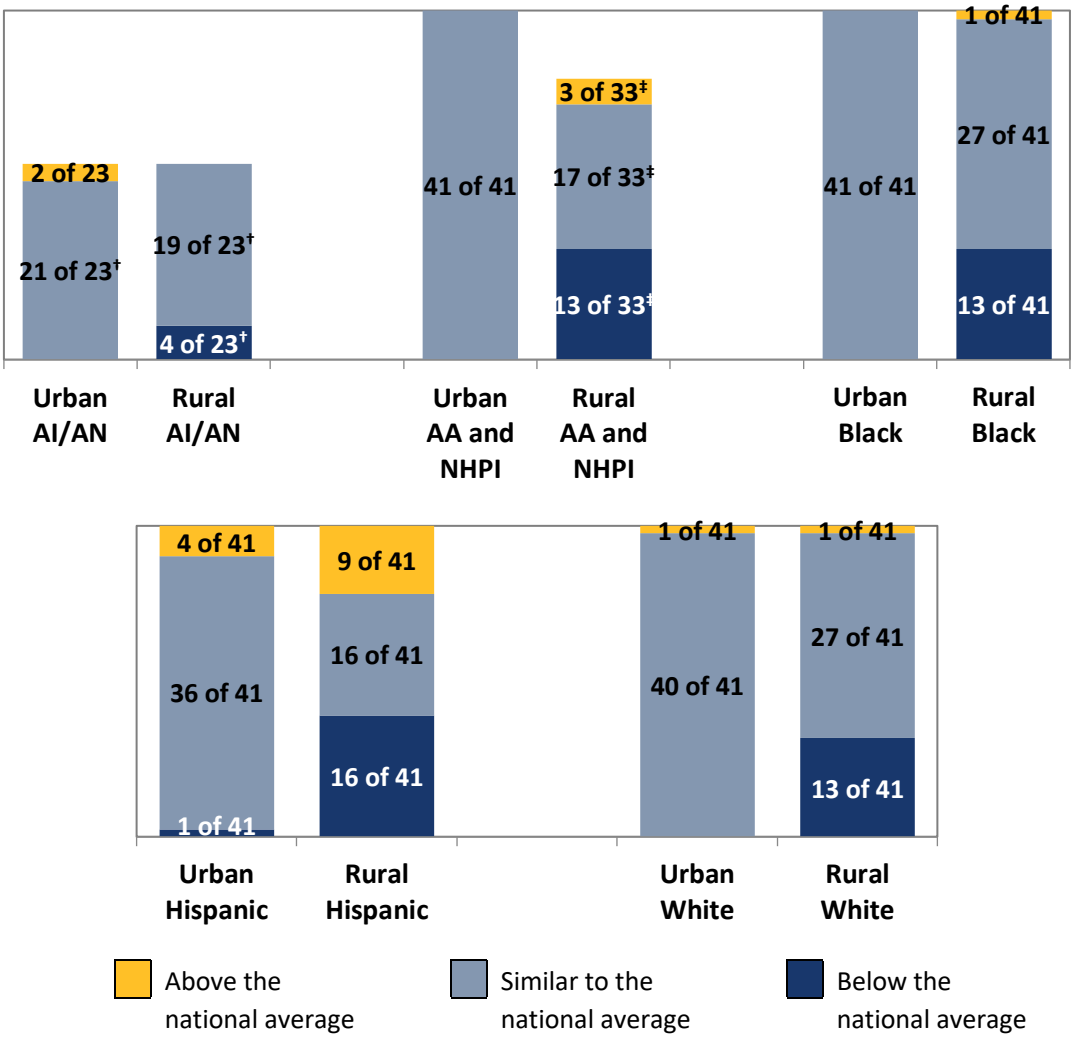
- The percentage of Hispanic people with FFS coverage living in urban areas who received the flu vaccine was **above** the national average for all Hispanic people with FFS coverage by less than 3 percentage points. The percentage of Hispanic people with FFS coverage living in rural areas who received the flu vaccine was **below** the national average for all Hispanic people with FFS coverage by more than 3 percentage points.

- The percentage of Multiracial people with FFS coverage living in urban areas who received the flu vaccine was **above** the national average for all Multiracial people with FFS coverage by less than 3 percentage points. The percentage of Multiracial people with FFS coverage living in rural areas who received the flu vaccine was **below** the national average for all Multiracial people with FFS coverage by more than 3 percentage points.

- The percentage of White people with FFS coverage living in urban areas who received the flu vaccine was **above** the national average for all White people with FFS coverage by less than 3 percentage points. The percentage of White people with FFS coverage living in rural areas who received the flu vaccine was **below** the national average for all White people with FFS coverage by more than 3 percentage points.

Rural-Urban Disparities in Care by Racial and Ethnic Group: All Clinical Care Measures, Medicare Advantage

Number of clinical care measures for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. For reporting clinical care data stratified by race and ethnicity, racial and ethnic group membership is estimated using a method that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when their accuracy does not meet the standards described on p. 241. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.
† There were not enough data from AI/AN MA enrollees living in urban areas to compare these group to the national average for all AI/AN MA enrollees on 18 clinical care measures. There were also not enough data from AI/AN MA enrollees living in rural areas to compare this group to the national average for all AI/AN MA enrollees on the same 18 measures.
‡ There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group to the national average for all AA and NHPI MA enrollees on eight clinical care measures.

Rural and urban residents enrolled in MA were compared with the national average for all MA enrollees of the same racial or ethnic group.

- **Above the national average** = Rural or urban residents had results that were above the national average for the racial or ethnic group. 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** = Rural and urban residents had results that were similar to the national average for the racial or ethnic group. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = Rural or urban residents had results that were below the national average for the racial or ethnic group. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

AI/AN MA enrollees living in urban areas had results that were above the national average for all AI/AN MA enrollees

- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Screening in Older Women

AI/AN MA enrollees living in rural areas had results that were below the national average for all AI/AN MA enrollees

- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Screening in Older Women
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls

AA and NHPI MA enrollees living in rural areas had results that were above the national average for all AA and NHPI MA enrollees

- Initiation of AOD Dependence Treatment
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

AA and NHPI MA enrollees living in rural areas had results that were below the national average for all AA and NHPI MA enrollees

- Breast Cancer Screening
- Testing to Confirm COPD
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Kidney Health Evaluation for Patients with Diabetes
- Statin Use in Patients with Diabetes
- Osteoporosis Screening in Older Women
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

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

Black MA enrollees living in rural areas had results that were above the national average for all Black MA enrollees
• Avoiding Use of Opioids from Multiple Prescribers

Black MA enrollees living in rural areas had results that were below the national average for all Black MA enrollees
• Diabetes Care—Eye Exam • Diabetes Care—Blood Pressure Controlled • Kidney Health Evaluation for Patients with Diabetes • Osteoporosis Screening in Older Women • Osteoporosis Management in Women Who Had a Fracture • 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) • Transitions of Care—Notification of Inpatient Admission • Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls • Avoiding Use of High-Risk Medications in Older Adults • Pharmacotherapy for Opioid Use Disorder

Hispanic MA enrollees living in urban areas had results that were above the national average for all Hispanic MA enrollees
• Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid • Pharmacotherapy Management of COPD Exacerbation—Bronchodilator • Kidney Health Evaluation for Patients with Diabetes • Initiation of AOD Dependence Treatment

Hispanic MA enrollees living in urban areas had results that were below the national average for all Hispanic MA enrollees
• Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Hispanic MA enrollees living in rural areas had results that were above the national average for all Hispanic MA enrollees
• Breast Cancer Screening • Colorectal Cancer Screening • Controlling High Blood Pressure • Diabetes Care—Eye Exam • Diabetes Care—Blood Pressure Controlled • Osteoporosis Management in Women Who Had a Fracture • Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge) • Transitions of Care—Medication Reconciliation After Inpatient Discharge • Avoiding Use of Opioids from Multiple Prescribers

Hispanic MA enrollees living in rural areas had results that were below the national average for all Hispanic MA enrollees
• Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid • Pharmacotherapy Management of COPD Exacerbation—Bronchodilator • Engagement of Cardiac Rehabilitation • Kidney Health Evaluation for Patients with Diabetes • Antidepressant Medication Management—Acute Phase Treatment • Antidepressant Medication Management—Continuation Phase Treatment • 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 • Transitions of Care—Notification of Inpatient Admission • Transitions of Care—Receipt of Discharge Information • Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls • Avoiding Use of High-Risk Medications in Older Adults

White MA enrollees living in urban areas had results that were above the national average for all White MA enrollees
• Kidney Health Evaluation for Patients with Diabetes

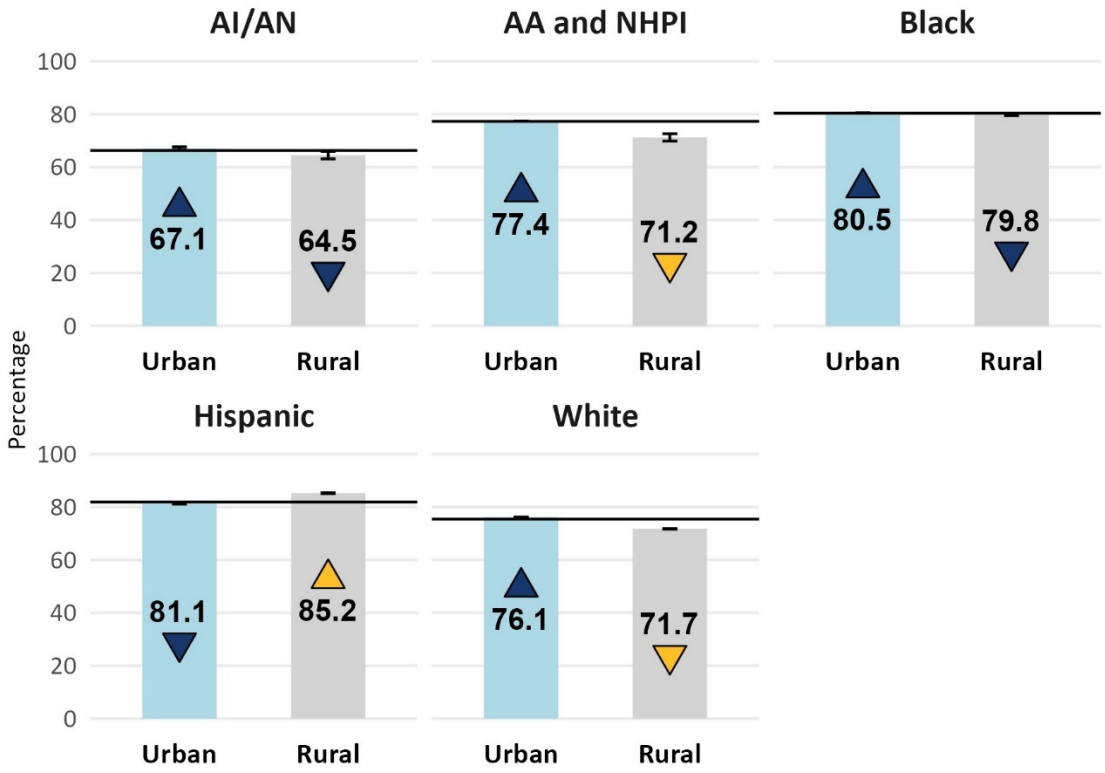
White MA enrollees living in rural areas had results that were above the national average for all White MA enrollees
• Initiation of AOD Dependence Treatment

White MA enrollees living in rural areas had results that were below the national average for all White MA enrollees
• Breast Cancer Screening • Colorectal Cancer Screening • Diabetes Care—Eye Exam • Diabetes Care—Blood Pressure Controlled • Kidney Health Evaluation for Patients with Diabetes • Osteoporosis Screening in Older Women • Osteoporosis Management in Women Who Had a Fracture • 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) • Transitions of Care—Notification of Inpatient Admission • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia • Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of eligible[†] female AI/AN MA enrollees living in urban areas who were appropriately screened for breast cancer was **above**[‡] the national average for all female AI/AN MA enrollees by less than 3 percentage points. The percentage of eligible female AI/AN MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all female AI/AN MA enrollees by less than 3 percentage points.

- The percentage of eligible female AA and NHPI MA enrollees living in urban areas who were appropriately screened for breast cancer was **above** the national average for all female AA and NHPI MA enrollees by less than 3 percentage points. The percentage of eligible female AA and NHPI MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all female AA and NHPI MA enrollees by more than 3 percentage points.

- The percentage of eligible female Black MA enrollees living in urban areas who were appropriately screened for breast cancer was **above** the national average for all female Black MA enrollees by less than 3 percentage points. The percentage of eligible female Black MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all female Black MA enrollees by less than 3 percentage points.

- The percentage of eligible female Hispanic MA enrollees living in urban areas who were appropriately screened for breast cancer was **below** the national average for all female Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible female Hispanic MA enrollees living in rural areas who were appropriately screened for breast cancer was **above** the national average for all female Hispanic MA enrollees by more than 3 percentage points.

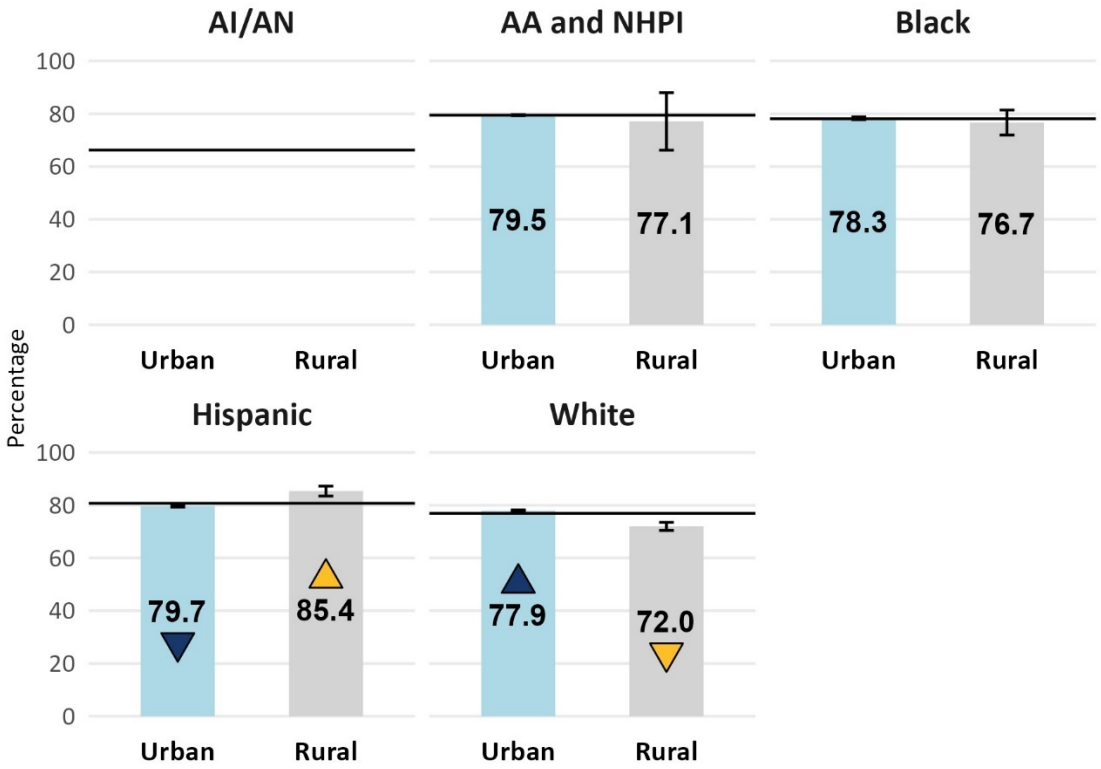
- The percentage of eligible female White MA enrollees living in urban areas who were appropriately screened for breast cancer was **above** the national average for all female White MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all female White 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 on pp. 105–108, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who were appropriately screened for colorectal cancer were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

- The percentages of eligible Black MA enrollees living in urban and rural areas who were appropriately screened for colorectal cancer were each **similar to** the national average for all eligible Black MA enrollees.

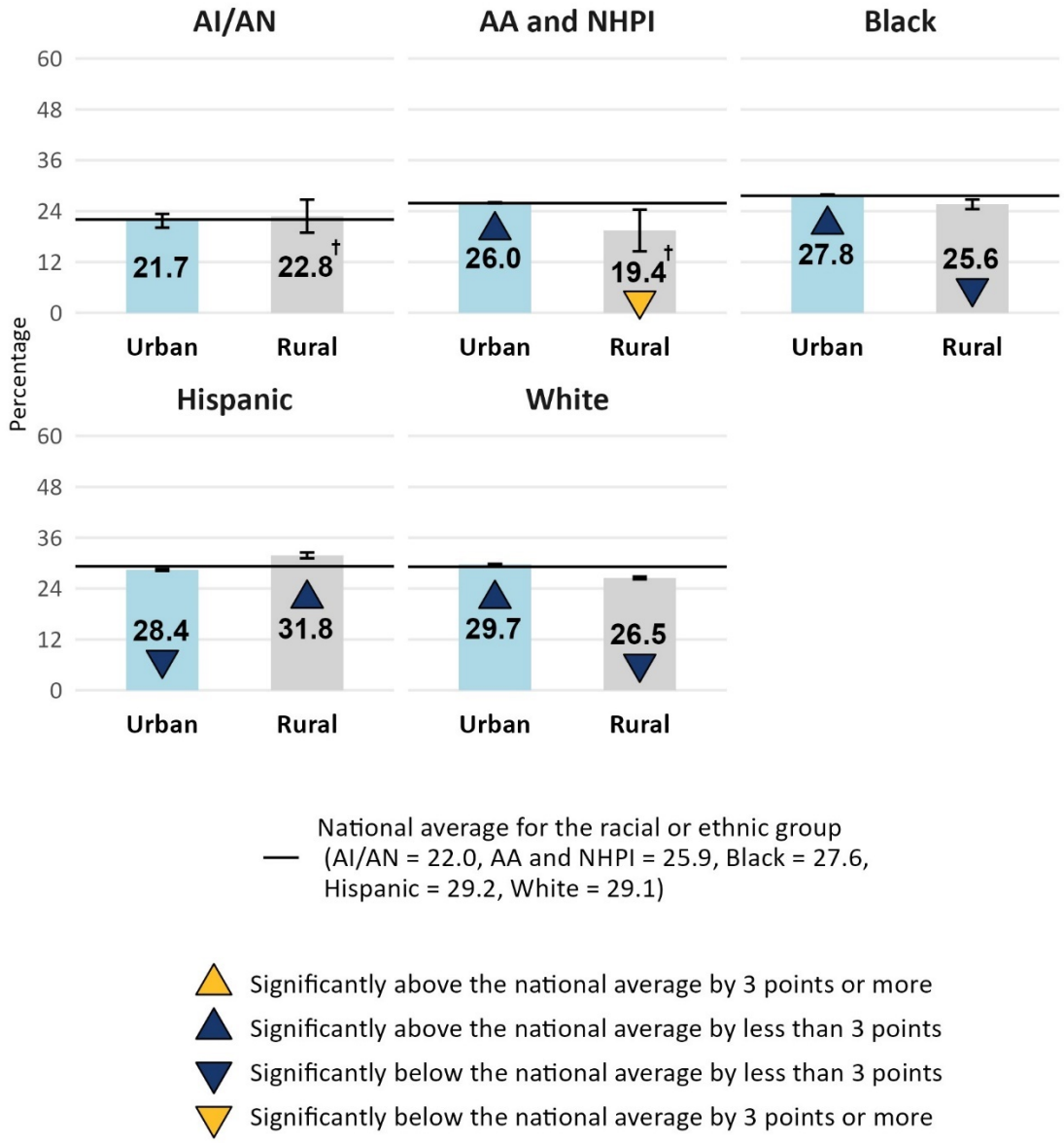
- The percentage of eligible Hispanic MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who were appropriately screened for colorectal cancer was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who were appropriately screened for colorectal cancer was **below** the national average for all eligible White MA enrollees by more than 3 percentage points.

Clinical Care: Respiratory Conditions

Testing to Confirm 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of eligible AI/AN MA enrollees living in urban and rural areas who received a spirometry test to confirm a diagnosis of COPD were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points. The percentage of eligible AA and NHPI MA enrollees living in rural areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible AA and NHPI MA enrollees by more than 3 percentage points.

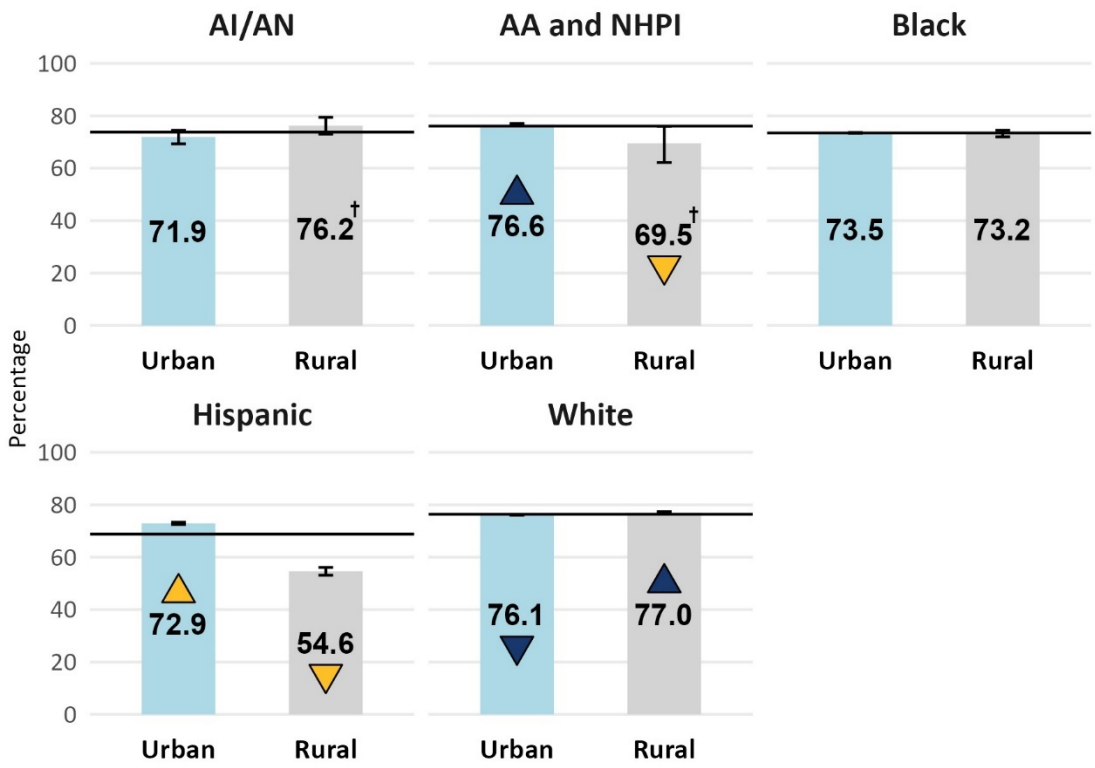
- The percentage of eligible Black MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible Black MA enrollees by less than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of eligible AI/AN MA enrollees living in urban and rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who were **above** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points. The percentage of eligible AA and NHPI MA enrollees living in rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible AA and NHPI MA enrollees by more than 3 percentage points.

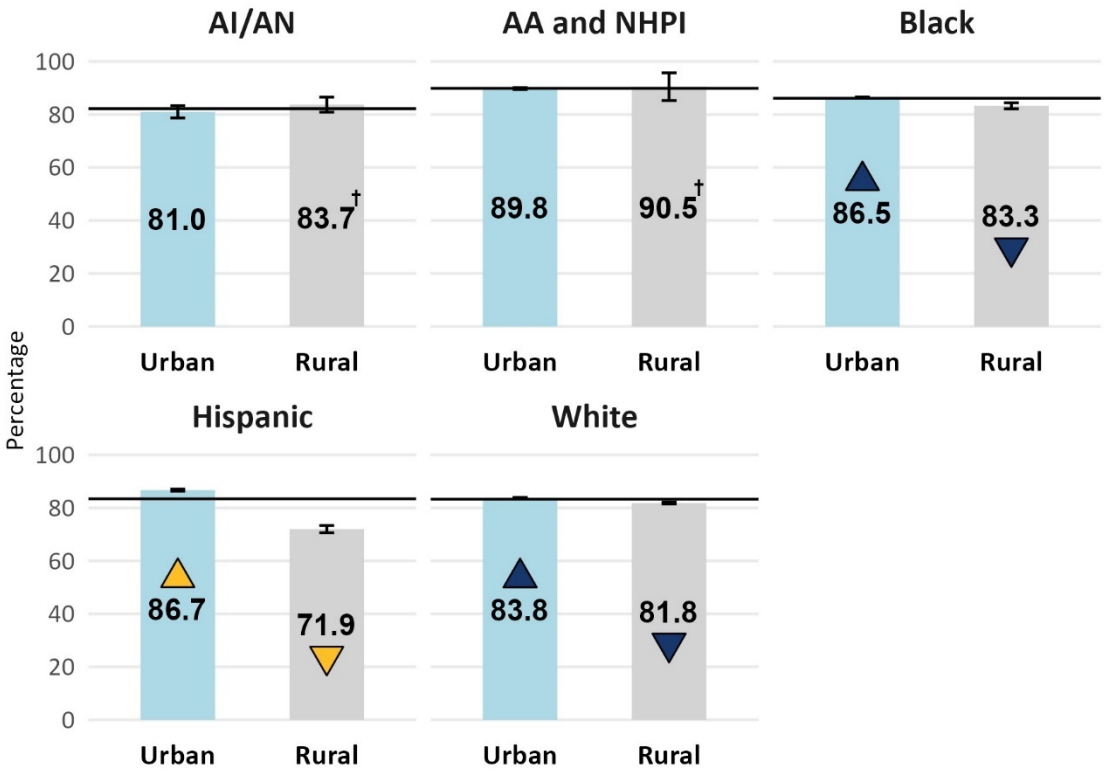
- The percentages of eligible Black MA enrollees living in urban and rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of eligible AI/AN MA enrollees living in urban and rural areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

- The percentage of eligible Black MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible Black MA enrollees by less than 3 percentage points.

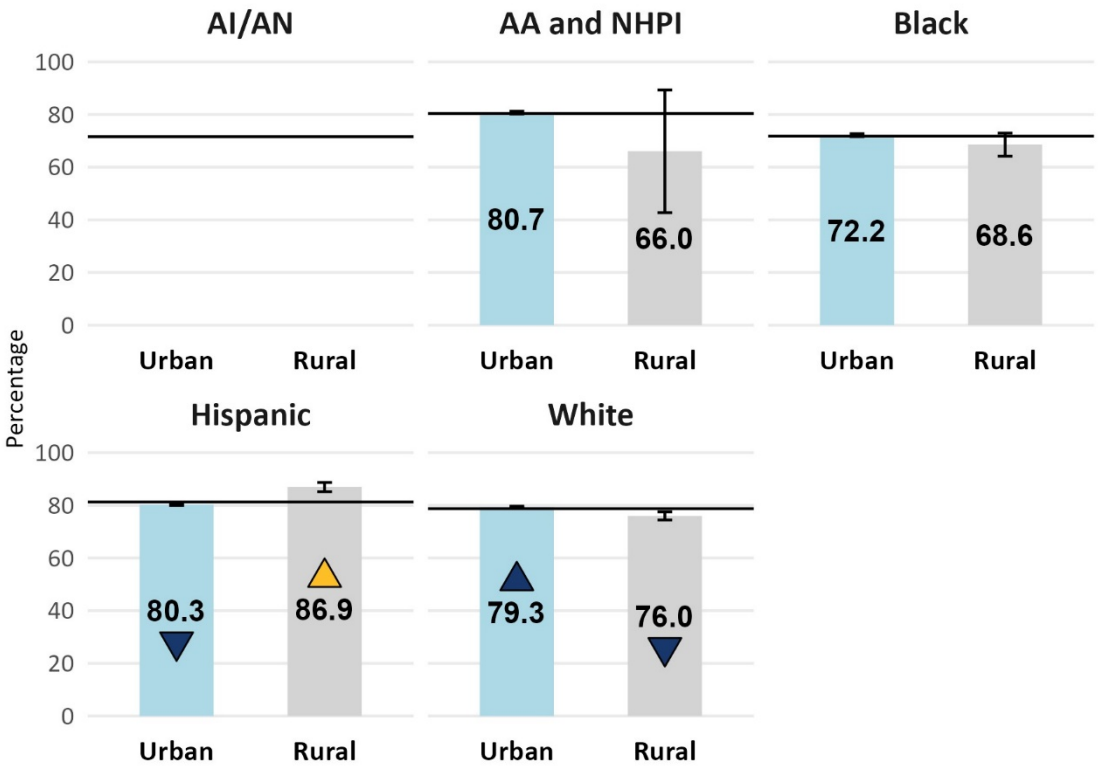
- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible White MA enrollees by less than 3 percentage points.

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by geography within racial and ethnic group, Reporting Year 2023



— National average for the racial or ethnic group (AI/AN = 71.6, AA and NHPI = 80.4, Black = 71.8, Hispanic = 81.3, White = 78.7)

▲ 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

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† 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

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who had their blood pressure adequately controlled were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

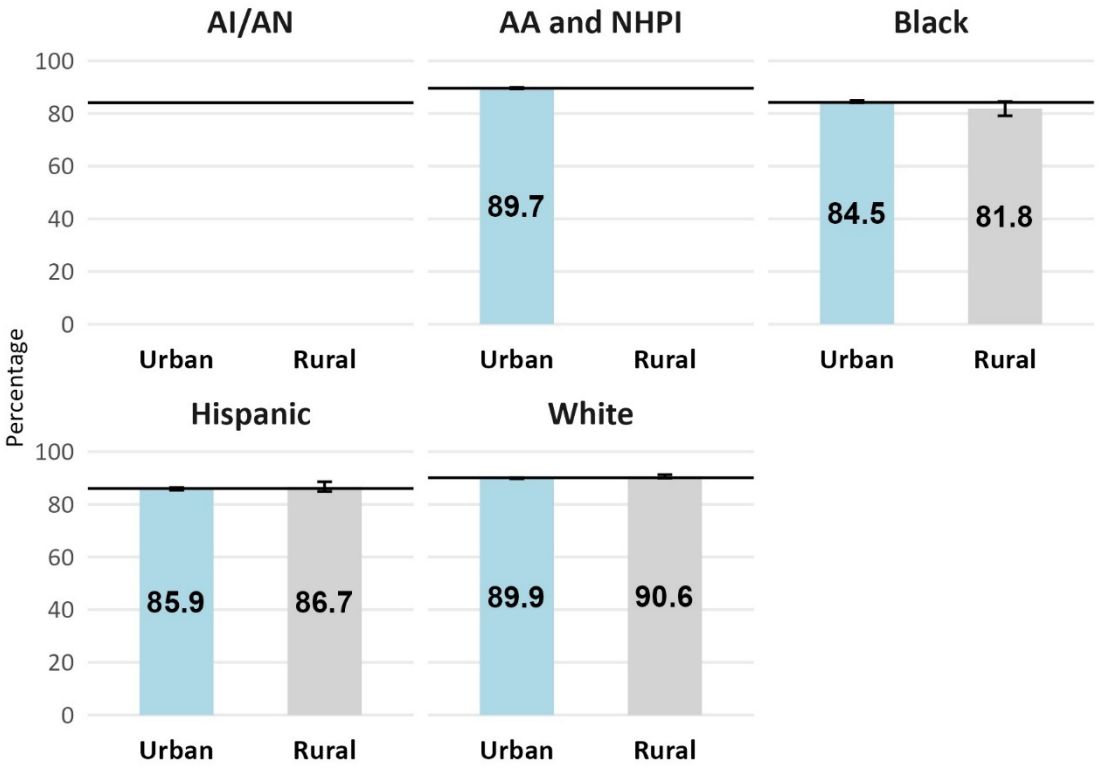
- The percentages of eligible Black MA enrollees living in urban and rural areas who had their blood pressure adequately controlled were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of eligible Hispanic MA enrollees living in urban areas who had their blood pressure adequately controlled was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who had their blood pressure adequately controlled was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who had their blood pressure adequately controlled was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who had their blood pressure adequately controlled was **below** the national average for all eligible White 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 AMI who received continuous beta-blocker treatment for six months after discharge, by geography within racial and ethnic group, Reporting Year 2023



— National average for the racial or ethnic group (AI/AN = 84.1, AA and NHPI = 89.6, Black = 84.2, Hispanic = 86.0, White = 90.1)

▲ 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

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas who received continuous beta-blocker treatment after a heart attack was **similar to** the national average for all eligible AA and NHPI MA enrollees. There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible AA and NHPI MA enrollees on this measure.

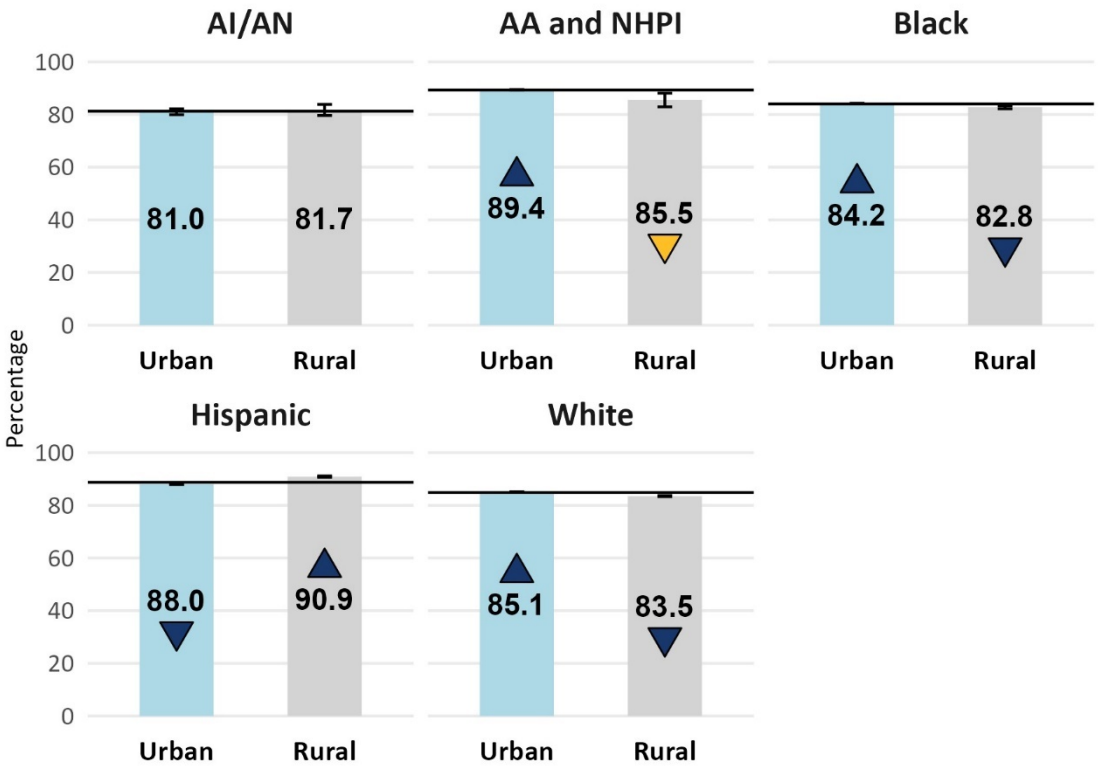
- The percentages of Black MA enrollees living in urban and rural areas who received continuous beta-blocker treatment after a heart attack were each **similar to** the national average for all eligible Black MA enrollees.

- The percentages of Hispanic MA enrollees living in urban and rural areas who received continuous beta-blocker treatment after a heart attack were each **similar to** the national average for all eligible Hispanic MA enrollees.

- The percentages of White MA enrollees living in urban and rural areas who received continuous beta-blocker treatment after a heart attack were each **similar to** the national average for all eligible White MA enrollees.

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 ASCVD who received statin therapy, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentages of AI/AN MA enrollees with clinical ASCVD living in urban and rural areas who received statin therapy were each **similar to** the national average for all AI/AN MA enrollees with clinical ASCVD.

- The percentage of AA and NHPI MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **above** the national average for all AA and NHPI MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **below** the national average for all AA and NHPI MA enrollees with clinical ASCVD by more than 3 percentage points.

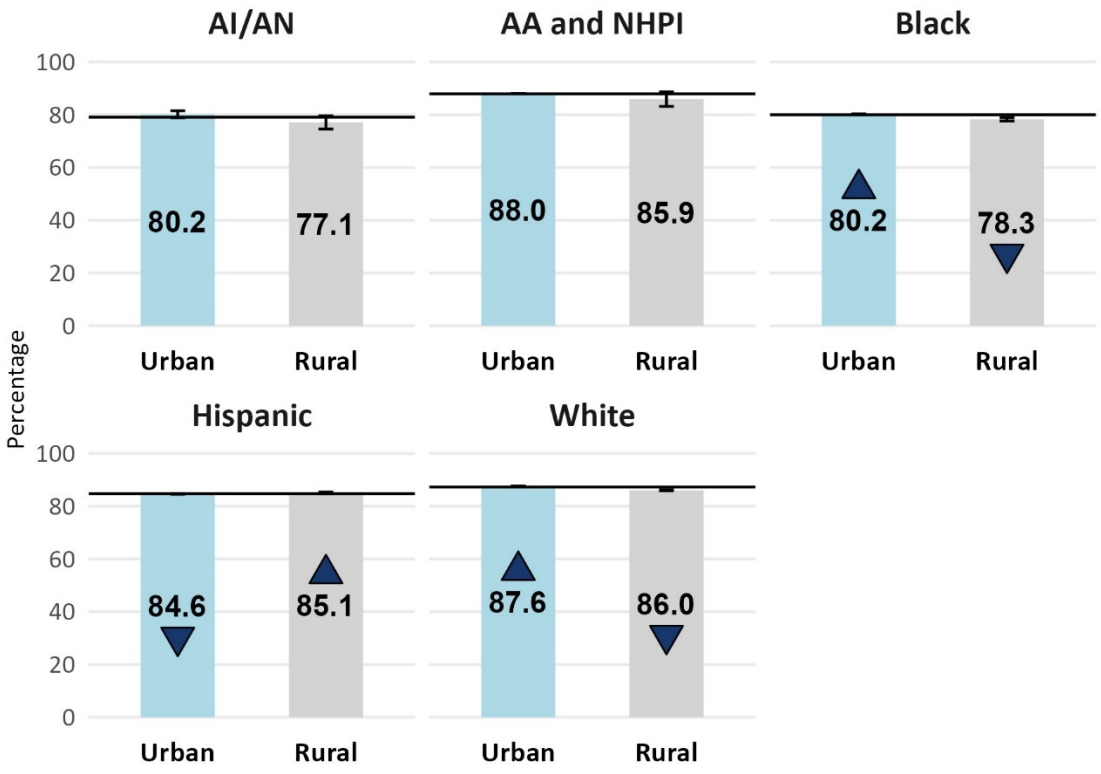
- The percentage of Black MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **above** the national average for all Black MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Black MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **below** the national average for all Black MA enrollees with clinical ASCVD by less than 3 percentage points.

- The percentage of Hispanic MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **below** the national average for all Hispanic MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Hispanic MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **above** the national average for all Hispanic MA enrollees with clinical ASCVD by less than 3 percentage points.

- The percentage of White MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **above** the national average for all White MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of White MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **below** the national average for all White 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 who remained on the medication for at least 80 percent of the treatment period, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentages of AI/AN MA enrollees with clinical ASCVD living in urban and rural areas who had proper statin medication adherence were each **similar to** the national average for all AI/AN MA enrollees with clinical ASCVD.

- The percentages of AA and NHPI MA enrollees with clinical ASCVD living in urban and rural areas who had proper statin medication adherence were each **similar to** the national average for all AA and NHPI MA enrollees with clinical ASCVD.

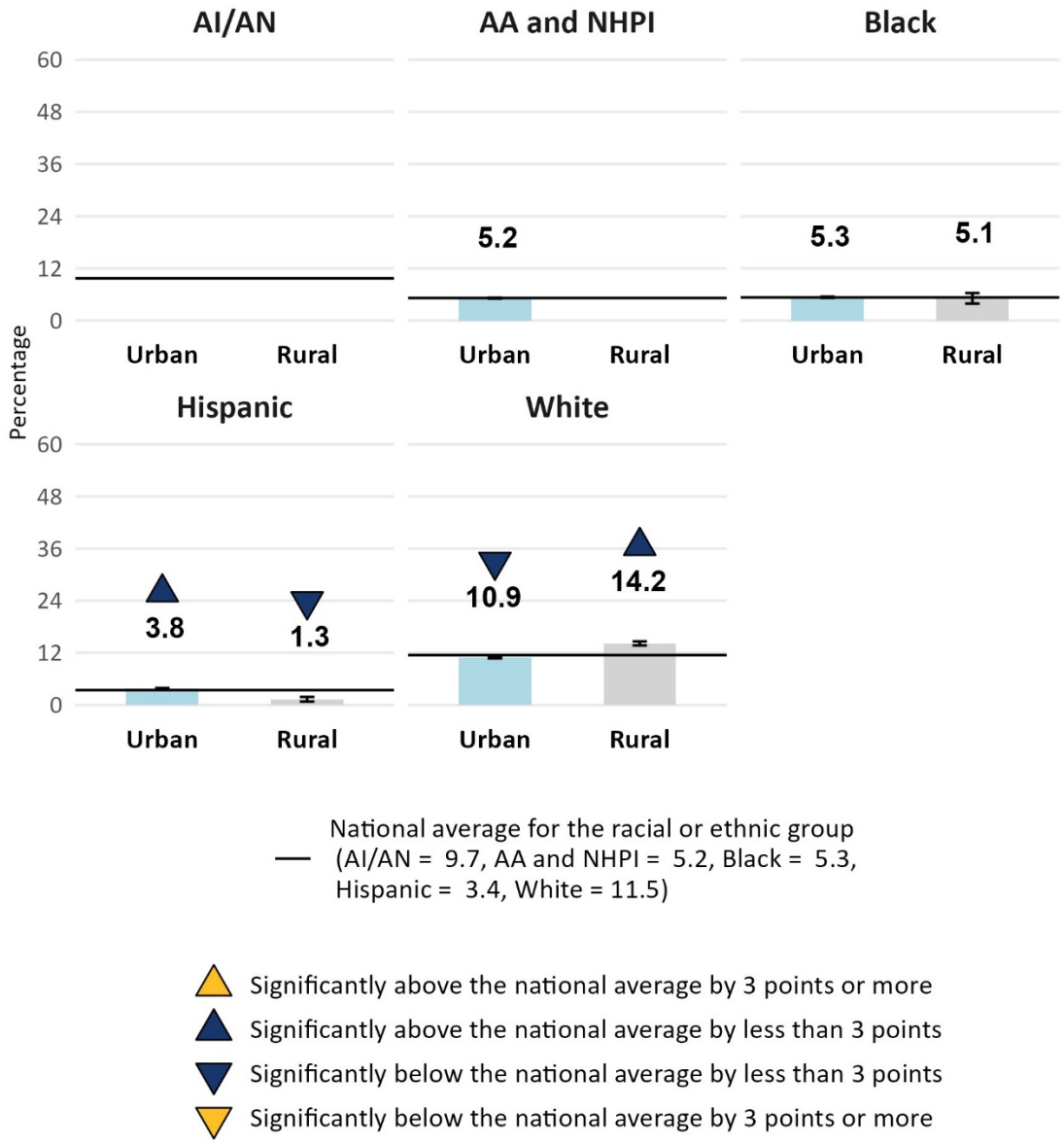
- The percentage of Black MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all Black MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Black MA enrollees with clinical ASCVD living in rural areas who had proper statin medication adherence was **below** the national average for all Black MA enrollees with clinical ASCVD by less than 3 percentage points.

- The percentage of Hispanic MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **below** the national average for all Hispanic MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Hispanic MA enrollees with clinical ASCVD living in rural areas who had proper statin medication adherence was **above** the national average for all Hispanic MA enrollees with clinical ASCVD by less than 3 percentage points.

- The percentage of White MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all White MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of White MA enrollees with clinical ASCVD living in rural areas who had proper statin medication adherence was **below** the national average for all White MA enrollees with clinical ASCVD by less than 3 percentage points.

Initiation of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older[†] who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

[†] 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

- There were not enough data from AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **similar to** the national average for all AA and NHPI MA enrollees who had a cardiac event. There were not enough data from AA and NHPI MA enrollees living in rural areas to compare the scores for these groups to the national average for all eligible AA and NHPI MA enrollees on this measure.

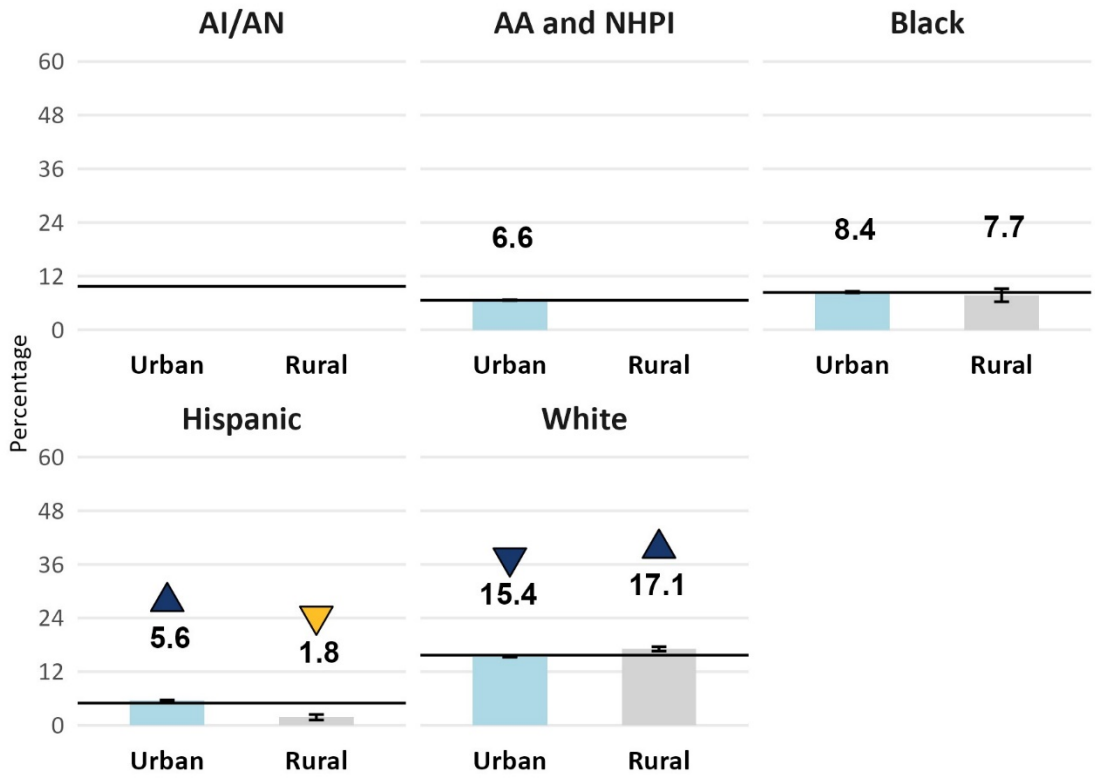
- The percentage of Black MA enrollees living in urban and rural areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all Hispanic MA enrollees who had a cardiac event by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all Hispanic MA enrollees who had a cardiac event by less than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all White MA enrollees who had a cardiac event by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all White MA enrollees who had a cardiac event by less than 3 percentage points.

Engagement of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older[†] who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

[†] 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

- There were not enough data from AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **similar to** the national average for all AA and NHPI MA enrollees who had a cardiac event. There were not enough data from AA and NHPI MA enrollees living in rural areas to compare the scores for these groups to the national average for all eligible AA and NHPI MA enrollees on this measure

- The percentages of Black MA enrollees living in urban and rural areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event were each **similar to** the national average for all Black MA enrollees who had a cardiac event.

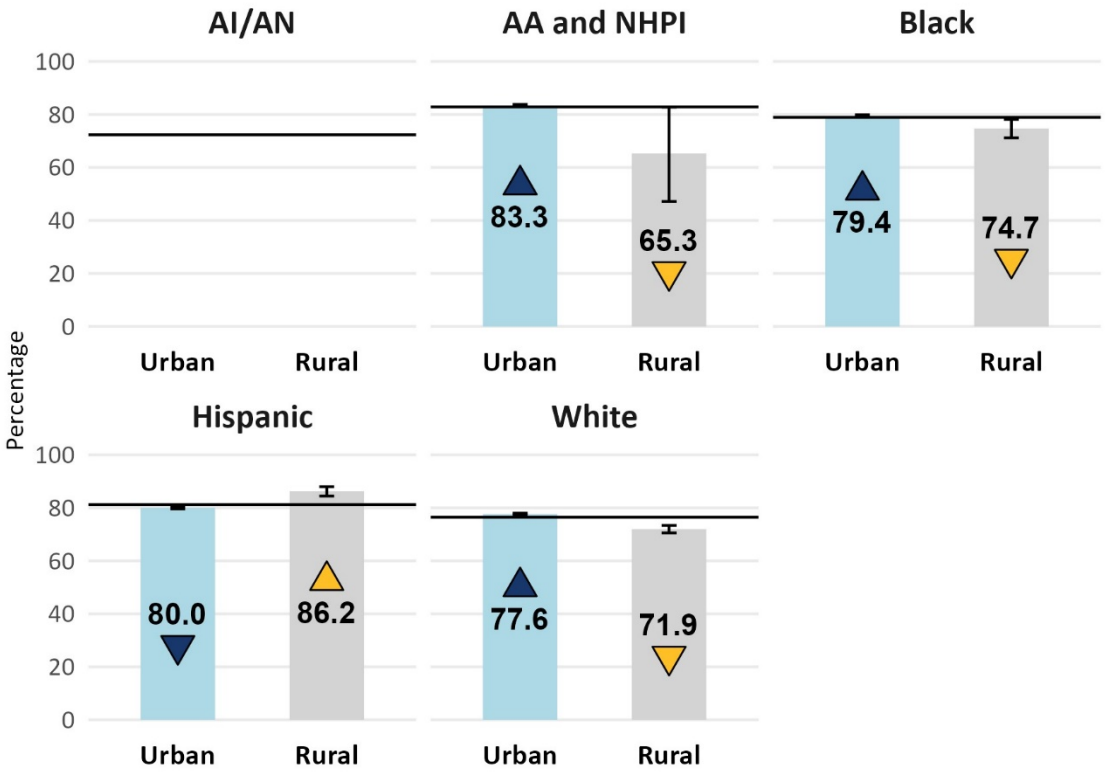
- The percentage of Hispanic MA enrollees living in urban areas who had a cardiac event who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all Hispanic MA enrollees who had a cardiac event by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all Hispanic MA enrollees who had a cardiac event by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who had a cardiac event who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all White MA enrollees who had a cardiac event by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all White MA enrollees who had a cardiac event by less than 3 percentage points.

Clinical Care: Diabetes

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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban or rural areas to compare the scores for these groups to the national average for all AI/AN MA enrollees with diabetes on this measure.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **below** the national average for all AA and NHPI MA enrollees with diabetes by more than 3 percentage points.

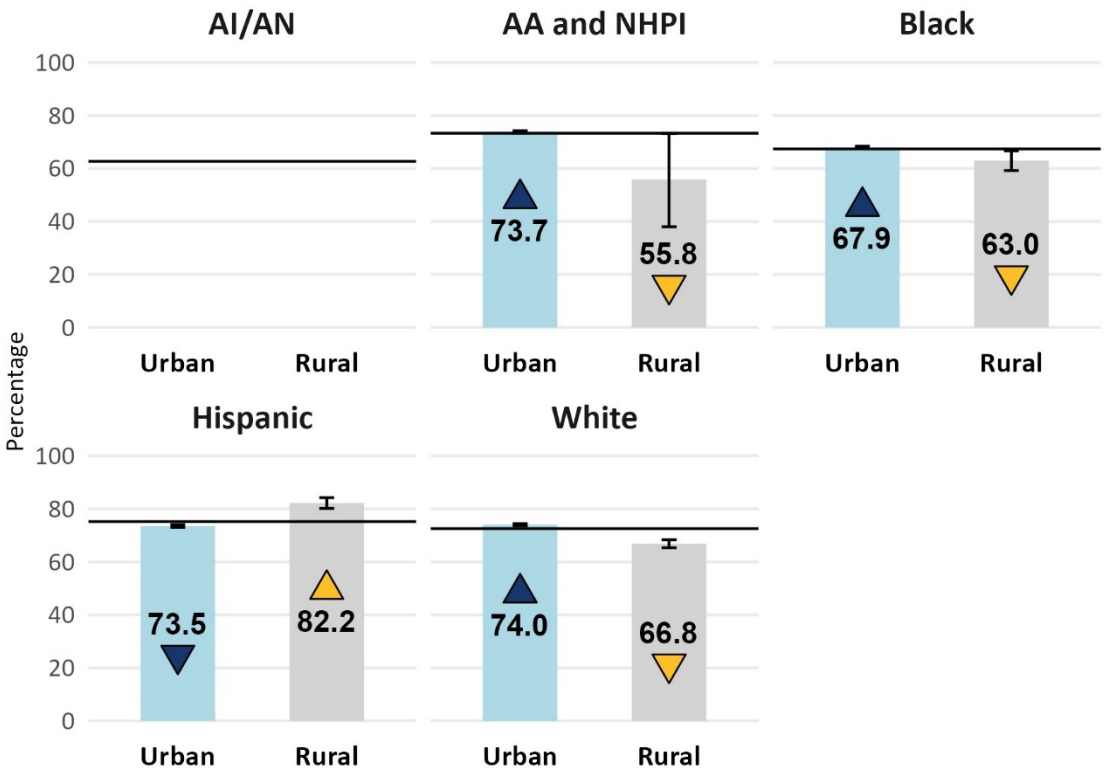
- The percentage of Black MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **below** the national average for all Black MA enrollees with diabetes by more than 3 percentage points.

- The percentage of Hispanic MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **below** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **above** the national average for all Hispanic MA enrollees with diabetes by more than 3 percentage points.

- The percentage of White MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **below** the national average for all White MA enrollees with diabetes by more 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban and rural areas to compare the scores for these groups to the national average for all AI/AN MA enrollees with diabetes on this measure.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had their blood pressure under control was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had their blood pressure under control was **below** the national average for all AA and NHPI MA enrollees with diabetes by more than 3 percentage points..

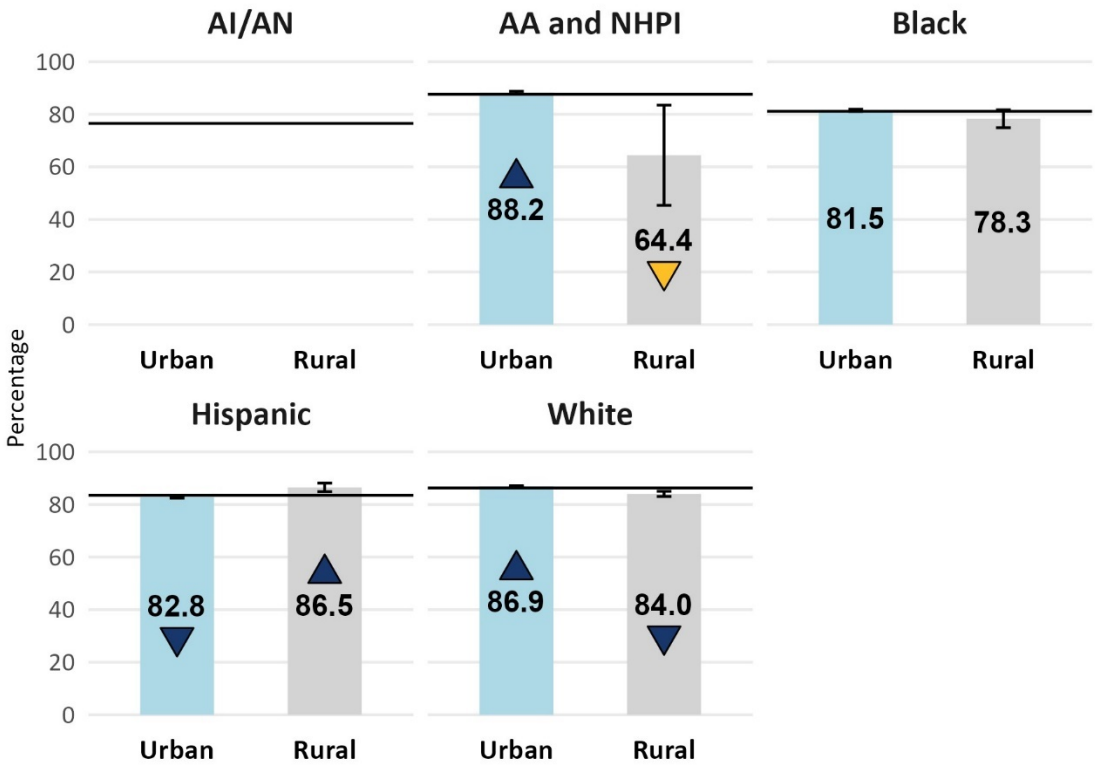
- The percentage of Black MA enrollees with diabetes living in urban areas who had their blood pressure under control was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who had their blood pressure under control was **below** the national average for all Black MA enrollees with diabetes by more than 3 percentage points.

- The percentage of Hispanic MA enrollees with diabetes living in urban areas who had their blood pressure under control was **below** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who had their blood pressure under control was **above** the national average for all Hispanic MA enrollees with diabetes by more than 3 percentage points.

- The percentage of White MA enrollees with diabetes living in urban areas who had their blood pressure under control was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who had their blood pressure under control was **below** the national average for all White MA enrollees with diabetes by more 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban and rural areas to compare the scores for these groups to the national average for all AI/AN MA enrollees with diabetes on this measure.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had their blood sugar level under control was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had their blood sugar level under control was **below** the national average for all AA and NHPI MA enrollees with diabetes by more than 3 percentage points.

- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had their blood sugar level under control were each **similar to** the national average for all Black MA enrollees with diabetes.

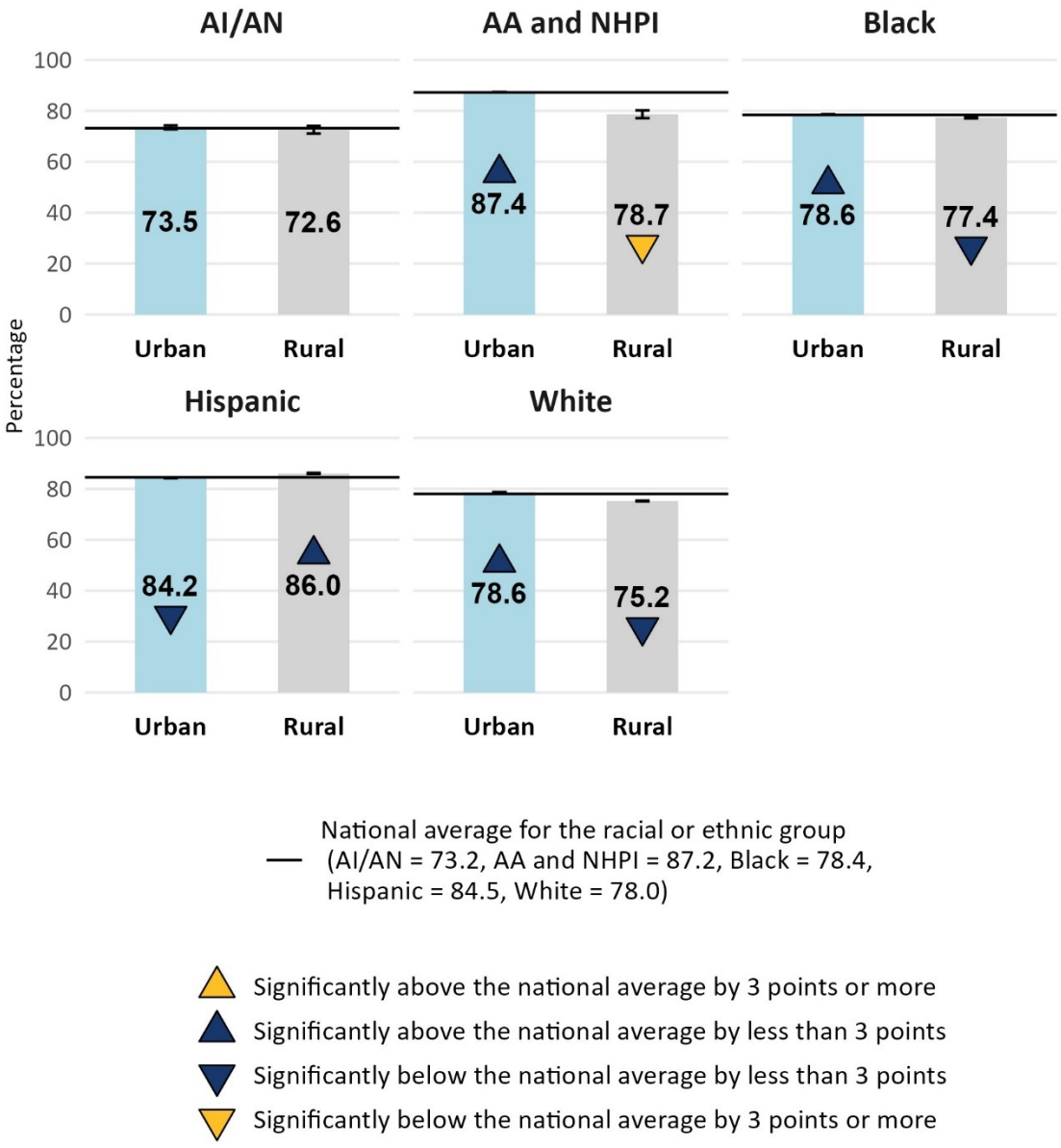
- The percentage of Hispanic MA enrollees with diabetes living in urban areas who had their blood sugar level under control was **below** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who had their blood sugar level under control was **above** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. [†]

- The percentage of White MA enrollees with diabetes living in urban areas who had their blood sugar level under control was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who had their blood sugar level under control was **below** the national average for all White MA enrollees with diabetes by less 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Excludes those who also have clinical ASCVD.

Disparities

- The percentages of AI/AN MA enrollees with diabetes living in urban and rural areas who received statin therapy were each **similar to** the national average for all AI/AN MA enrollees with diabetes.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who received statin therapy was **below** the national average for all AA and NHPI MA enrollees with diabetes by more than 3 percentage points.

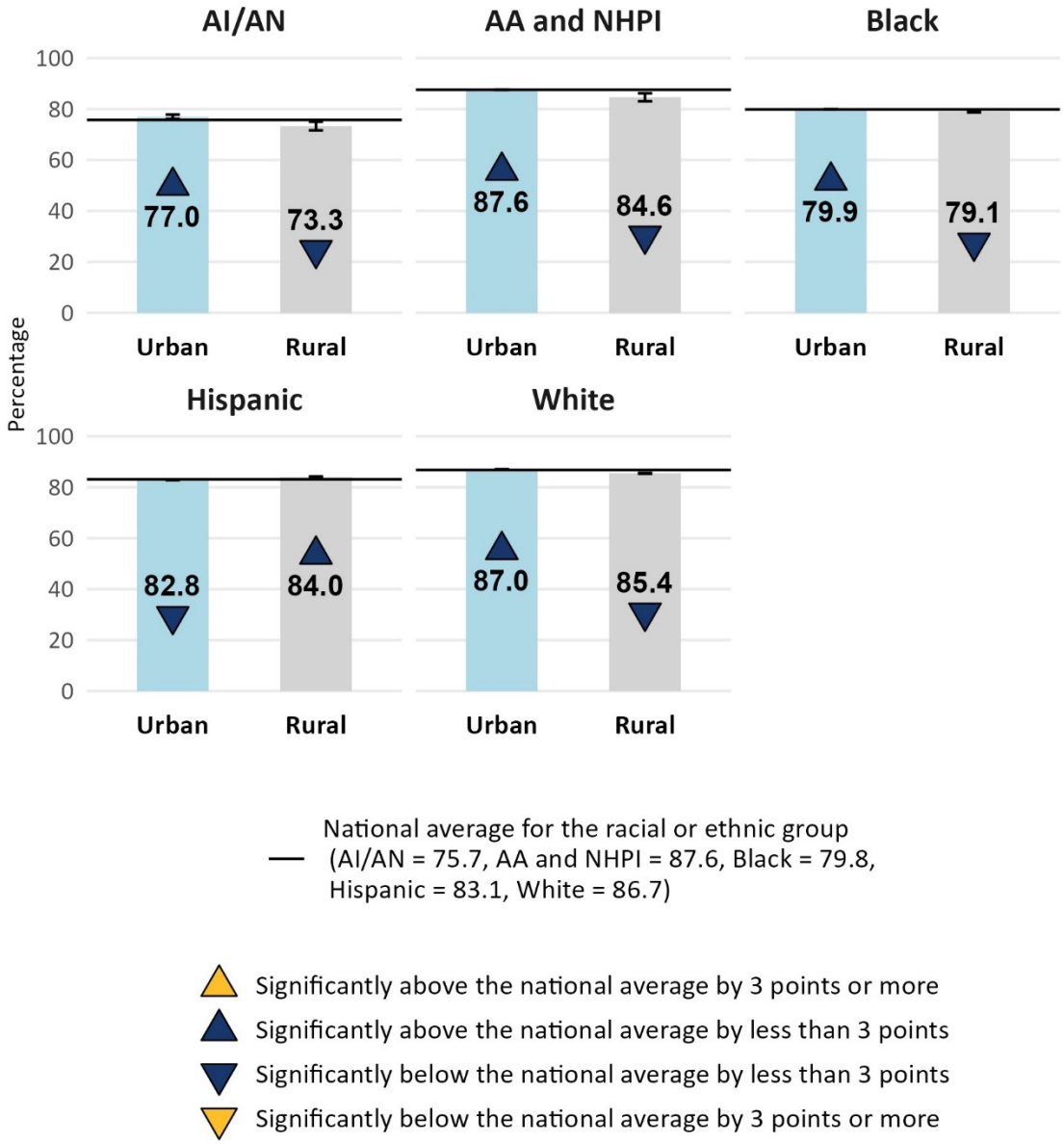
- The percentage of Black MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who received statin therapy was **below** the national average for all Black MA enrollees with diabetes by less than 3 percentage points.

- The percentage of Hispanic MA enrollees with diabetes living in urban areas who received statin therapy was **below** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who received statin therapy was **above** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points.

- The percentage of White MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who received statin therapy was **below** the national average for all White MA enrollees with diabetes by less than 3 percentage points.

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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Excludes those who also have clinical ASCVD.

Disparities

- The percentage of AI/AN MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all AI/AN MA enrollees with diabetes by less than 3 percentage points. The percentage of AI/AN MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **below** the national average for all AI/AN MA enrollees with diabetes by less than 3 percentage points.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **below** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points.[†]

- The percentage of Black MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **below** the national average for all Black MA enrollees with diabetes by less than 3 percentage points.

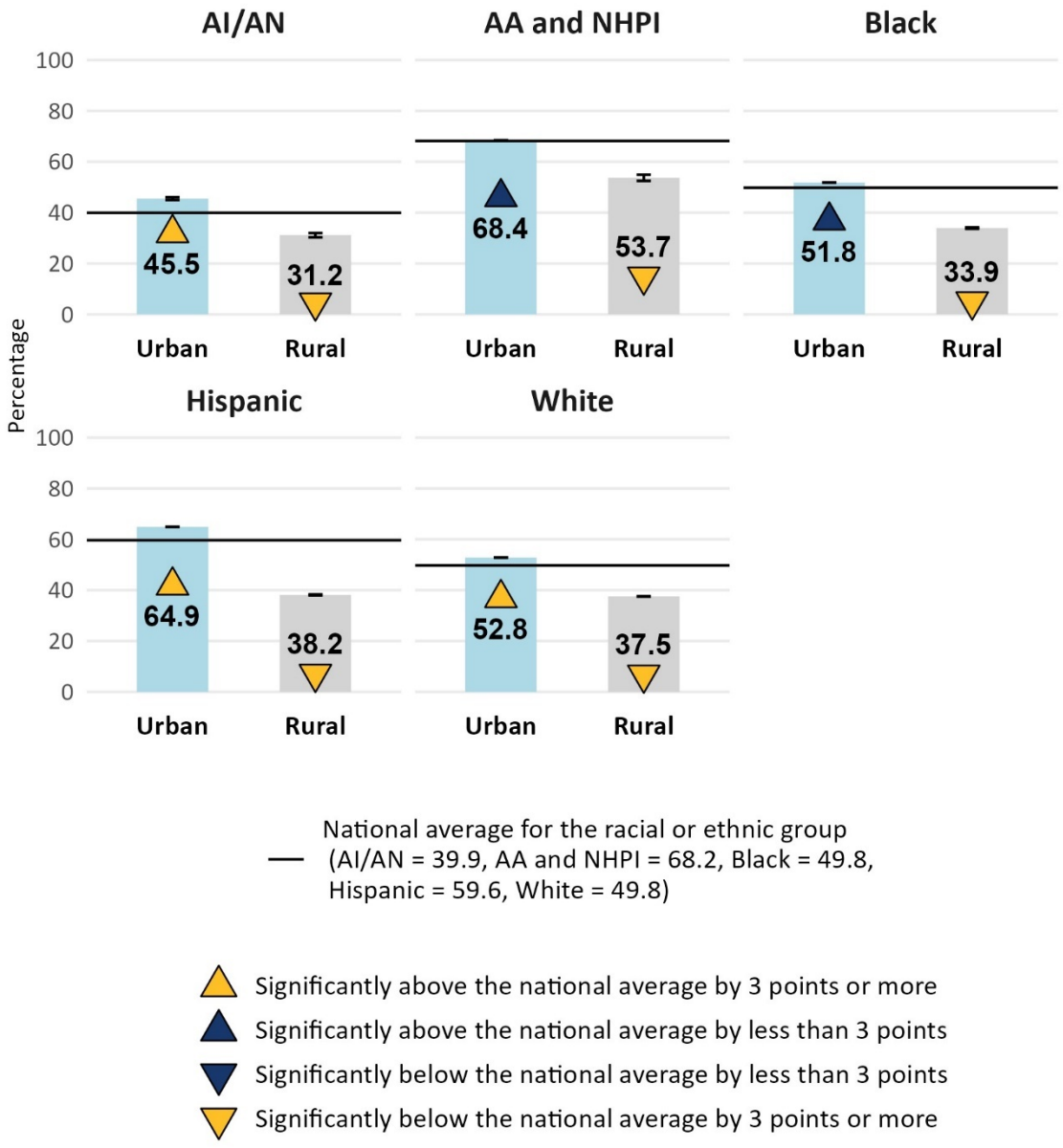
- The percentage of Hispanic MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **below** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **above** the national average for all Hispanic MA enrollees with diabetes by less than 3 percentage points.

- The percentage of White MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who had proper statin medication adherence was **below** the national average for all White MA enrollees with diabetes by less than 3 percentage points.

[†] Prior to rounding.

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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of AI/AN MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all AI/AN MA enrollees with diabetes by more than 3 percentage points. The percentage of AI/AN MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** the national average for all AI/AN MA enrollees with diabetes by more than 3 percentage points.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all AA and NHPI MA enrollees with diabetes by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** the national average for all AA and NHPI MA enrollees with diabetes by more than 3 percentage points.

- The percentage of Black MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** the national average for all Black MA enrollees with diabetes by more than 3 percentage points.

- The percentage of Hispanic MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all Hispanic MA enrollees with diabetes by more than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** the national average for all Hispanic MA enrollees with diabetes by more than 3 percentage points.

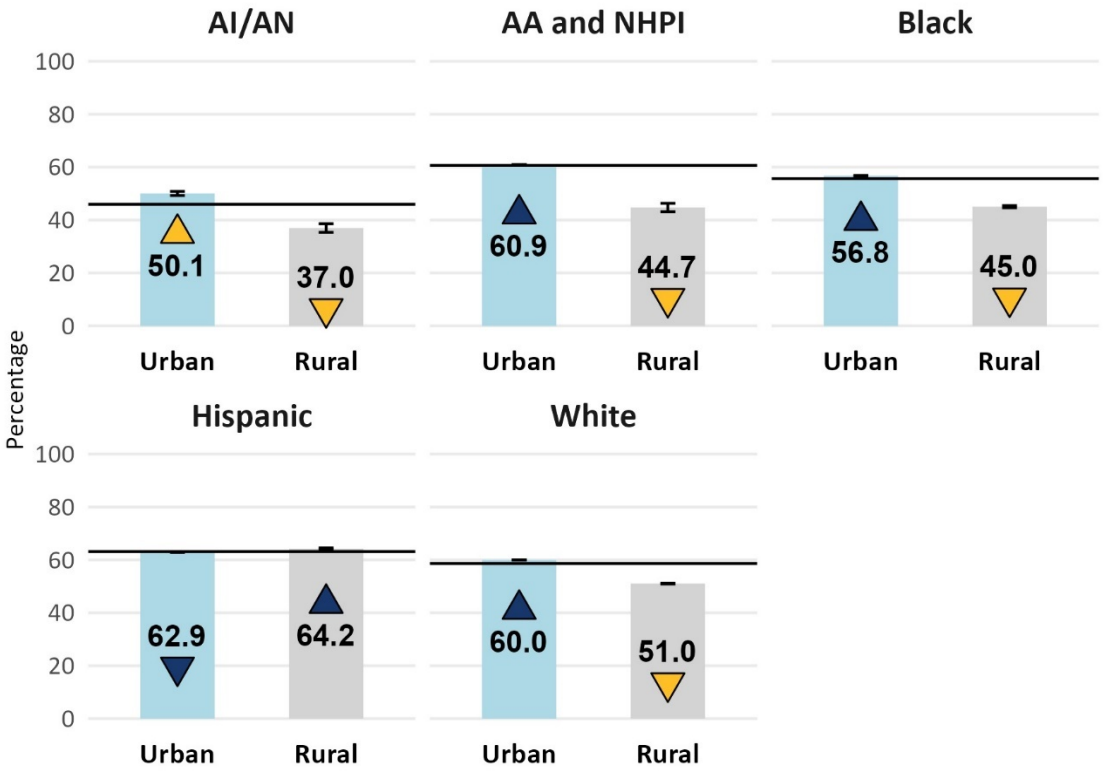
- The percentage of White MA enrollees with diabetes living in urban areas who received an annual kidney health evaluation was **above** the national average for all White MA enrollees with diabetes by more than 3 percentage points.[†] The percentage of White MA enrollees with diabetes living in rural areas who received an annual kidney health evaluation was **below** the national average for all White MA enrollees with diabetes by more than 3 percentage points.

[†] Prior to rounding.

Clinical Care: Musculoskeletal Conditions

Osteoporosis Screening in Older Women

Percentage of female MA enrollees aged 65 to 75 years who had appropriate screening for osteoporosis, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of eligible female AI/AN MA enrollees living in urban areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female AI/AN MA enrollees by more than 3 percentage points. The percentage of eligible female AI/AN MA enrollees living in rural areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female AI/AN MA enrollees by more than 3 percentage points.

- The percentage of eligible female AA and NHPI MA enrollees living in urban areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female AA and NHPI MA enrollees by less than 3 percentage points. The percentage of eligible female AA and NHPI MA enrollees living in rural areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female AA and NHPI MA enrollees by more than 3 percentage points.

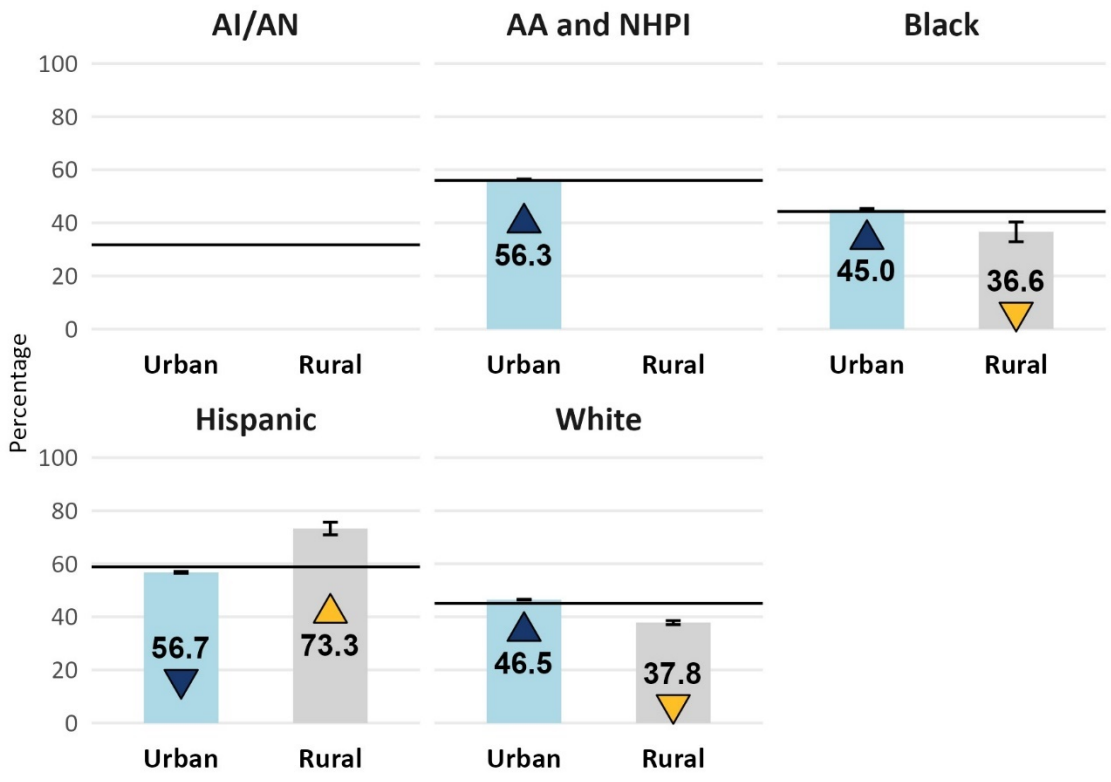
- The percentage of eligible female Black MA enrollees living in urban areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female Black MA enrollees by less than 3 percentage points. The percentage of eligible female Black MA enrollees living in rural areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female Black MA enrollees by more than 3 percentage points.

- The percentage of eligible female Hispanic MA enrollees living in urban areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible female Hispanic MA enrollees living in rural areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female Hispanic MA enrollees by less than 3 percentage points.

- The percentage of eligible female White MA enrollees living in urban areas who were appropriately screened for osteoporosis was **above** the national average for all eligible female White MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees living in rural areas who were appropriately screened for osteoporosis was **below** the national average for all eligible female White MA enrollees by more than 3 percentage points.

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 geography within racial and ethnic group, Reporting Year 2023



National average for the racial or ethnic group (AI/AN = 31.7, AA and NHPI = 56.0, Black = 44.3, Hispanic = 58.8, White = 45.1)

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

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from eligible female AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible female AI/AN MA enrollees on this measure.

- The percentage of eligible female AA and NHPI MA enrollees living in urban areas 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 AA and NHPI MA enrollees by less than 3 percentage points. There were not enough data from female AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible female AA and NHPI MA enrollees on this measure.

- The percentage of eligible female Black MA enrollees living in urban areas 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 Black MA enrollees by less than 3 percentage points. The percentage of eligible female Black MA enrollees living in rural areas 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 Black MA enrollees by more than 3 percentage points.

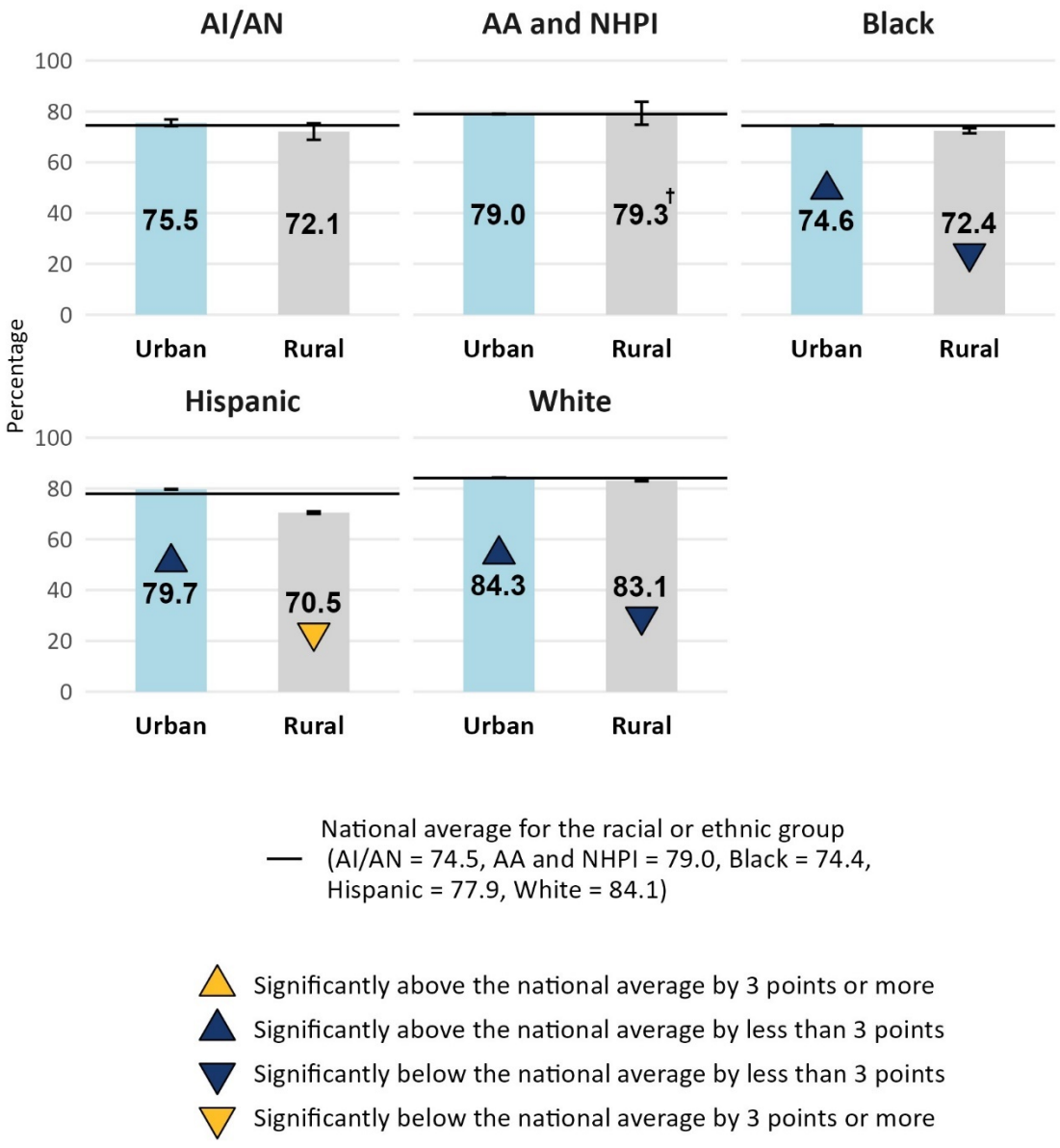
- The percentage of eligible female Hispanic MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible female Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible female White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees living in rural areas 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 White MA enrollees by more than 3 percentage points.

Clinical Care: 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of eligible AI/AN MA enrollees living in urban and rural areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

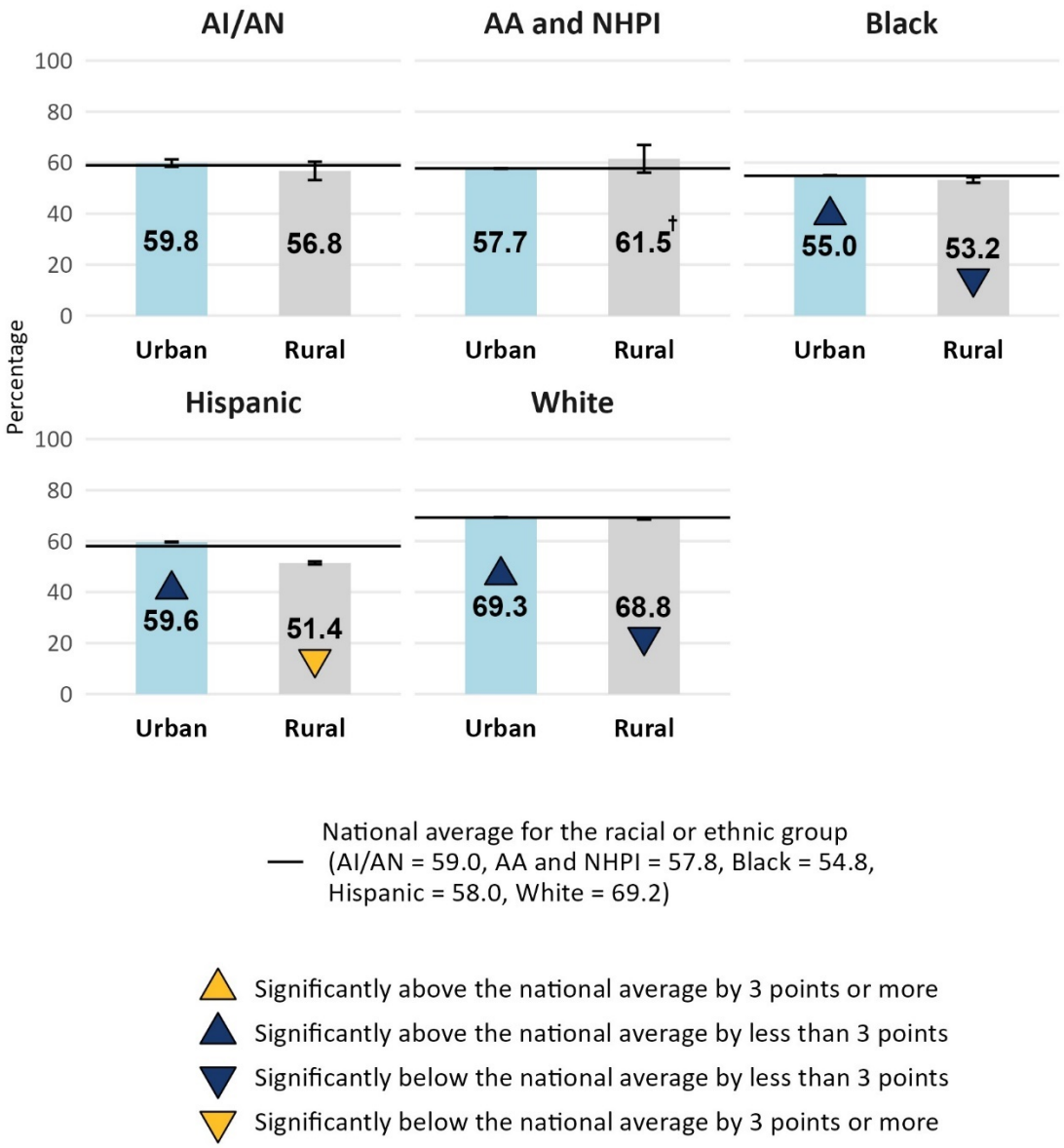
- The percentage of eligible Black MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas 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 Black MA enrollees by less than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas 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 White 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 the medication for at least 180 days, by geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- The percentages of eligible AI/AN MA enrollees living in urban and rural areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

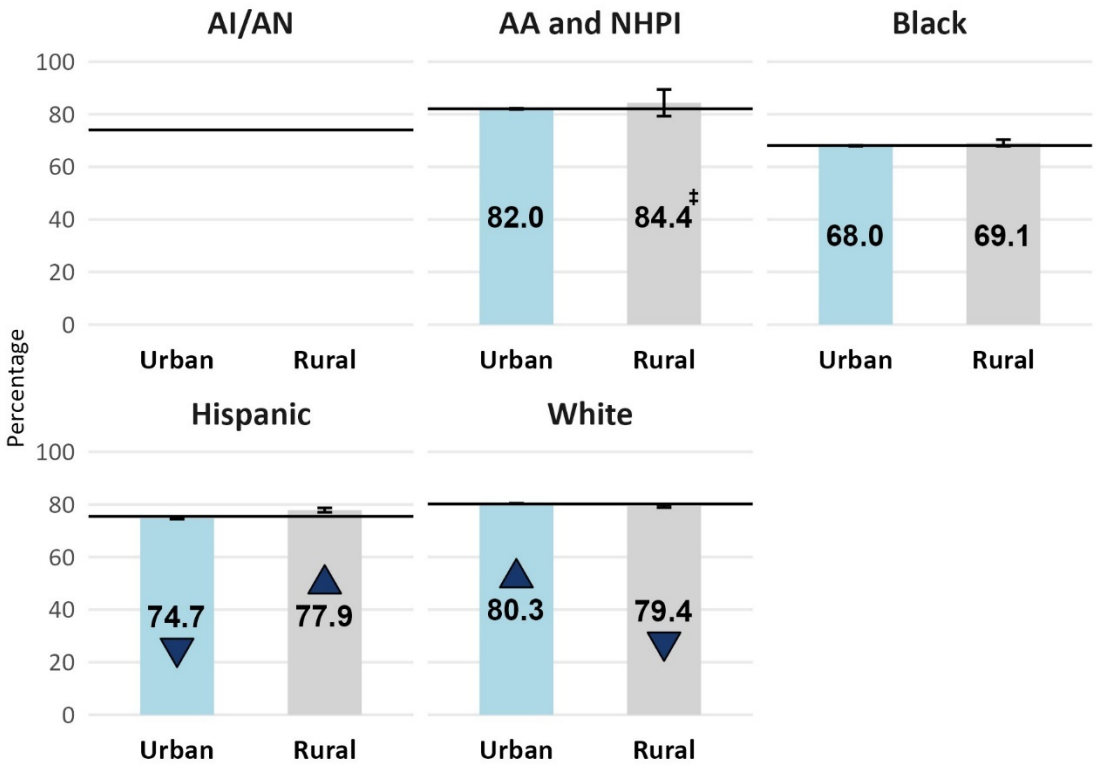
- The percentage of eligible Black MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas 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 Black MA enrollees by less than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas 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 White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

Disparities

- There were not enough data from AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentages of AA and NHPI MA enrollees with schizophrenia or schizoaffective disorder living in urban and rural areas who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

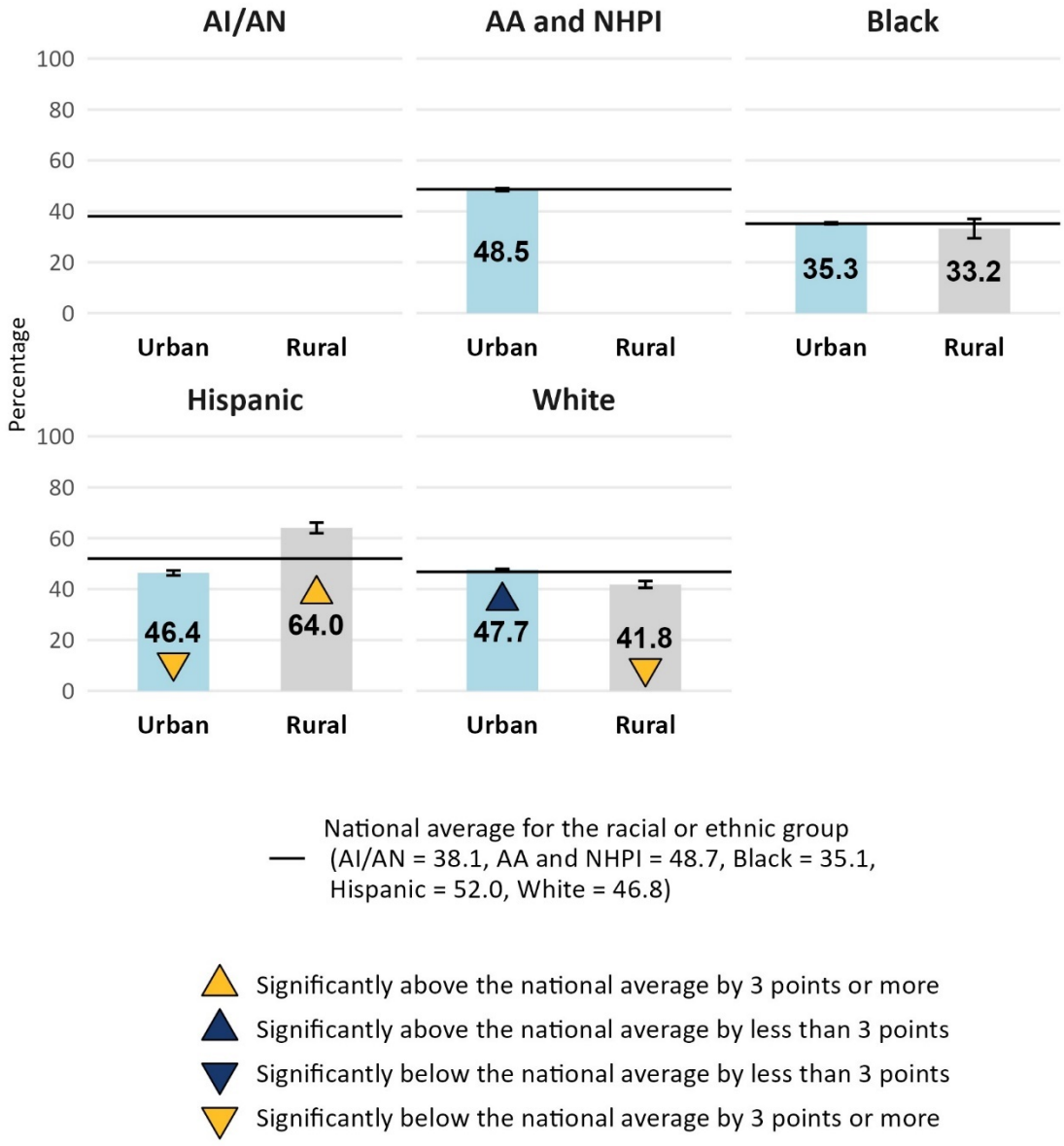
- The percentages of Black MA enrollees with schizophrenia or schizoaffective disorder living in urban and rural areas who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees with schizophrenia or schizoaffective disorder living in urban areas 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 eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees with schizophrenia or schizoaffective disorder living in rural areas 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 eligible Hispanic MA enrollees by less than 3 percentage points.

- The percentage of White MA enrollees with schizophrenia or schizoaffective disorder living in urban areas 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 eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees with schizophrenia or schizoaffective disorder living in rural areas 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 eligible White MA enrollees by less 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible AA and NHPI MA enrollees. There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible AA and NHPI MA enrollees on this measure.

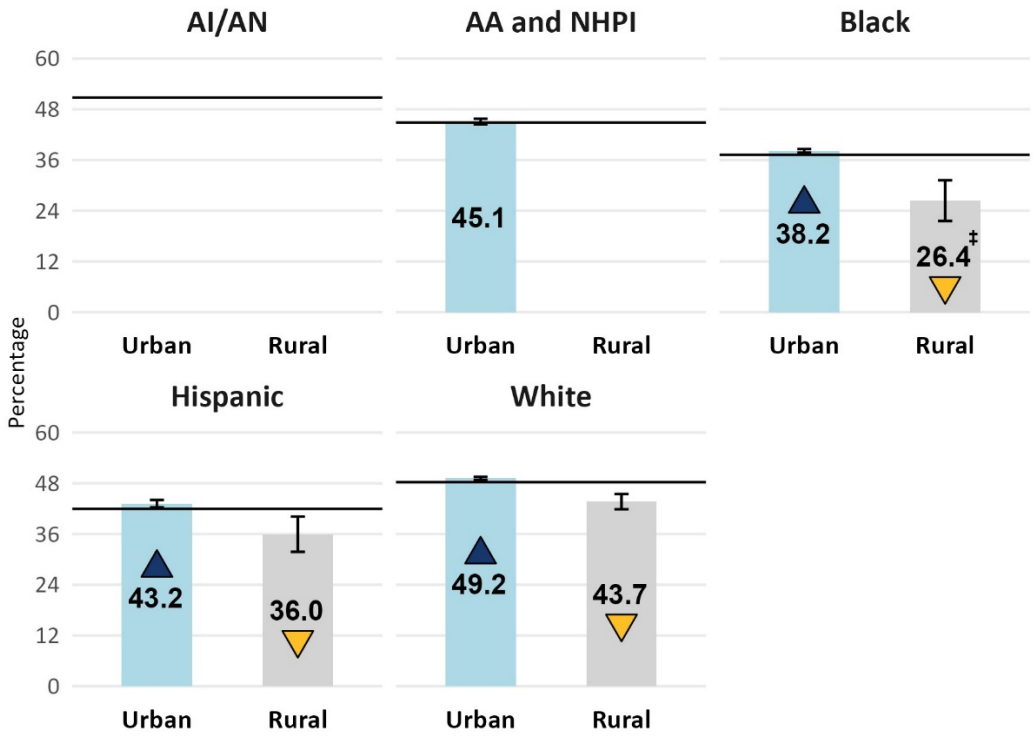
- The percentages of Black MA enrollees living in urban and rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas 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 White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all reportable group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas 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 AA and NHPI MA enrollees. There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible AA and NHPI MA enrollees on this measure.

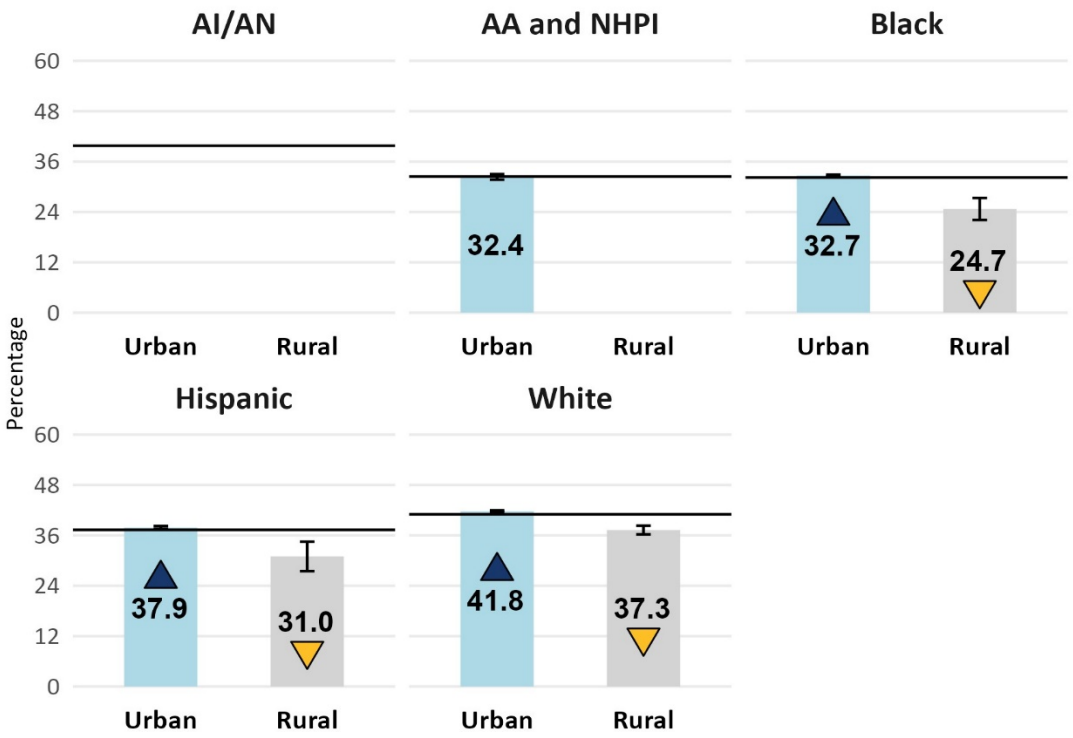
- The percentage of Black MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas 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 Black MA enrollees by more than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas 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 White MA enrollees by more than 3 percentage points.

Follow-Up After ED Visit for 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

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

Disparities

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas 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 AA and NHPI MA enrollees. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible AA and NHPI MA enrollees on this measure.

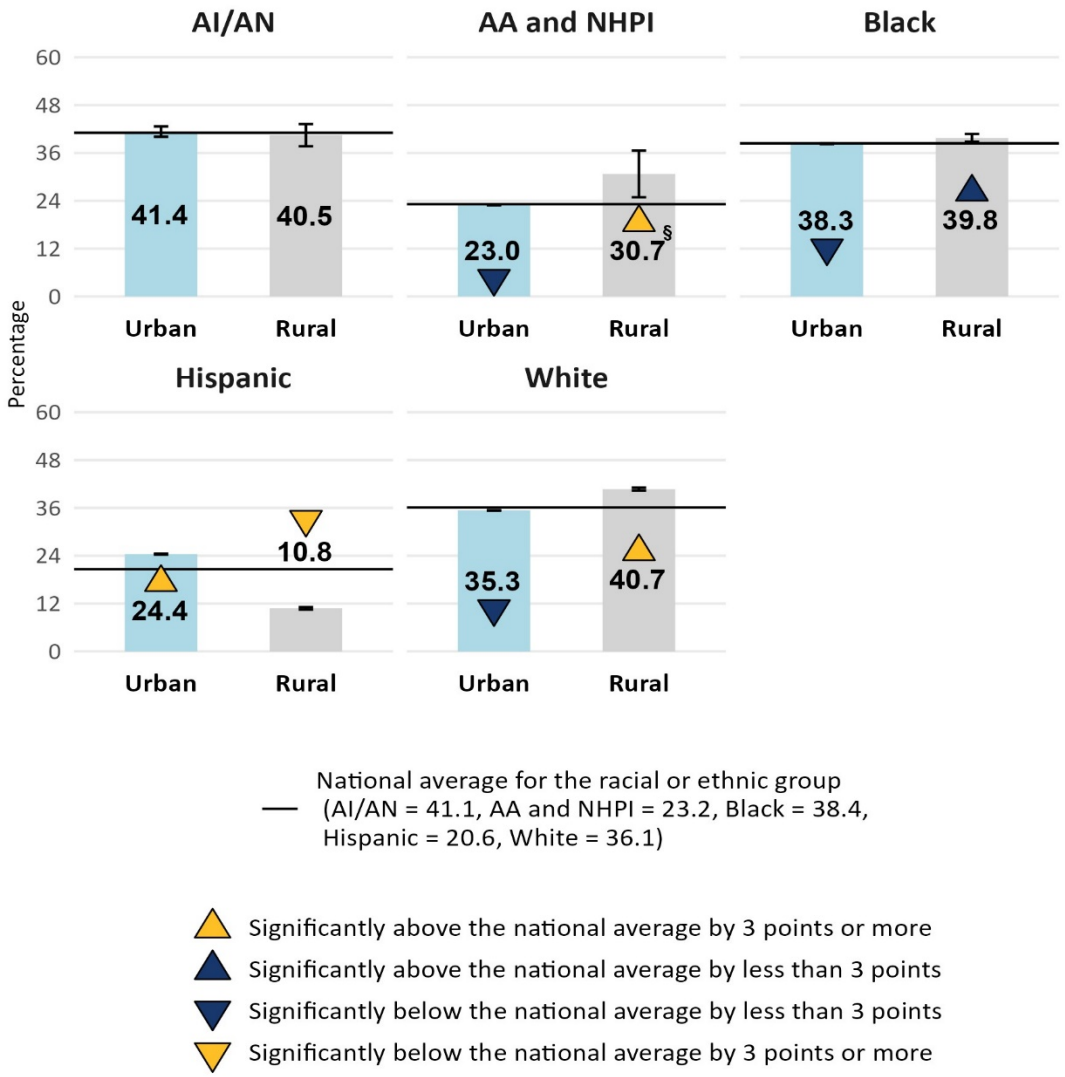
- The percentage of Black MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas 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 Black MA enrollees by more than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas 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 White MA enrollees by more than 3 percentage points.

Initiation of AOD 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.
[§] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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 percentages of AI/AN MA enrollees living in urban and rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentage of AA and NHPI MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible AA and NHPI MA enrollees by more than 3 percentage points.

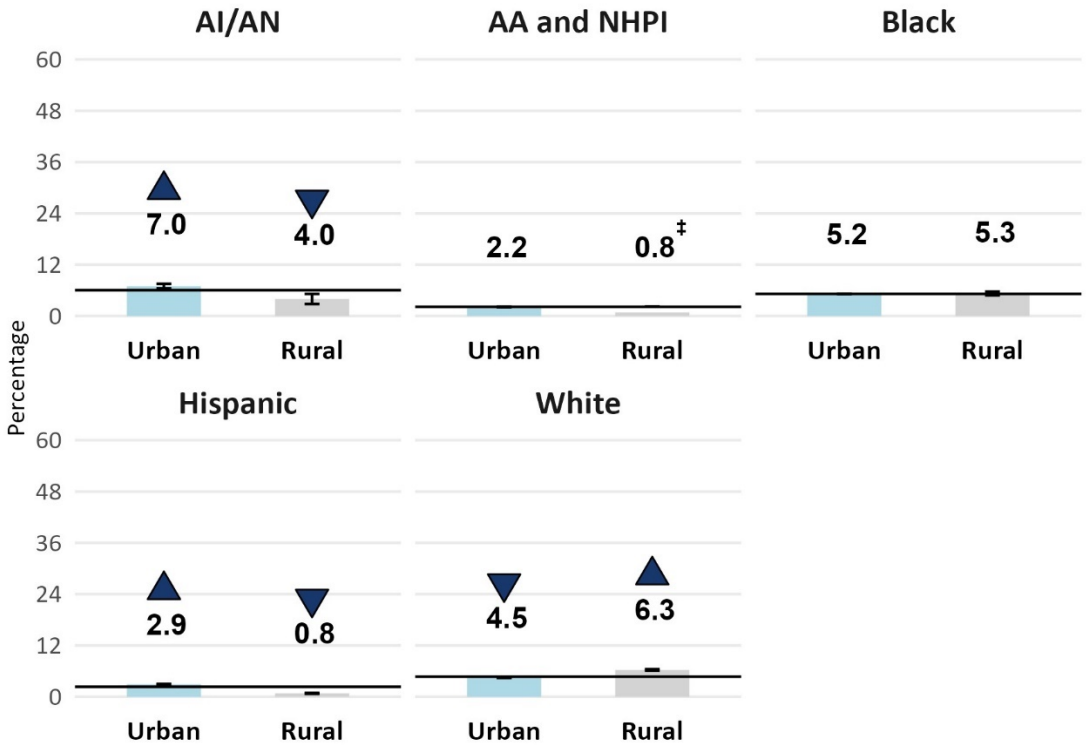
- The percentage of Black MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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 AI/AN MA enrollees with a new episode of AOD dependence living in urban areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible AI/AN MA enrollees by less than 3 percentage points. The percentage of AI/AN MA enrollees with a new episode of AOD dependence living in rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible AI/AN MA enrollees by less than 3 percentage points.

- The percentages of AA and NHPI MA enrollees with a new episode of AOD dependence living in urban and rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

- The percentages of Black MA enrollees with a new episode of AOD dependence living in urban and rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment were each **similar to** the national average for all eligible Black MA enrollees.

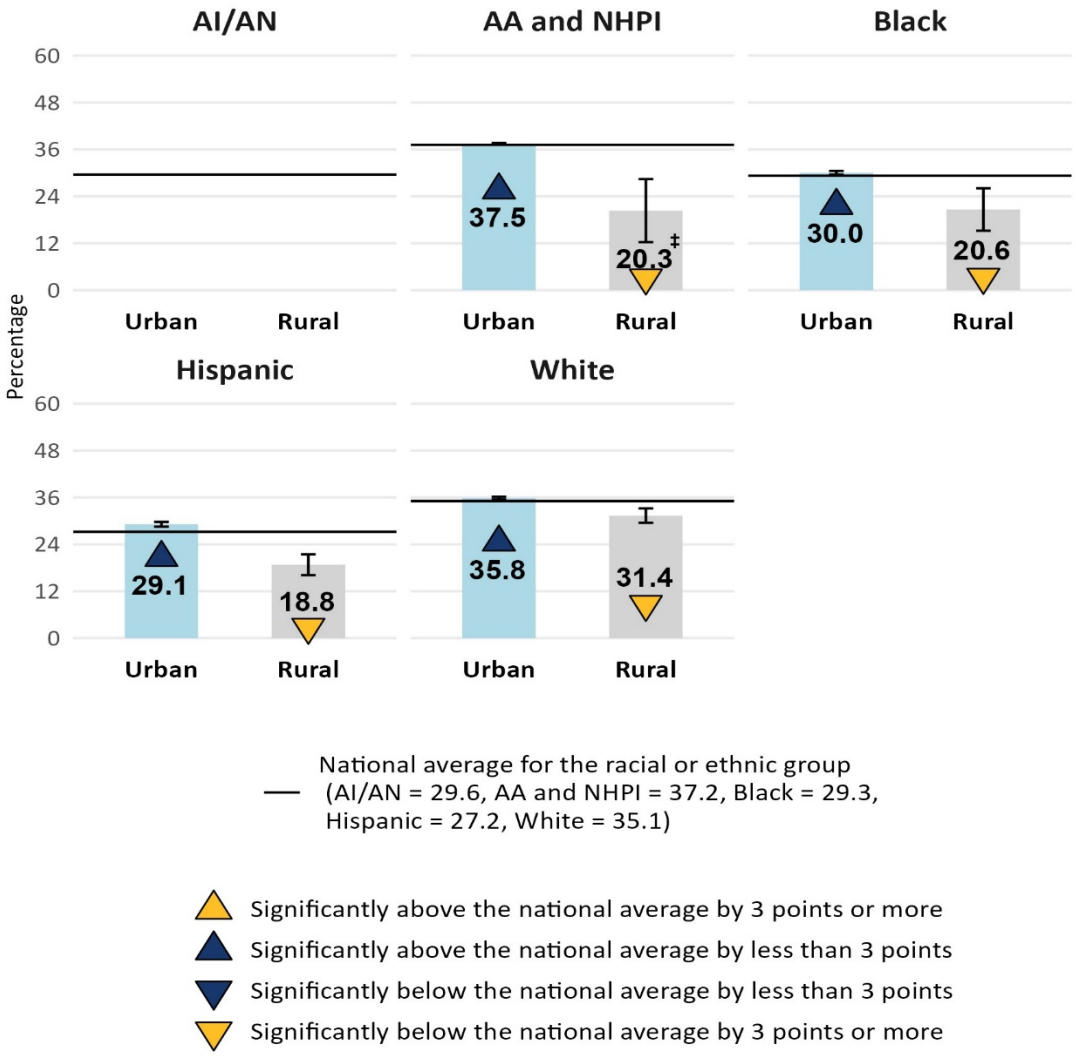
- The percentage of Hispanic MA enrollees with a new episode of AOD dependence living in urban areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees with a new episode of AOD dependence living in rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points.

- The percentage of White MA enrollees with a new episode of AOD dependence living in urban areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees with a new episode of AOD dependence living in rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible White MA enrollees by less than 3 percentage points.

Clinical Care: 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas 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 AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas 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 AA and NHPI MA enrollees by more than 3 percentage points.

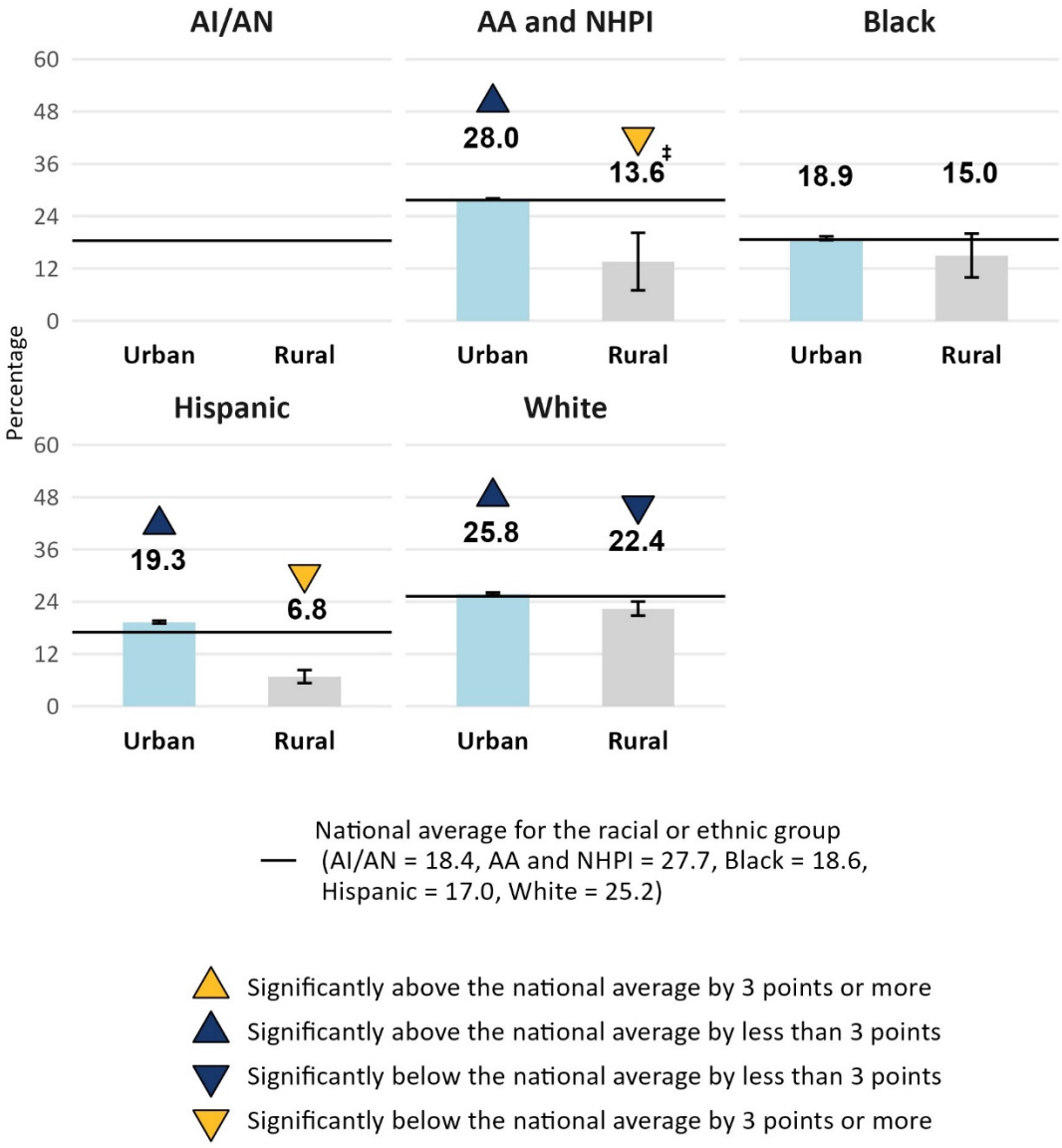
- The percentage of Black MA enrollees living in urban areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas 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 Black MA enrollees by more than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas 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 White MA enrollees by more 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the score for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of AA and NHPI MA enrollees living in urban areas 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 AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas 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 AA and NHPI MA enrollees by more than 3 percentage points.

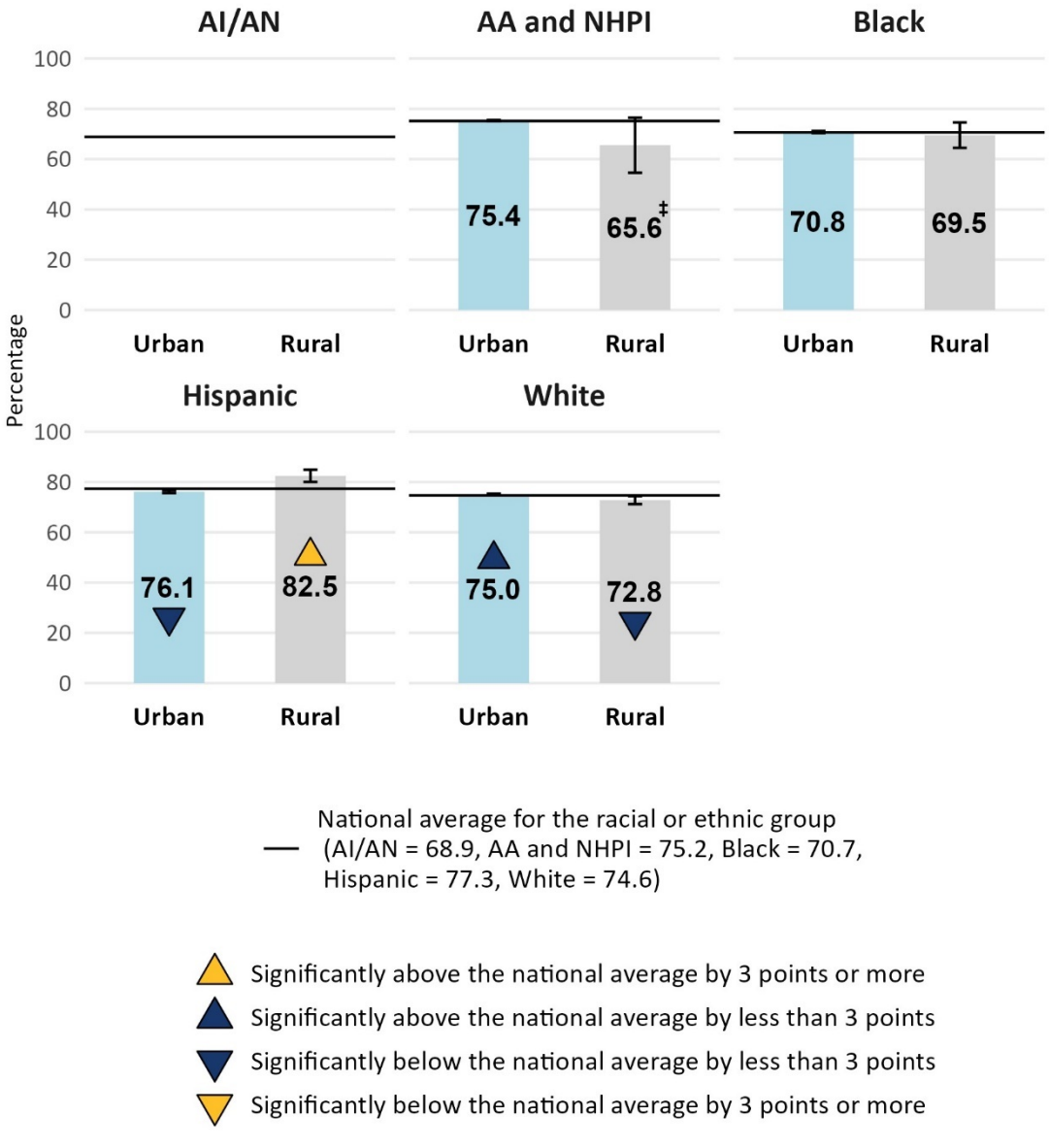
- The percentages of Black MA enrollees living in urban and rural areas who received discharge information on the day of or the day following discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas 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 Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas 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 Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas 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 White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas 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 White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentages of AA and NHPI MA enrollees living in urban and rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

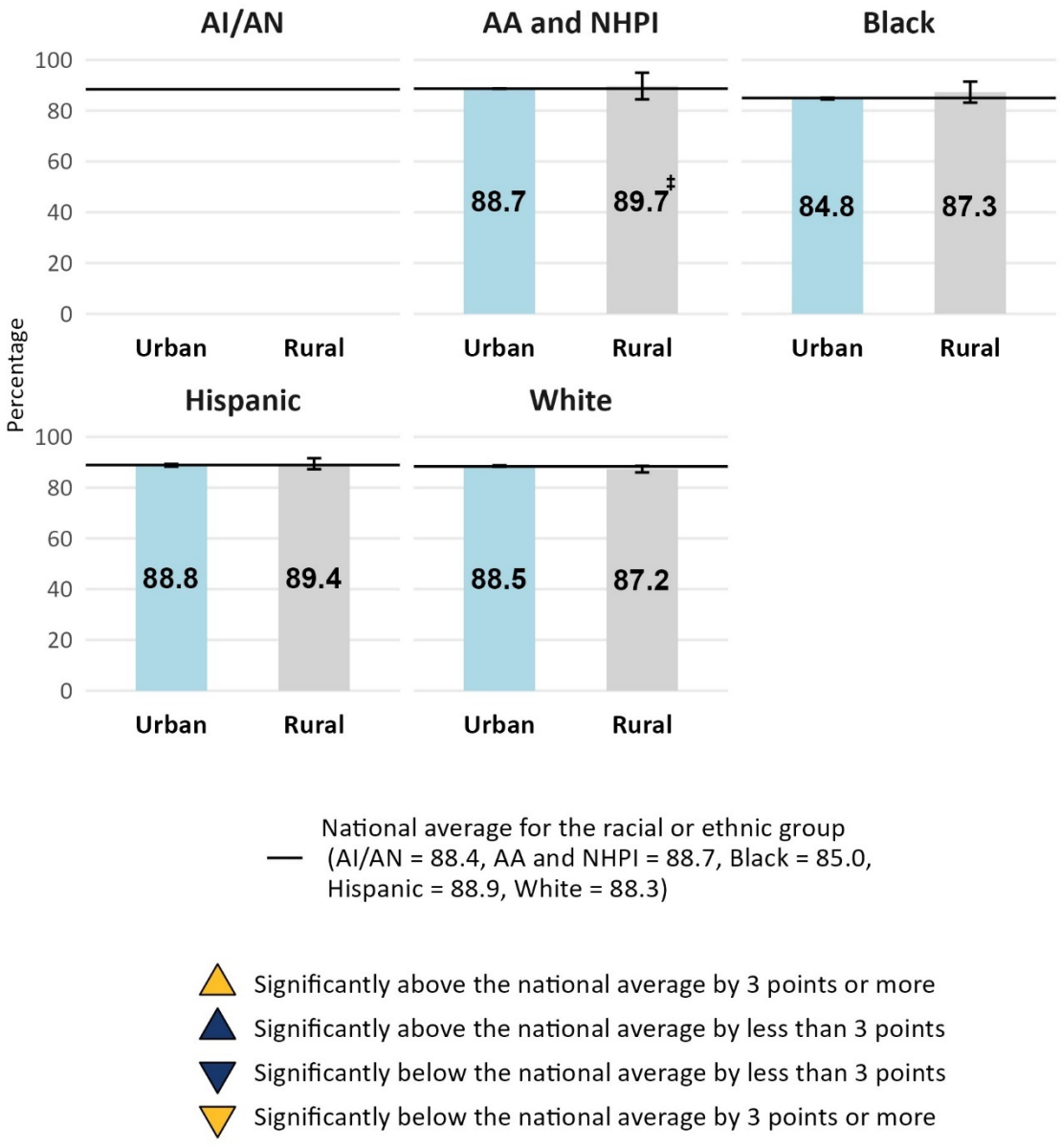
- The percentages of Black MA enrollees living in urban and rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

[†] 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

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentages of AA and NHPI MA enrollees living in urban and rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

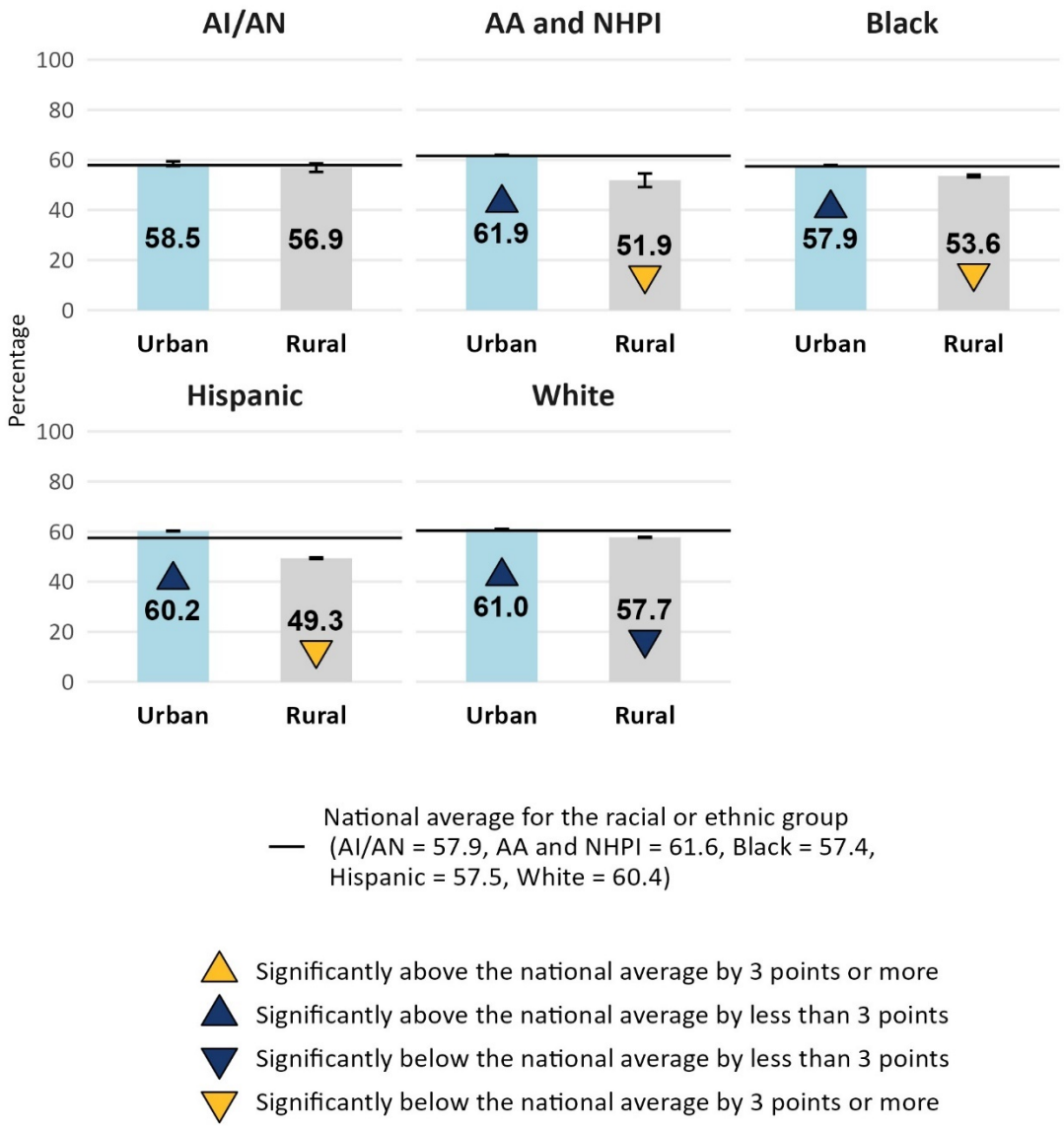
- The percentages of Black MA enrollees living in urban and rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

- The percentages of Hispanic MA enrollees living in urban and rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible Hispanic MA enrollees.

- The percentages of White MA enrollees living in urban and rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible White MA enrollees.

Follow-Up After ED Visit for People with High-Risk Multiple 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] 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 percentages of AI/AN MA enrollees with multiple high-risk chronic conditions living in urban and rural areas who received follow-up care within seven days of an ED visit were each **similar to** the national average for all eligible AI/AN MA enrollees.

- The percentage of AA and NHPI MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees with multiple high-risk chronic conditions living in rural areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible AA and NHPI MA enrollees by more than 3 percentage points.

- The percentage of Black MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees with multiple high-risk chronic conditions living in rural areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible Black MA enrollees by more than 3 percentage points.

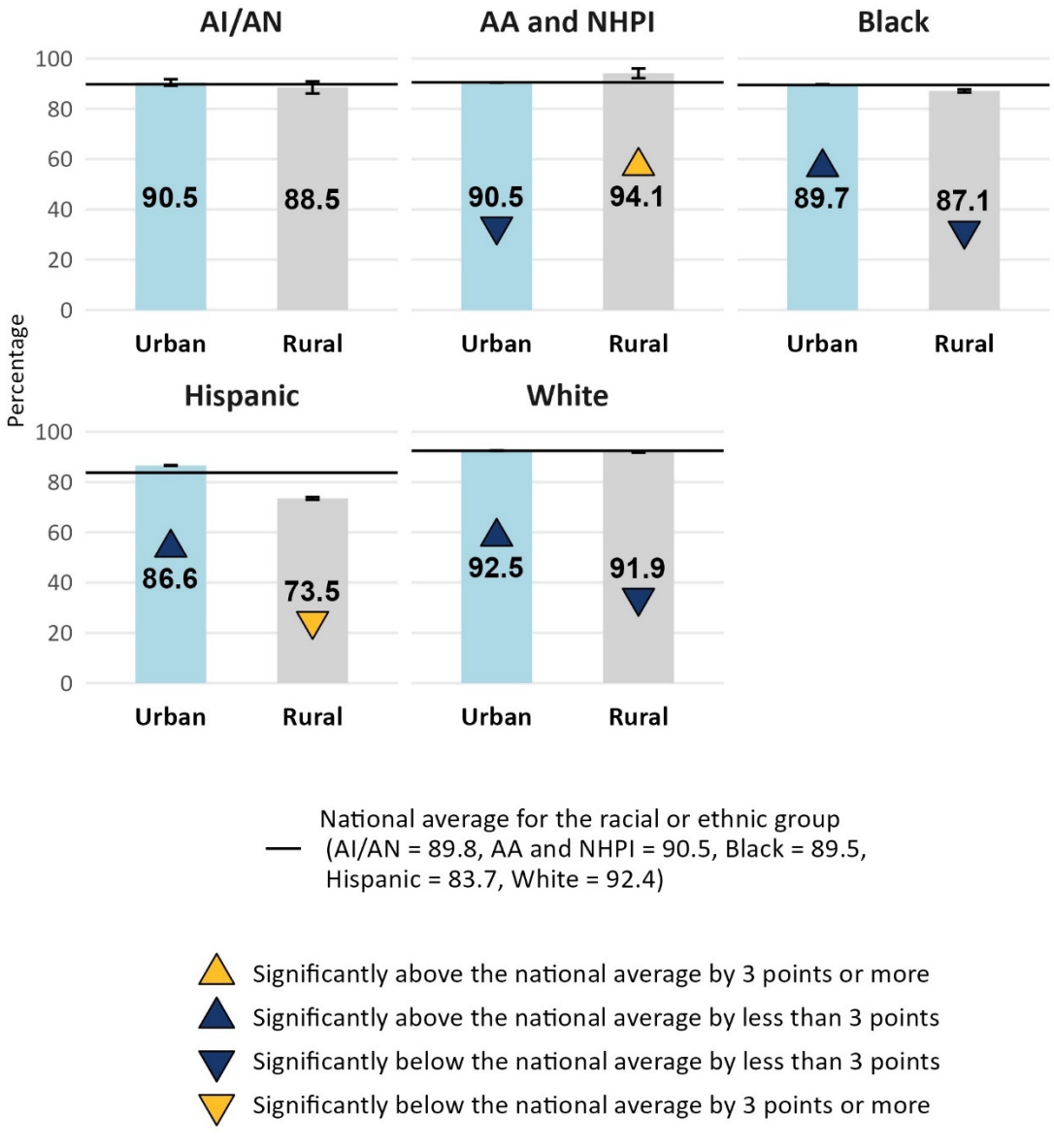
- The percentage of Hispanic MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees with multiple high-risk chronic conditions living in rural areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees with multiple high-risk chronic conditions living in rural areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible White MA enrollees by less than 3 percentage points.

Clinical Care: Overuse and Appropriate Use of Medications

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] This includes cyclooxygenase-2 selective NSAIDs or nonaspirin NSAIDs.

Disparities

- The percentages of older adult AI/AN MA enrollees with chronic renal failure living in urban and rural areas for whom use of potentially harmful medication was avoided were each **similar to** the national average for all eligible older adult AI/AN MA enrollees.

- The percentage of older adult AA and NHPI MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult AA and NHPI MA enrollees by less than 3 percentage points. The percentage of older adult AA and NHPI MA enrollees with chronic renal failure living in rural areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult AA and NHPI MA enrollees by more than 3 percentage points.

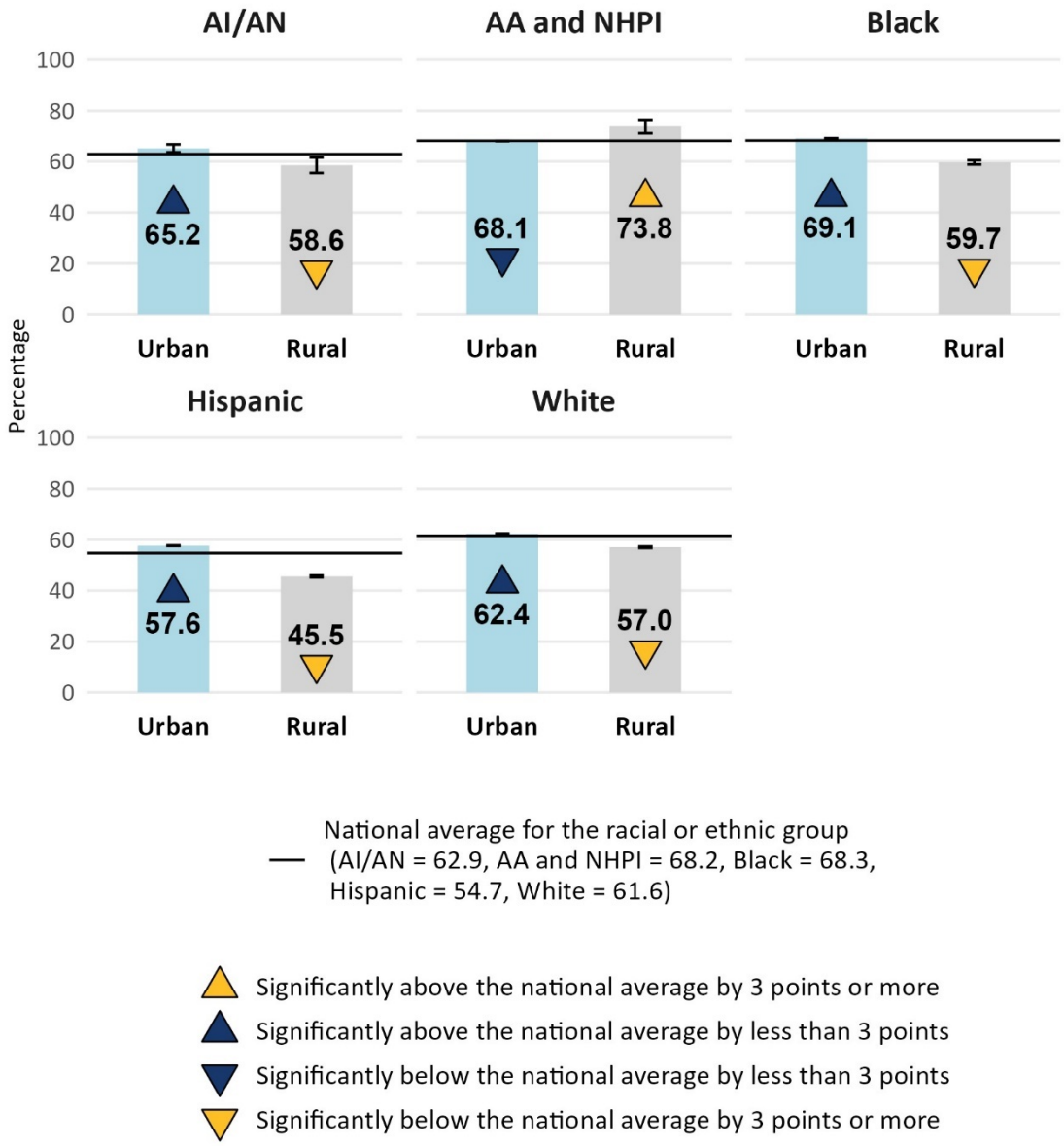
- The percentage of older adult Black MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Black MA enrollees by less than 3 percentage points. The percentage of older adult Black MA enrollees with chronic renal failure living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Black MA enrollees by less than 3 percentage points.

- The percentage of older adult Hispanic MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Hispanic MA enrollees by less than 3 percentage points. The percentage of older adult Hispanic MA enrollees with chronic renal failure living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Hispanic MA enrollees by more than 3 percentage points.

- The percentage of older adult White MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult White MA enrollees by less than 3 percentage points. The percentage of older adult White MA enrollees with chronic renal failure living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult White MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of older adult AI/AN MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult AI/AN MA enrollees by less than 3 percentage points. The percentage of older adult AI/AN MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult AI/AN MA enrollees by more than 3 percentage points.

- The percentage of older adult AA and NHPI MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult AA and NHPI MA enrollees by less than 3 percentage points. The percentage of older adult AA and NHPI MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult AA and NHPI MA enrollees by more than 3 percentage points.

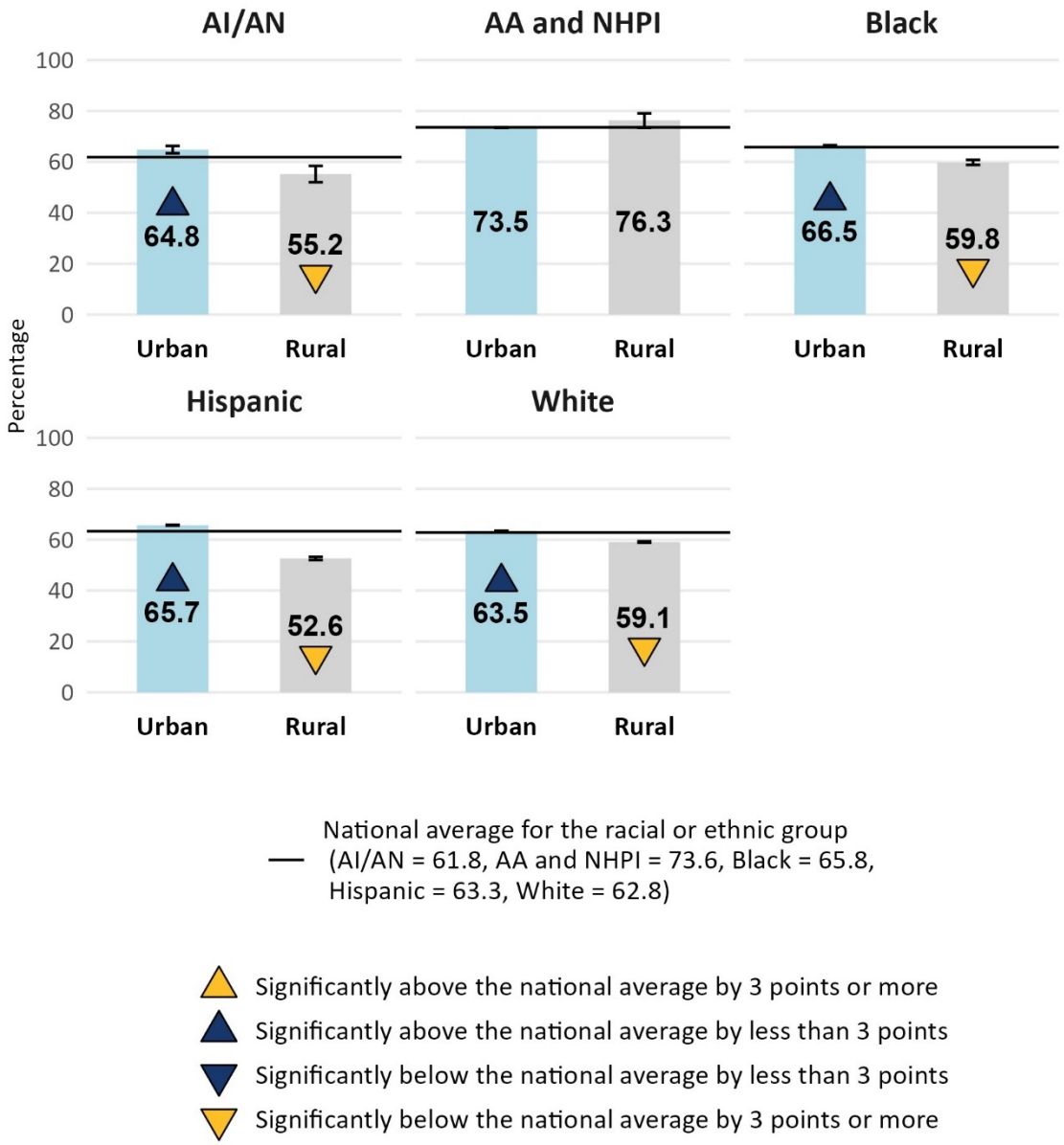
- The percentage of older adult Black MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Black MA enrollees by less than 3 percentage points. The percentage of older adult Black MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Black MA enrollees by more than 3 percentage points.

- The percentage of older adult Hispanic MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Hispanic MA enrollees by less than 3 percentage points. The percentage of older adult Hispanic MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Hispanic MA enrollees by more than 3 percentage points.

- The percentage of older adult White MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult White MA enrollees by less than 3 percentage points. The percentage of older adult White MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult White MA enrollees by more than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of older adult AI/AN MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult AI/AN MA enrollees by less than 3 percentage points.[†] The percentage of older adult AI/AN MA enrollees with a history of falls living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult AI/AN MA enrollees by more than 3 percentage points.

- The percentages of older adult AA and NHPI MA enrollees with a history of falls living in urban and rural areas for whom use of potentially harmful medication was avoided were each **similar to** the national average for all eligible older adult AA and NHPI MA enrollees.

- The percentage of older adult Black MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Black MA enrollees by less than 3 percentage points. The percentage of older adult Black MA enrollees with a history of falls living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Black MA enrollees by more than 3 percentage points.

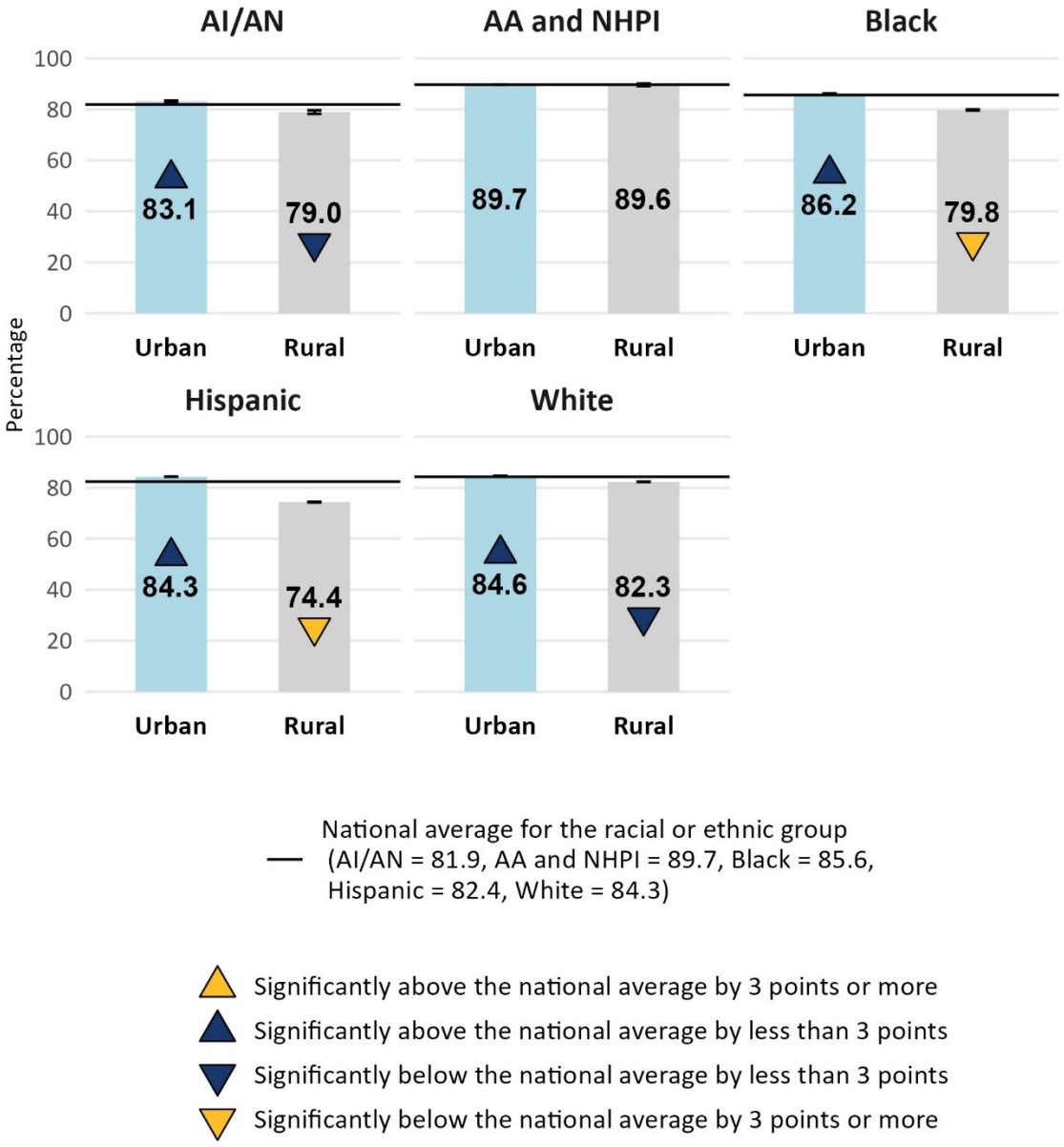
- The percentage of older adult Hispanic MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult Hispanic MA enrollees by less than 3 percentage points. The percentage of older adult Hispanic MA enrollees with a history of falls living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Hispanic MA enrollees by more than 3 percentage points.

- The percentage of older adult White MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult White MA enrollees by less than 3 percentage points. The percentage of older adult White MA enrollees with a history of falls living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult White MA enrollees by more than 3 percentage points.

[†] Prior to rounding.

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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of older adult AI/AN MA enrollees living in urban areas for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult AI/AN MA enrollees by less than 3 percentage points. The percentage of older adult AI/AN MA enrollees living in rural areas for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult AI/AN MA enrollees by less than 3 percentage points.

- The percentages of older adult AA and NHPI MA enrollees living in urban and rural areas for whom use of high-risk medications was avoided were each **similar to** the national average for all eligible older adult AA and NHPI MA enrollees.

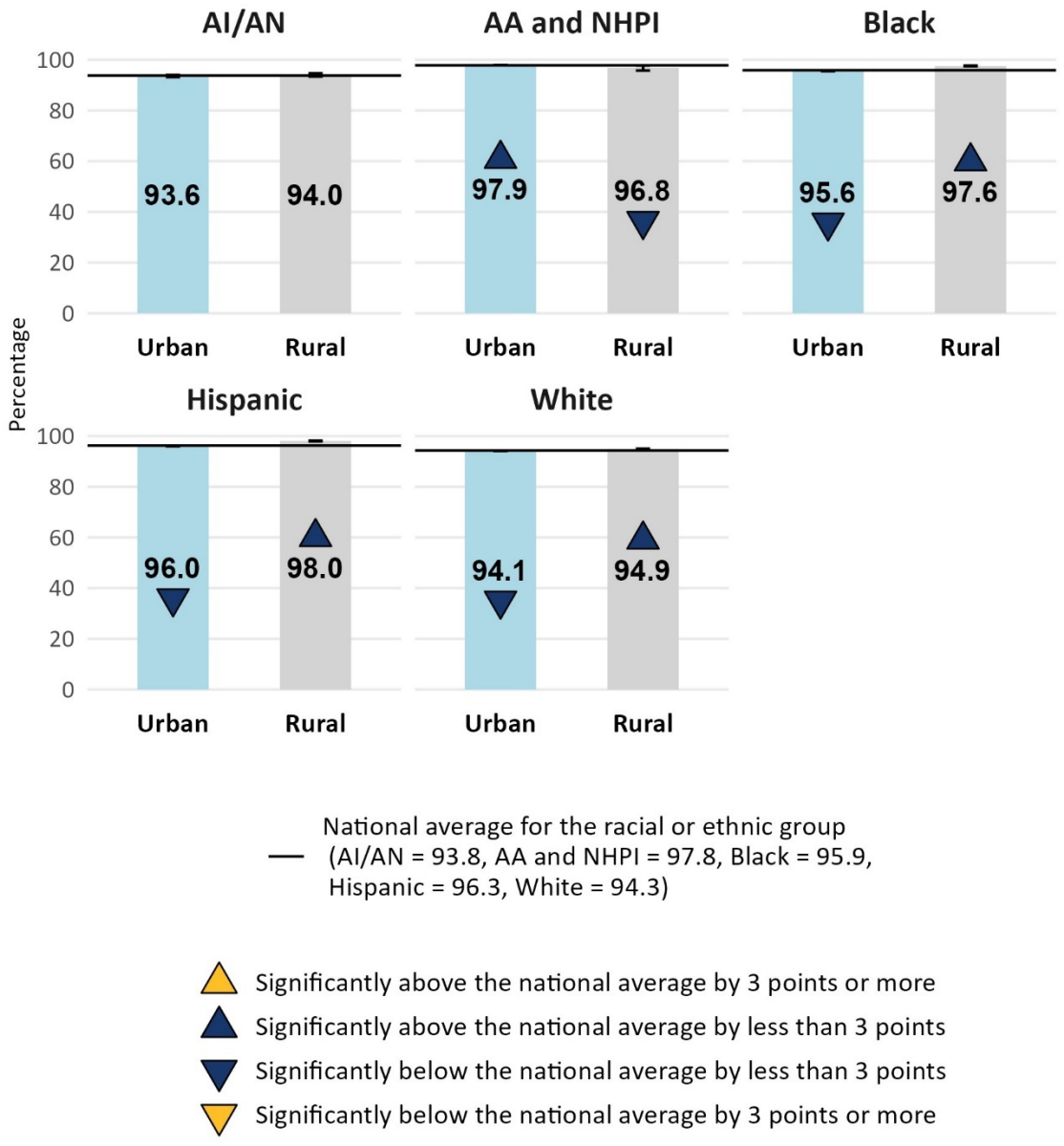
- The percentage of older adult Black MA enrollees living in urban areas for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult Black MA enrollees by less than 3 percentage points. The percentage of older adult Black MA enrollees living in rural areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult Black MA enrollees by more than 3 percentage points.

- The percentage of older adult Hispanic MA enrollees living in urban areas for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult Hispanic MA enrollees by less than 3 percentage points. The percentage of older adult Hispanic MA enrollees living in rural areas for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult Hispanic MA enrollees by more than 3 percentage points.

- The percentage of older adult White MA enrollees living in urban areas for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult White MA enrollees by less than 3 percentage points. The percentage of older adult White MA enrollees living in rural areas for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Average morphine equivalent dose ≥ 90 mg.

Disparities

- The percentages of AI/AN MA enrollees living in urban and rural areas for whom use of opioids at a high dosage was avoided were each **similar to** the national average for all eligible AI/AN MA enrollees.

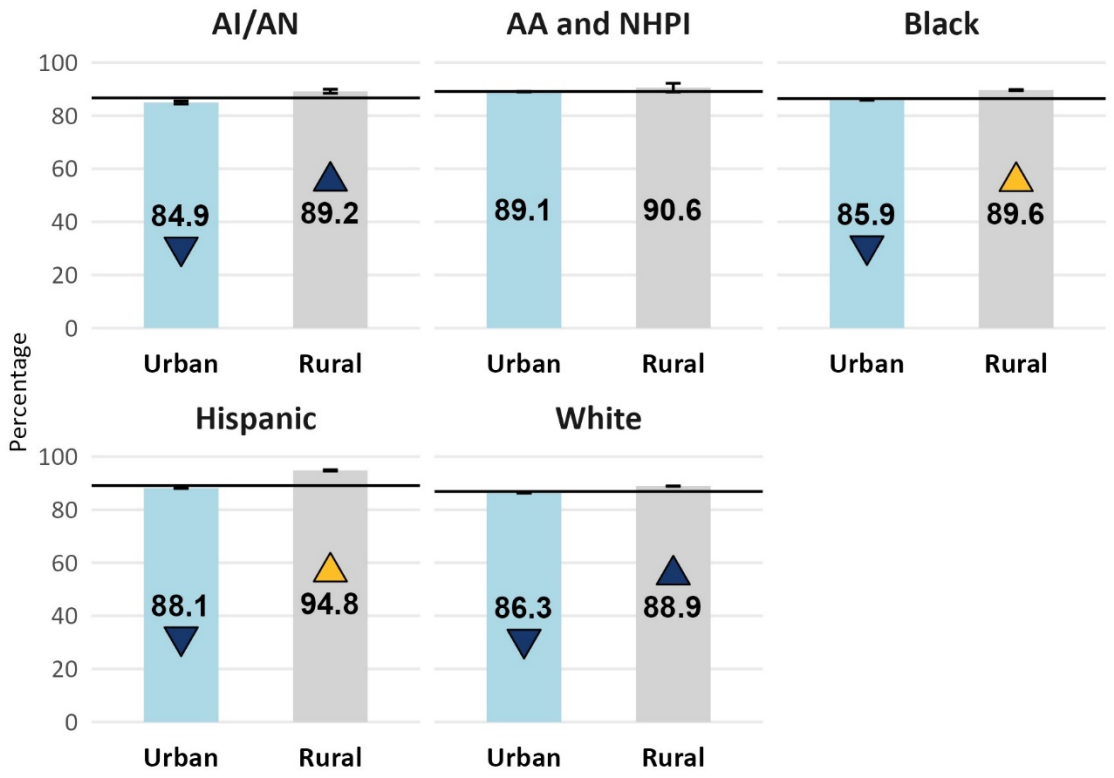
- The percentage of AA and NHPI MA enrollees living in urban areas for whom use of opioids at a high dosage was avoided was **above** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas for whom use of opioids at a high dosage was avoided was **below** the national average for all eligible AA and NHPI MA enrollees by less than 3 percentage points.
- The percentage of Black MA enrollees living in urban areas for whom use of opioids at a high dosage was avoided was **below** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas for whom use of opioids at a high dosage was avoided was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas for whom use of opioids at a high dosage was avoided was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas for whom use of opioids at a high dosage was avoided was **above** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points.

- The percentage of White MA enrollees living in urban areas for whom use of opioids at a high dosage was avoided was **below** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas for whom use of opioids at a high dosage was avoided was **above** the national average for all eligible White MA enrollees by less than 3 percentage points.

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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of AI/AN MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all AI/AN MA enrollees by less than 3 percentage points. The percentage of AI/AN MA enrollees living in rural areas for whom use of opioids from multiple prescribers was avoided was **above** the national average for all AI/AN MA enrollees by less than 3 percentage points.

- The percentages of AA and NHPI MA enrollees living in urban and rural areas for whom use of opioids from multiple prescribers was avoided were each **similar to** the national average for all AA and NHPI MA enrollees.

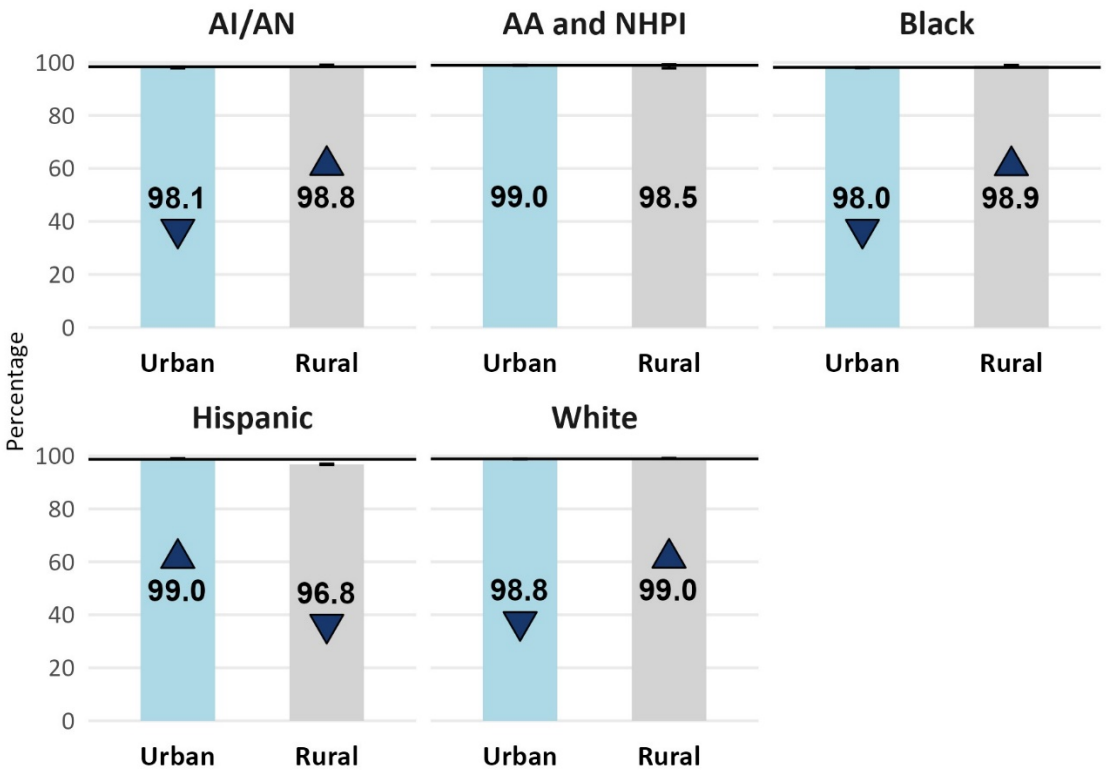
- The percentage of Black MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas for whom use of opioids from multiple prescribers was avoided was **above** the national average for all Black MA enrollees by more than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas for whom use of opioids from multiple prescribers was avoided was **above** the national average for all Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas for whom use of opioids from multiple prescribers was avoided was **above** the national average for all White 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of AI/AN MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all AI/AN MA enrollees by less than 3 percentage points. The percentage of AI/AN MA enrollees living in rural areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all AI/AN MA enrollees by less than 3 percentage points.

- The percentages of AA and NHPI MA enrollees living in urban and rural areas for whom use of opioids from multiple pharmacies was avoided were each **similar to** the national average for all AA and NHPI MA enrollees.

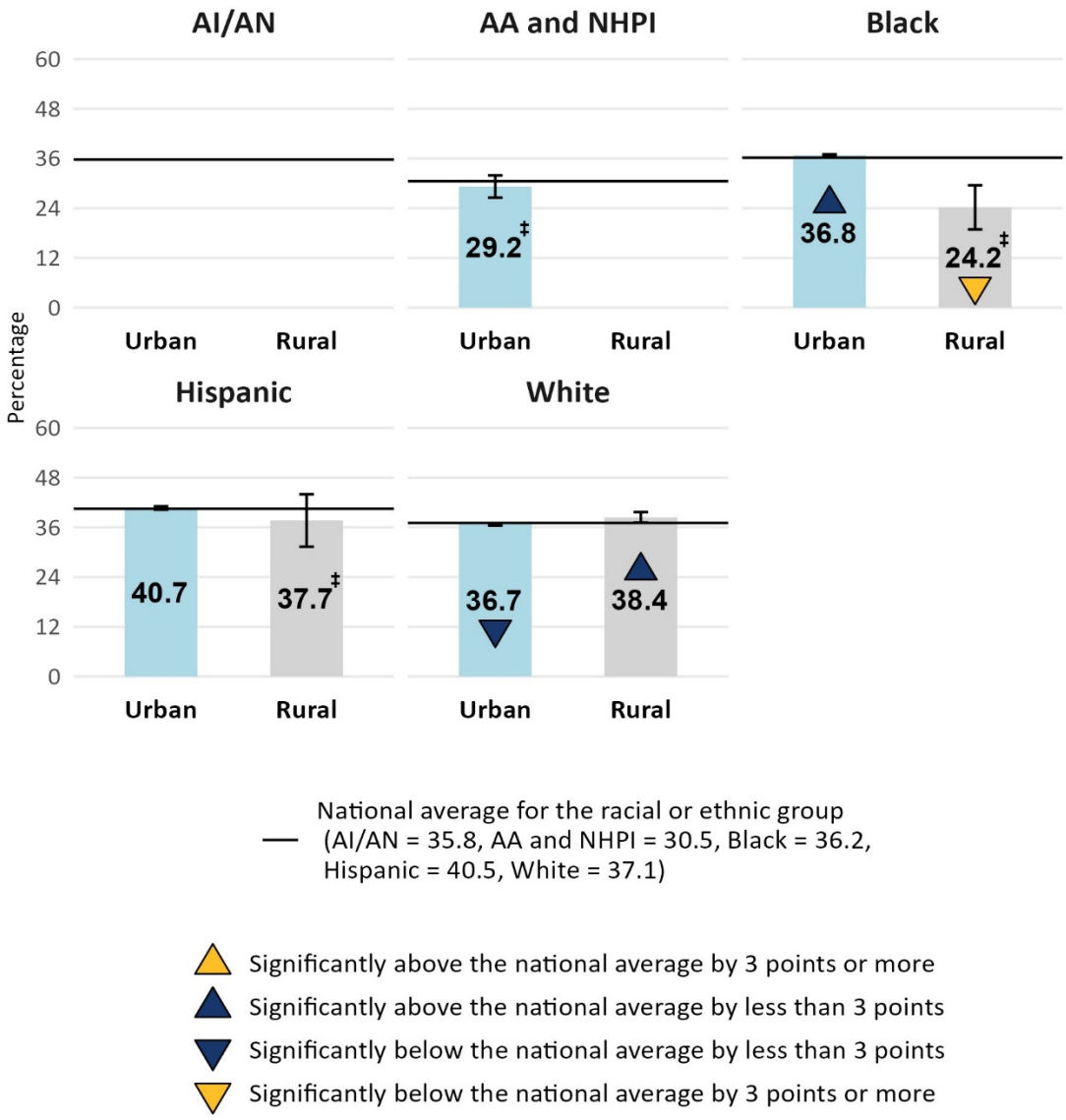
- The percentage of Black MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all Black MA enrollees by less than 3 percentage points.

- The percentage of Hispanic MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all Hispanic MA enrollees by less than 3 percentage points.

- The percentage of White MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all White MA enrollees by less than 3 percentage points.

Pharmacotherapy for Opioid Use Disorder

Percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees aged 18 years and older[†] that continued for at least 180 days, by geography within racial and ethnic groups, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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† Although the lower-bound age cutoff for this HEDIS measure is 16 years old, the data used in this report are limited to adults.

Disparities

- There were not enough data from eligible AI/AN MA enrollees living in urban or rural areas to compare the scores for these groups to the national average for all eligible AI/AN MA enrollees on this measure.

- The percentage of opioid use disorder pharmacotherapy treatment events among AA and NHPI MA enrollees living in urban areas that continued for at least 180 days was **similar to** the national average for all AA and NHPI MA enrollees. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare the scores for this group to the national average for all eligible AA and NHPI MA enrollees on this measure.

- The percentage of opioid use disorder pharmacotherapy treatment events among Black MA enrollees living in urban areas that continued for at least 180 days was **above** the national average for all Black MA enrollees by less than 3 percentage points. The percentage of opioid use disorder pharmacotherapy treatment events among Black MA enrollees living in rural areas that continued for at least 180 days was **below** the national average for all Black MA enrollees by more than 3 percentage points.

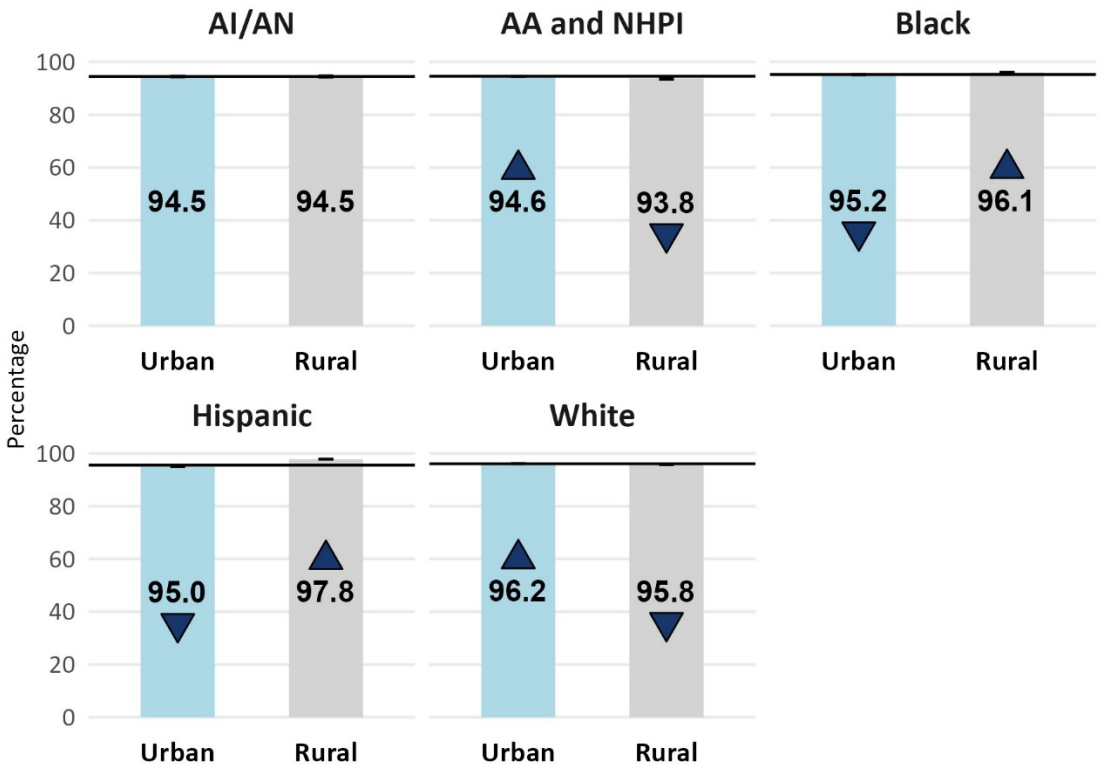
- The percentages of opioid use disorder pharmacotherapy treatment events among Hispanic MA enrollees living in urban and rural areas that continued for at least 180 days were each **similar to** the national average for all Hispanic MA enrollees.

- The percentage of opioid use disorder pharmacotherapy treatment events among White MA enrollees living in urban areas that continued for at least 180 days was **below** the national average for all White MA enrollees by less than 3 percentage points. The percentage of opioid use disorder pharmacotherapy treatment events among White MA enrollees living in rural areas that continued for at least 180 days was **above** the national average for all White MA enrollees by less than 3 percentage points.

Clinical Care: Access to and Availability of Care

Adult 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 geography within racial and ethnic group, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentages of AI/AN MA enrollees living in urban and rural areas who had an ambulatory or preventive care visit in the past year were each **similar to** the national average for all AI/AN MA enrollees.

- The percentage of AA and NHPI MA enrollees living in urban areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all AA and NHPI MA enrollees by less than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **below** the national average for all AA and NHPI MA enrollees by less than 3 percentage points.

- The percentage of Black MA enrollees living in urban areas who had an ambulatory or preventive care visit in the past year was **below** the national average for all Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all Black MA enrollees by less than 3 percentage points.

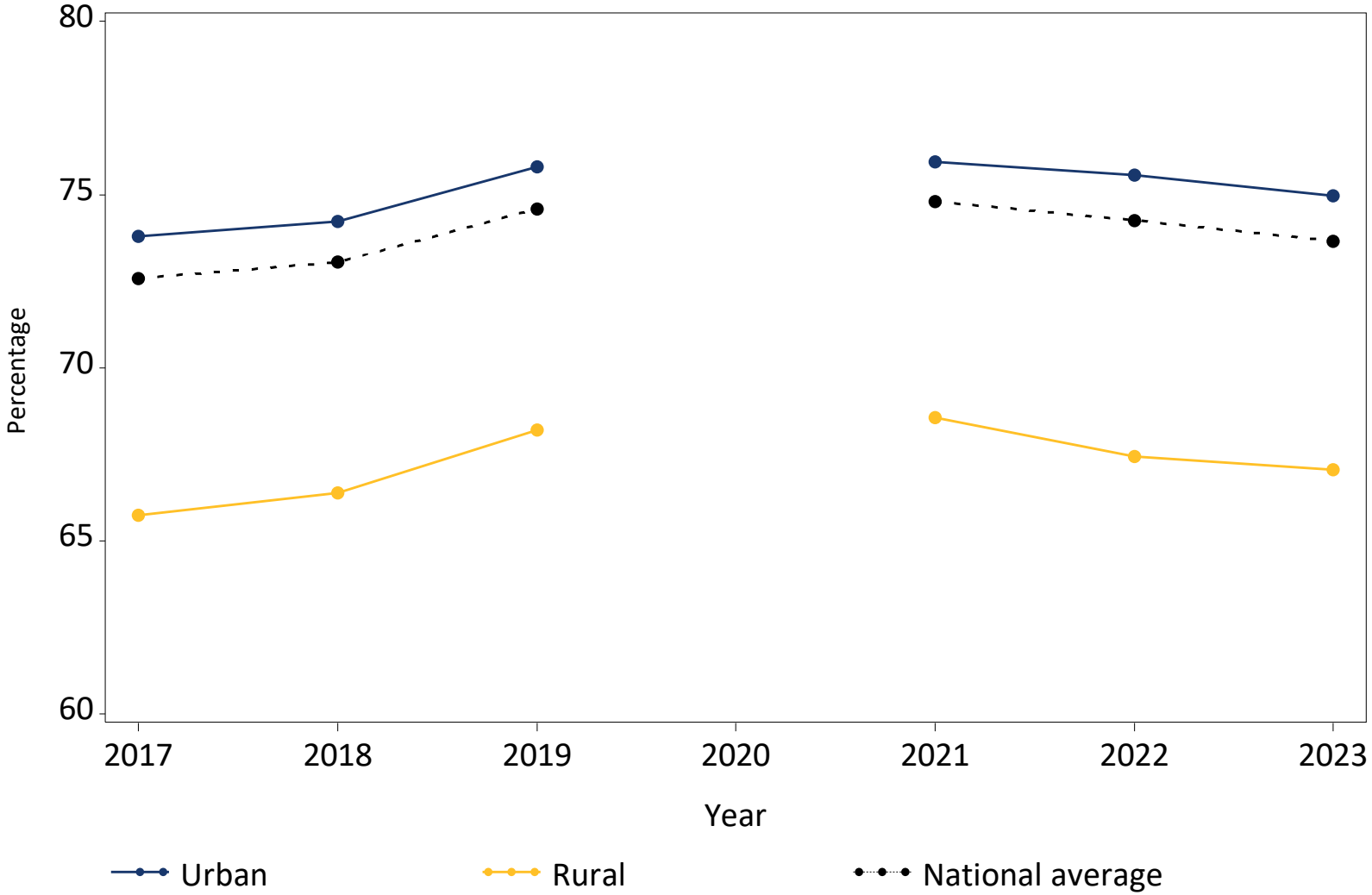
- The percentage of Hispanic MA enrollees living in urban areas who had an ambulatory or preventive care visit in the past year was **below** the national average for all Hispanic MA enrollees by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all Hispanic MA enrollees by less than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **below** the national average for all White MA enrollees by less than 3 percentage points.

Appendix C: Trends in Rural-Urban Disparities: 2017 to 2023

Annual Flu Vaccine Among MA Enrollees, 2017–2023

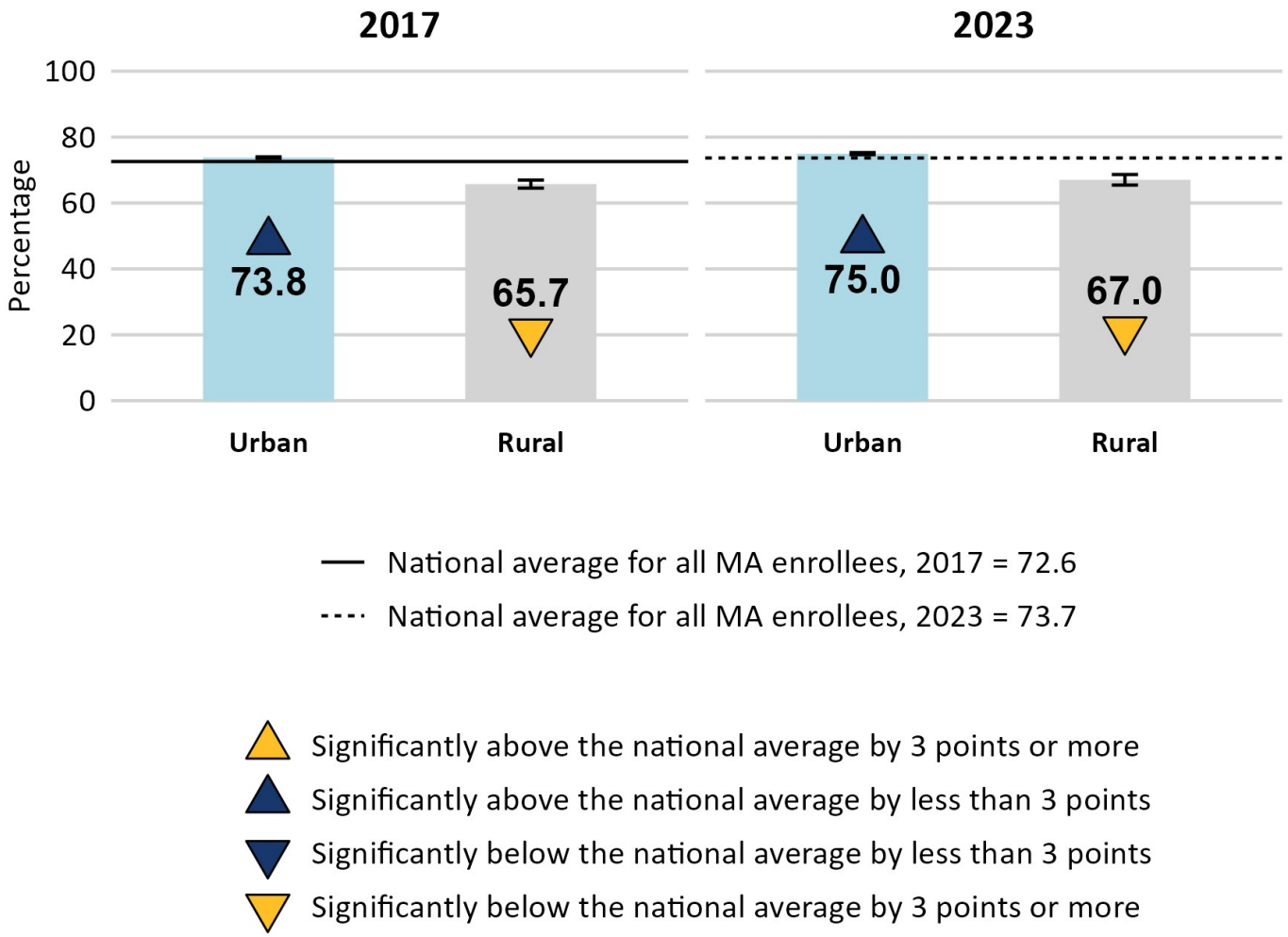
Percentage of MA enrollees who got a vaccine (flu shot), 2017–2023 trend, by geography



NOTE: The MA CAHPS surveys were not administered in 2020 because of the COVID-19 pandemic.

Annual Flu Vaccine Among MA Enrollees, 2017 and 2023

Percentage of MA enrollees who got a vaccine (flu shot), by geography, in Reporting Years 2017 and 2023



SOURCE: Data are from the 2017 and 2023 MA CAHPS surveys.

Annual Flu Vaccine Among MA Enrollees, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	73.8 ▲	75.0 ▲	+1.2	Remained about the same
Rural	65.7 ▼	67.0 ▼	+1.3	Remained about the same
National Average	72.6	73.7	+1.1	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

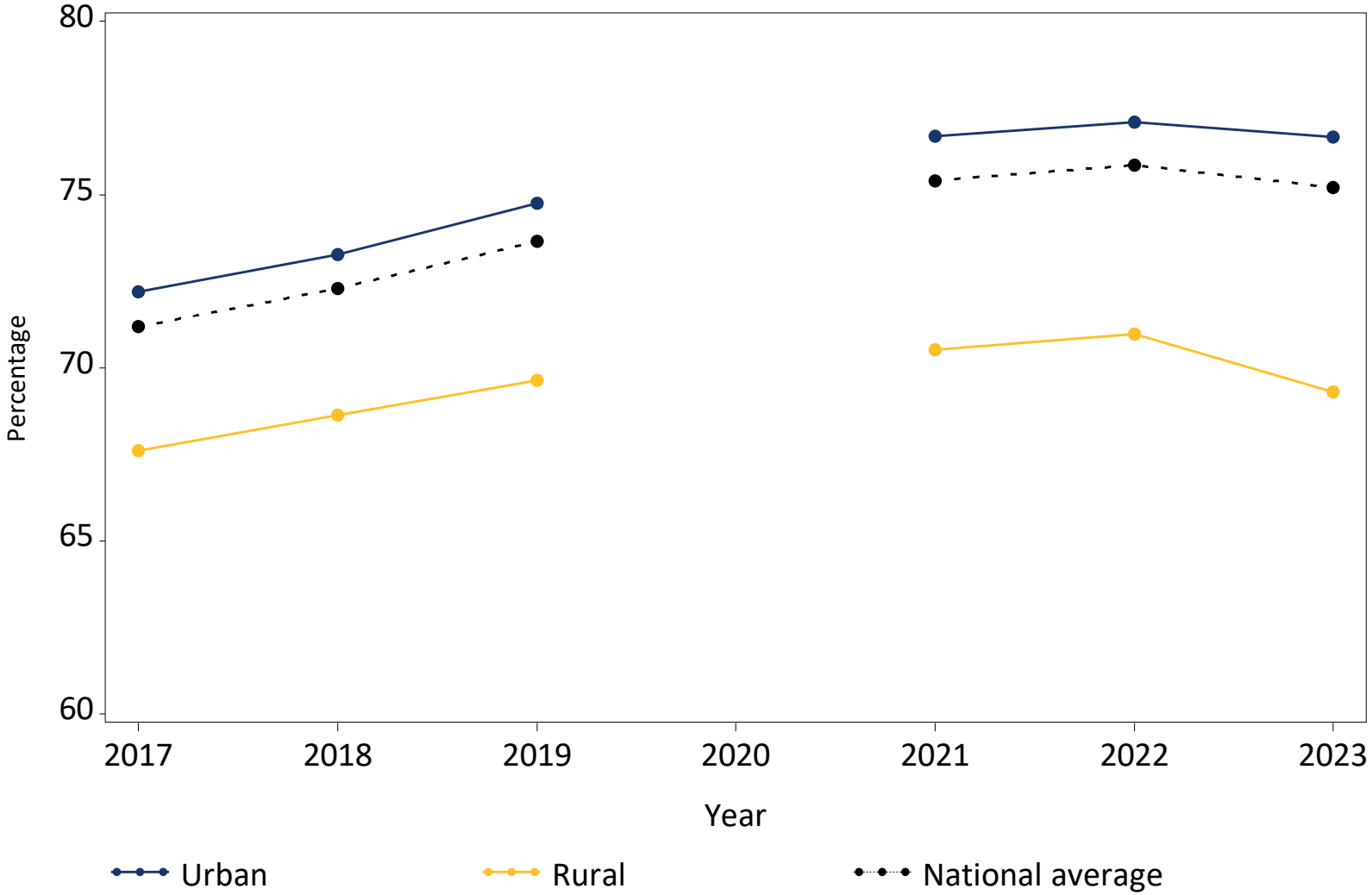
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023 in a manner that was comparable to the national average. As a result, an initial advantage relative to the national average for MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for MA enrollees living in rural areas.

Annual Flu Vaccine Among People with FFS Coverage, 2017-2023

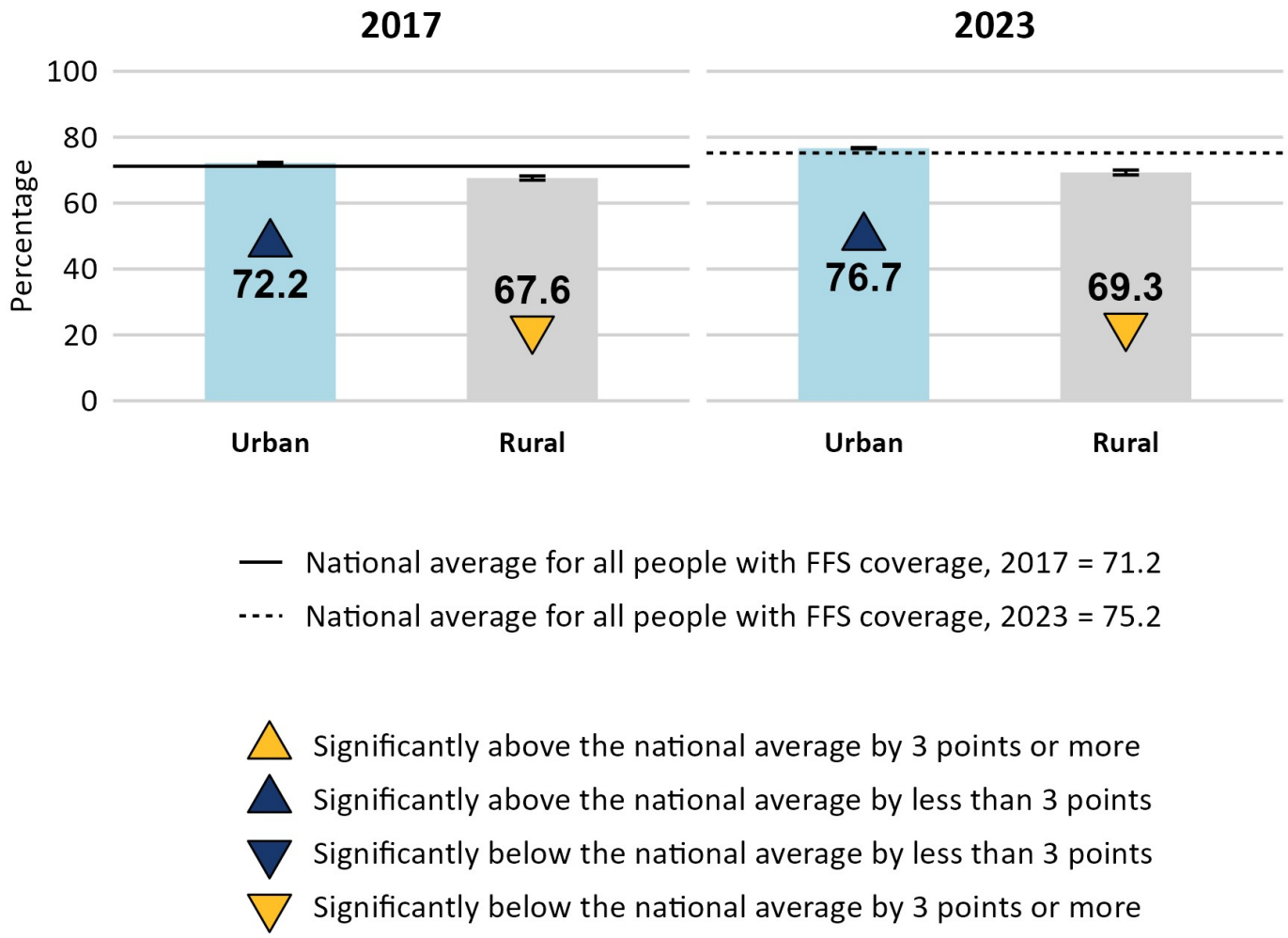
Percentage of people with FFS coverage who got a vaccine (flu shot), 2017–2023 trend, by geography



NOTE: The FFS CAHPS survey was not administered in 2020 because of the COVID-19 pandemic.

Annual Flu Vaccine Among People with FFS Coverage, 2017 and 2023

Percentage of people with FFS coverage who got a vaccine (flu shot), by geography, in Reporting Years 2017 and 2023



SOURCE: Data are from the 2017 and 2023 FFS CAHPS surveys.

Annual Flu Vaccine Among People with FFS Coverage, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	72.2 ▲	76.7 ▲	+4.5	Remained about the same
Rural	67.6 ▼	69.3 ▼	+1.7	-2.3
National Average	71.2	75.2	+4.0	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

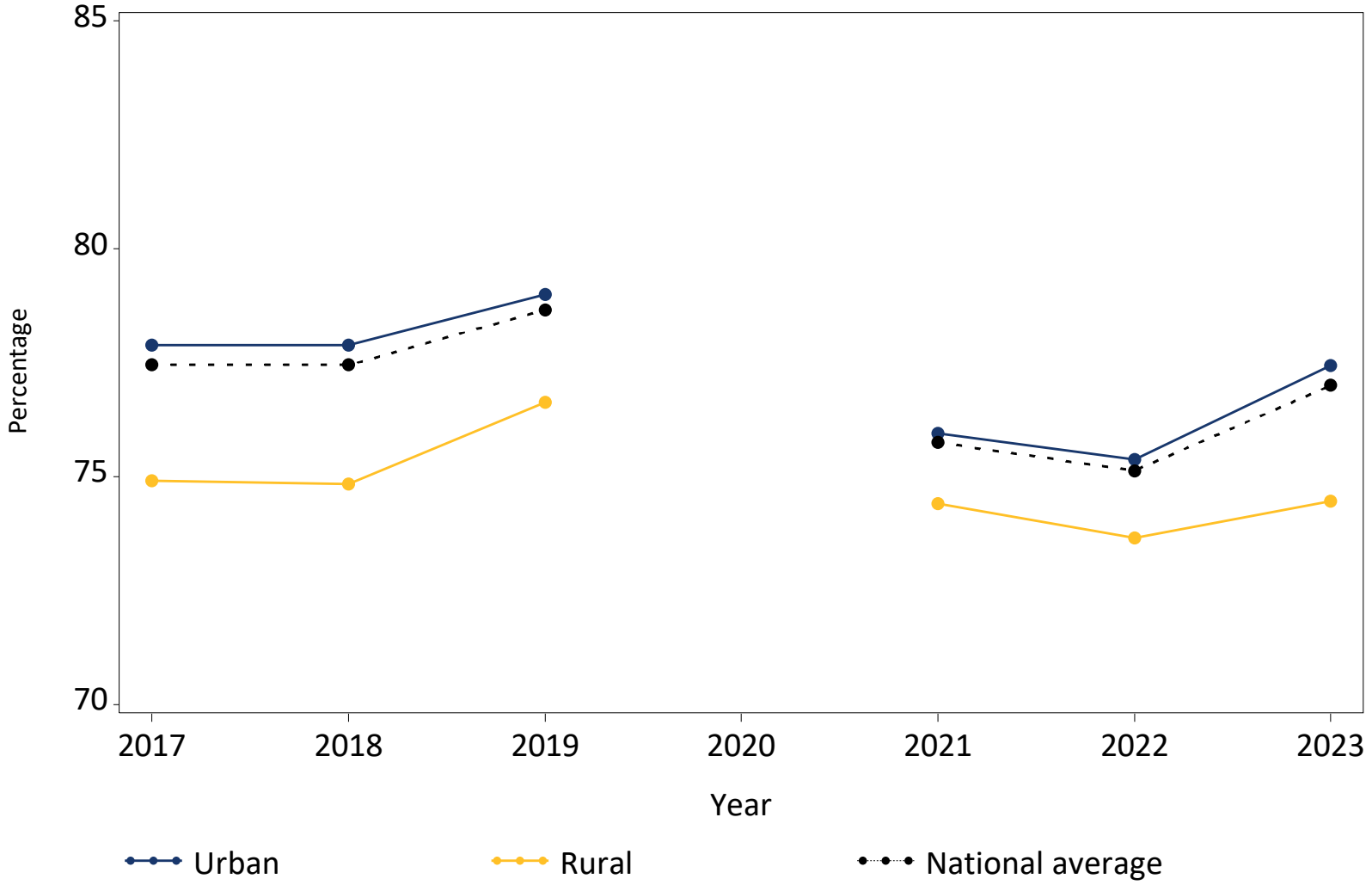
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For people with FFS coverage living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For people with FFS coverage living in rural areas, the increase was less than the national average, widening an initial gap for that group.

Breast Cancer Screening, 2017–2023

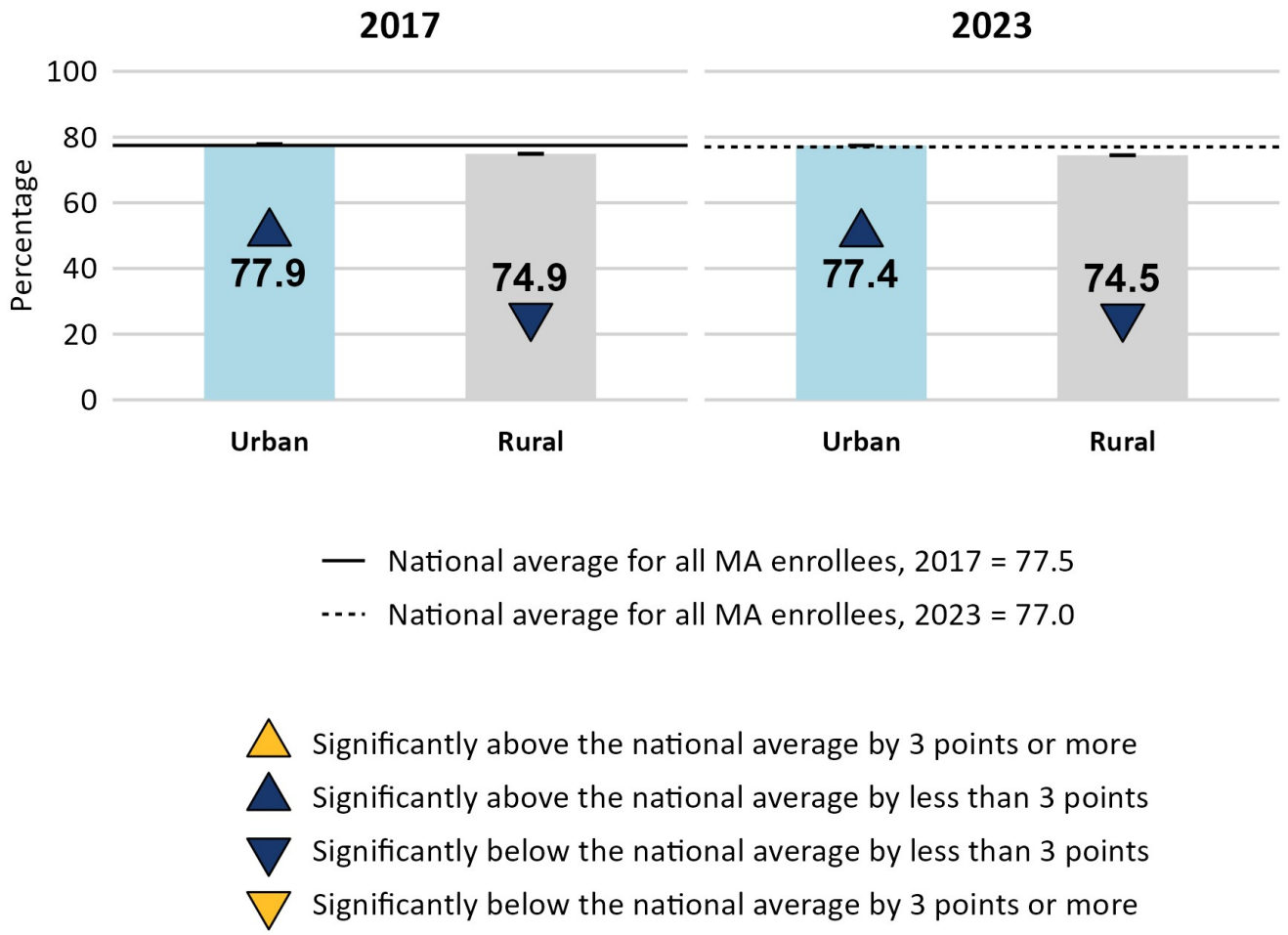
Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, 2017–2023 trend, by geography



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

Breast Cancer Screening, 2017 and 2023

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Breast Cancer Screening, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	77.9 ▲	77.4 ▲	Remained about the same	Remained about the same
Rural	74.9 ▼	74.5 ▼	Remained about the same	Remained about the same
National Average	77.5	77.0	Remained about the same	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

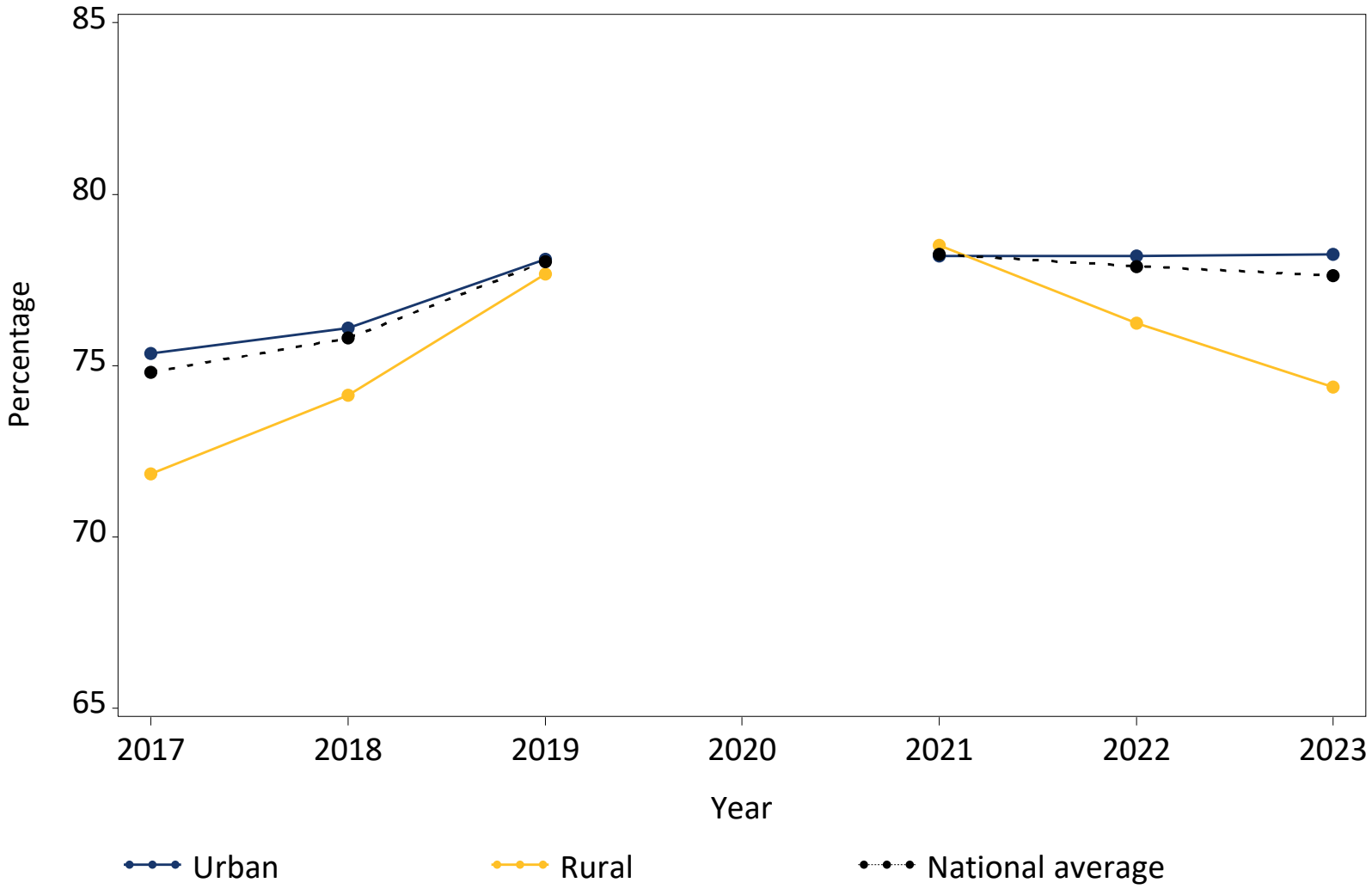
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores for female MA enrollees living in urban and rural areas were about the same in 2023 as in 2017. As a result, an initial advantage relative to the national average for female MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for female MA enrollees living in rural areas.

Colorectal Cancer Screening, 2017–2023

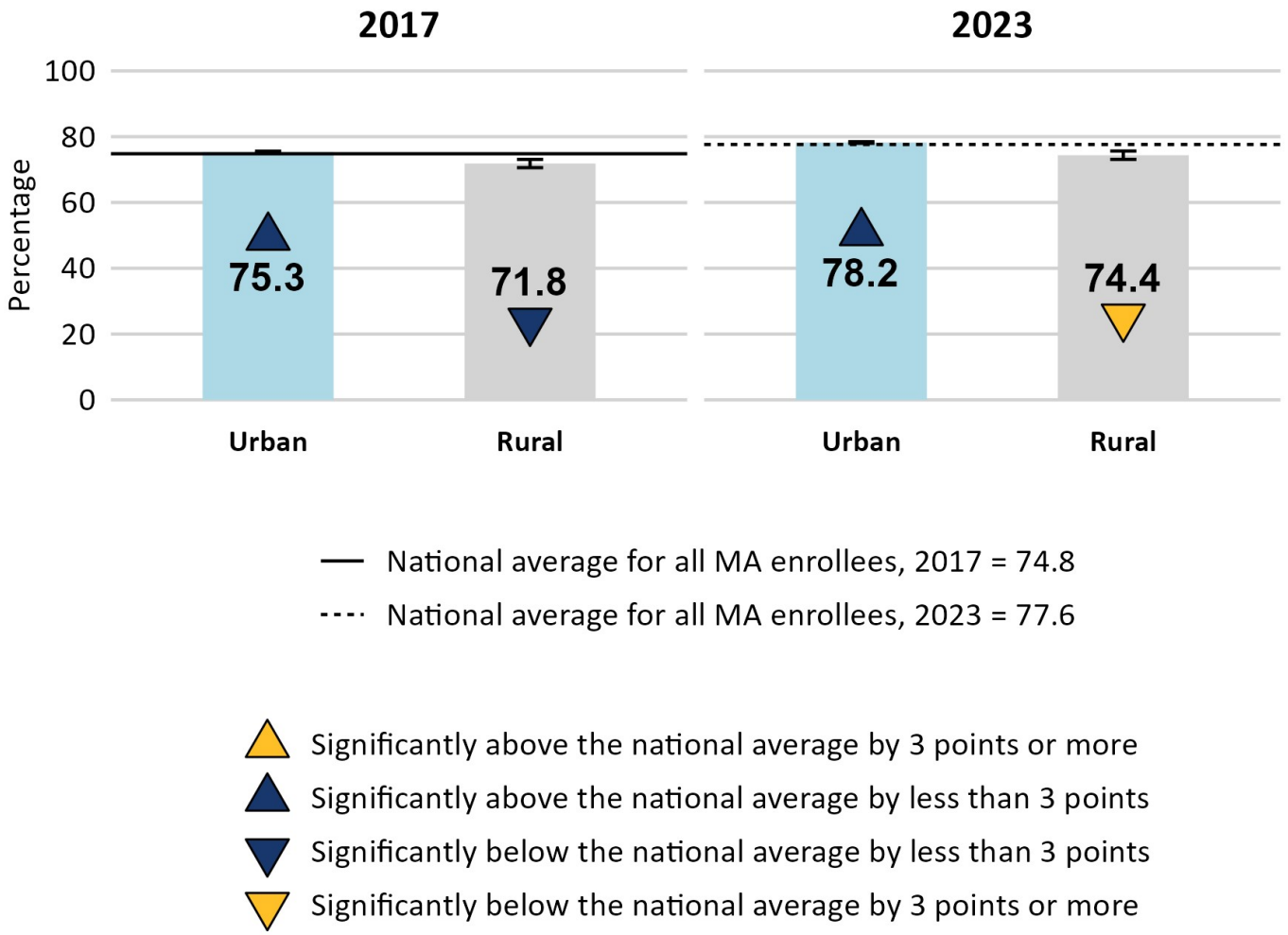
Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, 2017–2023 trend, by geography



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

Colorectal Cancer Screening, 2017 and 2023

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Colorectal Cancer Screening, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	75.3 ▲	78.2 ▲	+2.9	Remained about the same
Rural	71.8 ▼	74.4 ▽	+2.5	Remained about the same
National Average	74.8	77.6	+2.8	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

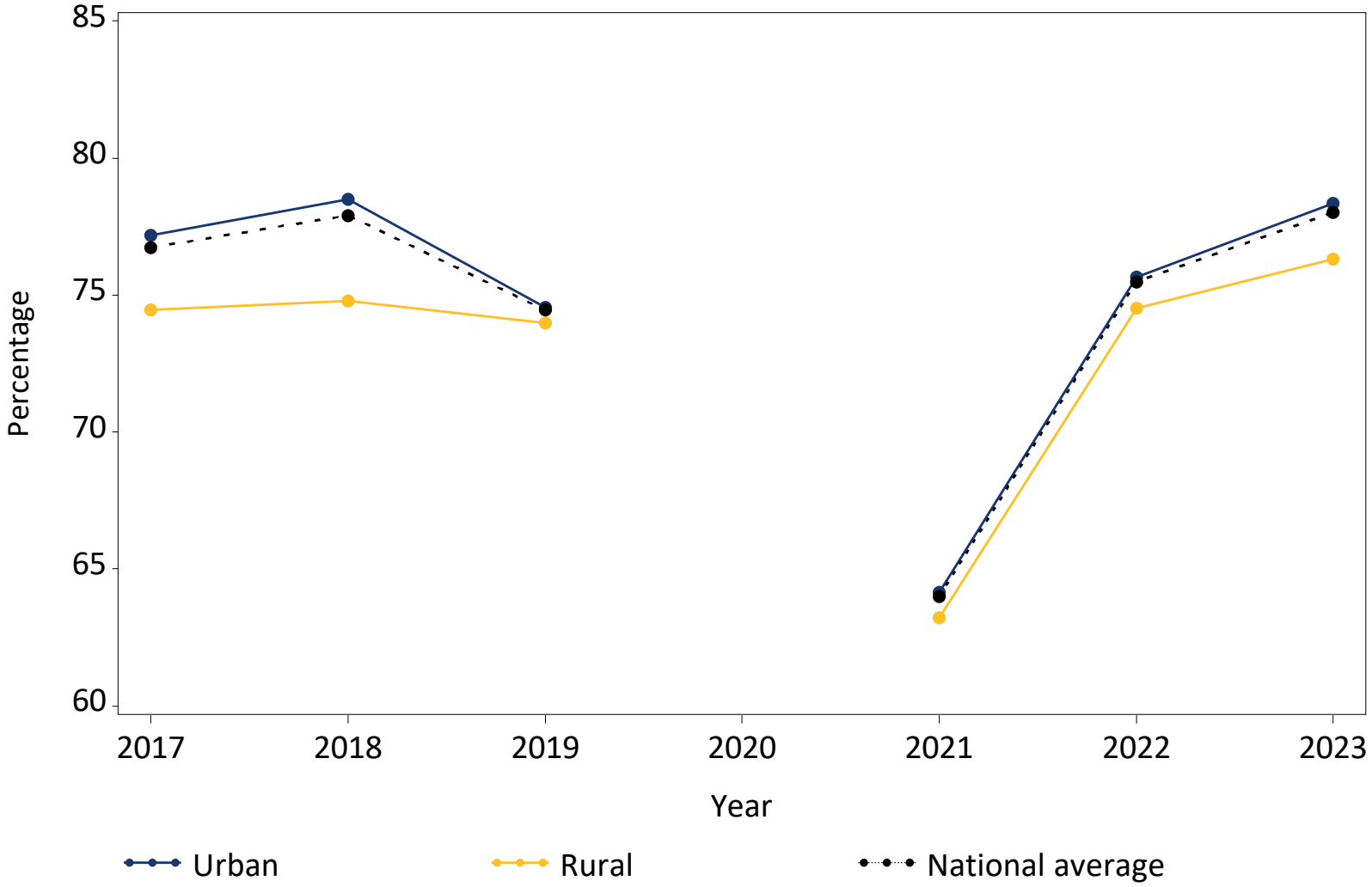
▽ Significantly below the national average by 3 points or more

NOTES. 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. The 2017 score for MA enrollees living in rural areas was significantly below the national average by less than 3 points prior to rounding. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023 in a manner that was comparable to the national average. As a result, an initial advantage relative to the national average for MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for MA enrollees living in rural areas.

Controlling High Blood Pressure, 2017–2023

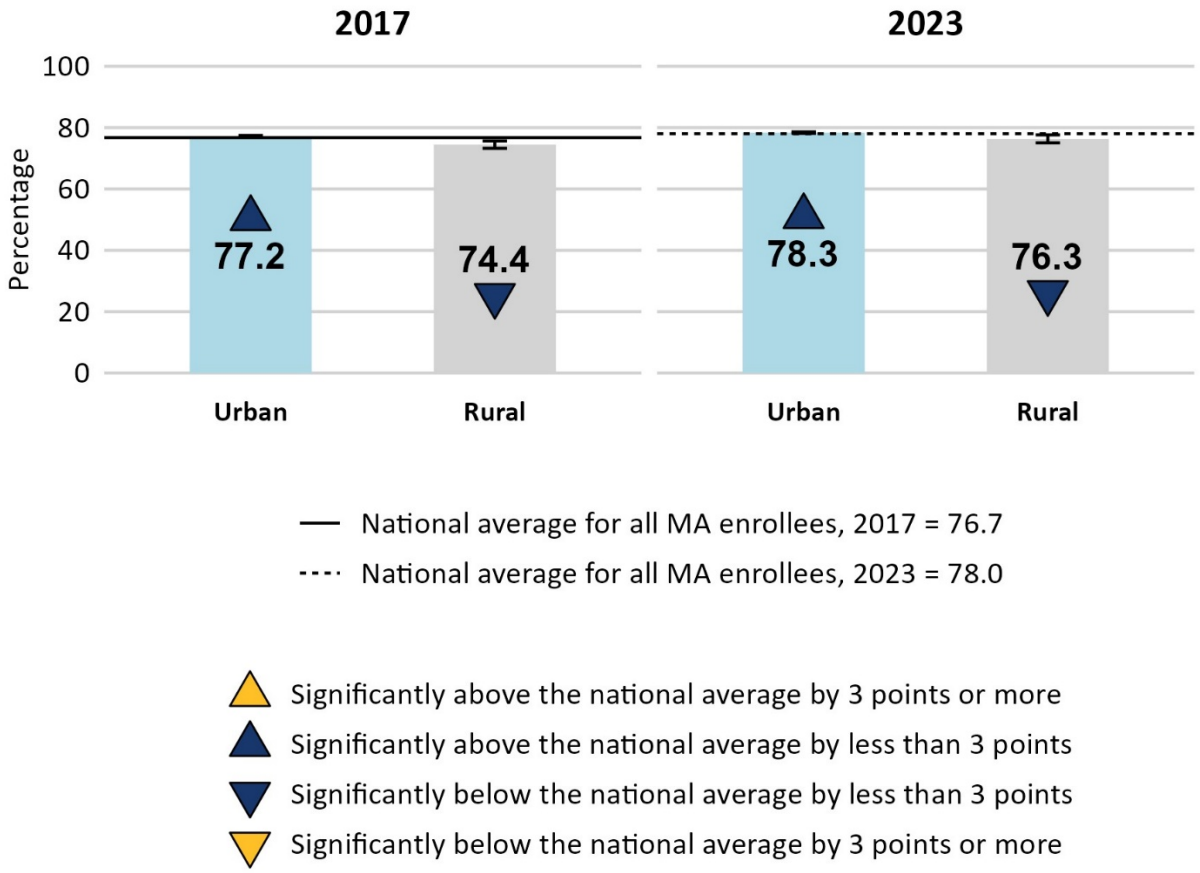
Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled during the past year, 2017–2023 trend, by geography



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

Controlling High Blood Pressure, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

† 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, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	77.2 ▲	78.3 ▲	+1.2	Remained about the same
Rural	74.4 ▼	76.3 ▼	+1.9	Remained about the same
National Average	76.7	78.0	+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

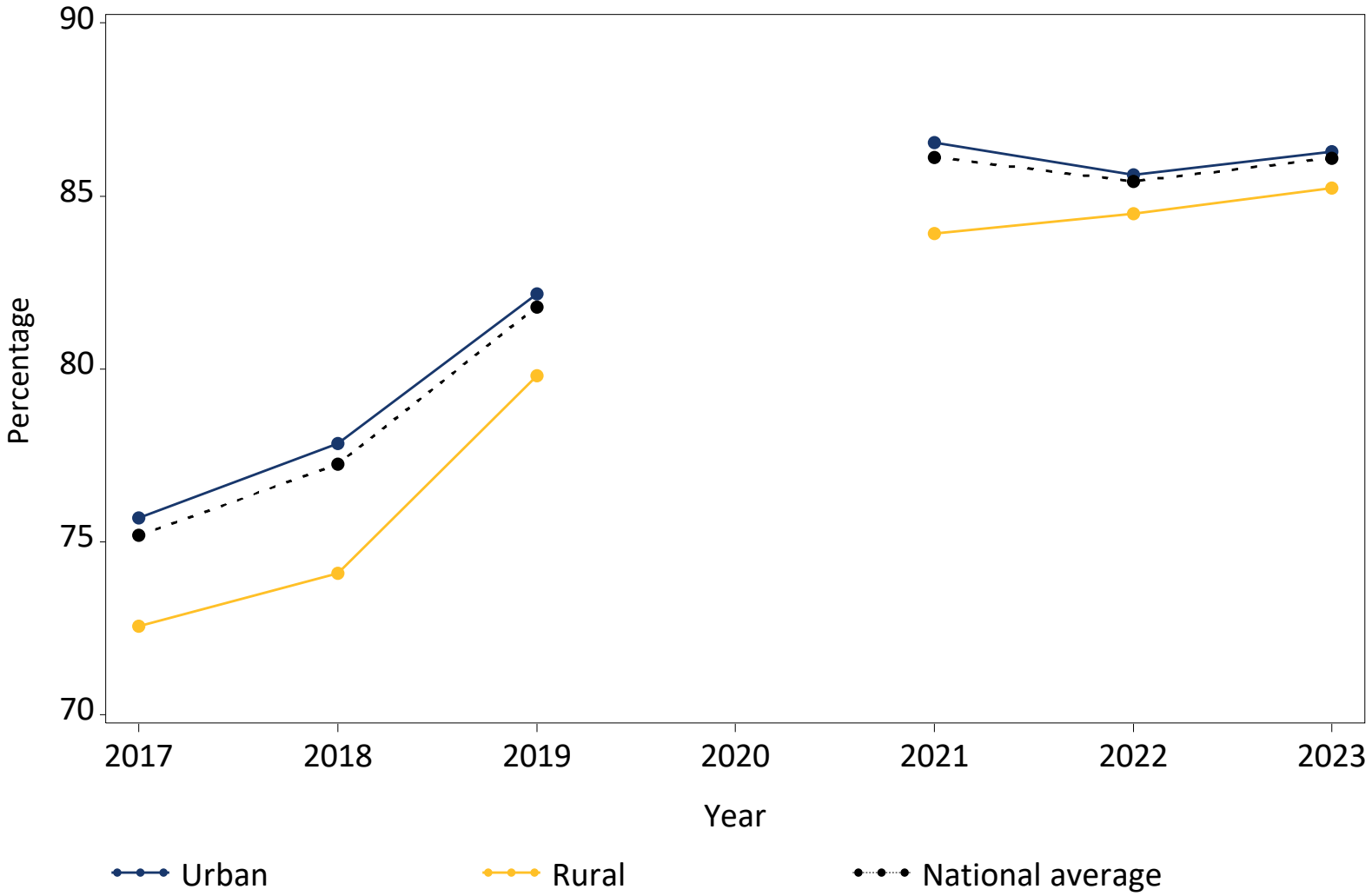
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023 in a manner that was comparable to the national average. As a result, an initial advantage relative to the national average for MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for MA enrollees living in rural areas.

Medication Adherence for Cardiovascular Disease—Statins, 2017–2023

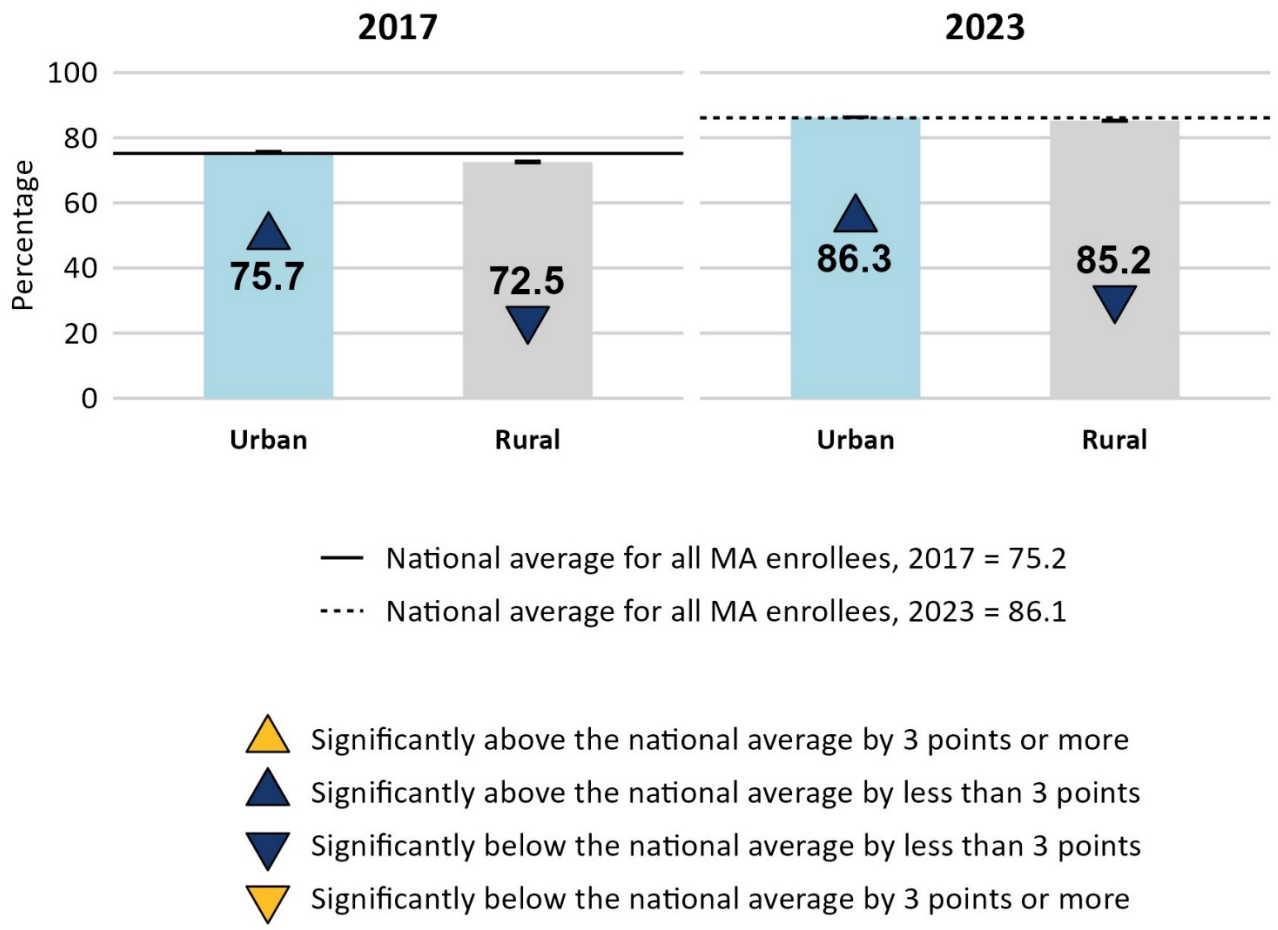
Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication who remained on the medication for at least 80 percent of the treatment period, 2017–2023 trend, by geography



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

Medication Adherence for Cardiovascular Disease—Statins, 2017 and 2023

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 who remained on the medication for at least 80 percent of the treatment period, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Medication Adherence for Cardiovascular Disease—Statins, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	75.7 ▲	86.3 ▲	+10.6	Remained about the same
Rural	72.5 ▼	85.2 ▼	+12.7	+1.8
National Average	75.2	86.1	+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

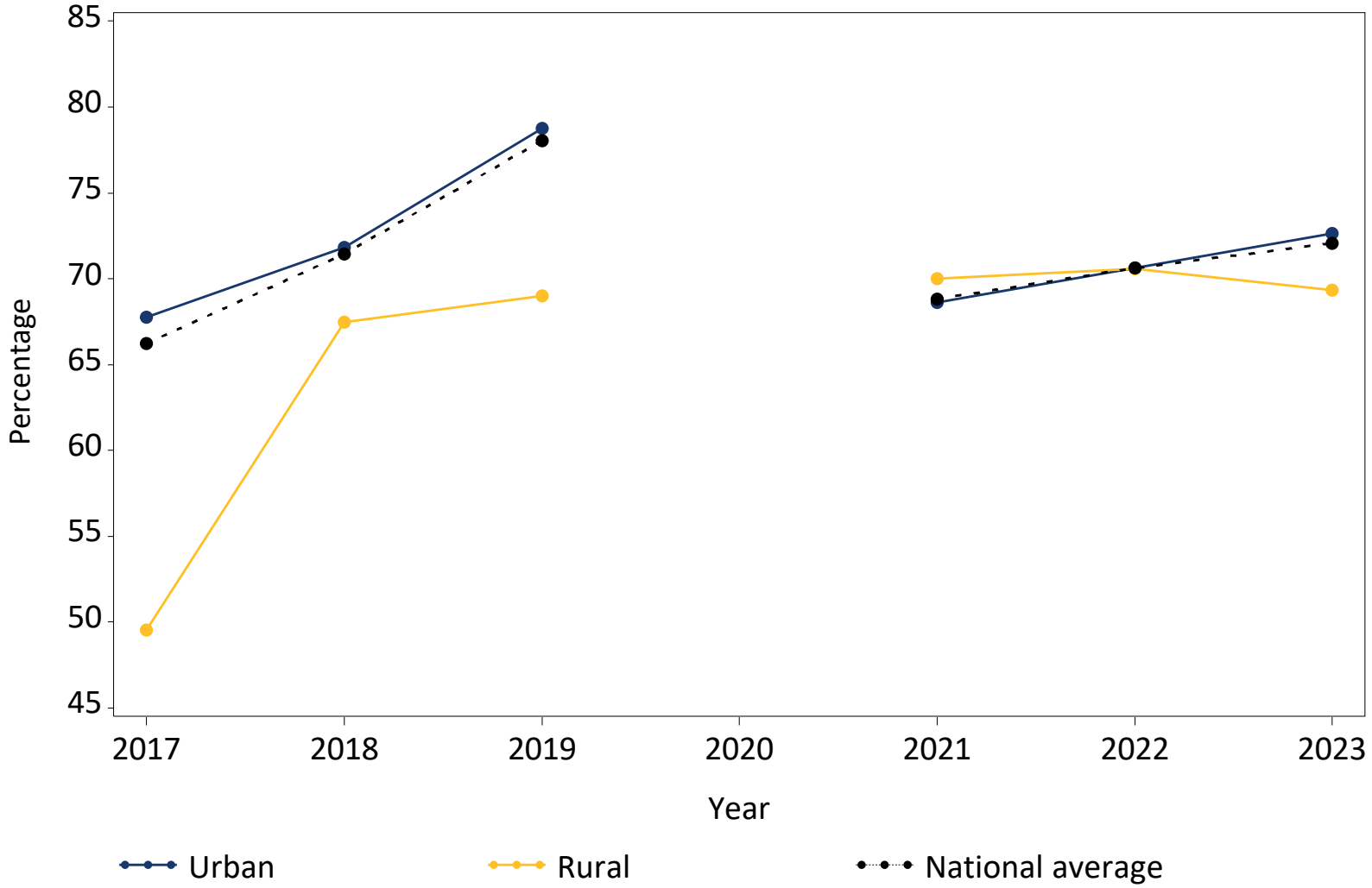
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For MA enrollees living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For MA enrollees living in rural areas, the increase was greater than the national average, shrinking an initial gap for that group.

Diabetes Care—Blood Pressure Controlled, 2017–2023

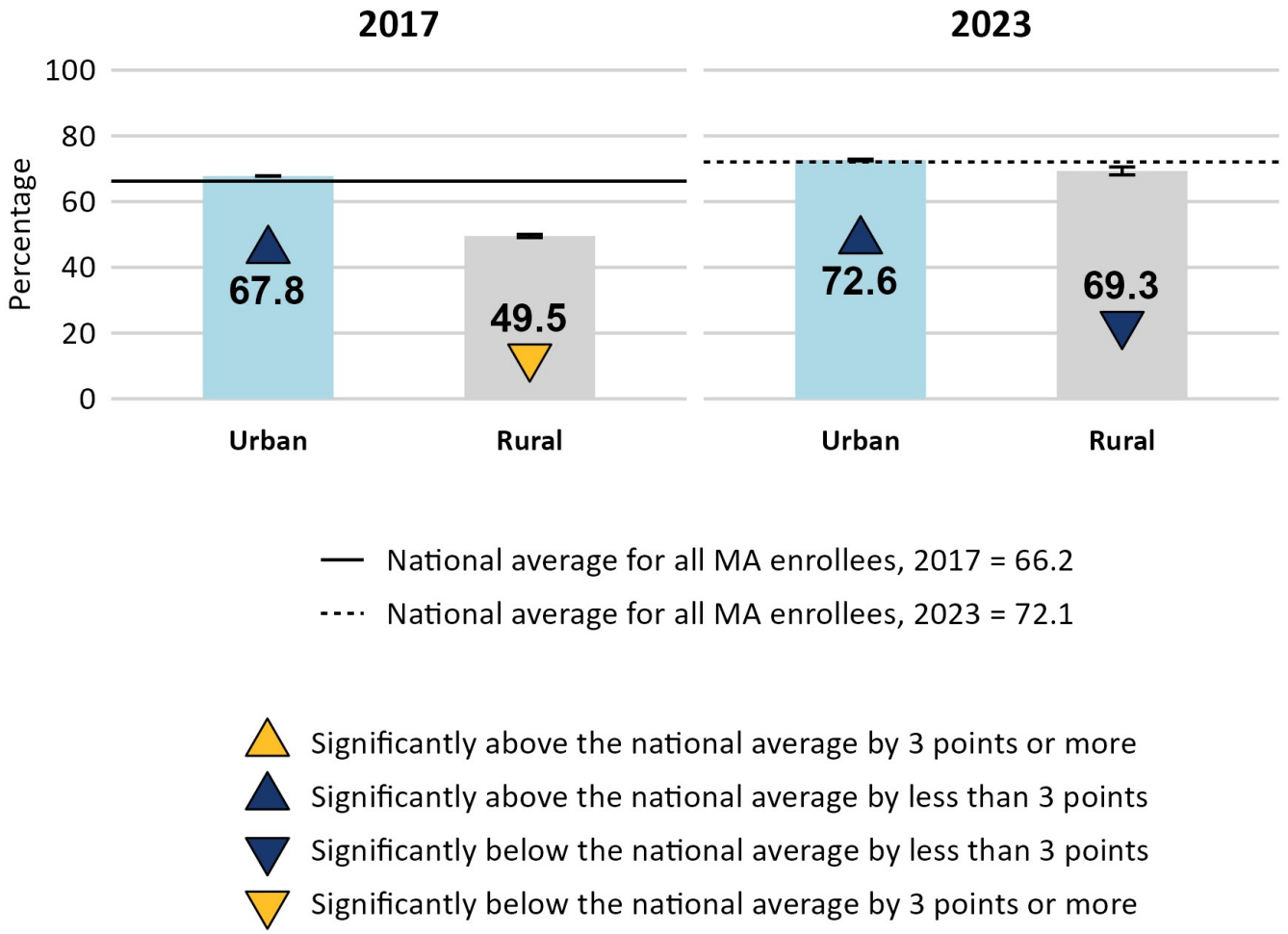
Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, 2017–2023 trend, by geography



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

Diabetes Care—Blood Pressure Controlled, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Diabetes Care—Blood Pressure Controlled, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	67.8 ▲	72.6 ▲	+4.9	Remained about the same
Rural	49.5 ▽	69.3 ▼	+19.8	+13.9
National Average	66.2	72.1	+5.8	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

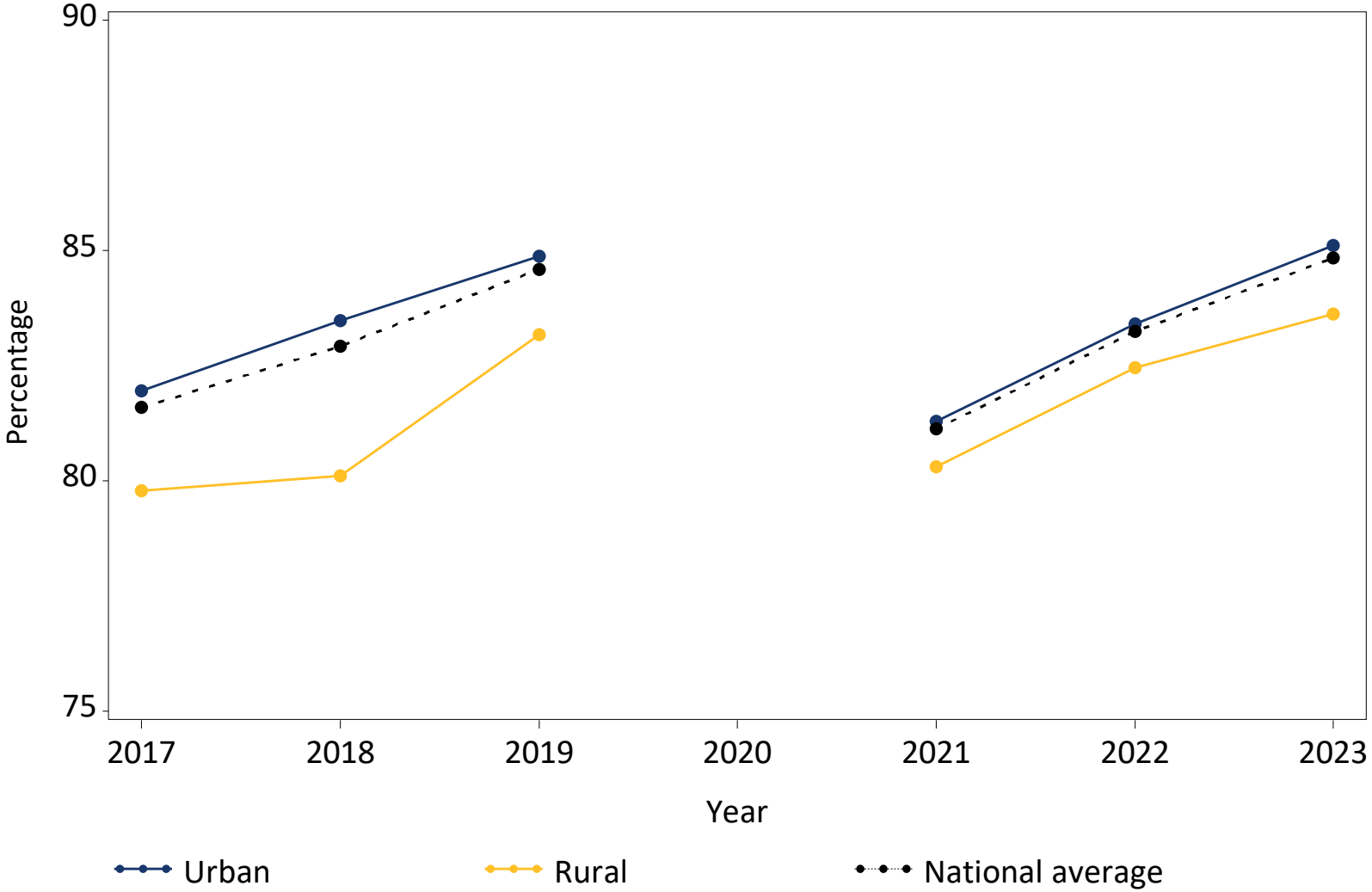
▽ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For MA enrollees living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For MA enrollees living in rural areas, the increase was greater than the national average, shrinking an initial gap for that group.

Diabetes Care—Blood Sugar Controlled, 2017–2023

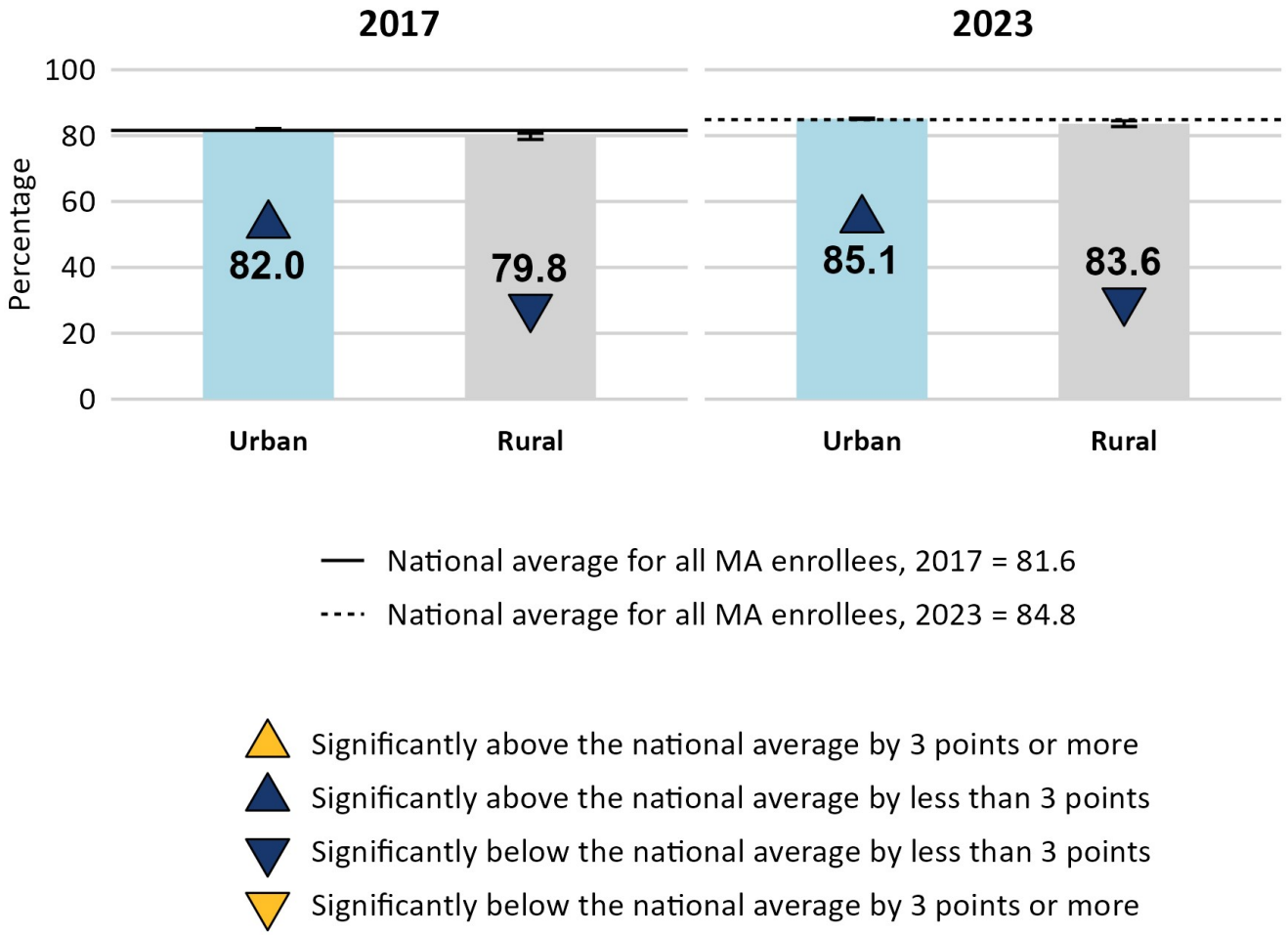
Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, 2017–2023 trend, by geography



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

Diabetes Care—Blood Sugar Controlled, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Diabetes Care—Blood Sugar Controlled, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	82.0 ▲	85.1 ▲	+3.1	Remained about the same
Rural	79.8 ▼	83.6 ▼	+3.8	Remained about the same
National Average	81.6	84.8	+3.3	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

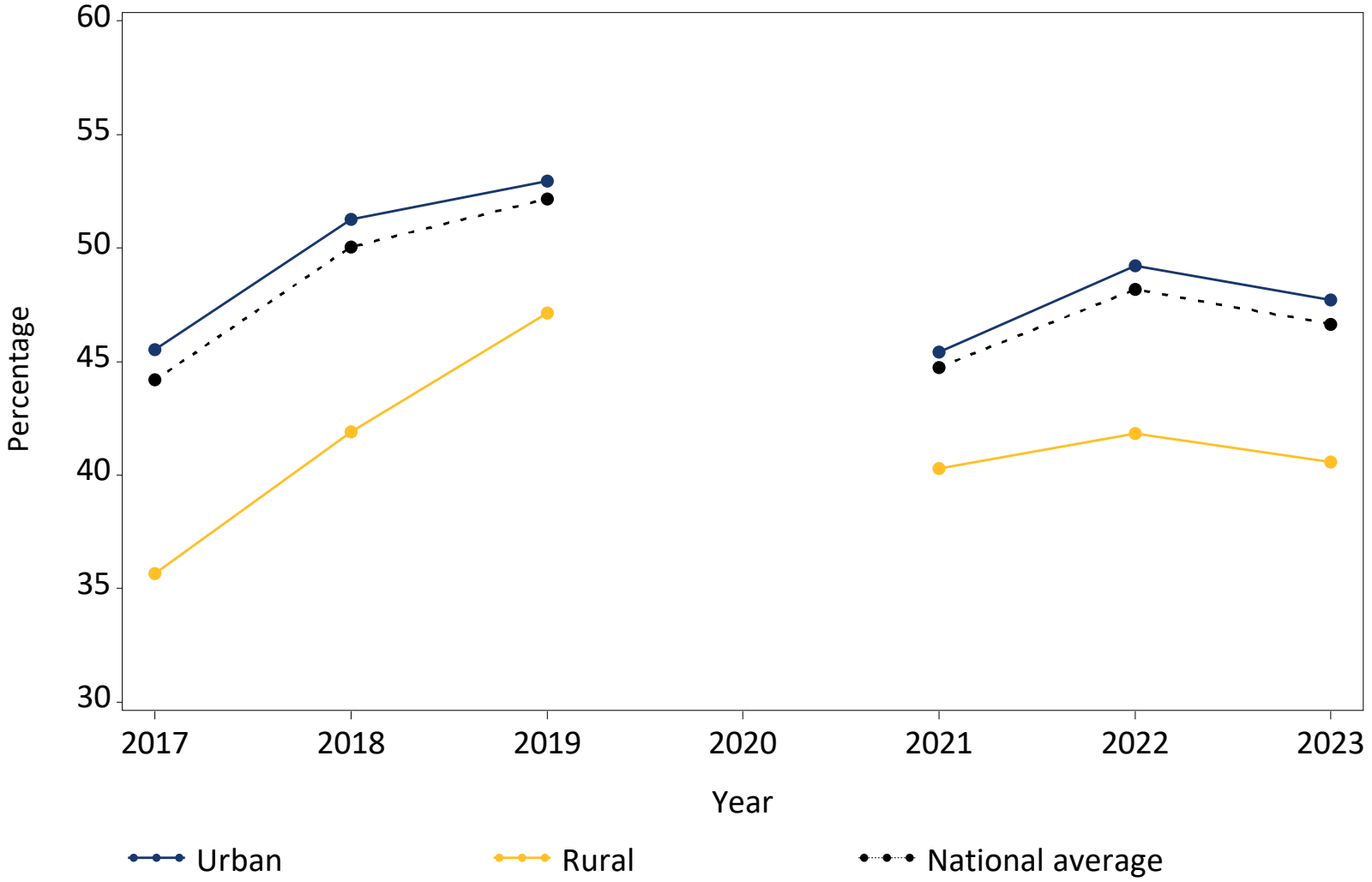
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023 in a manner that was comparable to the national average. As a result, an initial advantage relative to the national average for MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for MA enrollees living in rural areas.

Osteoporosis Management in Women Who Had a Fracture, 2017–2023

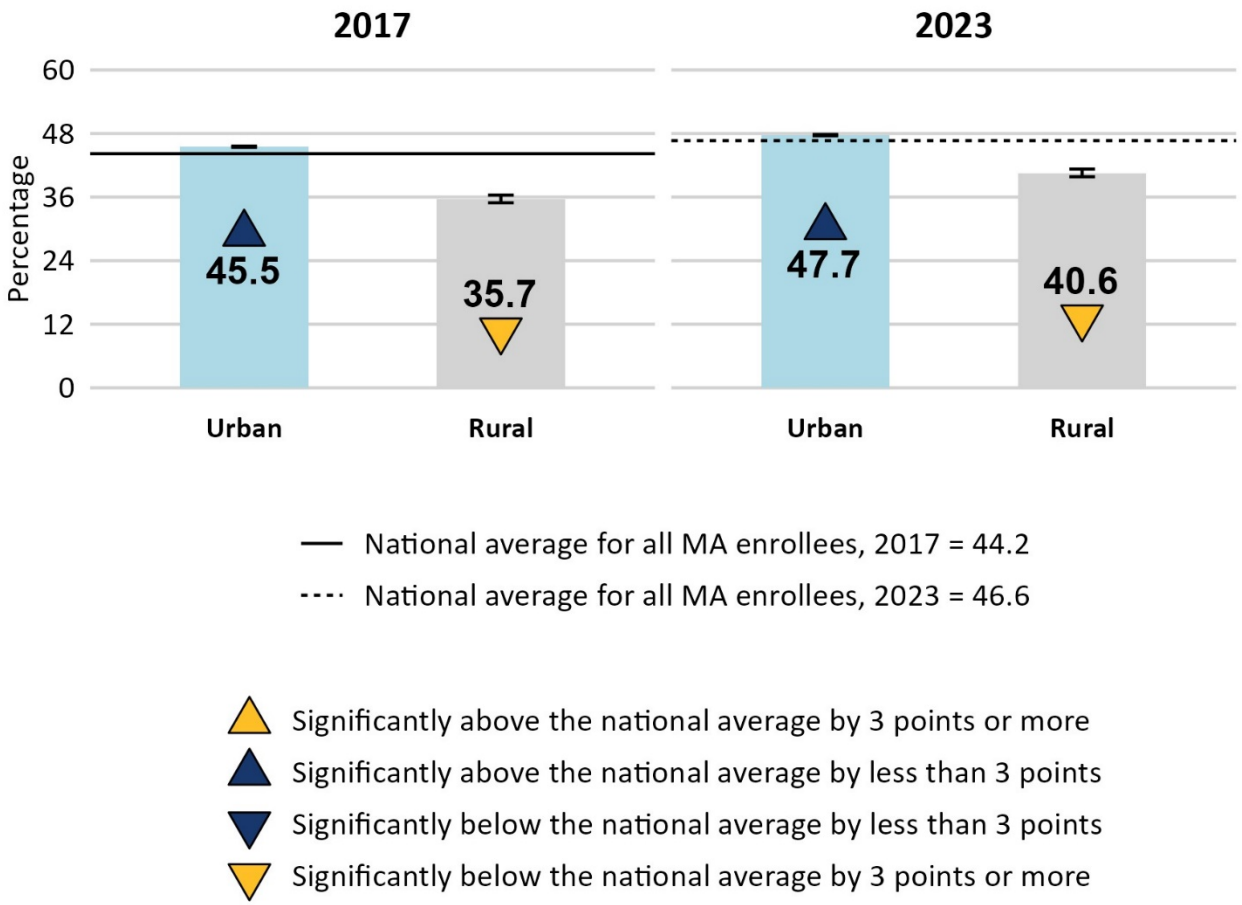
Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, 2017–2023 trend, by geography



NOTE: Clinical quality data were not released in Reporting Year 2020 due to the COVID-19 pandemic.

Osteoporosis Management in Women Who Had a Fracture, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Osteoporosis Management in Women Who Had a Fracture, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	45.5 ▲	47.7 ▲	+2.2	Remained about the same
Rural	35.7 ▽	40.6 ▽	+4.9	+2.4
National Average	44.2	46.6	+2.5	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

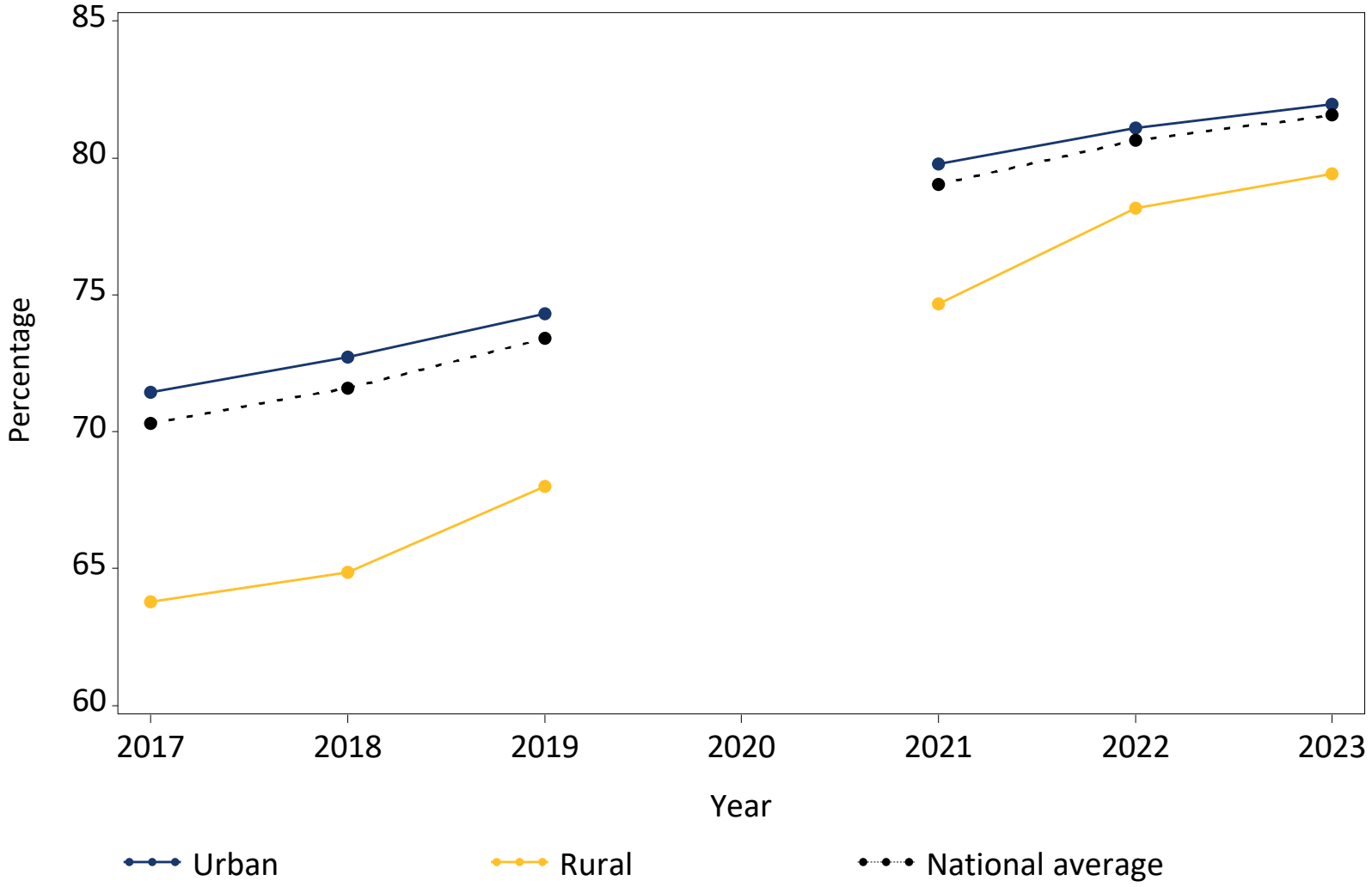
▽ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For female MA enrollees living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For female MA enrollees living in rural areas, the increase was greater than the national average, shrinking an initial gap for that group.

Antidepressant Medication Management—Acute Phase Treatment, 2017–2023

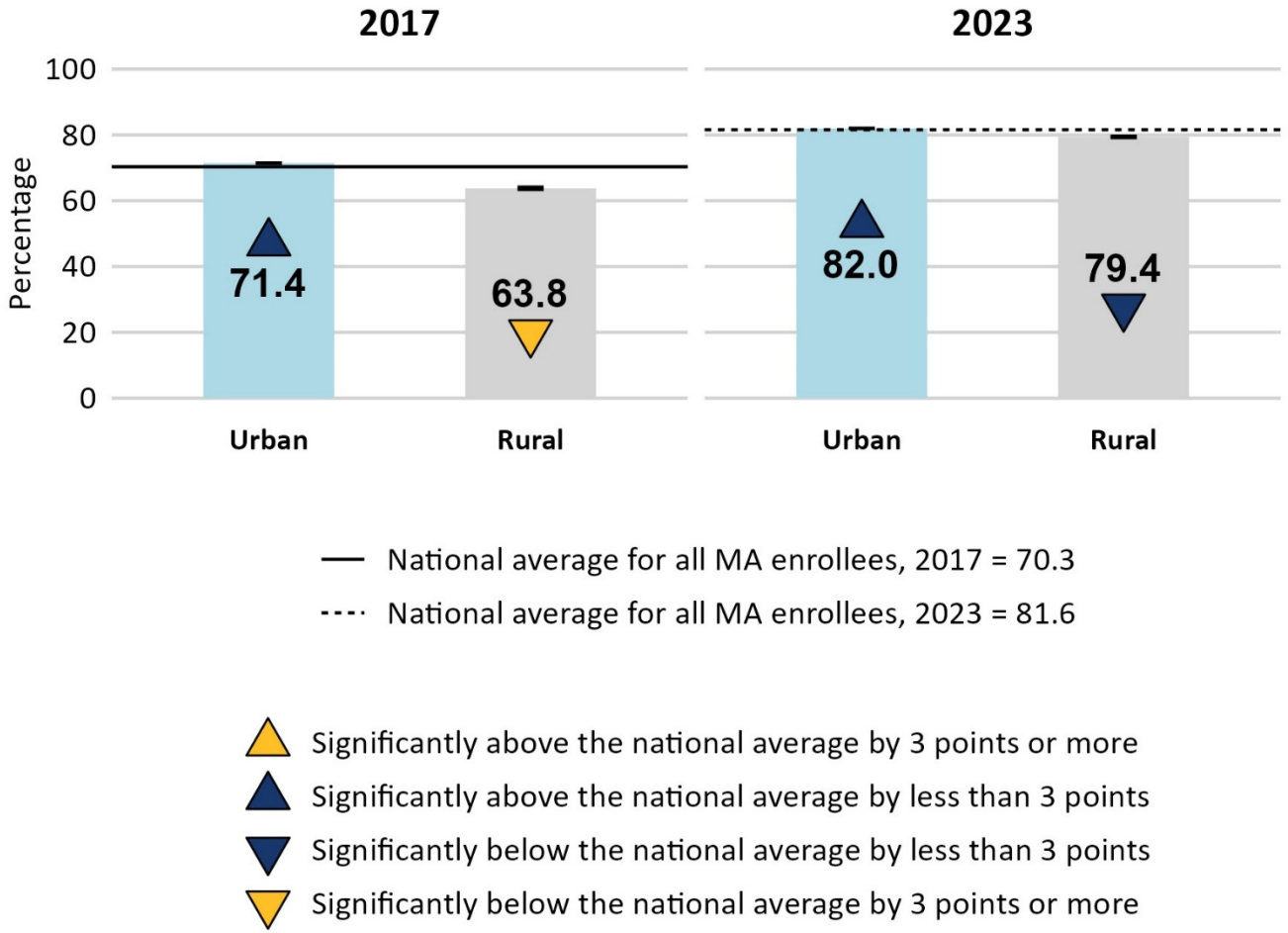
Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, 2017–2023 trend, by geography



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

Antidepressant Medication Management—Acute Phase Treatment, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

Antidepressant Medication Management—Acute Phase Treatment, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	71.4 ▲	82.0 ▲	+10.5	Remained about the same
Rural	63.8 ▽	79.4 ▼	+15.6	+4.4
National Average	70.3	81.6	+11.3	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

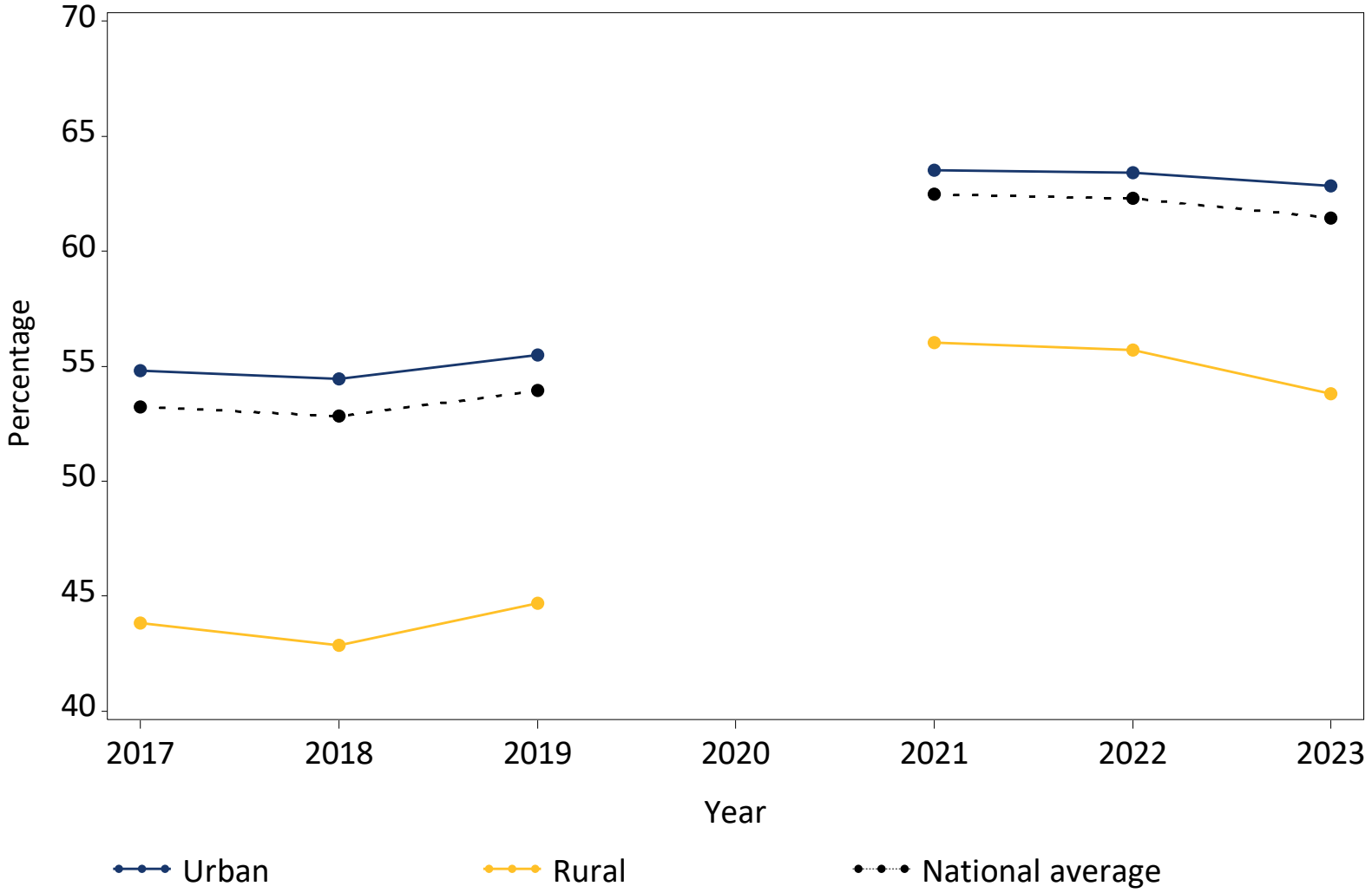
▽ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For MA enrollees living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For MA enrollees living in rural areas, the increase was greater than the national average, shrinking an initial gap for that group.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia, 2017–2023

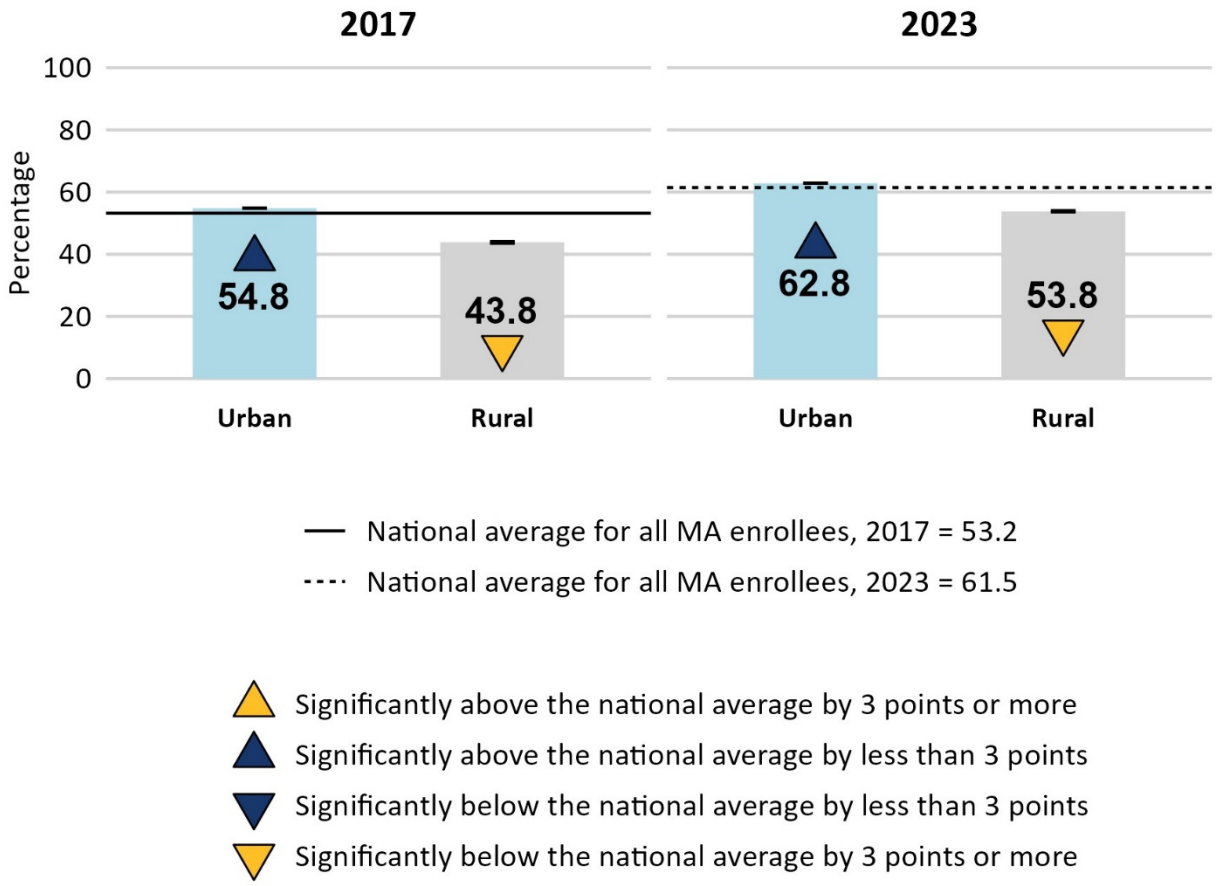
Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication, 2017–2023 trend, by geography



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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia, 2017 and 2023

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

[†] 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, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	54.8 ▲	62.8 ▲	+8.0	Remained about the same
Rural	43.8 ▼	53.8 ▼	+10.0	+1.7
National Average	53.2	61.5	+8.2	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

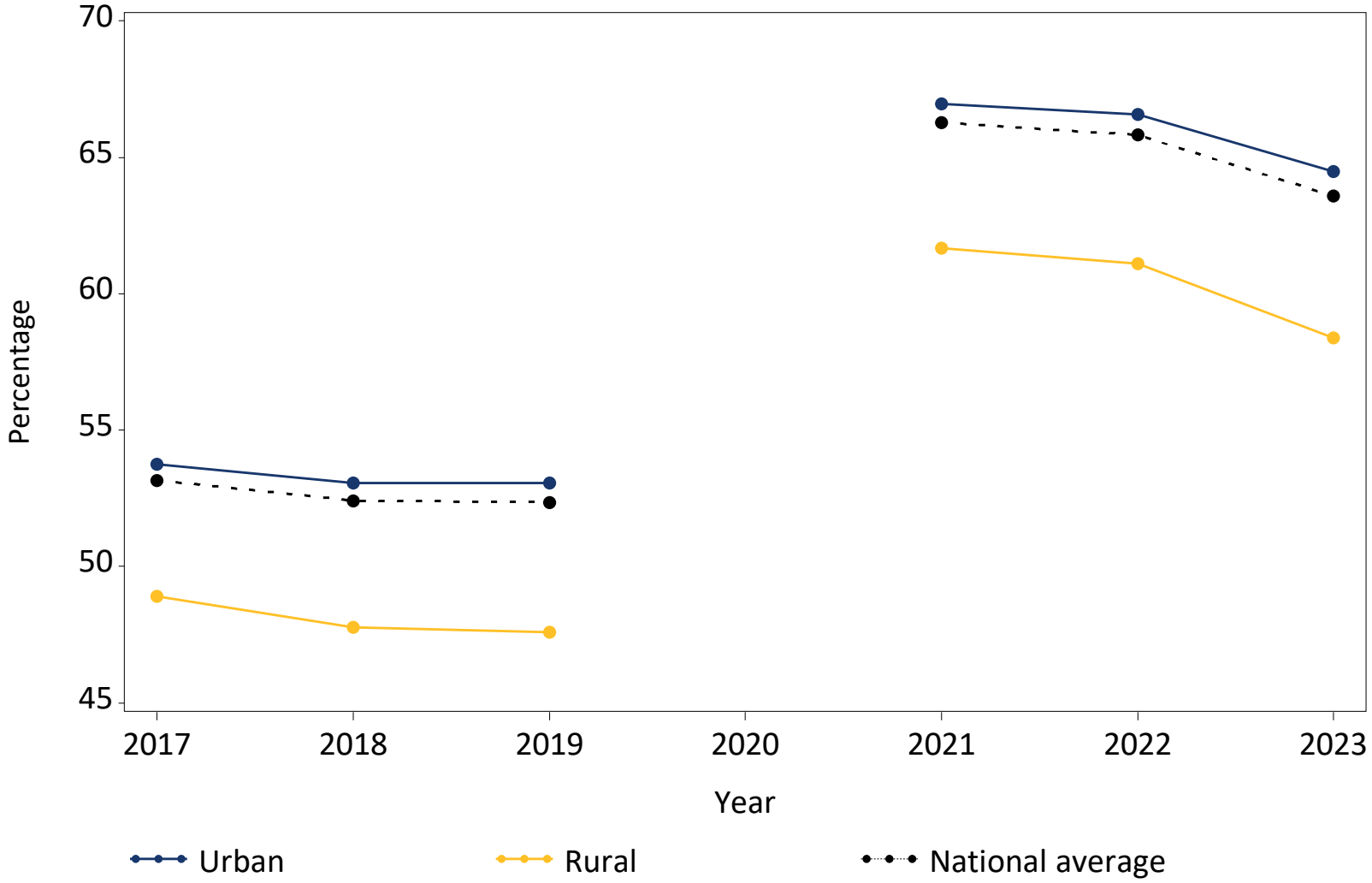
▼ Significantly below the national average by 3 points or more

NOTES. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023. For MA enrollees living in urban areas, the increase was comparable to the national average. As a result, an initial advantage for this group relative to the national average remained about the same in 2023. For MA enrollees living in rural areas, the increase was greater than the national average, shrinking an initial gap for that group.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls, 2017–2023

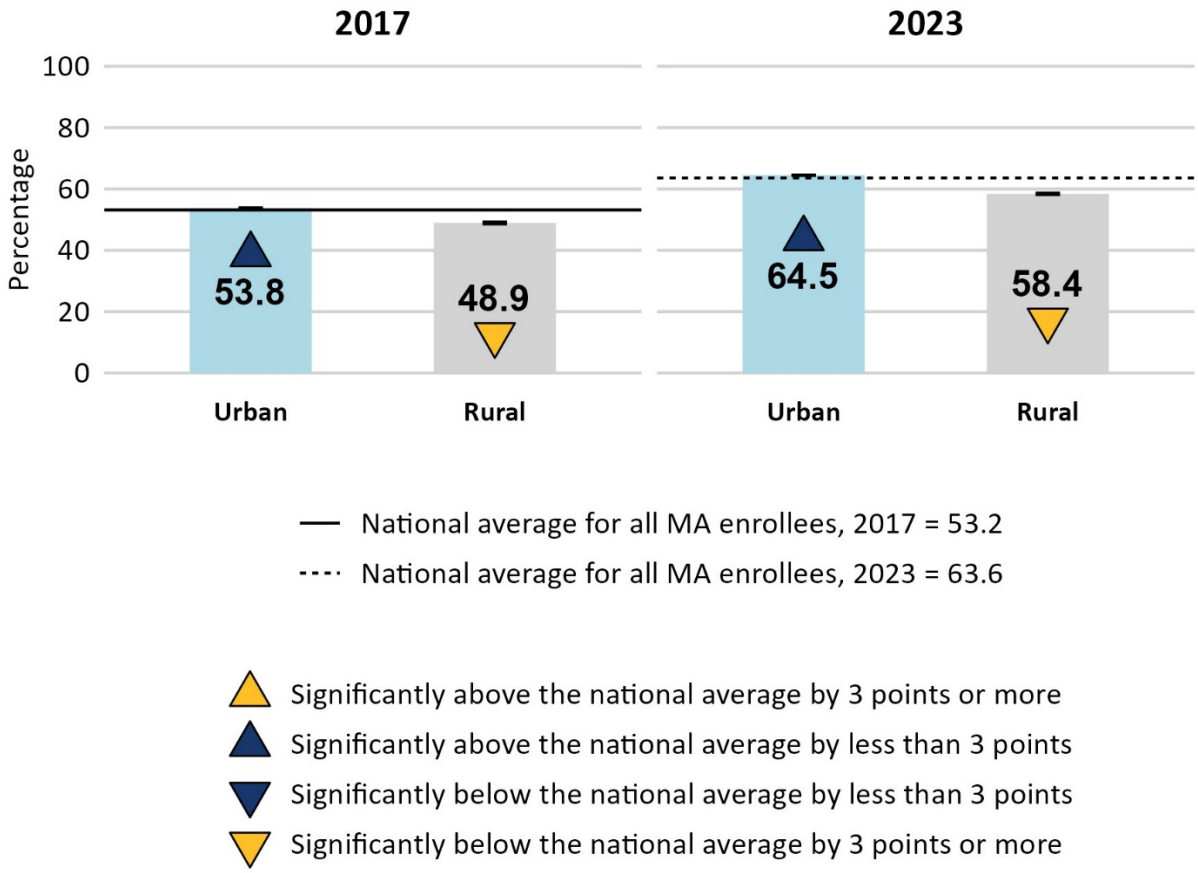
Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication, 2017–2023 trend, by geography



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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls, 2017 and 2023

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 geography, in Reporting Years 2017 and 2023



SOURCE: Clinical quality data were collected in 2016 and 2022 from MA plans nationwide.

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

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls, 2017 and 2023

Summary of Findings

Group	2017 score	2023 score	Change, 2017–2023	Change in difference between this group and the national average, 2017–2023
Urban	53.8 ▲	64.5 ▲	+10.7	Remained about the same
Rural	48.9 ▽	58.4 ▽	+9.5	Remained about the same
National Average	53.2	63.6	+10.4	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. 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. n/a = Not applicable.

Overall Summary: Scores increased for both groups from 2017 to 2023 in a manner that was comparable to the national average. As a result, an initial advantage relative to the national average for MA enrollees living in urban areas remained about the same in 2023, as did an initial gap for MA enrollees living in rural areas.

Appendix D: Data Sources and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems Survey

The Medicare CAHPS surveys are a set of mail surveys with telephone follow-ups using a stratified random sample of people with Medicare; contracts (referred to as *plans* in this report) serve as strata for MA enrollees and for people with Medicare FFS coverage who are enrolled in PDPs and states serve as strata for people with Medicare FFS coverage who are not enrolled in PDPs. These surveys are administered nationally each year; the data in this report are from the 2023 MA, FFS, and PDP CAHPS surveys. The MA CAHPS surveys are the source of data on all CAHPS measures for MA enrollees. For people with Medicare FFS coverage, the FFS CAHPS survey is the source of information on all CAHPS measures except those pertaining to prescription drugs, which come from the PDP CAHPS survey. More information on these surveys can be found on the MA and Prescription Drug Plan CAHPS page at CMS.gov (CMS, 2024b).

The 2023 MA, FFS, and PDP CAHPS surveys, which were fielded from March to June 2023, attempted to contact 1,129,395 people with Medicare and received responses from 391,298 for a 34.6-percent response rate. The 2023 surveys represent all people with Medicare FFS coverage, MA enrollees from 595 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP enrollees from 51 PDP contracts with at least 1,500 eligible enrollees. The table on page 234 shows MA and FFS sample sizes and the distribution of rural and urban groups on the annual flu vaccine measure, which is included on the MA and FFS CAHPS surveys and was selected for the 2017–2023 trend analysis.

The Healthcare Effectiveness Data and Information Set

The 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. Although CAHPS data are collected only via surveys, HEDIS data are gathered both via surveys and via 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 2023, there were 734 MA contracts that supplied the 26,867,324 HEDIS measure records used for the part of this report that is focused on cross-sectional differences in 2023 data. HEDIS data reported in 2023 were collected from MA plans throughout 2022 and thus correspond to care received from January to December 2022. The table on page 234 shows sample sizes and the distribution of rural and urban groups on the 10 measures selected for the 2017–2023 trend analysis.

Information on Geography

People were classified as living in a rural or urban area based on the ZIP Code of their mailing address and the corresponding U.S. Census Bureau CBSA. *CBSAs* consist of the county (or counties) or equivalent entities associated with at least one core urban area plus adjacent counties that have a high degree of social and economic integration with the core as measured through commuting ties with the counties that make up the core. Metropolitan statistical areas contain a core urban area with a population of 50,000 or more. Micropolitan statistical areas contain a core urban area with a population of at least 10,000 but less than 50,000. For this report, anyone living within a metropolitan division or metropolitan

statistical area was classified as an urban resident; anyone living in a micropolitan statistical area or outside a CBSA was classified as a rural resident. By this definition, 16.6 percent (approximately 4.1 million) of MA enrollees and 19.8 percent (approximately 5.8 million) of people with FFS coverage were rural residents in 2023. Of all people with Medicare residing in rural areas in 2023, 41.6 percent were enrolled in MA; of those residing in urban areas, 46.8 percent were enrolled in MA.

Information on Race and Ethnicity

The 2023 CAHPS survey asked respondents, "Are you of Hispanic or Latino origin or descent?" The response options were: "Yes, Hispanic or Latino" and "No, not Hispanic or Latino." The survey then asked, "What is your race? Please mark one or more," with response options of "White," "Black or African American," "Asian," "Native Hawaiian or Pacific Islander," and "American Indian or Alaska Native." Following a U.S. Census approach, answers to these two questions were used to classify respondents into one of seven mutually exclusive categories—AI/AN, AA and NHPI, Black, Hispanic, Multiracial, White, or unknown—according to the following criteria:

- Respondents who endorsed Hispanic ethnicity were classified as Hispanic regardless of races endorsed.
- Non-Hispanic respondents who endorsed two or more races were classified as Multiracial, with a single exception: Those who selected both "Asian" and "Native Hawaiian or Pacific Islander" and no other race were classified as AA and NHPI.
- Non-Hispanic respondents who selected exactly one race were classified as AI/AN, AA and NHPI, Black, or White, according to their responses.
- Respondents without data regarding race and ethnicity (about 4 percent) were classified as unknown.
- Unknown cases were dropped from the analysis of differences by race and ethnicity.

Scores on patient experience measures are reported for each of the six racial and ethnic groups named above whenever the reporting criteria are met.

HEDIS data, unlike CAHPS data, do not contain the patient's self-reported race and ethnicity. Therefore, we imputed race and ethnicity for the HEDIS data using a methodology that combines information from administrative data, first and last name, and residential location (Haas et al., 2019). This methodology is known as Medicare Bayesian Improved Surname Geocoding (MBISG). MBISG 2.1 imputations, which are used for this report, are strongly predictive of self-reported race and ethnicity. Predictive accuracy is measured using the C-statistic, also called the Concordance Statistic or Area Under the Curve, a common metric for the performance of classification models. The C-statistic summarizes the algorithm's sensitivity and specificity, with values of 0.5, 0.7, 0.8, 0.9, and 1.0 indicating chance, acceptable, excellent, outstanding, and perfect prediction, respectively (Hosmer, Lemeshow, and Sturdivant, 2013). C-statistics for MBISG 2.1 are outstanding for AA and NHPI, Black, Hispanic, and White MA enrollees (0.96–0.99), and excellent for AI/AN MA enrollees (0.85). Estimates of membership in the Multiracial group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for Multiracial MA enrollees on the clinical care measures. Scores on clinical care measures are reported for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees whenever the reporting criteria are met.

In 2023, AA and NHPI, Black, Hispanic, and Multiracial people with Medicare were more likely to be enrolled in MA than were AI/AN and White people with Medicare. In particular, whereas about half of AA and NHPI (49.1 percent), Black (55.2 percent), and Multiracial (49.2 percent) people with Medicare

were enrolled in MA and nearly two thirds of Hispanic people (63.1 percent), well less than half of AI/AN (38.9 percent) and White people with Medicare (42.0 percent) were enrolled in MA.

Reportability of Information

Scores based on 400 or more observations were considered sufficiently precise for reporting patient experience and clinical care scores for rural and urban residents; they are also considered sufficiently precise for reporting patient experience scores for all racial and ethnic groups and for reporting clinical care scores for AA and NHPI, Black, Hispanic, and White MA enrollees. Scores based on more than 99 but fewer than 400 observations were considered low in precision and were flagged as such.[15] Flagged scores—which should be regarded as tentative information—are shown unbolded with a superscript symbol appended; the symbol links to a note at the bottom of the chart that cautions about the precision of the score. Scores based on 99 or fewer observations are suppressed (i.e., not reported). When a score is suppressed for a particular group, a note at the bottom of the relevant chart states that there were not enough data from that group to make a racial and ethnic comparison on the measure. As stated previously, the algorithm used to predict AI/AN group membership for the clinical care data—although adequate in many cases—is not as good as it is for predicting membership in other racial or ethnic groups. Accordingly, stricter criteria are required for reporting clinical care scores for AI/AN MA enrollees. In this report, we required both a minimum sample size of 400 observations and that the standard error of the log-odds coefficient in a logistic regression model comparing AI/AN scores with the national mean be 0.25 or smaller (indicating adequate precision). Clinical care scores for AI/AN MA enrollees not meeting these stricter criteria are suppressed (i.e., not reported).

Analytic Approach: Cross-Sectional Analysis of 2023 Data

The CAHPS patient experience measures presented in this report are composite measures that summarize, through averaging, the answers to two or more related CAHPS survey questions or items. The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report. This is a single-item measure rather than a composite.

We present estimated scores for rural and urban residents within coverage type (MA or FFS). CAHPS patient experience scores for rural and urban residents were estimated from case mix–adjusted linear regression models that contained an indicator for rurality and the following case-mix adjustors: age, education, self-rated general and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. In keeping with how the measure is officially scored, no case-mix adjustment was made for the annual flu vaccine measure.

CAHPS scores for rural and urban residents of different racial and ethnic backgrounds were estimated from linear regression models, stratified by race and ethnicity. These models were constructed in the same manner as the overall rural and urban models.

CAHPS scores for different racial and ethnic groups living in rural and urban areas were estimated from linear regression models, case mix–adjusted for the patient experience measures, that were stratified by rurality. Within each stratum (i.e., rural and urban), six linear regression models were run for each outcome; AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White people successively served as the focal racial or ethnic group. Each time the model was run, it contained records for people of all racial

[15] A sample size of 400 ensures that the margin of error for a dichotomous measure is no greater than 5 percent. With a sample size of 100, the maximum margin of error is 10 percent.

and ethnic groups in a rurality stratum; what changed were predictors. These linear regression models contained an indicator for the focal racial/ethnic group, plus the set of case-mix adjustors described earlier. These models yielded estimates of each racial and ethnic group's score in each rurality stratum 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 rural or urban residents (depending on the stratum) with the same coverage.[16]

HEDIS measures are available only for MA enrollees. None of the HEDIS measures reported was case mix–adjusted, which is consistent with their official scoring. Thus, HEDIS scores for rural and urban residents were estimated from logistic regression models that contained only an indicator for rurality.

HEDIS scores for different racial and ethnic groups living in rural and urban areas were estimated from logistic regression models. Five logistic regression models were run for each outcome; AI/AN, AA and NHPI, Black, Hispanic, and White people successively served as the focal racial or ethnic group. The sole predictors in these logistic regression models were the MBISG predicted probability that a person belonged to the focal racial/ethnic group in each model, an indicator for rurality, and the interaction term between them. These models yielded estimates of each racial and ethnic group's score, in the form of a proportion, in each rurality stratum, as well as statistical tests of the difference between the score for a racial and ethnic group in a rurality stratum and (1) the score for all members of that racial and ethnic group and (2) the score for everyone in that rurality stratum.

In comparisons of estimated scores with the national average, a difference is denoted as statistically significant if there is less than a 5-percent chance that the difference could have resulted because of sampling error alone. Differences that are statistically significant and larger than 3 points on a 0–100 scale (CAHPS) or larger than 3 percentage points (HEDIS) are further denoted as practically significant. In the summary charts that appear in the report and at the beginning of each appendix that shows measure-by-measure results, the focus is on practically significant differences. In the charts that present results on individual measures of patient experience (CAHPS) and clinical care (HEDIS), the focus is on statistically significant differences. In 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 through the coloring of the upward- and downward-facing arrows that appear in the bars. Blue arrows indicate statistically significant differences that are less than 3 points in magnitude; yellow arrows indicate statistically 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, 2017–2023

Line graphs were generated showing estimated scores for each group in 2017, 2018, 2019, 2021, 2022, and 2023 (no data were reported in 2020) to show differences in how scores on the selected set of outcome measures changed over time for rural and urban residents. To construct these graphs, we ran one cross-sectional model (logistic for HEDIS measures, linear for the annual flu vaccine measure) per year for each group and included an indicator for whether a person belonged to the focal group for the

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

model. These models were used to estimate and test differences between each group and the national average in each year.

We then ran a series of models (logistic for HEDIS measures, linear for the annual flu vaccine measure) using Reporting Year 2017 and 2023 data to estimate and test (1) change in measure scores over time for each group and (2) differences in differences over time to look at whether each group's change over time was different from national average change.

Two models were run for each outcome; rural and urban residents successively served as the focal group. For each model, predictors included (1) an indicator for 2023, which estimates the overall change in the outcome since 2017 for the nonfocal group; (2) an indicator of whether a person belonged to the focal group, which estimates the difference in scores between the focal group and the non-focal group in 2017; and (3) an interaction between 2023 and the group indicator, which indicates whether the score for the focal group changed differently over time compared with the nonfocal group. Planned contrasts were conducted using these models to estimate change between 2017 and 2023 for the focal group relative to the national average.

Sample Sizes and Distribution of Urban and Rural Groups for Measures Included in the Trends Section of this Report, 2017–2023

Clinical Care Measure	***N***	**% Urban**	**% Rural**
Annual Flu Vaccine	1,332,955	84.3	15.7
Medicare Advantage	493,156	79.0	21.0
Medicare Fee-for-Service	24,816,248	85.8	14.2
Breast Cancer Screening	5,805,321	84.8	15.2
Colorectal Cancer Screening	5,119,526	84.3	15.7
Controlling High Blood Pressure	4,836,878	83.4	16.6
Medication Adherence for Patients with Cardiovascular Disease—Statins	2,703,277	83.7	16.3
Diabetes Care—Blood Pressure Controlled	2,333,318	83.2	16.8
Diabetes Care—Blood Sugar Controlled	559,217	86.5	13.5
Osteoporosis Management in Women Who Had a Fracture	3,192,810	85.0	15.0
Antidepressant Medication Management—Acute Phase Treatment	5,102,274	85.5	14.5
Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with Dementia	5,057,430	86.8	13.2
Avoiding Potentially Harmful Drug-Disease Interactions in Older Adults with a History of Falls	1,332,955	84.3	15.7

NOTES: Sample sizes and distributions reflect data from Reporting Year 2017 to Reporting Year 2023, excluding Reporting Year 2020. Percentages are weighted for sampling. Sample sizes are unweighted.

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