Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex

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Preface

This report presents summary information on the quality of health care received by Medicare Advantage enrollees nationwide (48 percent of all people with Medicare in 2022). The report highlights (1) racial and ethnic differences in health care experiences and clinical care, (2) differences in health care experiences and clinical care by sex, and (3) how racial and ethnic differences in quality of care vary by sex.

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Introduction

This report presents summary information on the quality of health care received by Medicare Advantage (MA) enrollees nationwide (48 percent of all people with Medicare in 2022). The report highlights (1) racial and ethnic differences in health care experiences and clinical care, (2) differences in health care experiences and clinical care by sex, and (3) how racial and ethnic differences in quality of care vary by sex.

The report is based on an analysis of two sources of information. The first source is the MA and Prescription Drug Plan (PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which is conducted annually by the Centers for Medicare & Medicaid Services (CMS) and focuses on the health care experiences (e.g., ease of getting needed care, how well providers communicate, getting needed prescription drugs) of people with Medicare across the country. 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 with Medicare receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. A comprehensive list of the seven patient experience and 37 clinical care measures is provided in the section titled "Patient Experience and Clinical Care Measures Included in This Report." Scores on MA and PDP CAHPS—hereafter referred to simply as CAHPS—measures are case mix–adjusted, as described in the appendix. HEDIS measures are not case mix–adjusted.

The report uses data reported in 2022. The CAHPS data pertain to care experiences reported on the 2022 Medicare CAHPS survey, which was fielded from March to May 2022. Respondents were asked about care received in the six months prior to the survey. HEDIS data reported in 2022 (hereafter referred to as "Reporting Year 2022") correspond to care received from January to December 2021.

Distribution of Race, Ethnicity, and Sex Among MA Enrollees

In 2022, 69.4 percent of MA enrollees were White; 12.5 percent were Hispanic; 11.4 percent were Black; 4.7 percent were Asian Americans, Native Hawaiians, or Pacific Islanders; 1.7 percent were Multiracial;[1] and 0.3 percent were American Indians or Alaska Natives, while 56.2 percent were female and 43.8 were male.

By comparison, in 2022, 79.3 percent of Medicare fee-for-service (FFS) enrollees were White; 6.4 percent were Hispanic; 8.1 percent were Black; 4.1 percent were Asian Americans, Native Hawaiians, or Pacific Islanders; 1.5 percent were Multiracial; and 0.7 percent were American Indians or Alaska Natives, while 52.2 percent were female and 47.8 were male.

Disparities in Health Care in MA by Race and Ethnicity

American Indian and Alaska Native (AI/AN) MA enrollees reported experiences with care that were similar to the national average on all seven patient experience measures (see Figure 1).[2] Asian American and Native Hawaiian or other Pacific Islander (AA and NHPI) MA enrollees reported care that was worse than the national average on six measures and above the national average on one measure (Annual Flu

[1] For this report, we classify as *Multiracial* non-Hispanic people who reported belonging to more than one racial group.

[2] Here, 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 the appendix. We characterize a score as *similar to* the national average if the difference is not statistically significant, falls below a magnitude threshold, or both.

Vaccine).[3] Black MA enrollees reported care that was below the national average on one measure (Annual Flu Vaccine) and similar to the national average on six measures. Hispanic MA enrollees also reported care that was below the national average on one measure (Getting Appointments and Care Quickly) and similar to the national average on six measures. Multiracial MA enrollees reported care that was below the national average on two measures (Getting Needed Care and Annual Flu Vaccine) and similar to the national average on five measures. White MA enrollees reported care that was similar to the national average on all measures.

Racial and ethnic differences were evident more often for the 37 clinical care measures presented in this report than for the seven patient experience measures (see Figure 2). Scores for AI/AN MA enrollees were below the national average on 14 clinical care measures, similar to the national average on eight measures, and above the national average on two measures.[4] Scores for AA and NHPI MA enrollees were below the national average on four clinical care measures, similar to the national average on 18 measures, and above the national average on 15 measures. Scores for Black MA enrollees were below the national average on 15 clinical care measures, similar to the national average on 19 measures, and above the national average on three measures. Scores for Hispanic MA enrollees were below the national average on nine clinical care measures, similar to the national average on 20 measures, and above the national average on eight measures. Scores for White MA enrollees were similar to the national average on 34 measures and above the national average on three measures.[5]

Disparities in Health Care in MA by Sex

Scores for female and male MA enrollees were similar to the national average for all measures of patient experience (see Figure 3). Scores for female enrollees were similar to the national average for all clinical care measures.[6] Scores for male enrollees were below the national average on one clinical care measure (Follow-Up After Hospital Stay for Mental Illness), similar to the national average on 29 measures, and above the national average on three measures (see Figure 4).[7]

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[3] Interpretation of these results is complicated because of a known tendency of Asian American respondents to use response scales for CAHPS items differently from the way in which other racial and ethnic groups use them. When asked to evaluate the care described in standardized clinical vignettes, Asian American respondents are less likely to use response options at either the bottom or top of the scale compared with White respondents (Mayer et al., 2016). Mean CAHPS scores are generally high, so this difference in scale use generally manifests as lower mean responses among Asian American survey respondents compared with White respondents. No comparison of CAHPS response scale use between Native Hawaiian or other Pacific Islander and Asian American respondents has been published. However, because Native Hawaiians and Pacific Islanders constitute a small proportion of the AA and NHPI group, CAHPS scores for this group are largely determined by responses from Asian Americans.

[4] For AI/AN MA enrollees, only a subset of the clinical care measures met reportability criteria, as described on page 4.

[5] 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.

[6] Two clinical care measures, Breast Cancer Screening and Osteoporosis Management in Women Who Had a Fracture, pertain to only female MA enrollees and so were not eligible for stratified reporting by sex. Two other measures, Statin Use for Cardiovascular Disease and Medication Adherence for Cardiovascular Disease—Statins, are defined differently for female and male people and thus also were not eligible for stratified reporting by sex.

[7] When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—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 contains two-thirds of MA enrollees

Disparities in Health Care in MA by Race and Ethnicity Within Sex

Patterns of racial and ethnic differences (compared with the national average) in patient experience were largely similar for female and male MA enrollees (see Figure 5). The one exception was that female Multiracial MA enrollees reported care that was below the national average for all female MA enrollees on three measures, whereas male Multiracial MA enrollees reported care that was below the national average for all male MA enrollees on just one measure.

Patterns of racial and ethnic differences (compared with the national average) in clinical care were also largely similar for female and male MA enrollees (see Figure 6). There was an exception to this pattern for AA and NHPI MA enrollees: Whereas scores for female AA and NHPI MA enrollees were above the national average for all female MA enrollees on 31 percent of the clinical care measures, scores for male AA and NHPI MA enrollees were above the national average for all male MA enrollees on 43 percent of the clinical care measures.

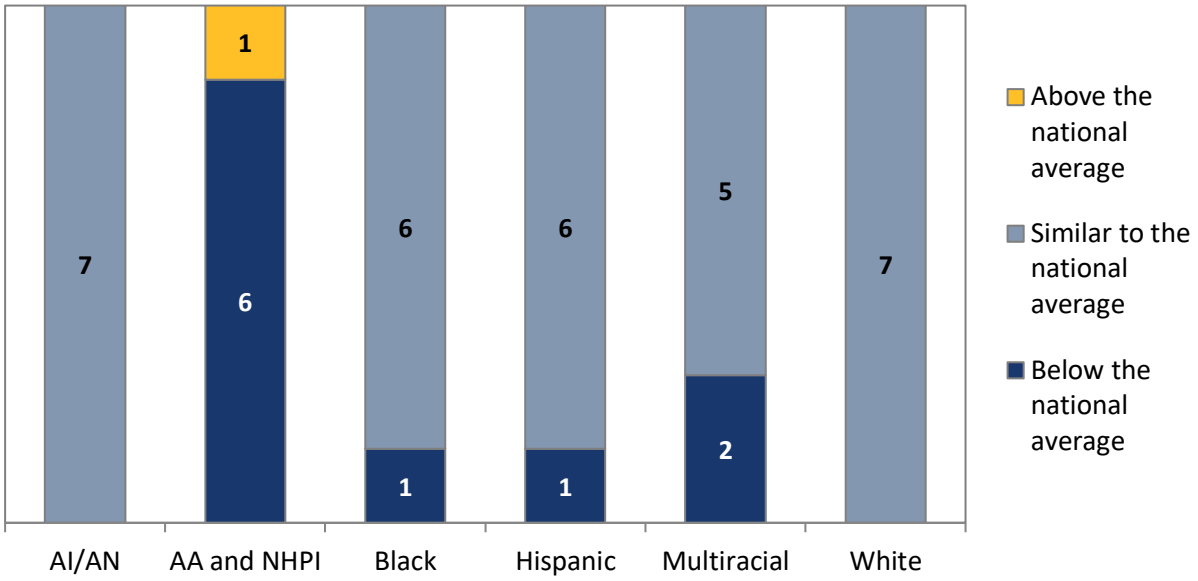
Conclusion

This report focuses on national racial, ethnic, and sex differences in patient experience and clinical quality of care in MA. This information might be of interest to MA organizations and Medicare Part D sponsors as they consider strategies to improve the quality of care received by underserved groups. Rates of flu vaccination for Black and Multiracial MA enrollees were below the national average. In addition, a substantial proportion of clinical care scores were below the national average for AI/AN, Black, and Hispanic MA enrollees. Across racial and ethnic groups, there were few differences in scores by sex on either the patient experience or the clinical care measures. This analysis did find that female Multiracial MA enrollees fared worse than male Multiracial MA enrollees on measures of patient experience, and male AA and NHPI MA enrollees fared better than female AA and NHPI MA enrollees on measures of clinical care. Efforts are particularly needed to increase flu vaccination rates for Black and Multiracial MA enrollees and improve clinical care for AI/AN, Black, and Hispanic MA enrollees.

and Group B contains one-third of MA enrollees, then the overall average will be half as far from Group A's score than from Group B's score.

Figure 1. Disparities in Care by Race and Ethnicity: All Patient Experience Measures

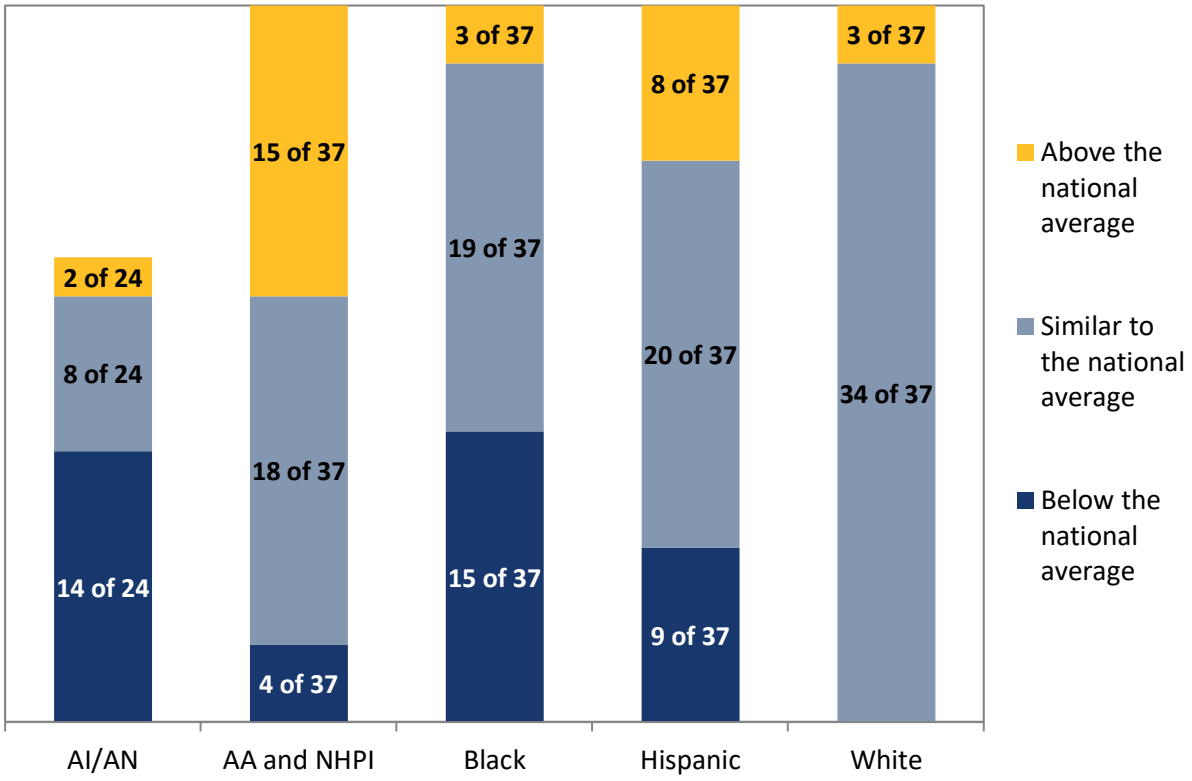
Number of patient experience measures (out of 7) for which members of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average in 2022



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other 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 2. Disparities in Care by Race and Ethnicity: All Clinical Care Measures

Number of clinical care measures for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in Reporting Year 2022

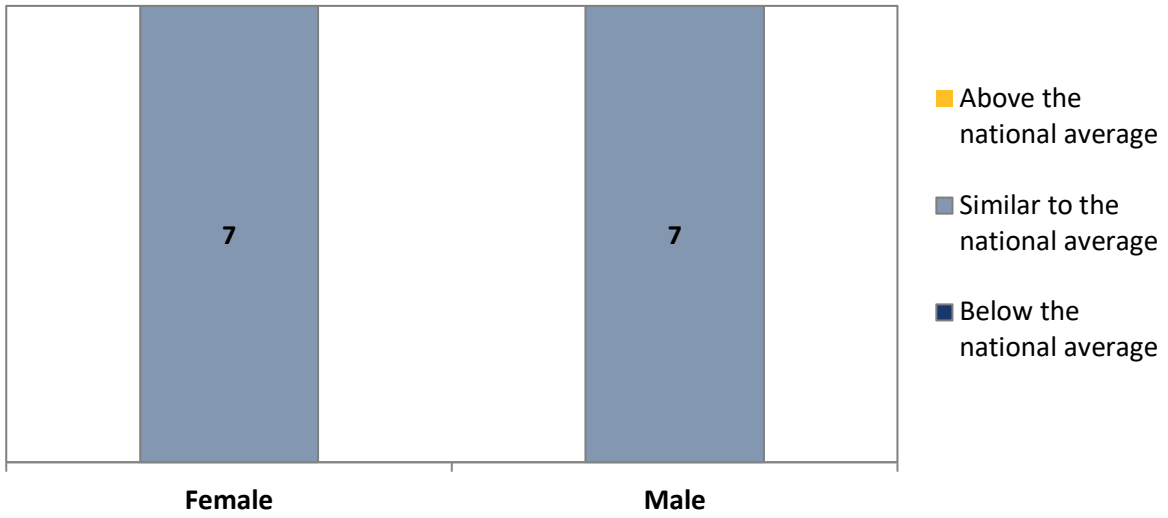


SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2021 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (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 for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet the standards described on page 4. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Figure 3. Disparities in Care by Sex: All Patient Experience Measures

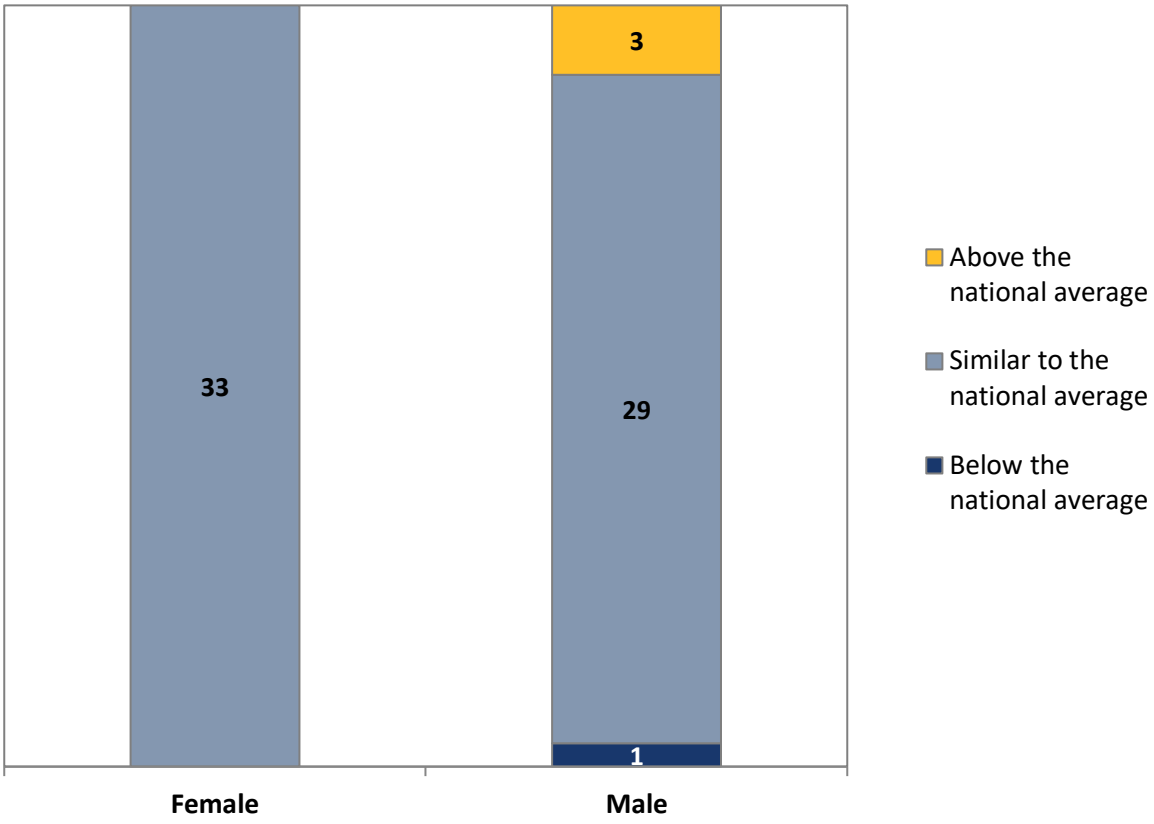
Number of patient experience measures (out of 7) for which female and male MA enrollees reported experiences that were above, similar to, or below the national average in 2022



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.

Figure 4. Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures (out of 33) for which female and male MA enrollees had results that were above, similar to, or below the national average in Reporting Year 2022

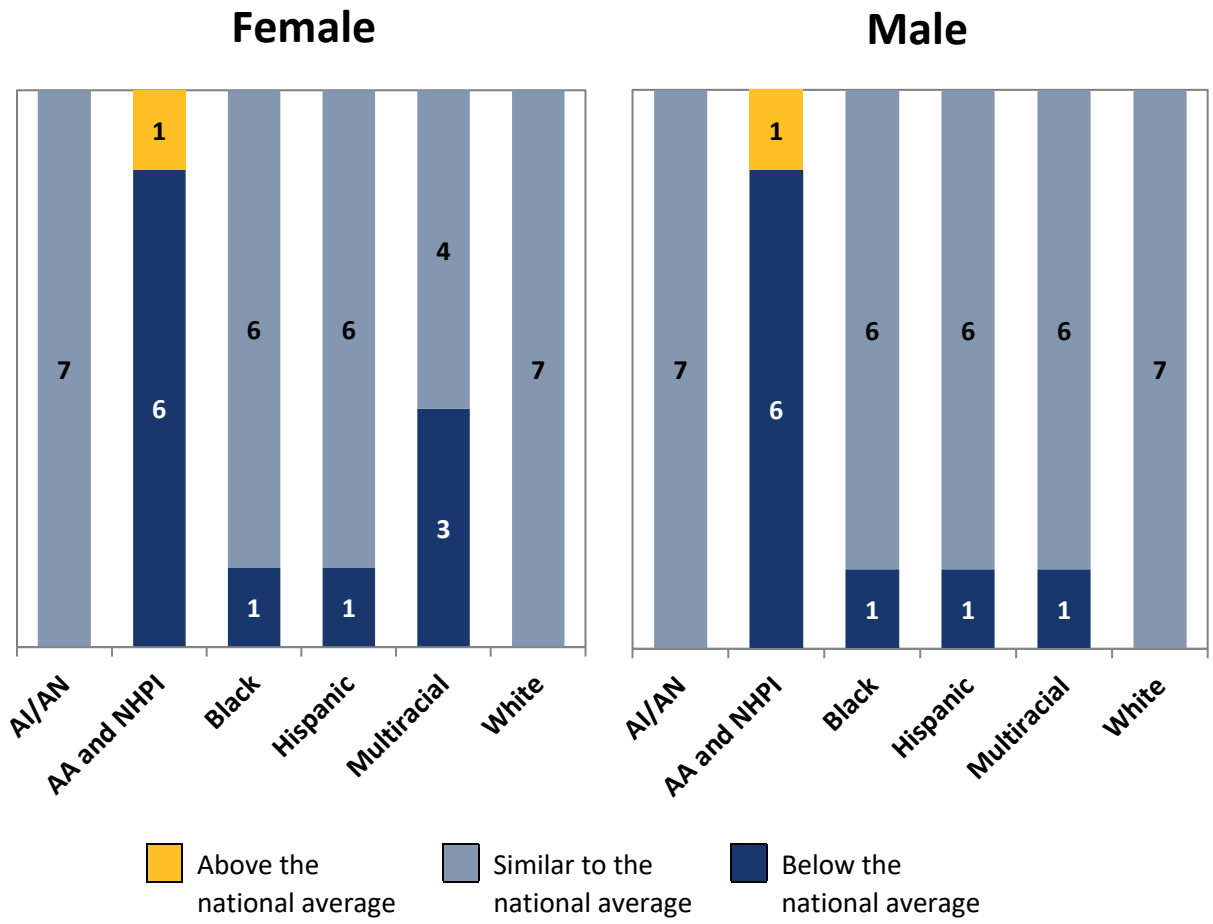


SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2021 from MA plans nationwide.

NOTES: When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—will always be closer to the overall (national) average than scores for the smaller group.

Figure 5. Racial and Ethnic Disparities in Care by Sex: All Patient Experience Measures

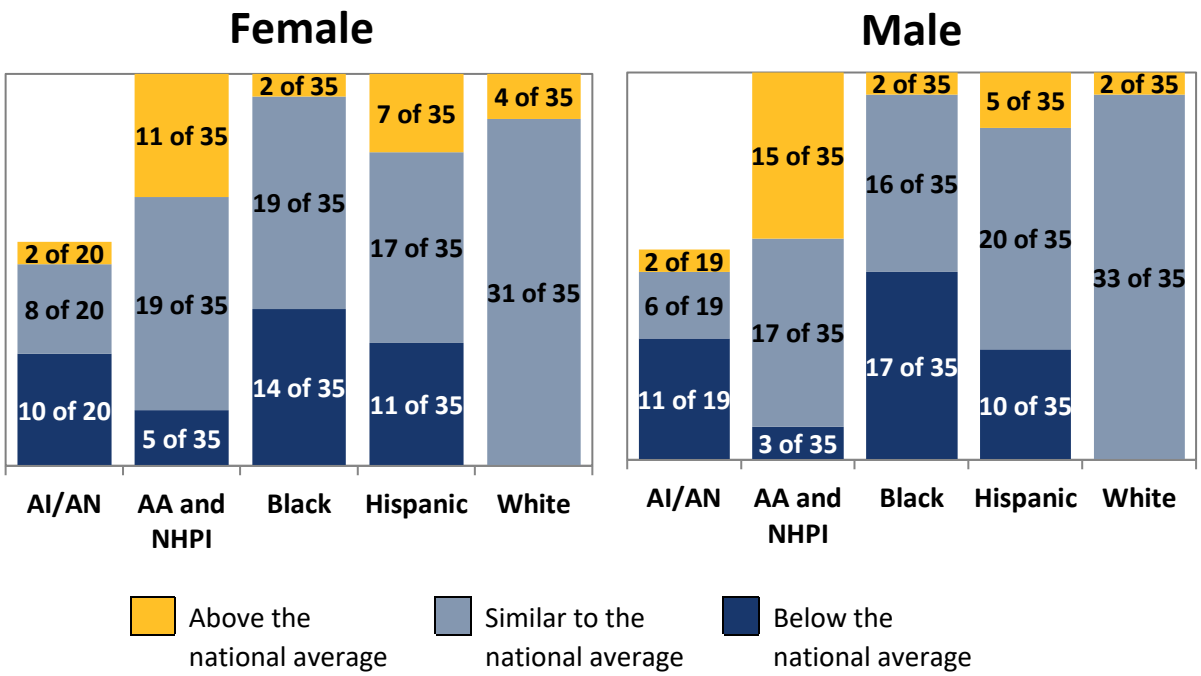
Number of patient experience measures (out of 7) for which female or male MA enrollees of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all female or male MA enrollees in 2022



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other 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 6. Racial and Ethnic Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures for which female or male MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all female or male MA enrollees in Reporting Year 2022



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (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 for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet the standards described on page 4. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Patient Experience and Clinical Care Measures Included in This Report[8]

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[9]

Clinical Care (HEDIS) Measures

Prevention and Screening

- Breast Cancer Screening[10]
- Colorectal Cancer Screening

Respiratory Conditions

- Testing to Confirm Chronic Obstructive Pulmonary Disease (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[11]
- Medication Adherence for Cardiovascular Disease—Statins[12]

Diabetes

- Diabetes Care—Blood Sugar Testing
- Diabetes Care—Eye Exam
- Diabetes Care—Kidney Disease Monitoring
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins

[8] This report considers a larger set of HEDIS measures than the one used in the CMS Part C and D Star Ratings program.

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

[10] This measure is specific to female patients and is therefore not included in the set of comparisons by sex.

[11] This measure is defined differently for male and female patients and therefore is not included in the set of comparisons by sex. It is, however, included in the set of comparisons by race and ethnicity within sex.

[12] This measure is defined differently for male and female patients and therefore is not included in the set of comparisons by sex. It is, however, included in the set of comparisons by race and ethnicity within sex.

Musculoskeletal Conditions

- Osteoporosis Management in Women Who Had a Fracture[13]

Behavioral Health

- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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 Alcohol and Other Drug (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—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Overuse and Appropriate Use of Medication

- Avoiding Potentially Harmful Drug-Disease Interactions in Older 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

Access to and Availability of Care

- Older Adults' Access to Preventive and Ambulatory Services

[13] This measure is specific to female patients and is therefore not included in the set of comparisons by sex.

Abbreviations Used in This Report

AA and NHPI	Asian American and Native Hawaiian or other 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
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
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

Overview and Methods

Overview

This report presents summary information on the quality of health care reported in 2022 by Medicare Advantage (MA) enrollees nationwide. Two types of quality-of-care data are presented: (1) measures of patient experience, which describe how well the care that patients receive meets their needs for such things as timely appointments, respectful care, clear communication, and access to information; and (2) measures of clinical care, which describe the extent to which patients receive appropriate screening and treatment for specific health conditions. In 2022, 48 percent of all people with Medicare were enrolled in MA (Freed et al., 2022). Enrollment in MA has increased rapidly in recent years, particularly among Black and Hispanic people with Medicare (Meyers et al., 2021). Therefore, disparities in care in MA have taken on heightened significance.

Previous versions of this report, which are available on the Stratified Reporting page at CMS.gov (Centers for Medicare & Medicaid Services [CMS], 2022), presented information on the quality of care received by MA enrollees nationwide based on data reported in 2016, 2017, 2018, 2019, and 2021. Because of the coronavirus disease 2019 (COVID-19) pandemic, patient experience and clinical care data were not reported by MA plans in 2020.

The Institute of Medicine (now the National Academy of Medicine) has identified the equitable delivery of care as a hallmark of quality (Institute of Medicine, 2001). Assessing equitability in the delivery of care requires making comparisons of quality by personal characteristics of patients, such as race, ethnicity, and sex. Three sets of such comparisons are presented in this report. In the first set, quality of care for six racial and ethnic groups—American Indian and Alaska Native (AI/AN), Asian American and Native Hawaiian or other Pacific Islander (AA and NHPI), Black, Hispanic, Multiracial, and White MA enrollees—is compared with quality of care for all MA enrollees combined (i.e., the national average). In the second set of comparisons, quality of care for female and male MA enrollees is compared with quality of care for all MA enrollees combined. In the third set, quality of care for racial and ethnic groups is compared with quality of care for all MA enrollees of the same sex. As in the 2018–2022 reports, the three sets of comparisons just described—which might be of interest to people with Medicare, MA organizations, Medicare Part D sponsors, and federal policymakers—are being presented in a single report to provide a comprehensive understanding of the ways in which care differs by race/ethnicity, sex, and the intersection of these characteristics. The focus of this report is on differences at the national level. Interested readers can find information about health care quality for specific Medicare plans (more specifically, contracts) 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, 2022).

Data Sources

In all, this report provides data regarding seven patient experience measures and 37 clinical care measures. The set of patient experience measures presented in this report is the same as the set reported on in the 2018–2022 reports (reporting 2016, 2017, 2018, 2019, and 2021 data). One clinical care measure that was included in the 2022 report, Rheumatoid Arthritis Management, was excluded from this report because it was retired from the Healthcare Effectiveness Data and Information Set (HEDIS) effective Measurement Year 2021. Two clinical care measures that had been included in earlier reports but were excluded from the 2022 report because they were undergoing specification changes are reintroduced in this report: Avoiding Use of High-Risk Medications in Older Adults and Avoiding Use of Opioids at High Dosage.

Patient experience data were collected from a national survey of people with Medicare, known as the MA and Prescription Drug Plan (PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey is administered each year; the data in this report are from the 2022 Medicare CAHPS survey (more information on this survey can be found on the MA and PDP CAHPS page at CMS.gov [CMS, 2021]). The 2022 Medicare CAHPS survey was fielded from March to May 2022. In the survey, respondents were asked about care they received in the six months prior to the survey. Examples of patient experience measures include how easy it is to get needed care, how well doctors communicate, and how easy it is to get needed prescription drugs. The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report.

Clinical care data were gathered through medical records and insurance claims or encounter data for hospitalizations, medical office visits, and procedures. These data, which are collected each year from MA plans nationwide, are part of HEDIS; detailed information about these data can be found on the National Committee for Quality Assurance's HEDIS webpage (National Committee for Quality Assurance, undated). In this report, clinical care measures are grouped into nine categories: prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse and appropriate use of medication, and access to and availability of care. Two of the clinical care measures presented in this report, one of which pertains to breast cancer screening and the other to management of osteoporosis, are specific to female patients. Thus, the set of comparisons by sex and the set of comparisons by race and ethnicity within sex exclude these two measures. Two other clinical care measures, both dealing with statin therapy for patients with cardiovascular disease, are defined differently for female and male patients and thus are excluded from the set of comparisons by sex. The 2022 HEDIS data reported here pertain to care received from January to December 2021. Whereas all patient experience measures are applicable to people with Medicare aged 18 years and older, certain HEDIS measures apply to people in a more limited age range, as noted throughout the report.

Table 1 shows the distribution of race, ethnicity, and sex in the 2022 MA population compared with the Medicare fee-for-service (FFS) population. Outside the parentheses are column percentages. Inside the parentheses are row percentages. 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, and female people with Medicare were more likely to be enrolled in MA than were male people with Medicare.

Table 1. Distribution of the 2022 MA and FFS Populations

Characteristic	MA, Percentage	Medicare FFS, Percentage
Race or ethnicity		
AI/AN	0.3 (28.8)	0.7 (71.2)
AA and NHPI	4.7 (47.5)	4.1 (52.5)
Black	11.4 (52.6)	8.1 (47.4)
Hispanic	12.5 (60.4)	6.4 (39.6)
White	69.4 (40.7)	79.3 (59.3)
Multiracial	1.7 (46.9)	1.5 (53.1)
Sex		
Female	56.2 (46.0)	52.2 (54.0)
Male	43.8 (42.0)	47.8 (58.0)

NOTE: Row and column percentages may not sum to 100 percent because of rounding.

Scores on patient experience measures are reported for each of six racial and ethnic groups whenever the reporting criteria specified below are met. Those six groups are AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White. Scores on clinical care measures are reported for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees whenever the reporting criteria specified below are met. This is the first time in this series of reports that clinical care data are being reported for AI/AN people. The algorithm used to predict racial and ethnic group membership for the clinical care data is not accurate enough to permit reporting of scores for the Multiracial group.[14]

Reportability of Information

Scores based on 400 or more observations were 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. 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. Here, 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.

Disparities in Health Care in MA by Race and Ethnicity

Section I of this report begins with a stacked bar chart showing the number of patient experience measures for which members of each racial and ethnic group reported experiences of care that were above, similar to, or below the national average. In this stacked bar chart, 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). Following the stacked bar chart are separate, unstacked bar charts for each patient experience measure. These charts show the average scores (and associated 95-percent confidence intervals) for each racial and ethnic group on a 0–100 scale and indicate how each group's average score compares with the national average for all MA enrollees. Scores on patient experience measures 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, all differences from the national average that are statistically significant (regardless of magnitude) are indicated through the use of

[14] Details on this algorithm can be found in the appendix. Race and ethnicity are self-reported on the CAHPS survey, so the issue of reliability of racial and ethnic data does not apply to the patient experience measures reported here.
[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.

symbols.[16] In the bullet-point summaries that appear below these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically significant differences that are 3 points in magnitude or larger. After the patient experience measures, Section I presents a stacked bar chart showing the number of clinical care measures on which members of each racial and ethnic group 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 MA enrollees in each racial and ethnic group whose care met the standard called for by the specific measure (e.g., a test or treatment). In these unstacked bar charts, all differences from the national average that are statistically significant (regardless of magnitude) are indicated through the use of symbols; statistically significant differences that are less than 3 points in magnitude are distinguished—via bullet-point commentary—from statistically significant differences that are 3 points in magnitude or larger.

Disparities in Health Care in MA by Sex

Section II of this report begins with a stacked bar chart showing the number of patient experience measures for which female and male MA enrollees reported experiences of care that were above, similar to, or below the national average for all MA enrollees. Following this stacked bar chart are separate, unstacked bar charts for each patient experience measure. After the patient experience measures, Section II presents a stacked bar chart showing the number of clinical care measures for which female and male MA enrollees scored above, similar to, or below the national average for all MA enrollees. Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure.

Disparities in Health Care in MA by Race and Ethnicity Within Sex

Section III of the report begins with a pair of stacked bar charts that show, separately for female and male MA enrollees, the number of patient experience measures for which members of each racial and ethnic group reported experiences of care that were above, similar to, or below the national average for all MA enrollees of their sex. Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for female and male MA enrollees, the average score for each racial and ethnic group on a 0–100 scale. After the patient experience measures, Section III presents a pair of stacked bar charts that show, separately for female and male MA enrollees, the number of clinical care measures for which members of each racial and ethnic group scored above, similar to, or below the national average for all MA enrollees of their sex. Following these stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for female and male MA enrollees, the percentage of enrollees in each racial and ethnic group whose care met the standard called for by the specific measure.

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

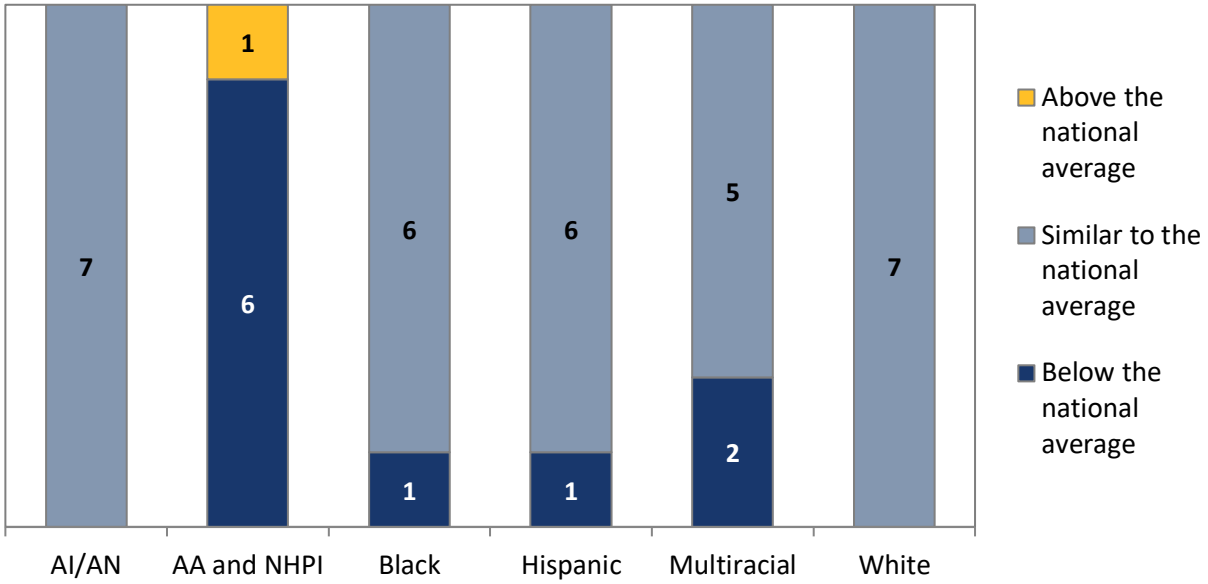
[16] In some cases, confidence intervals for group averages are very narrow and thus difficult to see on these charts. In those instances, these symbols denoting statistically significant differences can be relied on to tell whether the confidence interval crosses the national average line.

SECTION I

Disparities in Health Care in Medicare Advantage by Race and Ethnicity

Disparities in Care by Race and Ethnicity: All Patient Experience Measures

Number of patient experience measures (out of 7) for which members of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average in 2022



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

- **Above the national average** = The group reported experiences 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 reported experiences 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 reported experiences 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).

AA and NHPI MA enrollees had results that were below the national average

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Doctors Who Communicate Well
- Care Coordination
- Getting Needed Prescription Drugs

AA and NHPI MA enrollees had results that were above the national average

- Annual Flu Vaccine

Black MA enrollees had results that were below the national average

- Annual Flu Vaccine

Hispanic MA enrollees had results that were below the national average

- Getting Appointments and Care Quickly

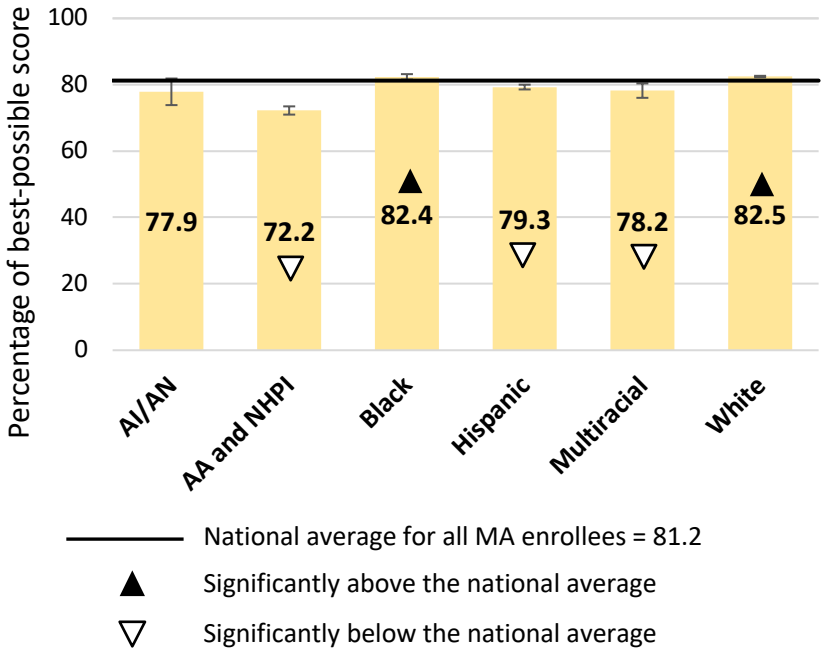
Multiracial MA enrollees had results that were below the national average

- Getting Needed Care
- Annual Flu Vaccine

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Disparities

- AI/AN MA enrollees reported experiences getting needed care that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences getting needed care that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences getting needed care that were **above**[‡] the national average by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences getting needed care that were **below** the national average by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences getting needed care that were **below** the national average by more than 3 points on a 0–100 scale.[§]
- White MA enrollees reported experiences getting needed care that were **above** the national average by less than 3 points on a 0–100 scale.

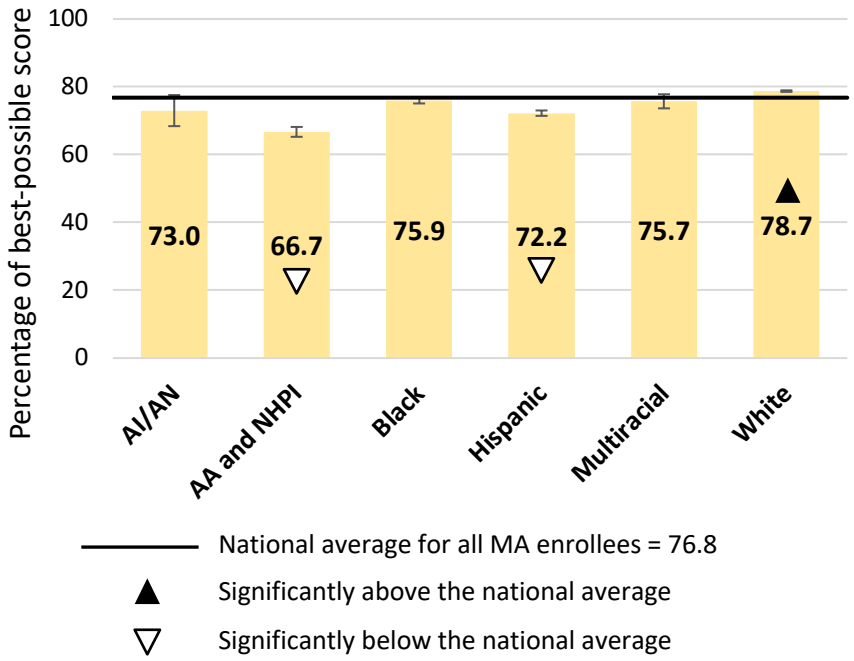
[†] This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

[‡] Unlike on the preceding 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.

[§] Prior to rounding.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

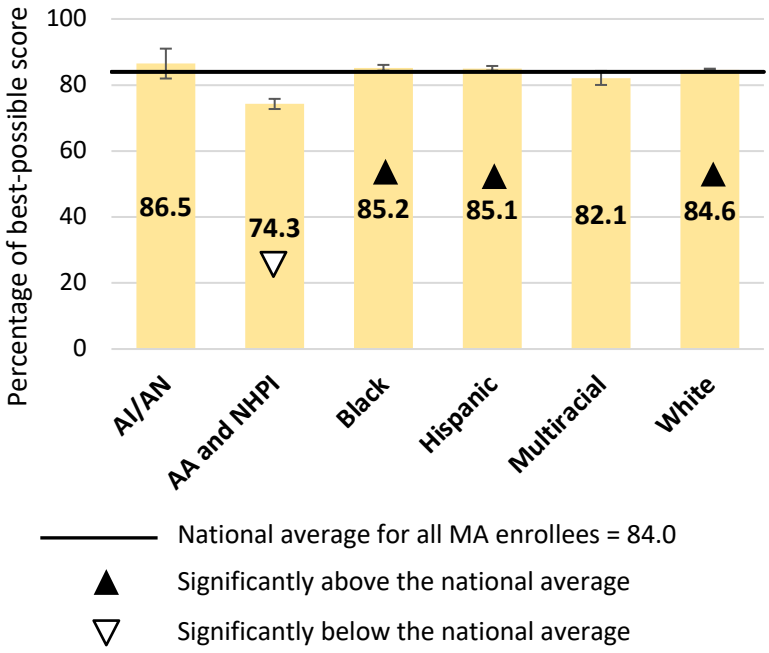
Disparities

- AI/AN MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences with getting appointments and care quickly that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average.
- Hispanic MA enrollees reported experiences with getting appointments and care quickly that were **below** the national average by more than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average.
- White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average 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 race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

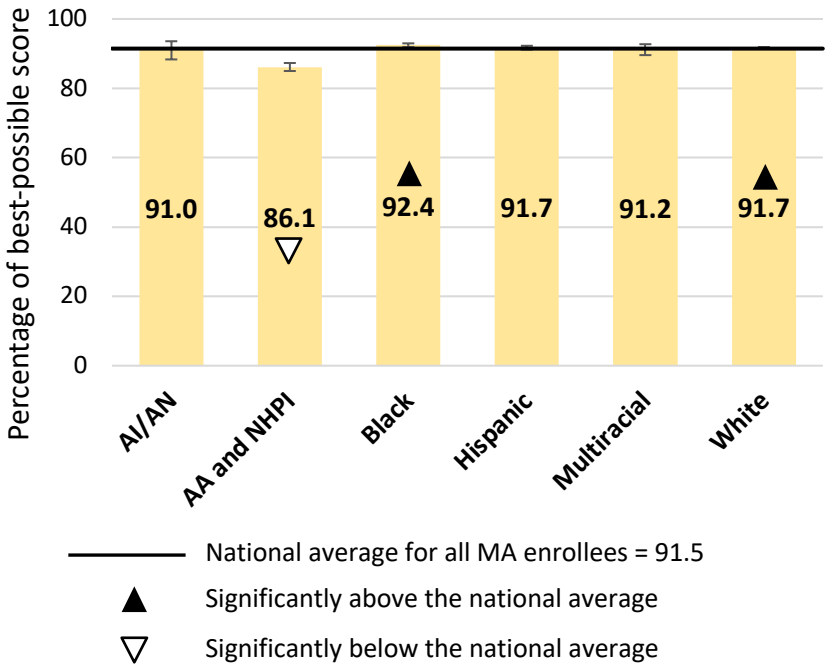
Disparities

- AI/AN MA enrollees reported experiences with customer service that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with customer service that were **above** the national average by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences with customer service that were **above** the national average by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with customer service that were **similar to** the national average.
- White MA enrollees reported experiences with customer service that were **above** the national average by less than 3 points on a 0–100 scale.

† 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 race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

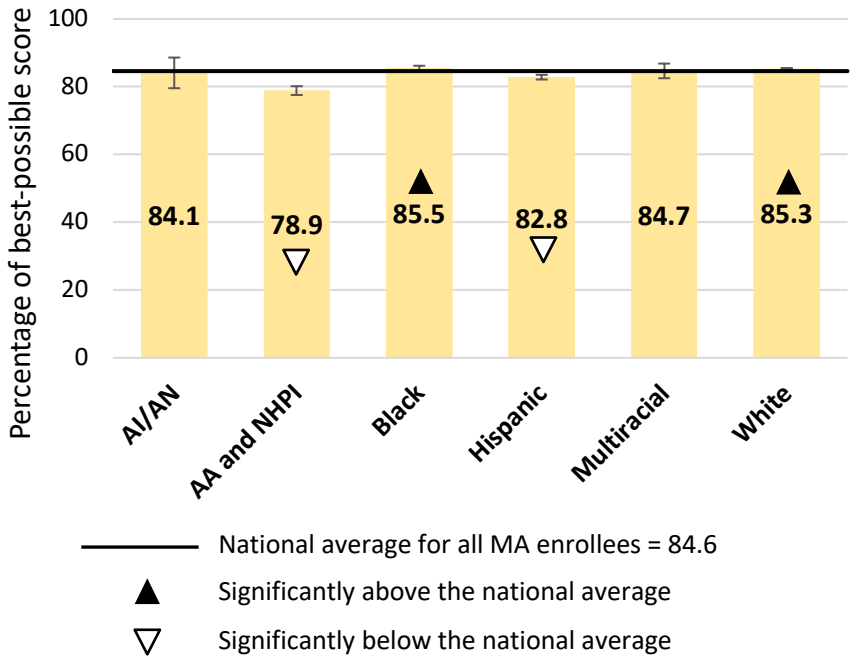
Disparities

- AI/AN MA enrollees reported experiences with doctor communication that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences with doctor communication that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with doctor communication that were **above** the national average by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences with doctor communication that were **similar to** the national average.
- Multiracial MA enrollees reported experiences with doctor communication that were **similar to** the national average.
- White MA enrollees reported experiences with doctor communication that were **above** the national average 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 race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

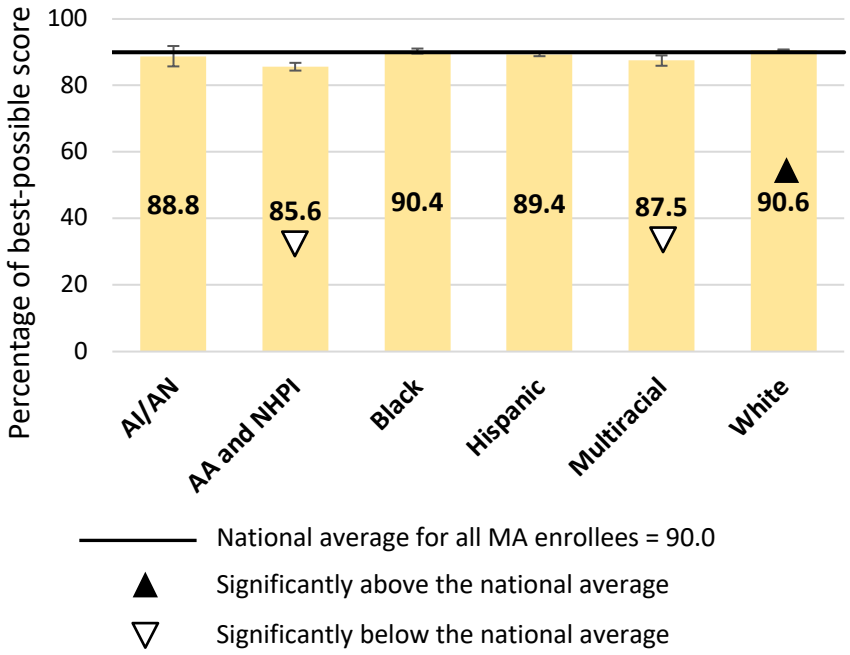
Disparities

- AI/AN MA enrollees reported experiences with care coordination that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences with care coordination that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with care coordination that were **above** the national average by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences with care coordination that were **below** the national average by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with care coordination that were **similar to** the national average.
- White MA enrollees reported experiences with care coordination that were **above** the national average 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 race and ethnicity, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

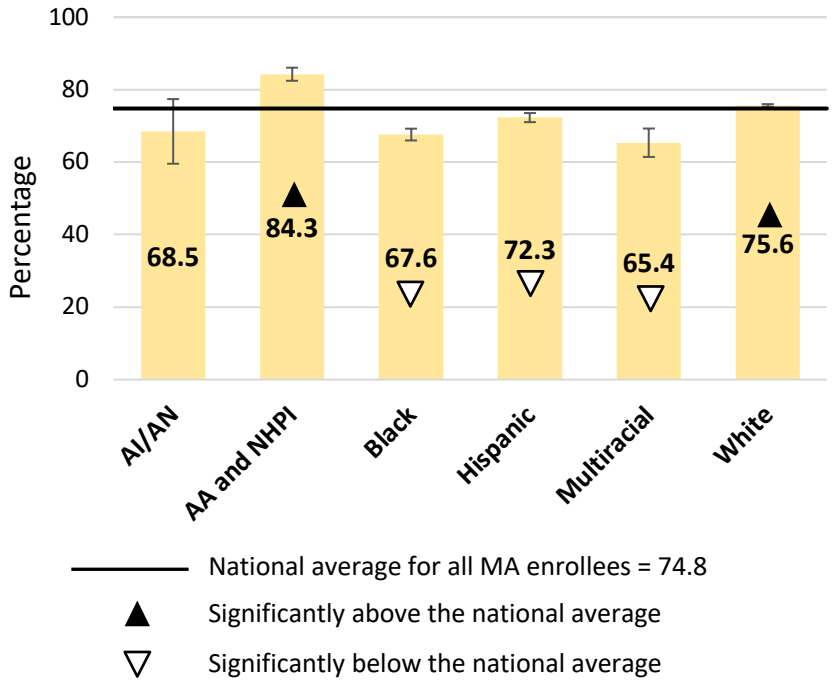
Disparities

- AI/AN MA enrollees reported experiences with getting needed prescription drugs that were **similar to** the national average.
- AA and NHPI MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with getting needed prescription drugs that were **similar to** the national average.
- Hispanic MA enrollees reported experiences with getting needed prescription drugs that were **similar to** the national average.
- Multiracial MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average by less than 3 points on a 0–100 scale.
- White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average by less than 3 points on a 0–100 scale.

[†] 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 race and ethnicity, 2022



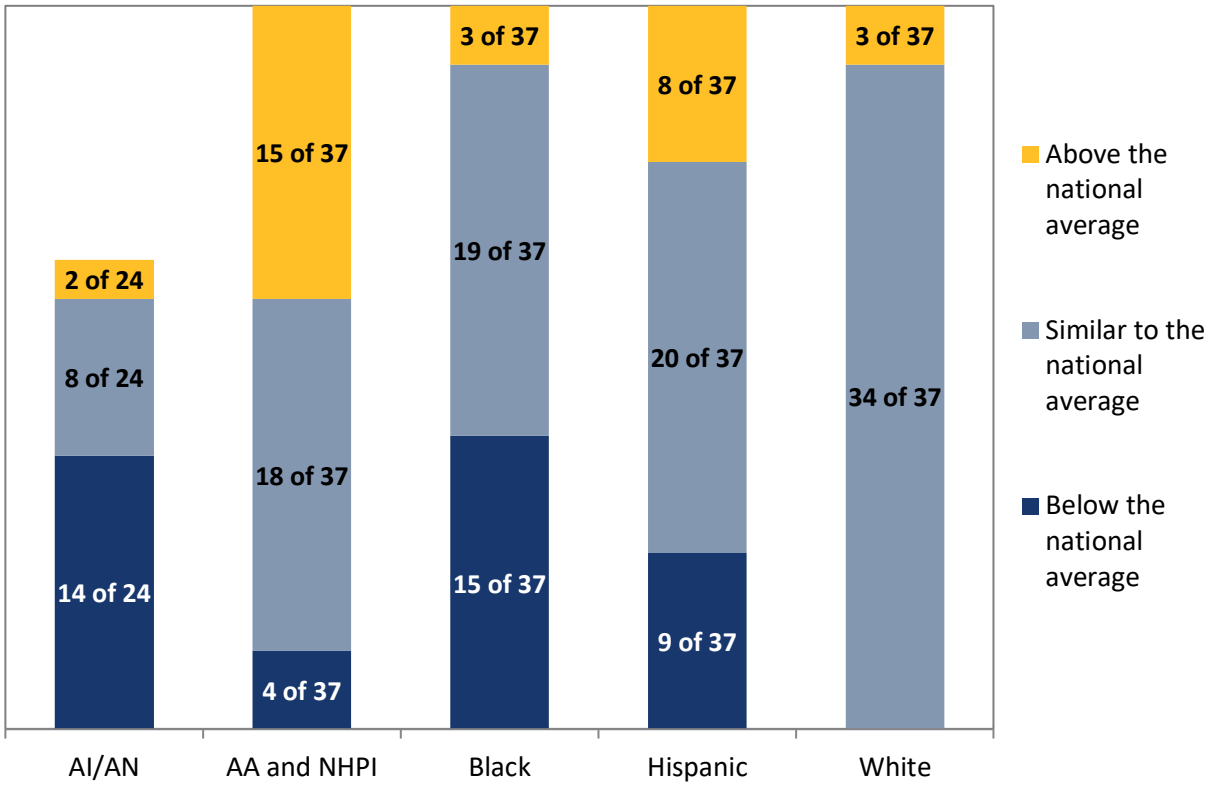
SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Disparities

- The percentage of AI/AN MA enrollees who received the flu vaccine was **similar to** the national average.
- The percentage of AA and NHPI MA enrollees who received the flu vaccine was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees who received the flu vaccine was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who received the flu vaccine was **below** the national average by less than 3 percentage points.
- The percentage of Multiracial MA enrollees who received the flu vaccine was **below** the national average by more than 3 percentage points.
- The percentage of White MA enrollees who received the flu vaccine was **above** the national average by less than 3 percentage points.

Disparities in Care by Race and Ethnicity: All Clinical Care Measures

Number of clinical care measures for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in Reporting Year 2022



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

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (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 for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet standards described on page 4. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

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

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

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

AI/AN MA enrollees had results that were below the national average

- Breast Cancer Screening
- Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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
- Older Adults' Access to Preventive and Ambulatory Services

AI/AN MA enrollees had results that were above the national average

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

AA and NHPI MA enrollees had results that were below the national average

- Testing to Confirm COPD
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Initiation of AOD Dependence Treatment

AA and NHPI MA enrollees had results that were above the national average

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Emergency Department (ED) Visit for Mental Illness (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- 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
- Avoiding Use of Opioids at High Dosage

Black MA enrollees had results that were below the national average

- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Patient Engagement After Inpatient Discharge

Black MA enrollees had results that were better than the national average

- Breast Cancer Screening
- Initiation of AOD Dependence Treatment
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Hispanic MA enrollees had results that were below the national average

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Continuous Beta-Blocker Treatment After a Heart Attack
- 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)
- Initiation of AOD Dependence Treatment
- 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

Hispanic MA enrollees had results that were above the national average

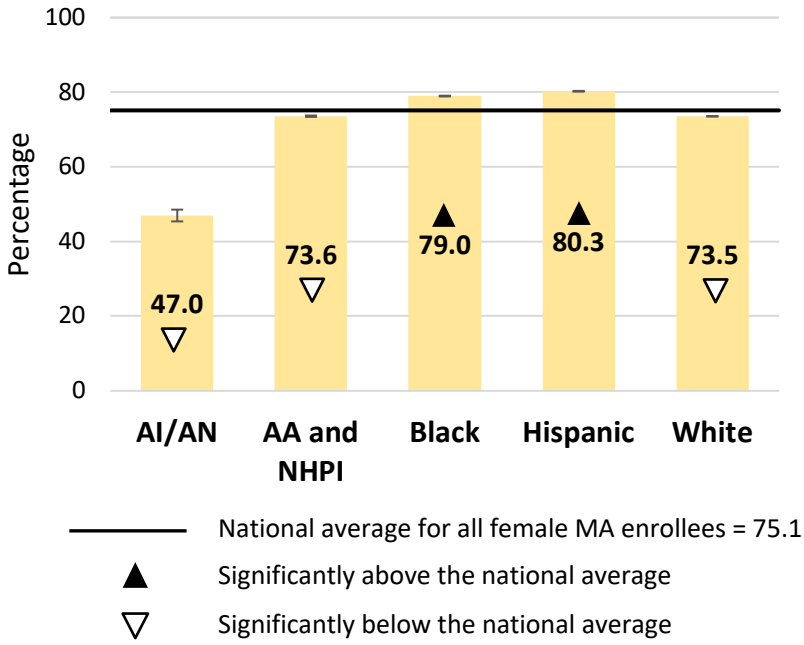
- Breast Cancer Screening
- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

White MA enrollees had results that were above the national average
• 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)

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

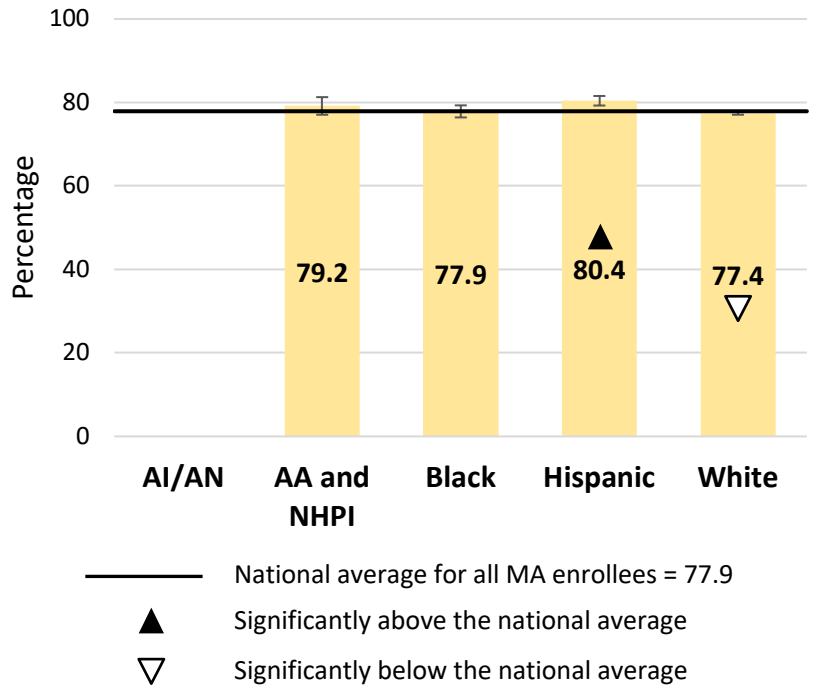
- The percentage of eligible[†] female AI/AN MA enrollees who were appropriately screened for breast cancer was **below**[‡] the national average for all female MA enrollees by more than 3 percentage points.
- The percentage of eligible female AA and NHPI MA enrollees who were appropriately screened for breast cancer was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of eligible female Black MA enrollees who were appropriately screened for breast cancer was **above** the national average for all female MA enrollees by more than 3 percentage points.
- The percentage of eligible female Hispanic MA enrollees who were appropriately screened for breast cancer was **above** the national average for all female MA enrollees by more than 3 percentage points.
- The percentage of eligible female White MA enrollees who were appropriately screened for breast cancer was **below** the national average for all 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 in the chart subtitle).

[‡] Unlike on the preceding four 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

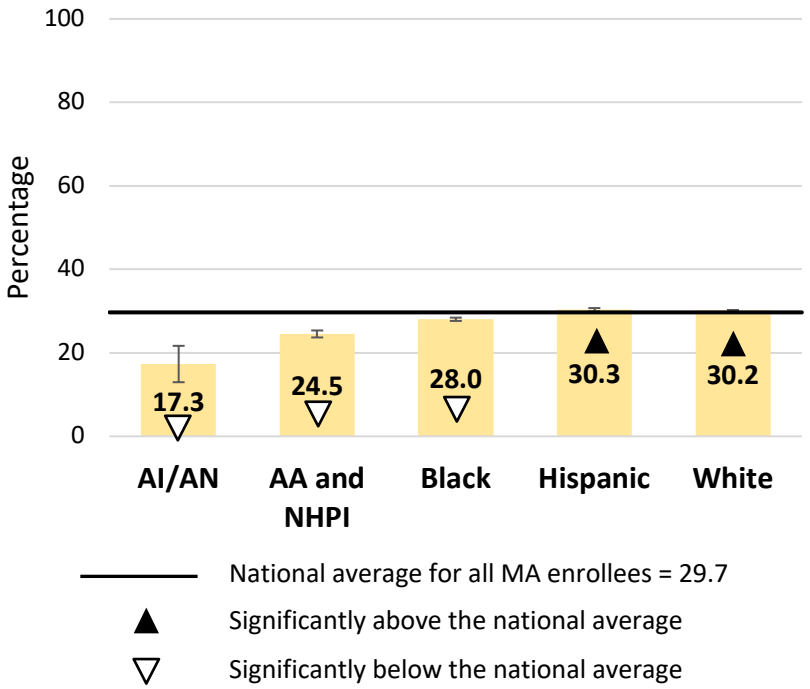
Disparities

- The percentage of eligible AA and NHPI MA enrollees who were appropriately screened for colorectal cancer was **similar to** the national average.
- The percentage of eligible Black MA enrollees who were appropriately screened for colorectal cancer was **similar to** the national average.
- The percentage of eligible Hispanic MA enrollees who were appropriately screened for colorectal cancer was **above** the national average by less than 3 percentage points.
- The percentage of eligible White MA enrollees who were appropriately screened for colorectal cancer screening was **below** the national average by less 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 race and ethnicity, Reporting Year 2022



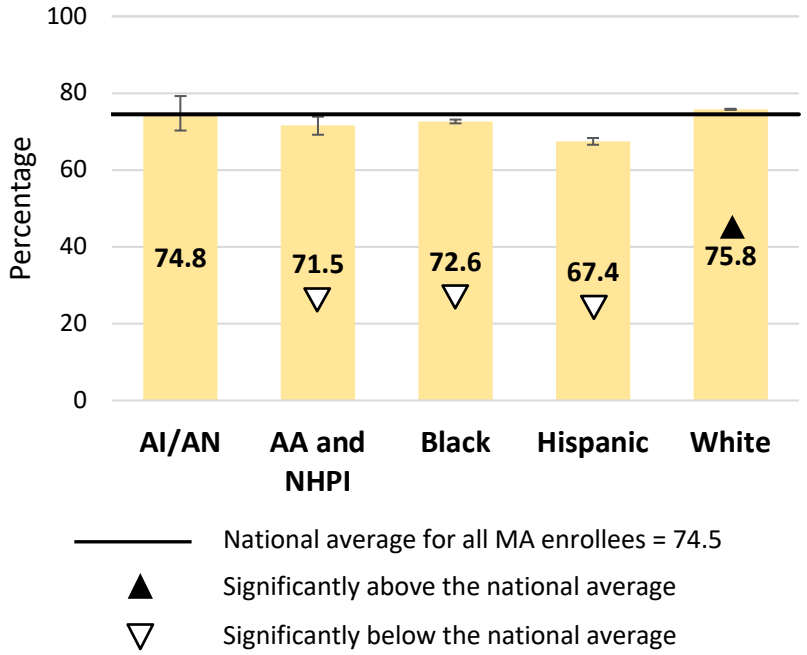
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible AI/AN MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average by less than 3 percentage points.
- The percentage of eligible White MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

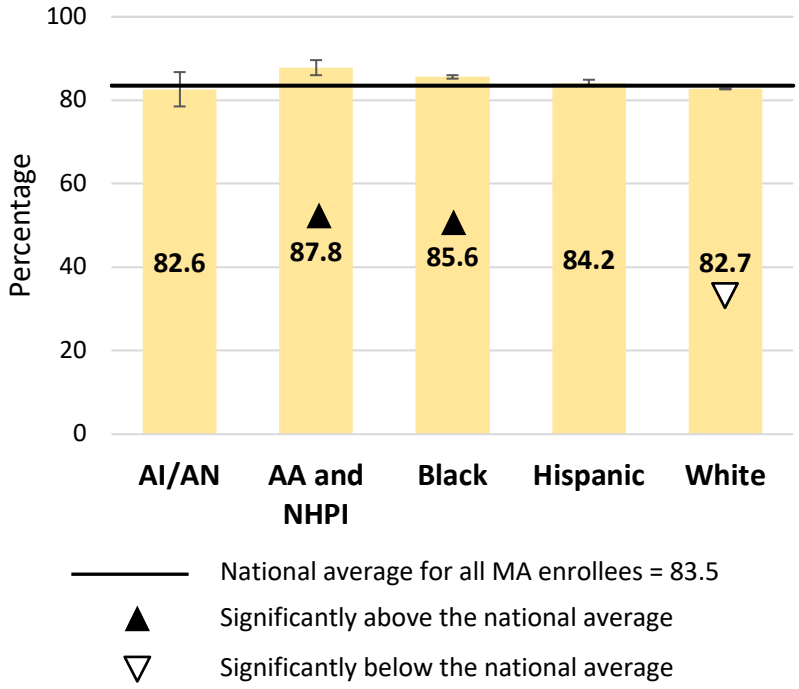
Disparities

- The percentage of eligible AI/AN MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average.
- The percentage of eligible AA and NHPI MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average by less than 3 percentage points.[†]
- The percentage of eligible Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average by less than 3 percentage points.

[†] Prior to rounding.

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

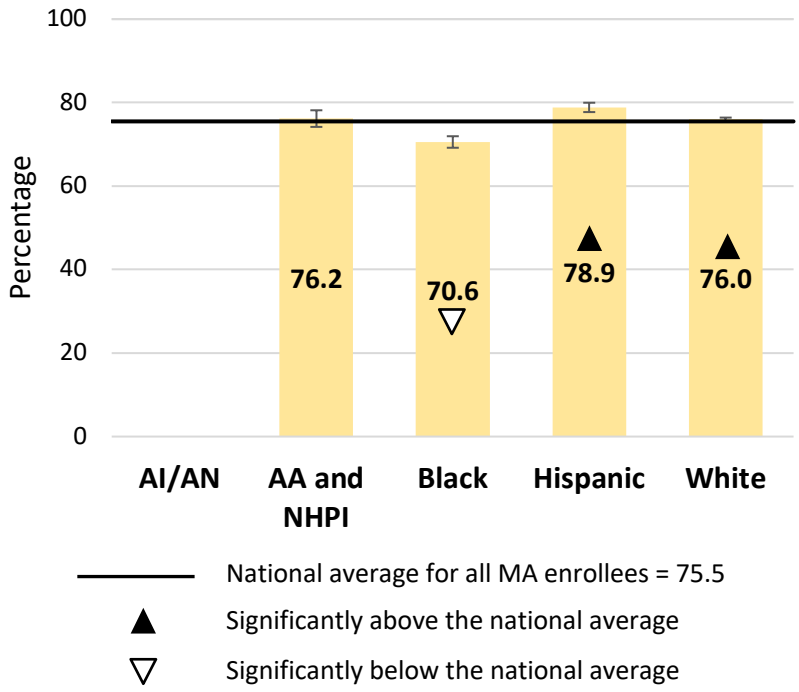
Disparities

- The percentage of eligible AI/AN MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average.
- The percentage of eligible AA and NHPI MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average.
- The percentage of eligible White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

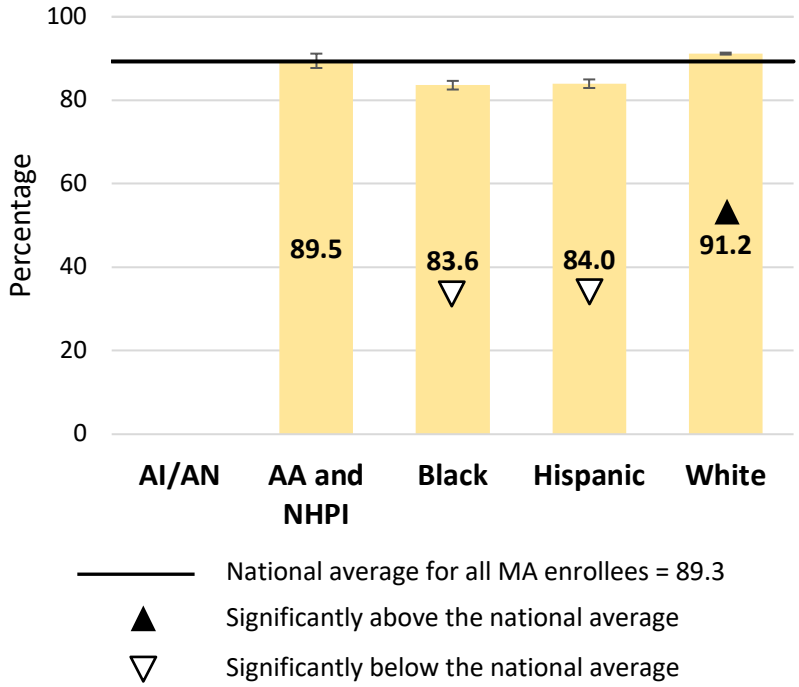
Disparities

- The percentage of eligible AA and NHPI MA enrollees who had their blood pressure adequately controlled was **similar to** the national average.
- The percentage of eligible Black MA enrollees who had their blood pressure adequately controlled was **below** the national average by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who had their blood pressure adequately controlled was **above** the national average by more than 3 percentage points.
- The percentage of eligible White MA enrollees who had their blood pressure adequately controlled was **above** the national average 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 race and ethnicity, Reporting Year 2022



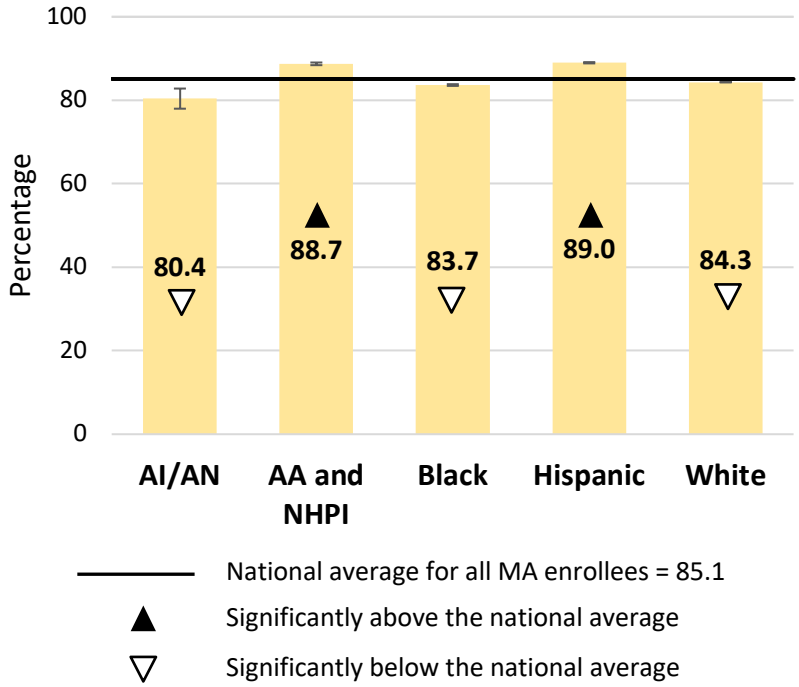
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of eligible AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average.
- The percentage of eligible Black MA enrollees who received continuous beta-blocker treatment was **below** the national average by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who received continuous beta-blocker treatment was **below** the national average by more than 3 percentage points.
- The percentage of eligible White MA enrollees who received continuous beta-blocker treatment was **above** the national average by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity, Reporting Year 2022



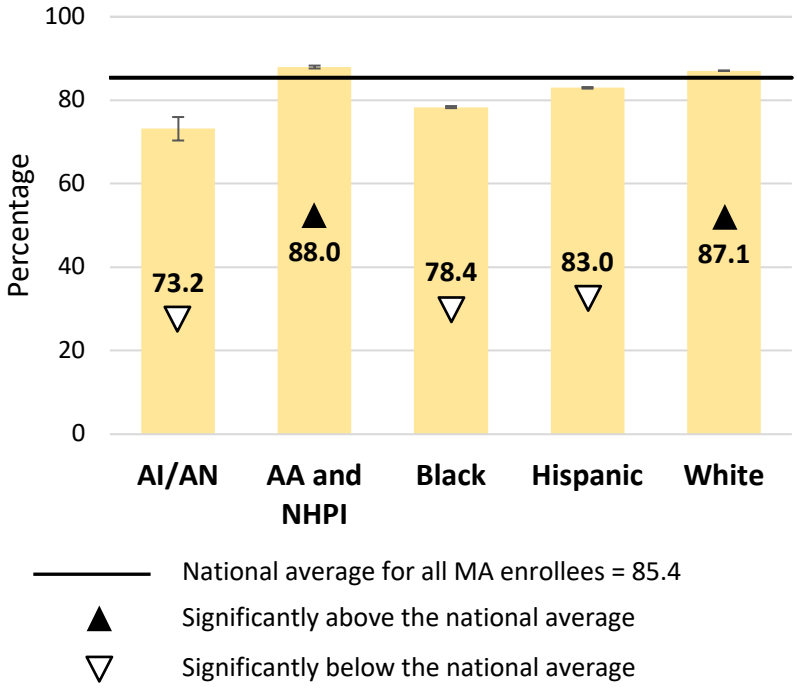
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with clinical ASCVD who received statin therapy was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with clinical ASCVD who received statin therapy was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with clinical ASCVD who received statin therapy was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with clinical ASCVD who received statin therapy was **above** the national average by more than 3 percentage points.
- The percentage of White MA enrollees with clinical ASCVD who received statin therapy was **below** the national average 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

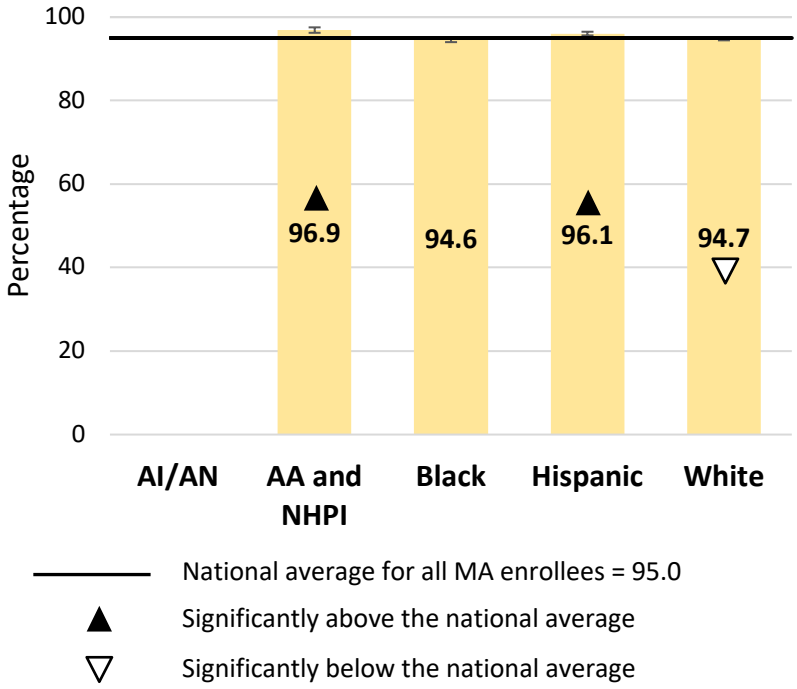
Disparities

- The percentage of AI/AN MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with clinical ASCVD who had proper statin medication adherence was **above** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average by less than 3 percentage points.
- The percentage of White MA enrollees with clinical ASCVD who had proper statin medication adherence was **above** the national average by less than 3 percentage points.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

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



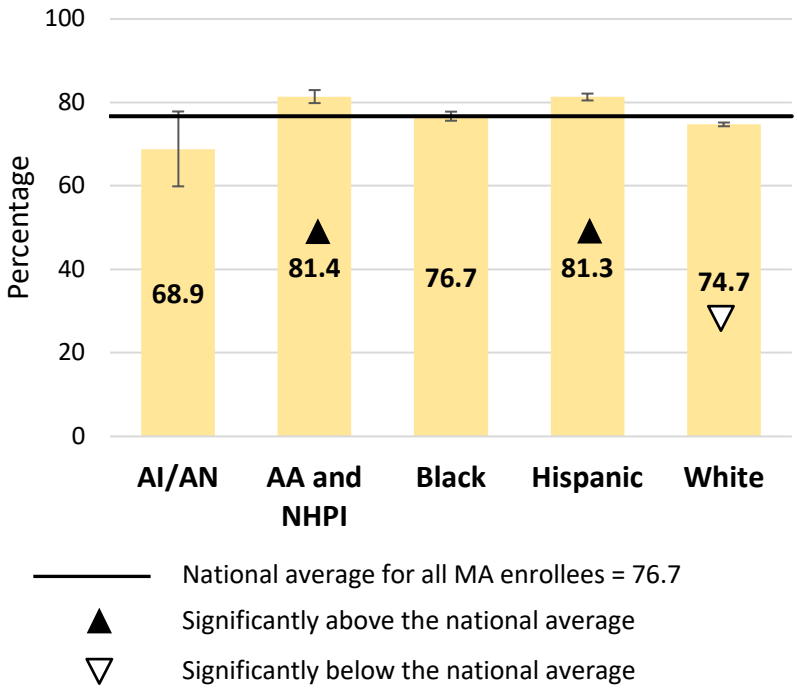
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **above** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **similar to** the national average.
- The percentage of Hispanic MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **below** the national average by less than 3 percentage points.

Diabetes Care—Eye Exam

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



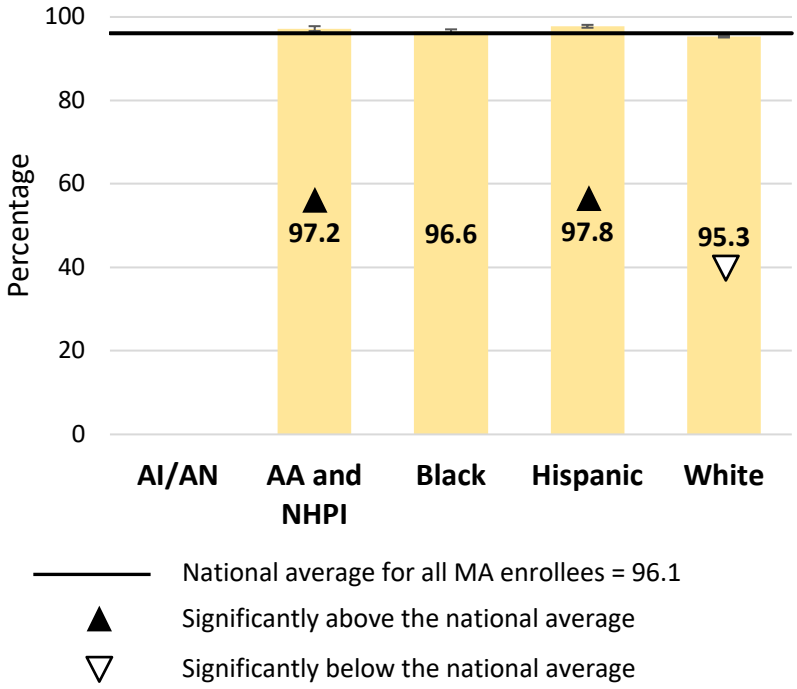
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with diabetes who had an eye exam in the past year was **similar to** the national average.
- The percentage of AA and NHPI MA enrollees with diabetes who had an eye exam in the past year was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had an eye exam in the past year was **similar to** the national average.
- The percentage of Hispanic MA enrollees with diabetes who had an eye exam in the past year was **above** the national average by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had an eye exam in the past year was **below** the national average by less than 3 percentage points.

Diabetes Care—Kidney Disease Monitoring

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



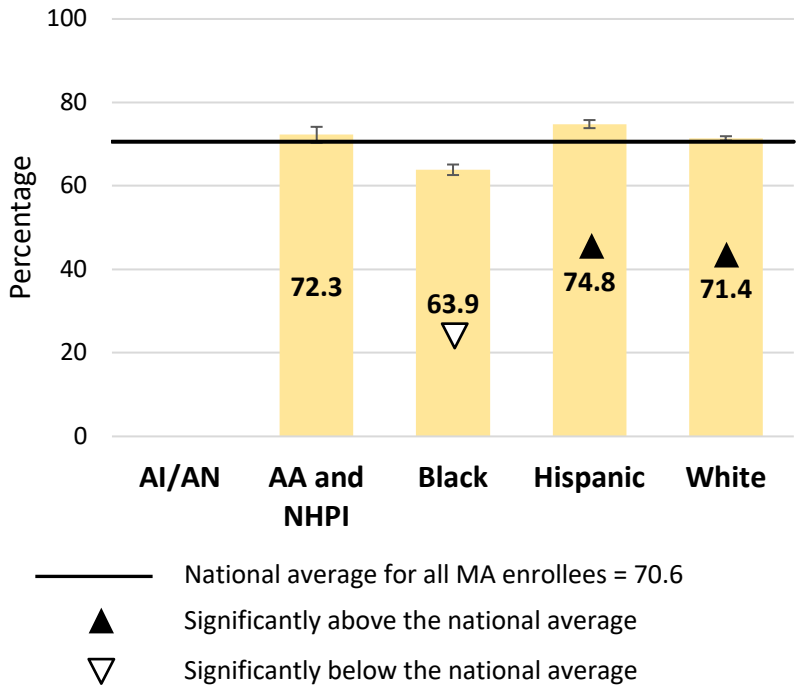
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had medical attention for nephropathy in the past year was **above** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had medical attention for nephropathy in the past year was **similar to** the national average.
- The percentage of Hispanic MA enrollees with diabetes who had medical attention for nephropathy in the past year was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had medical attention for nephropathy in the past year was **below** the national average by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

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



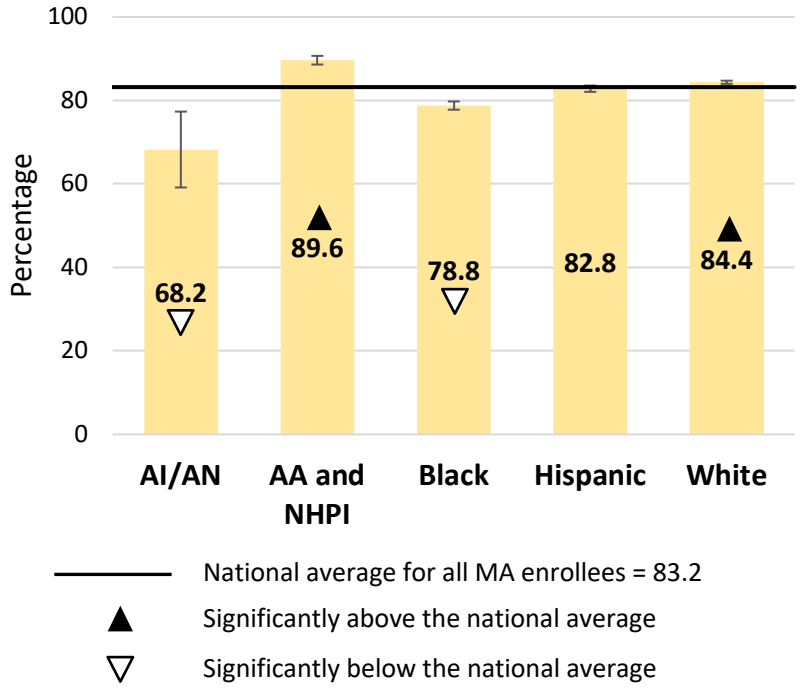
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average.
- The percentage of Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had their blood pressure under control was **above** the national average by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had their blood pressure under control was **above** the national average 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 race and ethnicity, Reporting Year 2022



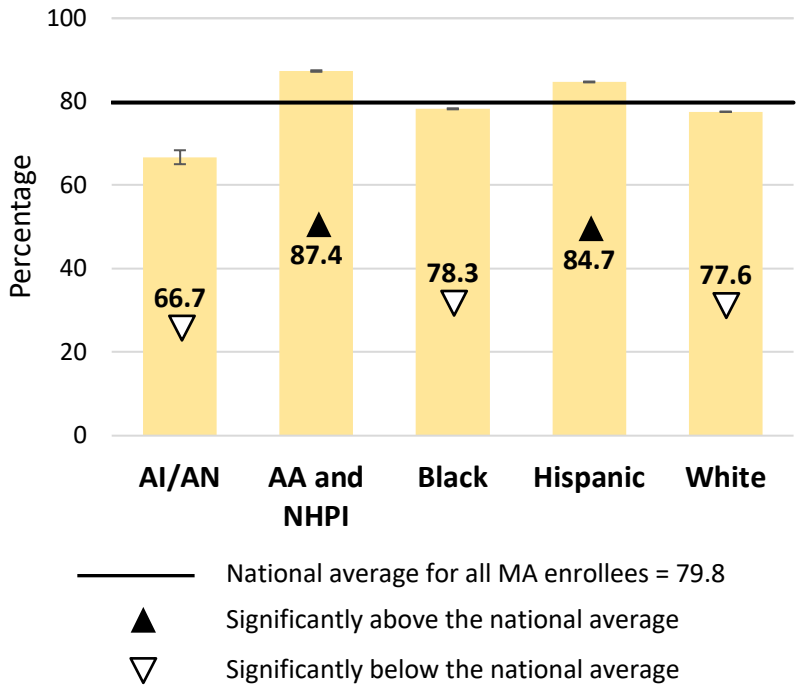
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with diabetes who had their blood sugar level under control was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who had their blood sugar level under control was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had their blood sugar level under control was **similar to** the national average.
- The percentage of White MA enrollees with diabetes who had their blood sugar level under control was **above** the national average 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

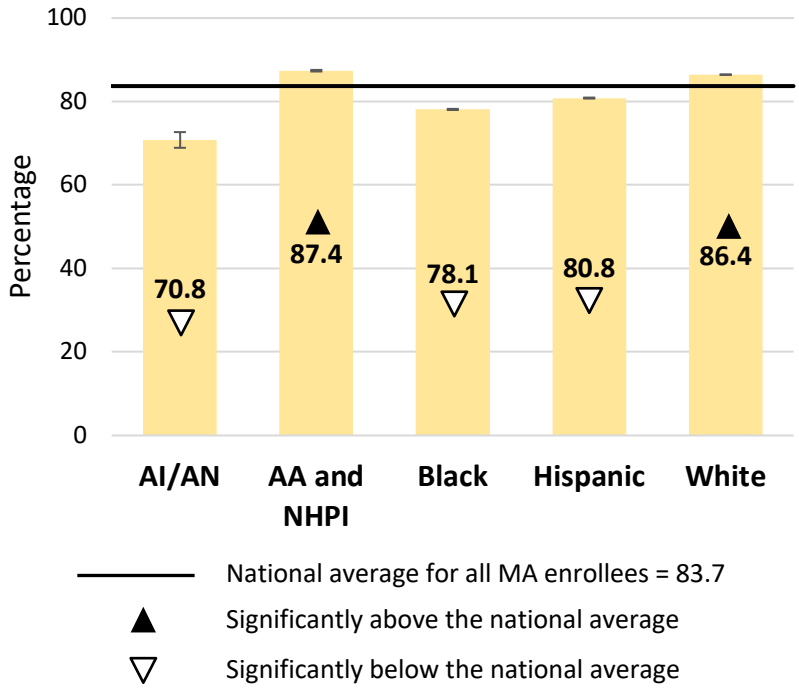
Disparities

- The percentage of AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who received statin therapy was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who received statin therapy was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who received statin therapy was **above** the national average by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who received statin therapy was **below** the national average 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 who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

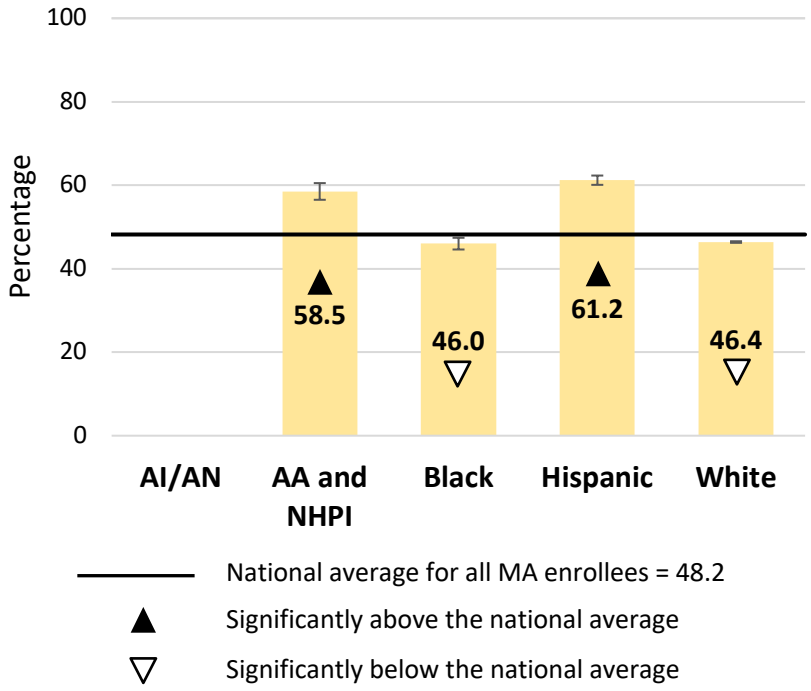
- The percentage of AI/AN MA enrollees with diabetes who had proper statin medication adherence was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who had proper statin medication adherence was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had proper statin medication adherence was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had proper statin medication adherence was **below** the national average by less than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had proper statin medication adherence was **above** the national average by less than 3 percentage points.

[†] Excludes those who also have clinical ASCVD.

Clinical Care: Musculoskeletal Conditions

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

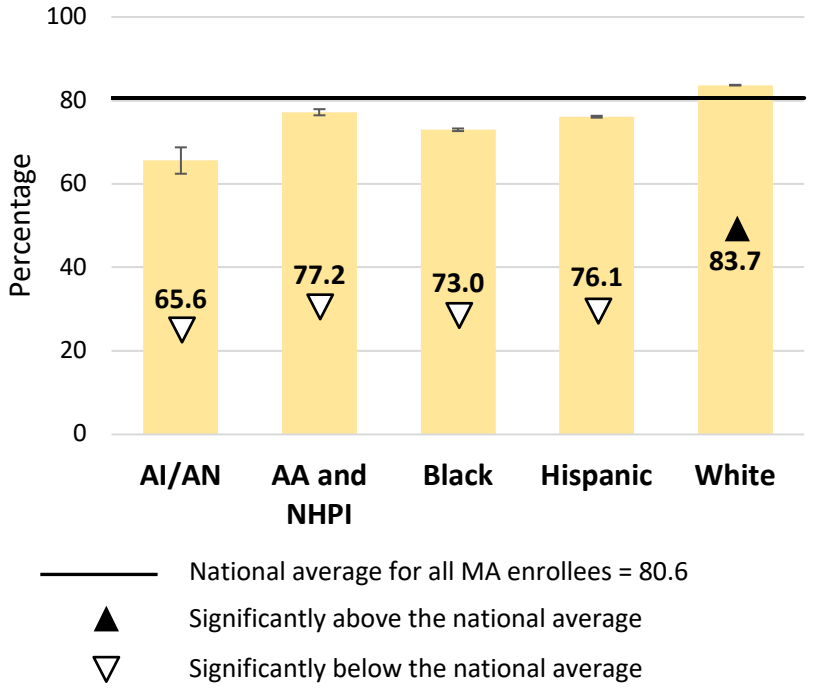
Disparities

- The percentage of eligible female AA and NHPI MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all female MA enrollees by more than 3 percentage points.
- The percentage of eligible female Black MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of eligible female Hispanic MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all female MA enrollees by more than 3 percentage points.
- The percentage of eligible female White MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all female MA enrollees by less 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

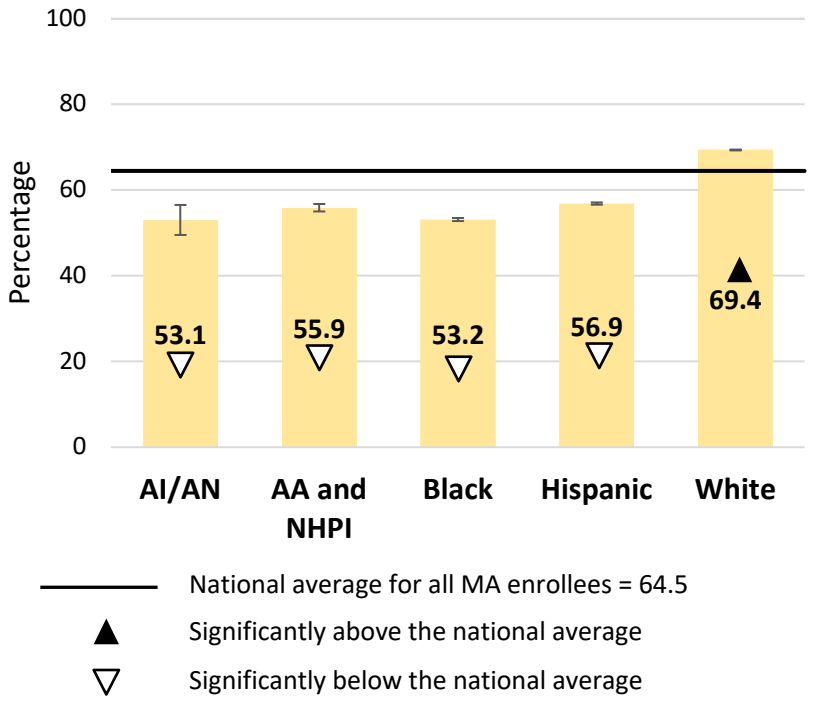
Disparities

- The percentage of eligible AI/AN MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average by more than 3 percentage points.

- The percentage of eligible White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average by more than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

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



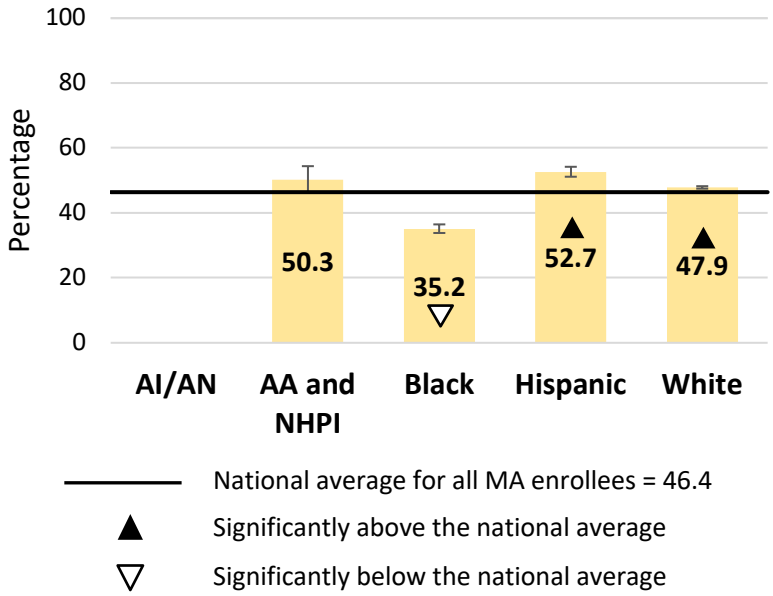
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible AI/AN MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average by more than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

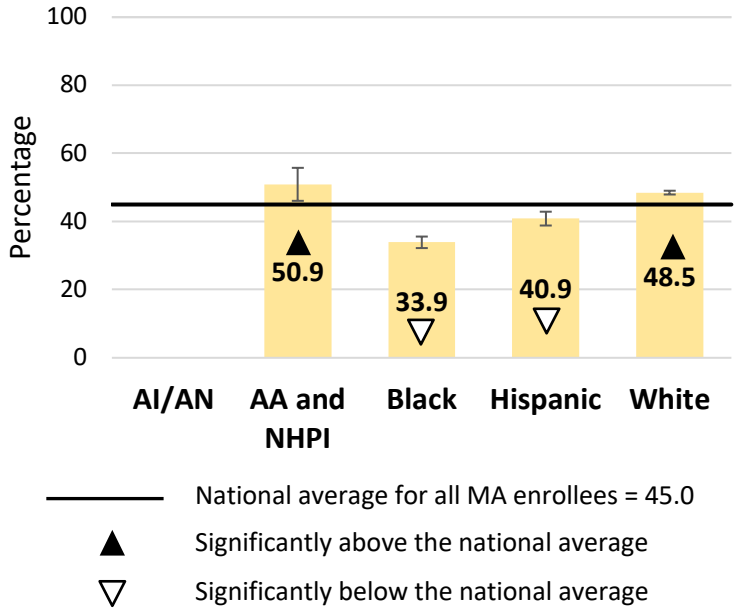
Disparities

- The percentage of AA and NHPI MA enrollees 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.
- The percentage of Black MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average by more than 3 percentage points.
- The percentage of White MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average by less than 3 percentage points.

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

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

Percentage of MA enrollees aged 18 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

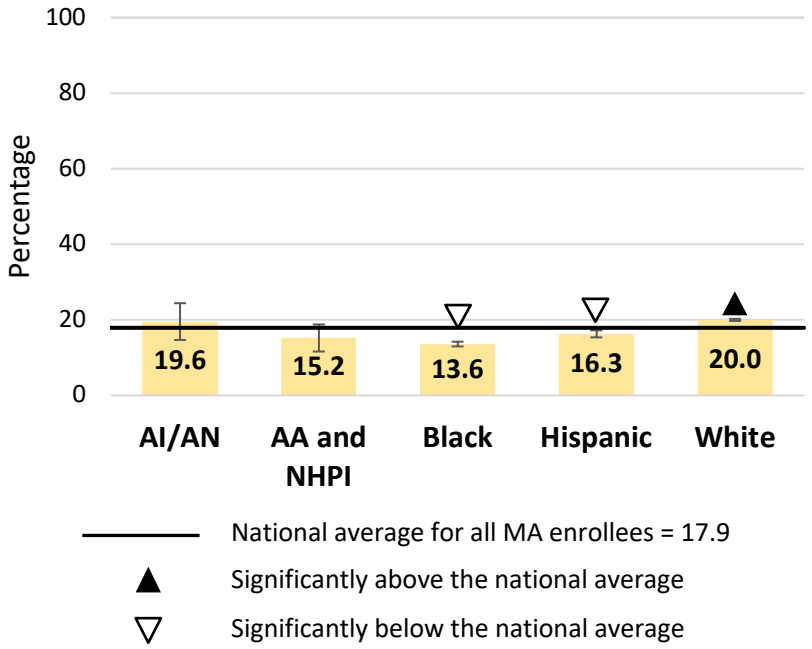
Disparities

- The percentage of AA and NHPI MA enrollees 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 by more than 3 percentage points.
- The percentage of Black MA enrollees 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 by more than 3 percentage points.
- The percentage of Hispanic MA enrollees 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 by more than 3 percentage points.
- The percentage of White MA enrollees 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 by more than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

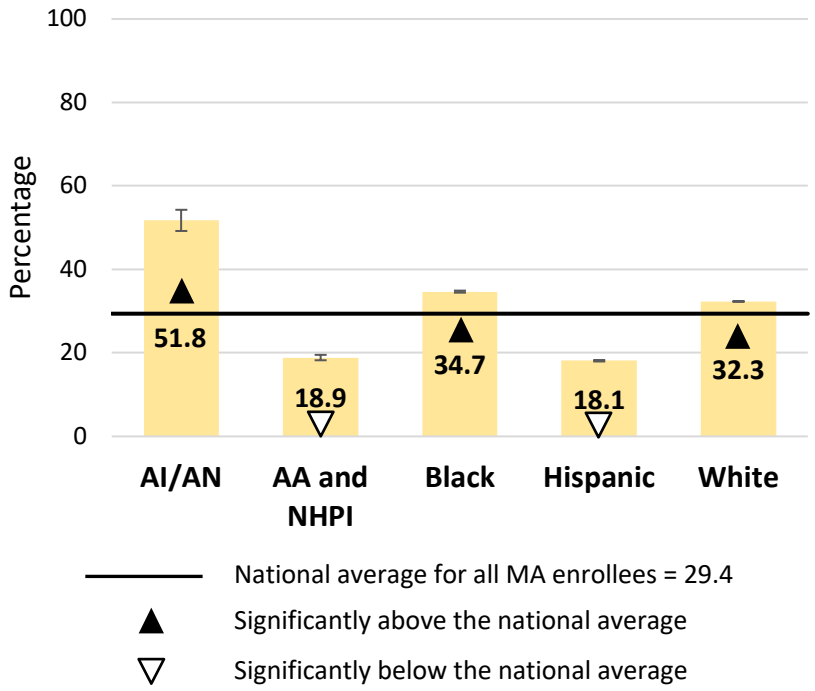
Disparities

- The percentage of AI/AN MA enrollees 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.
- The percentage of AA and NHPI MA enrollees 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.
- The percentage of Black MA enrollees 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 by more than 3 percentage points.
- The percentage of Hispanic MA enrollees 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 by less than 3 percentage points.
- The percentage of White MA enrollees 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 by less than 3 percentage points.

[†] 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 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

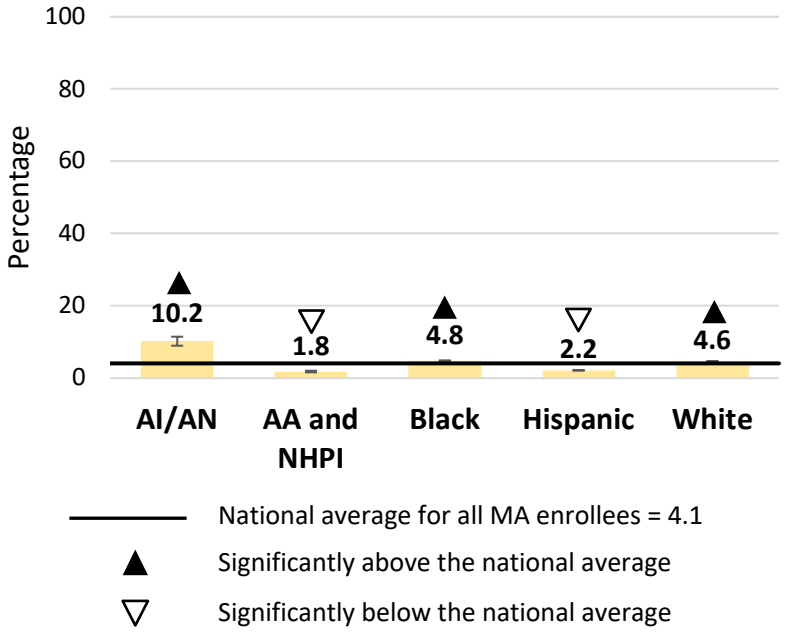
- The percentage of AI/AN MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average by more than 3 percentage points.
- The percentage of White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average by less than 3 percentage points.

[†] 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.

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

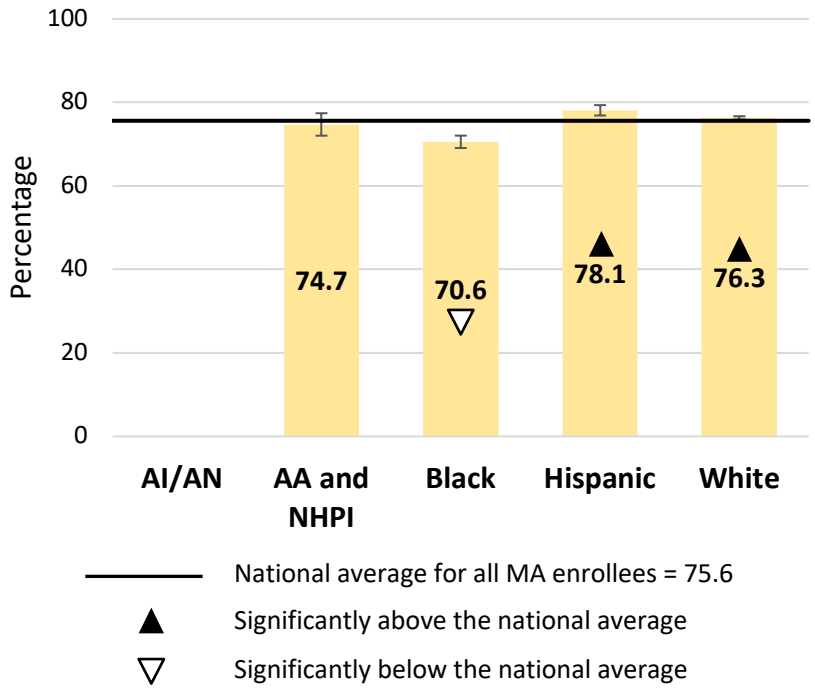
- The percentage of AI/AN MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average by less than 3 percentage points.
- The percentage of White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average by less than 3 percentage points.

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

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by race and ethnicity, Reporting Year 2022



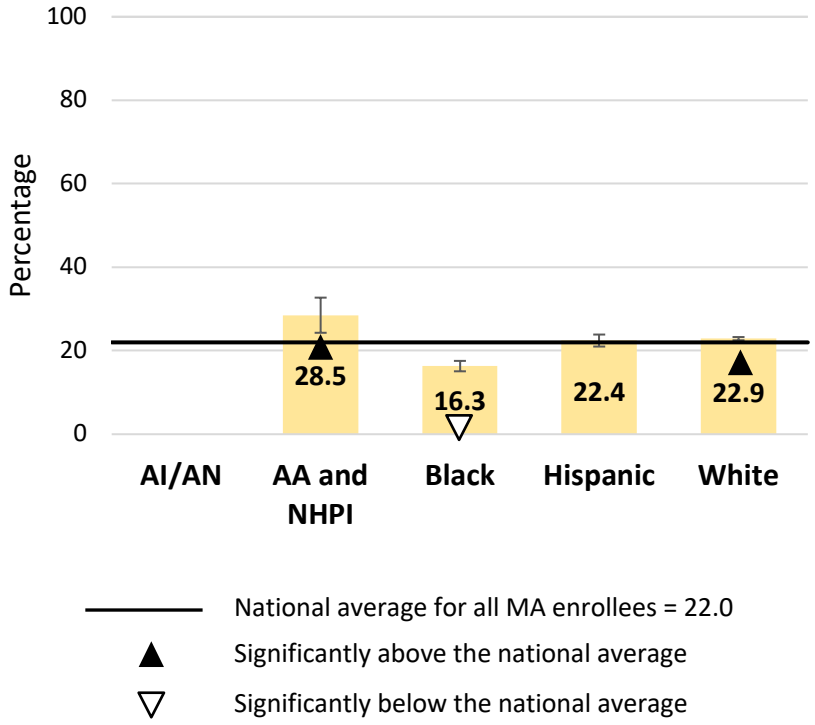
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average.
- The percentage of Black MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average by less than 3 percentage points.

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 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 race and ethnicity, Reporting Year 2022



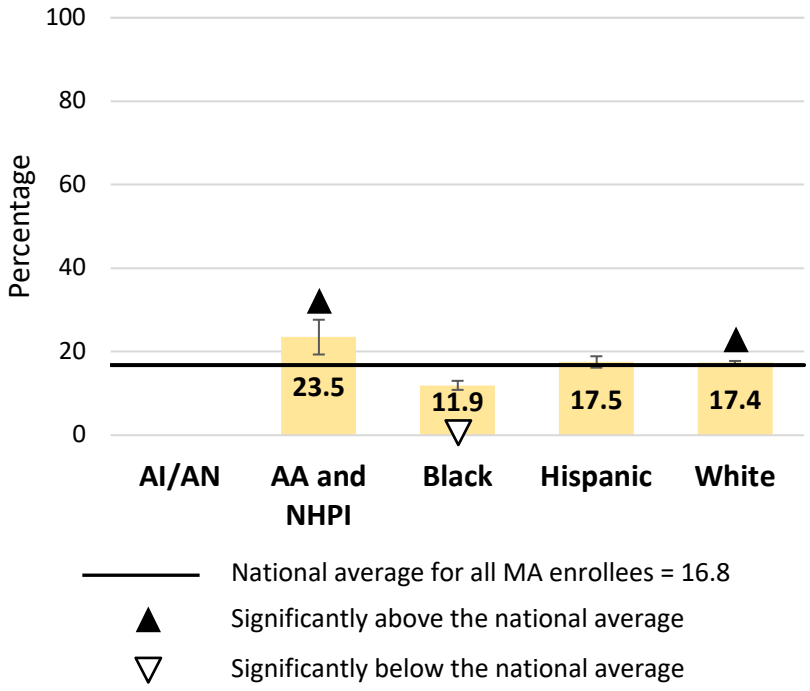
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees 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 by more than 3 percentage points.
- The percentage of Black MA enrollees 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 by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average.
- The percentage of White MA enrollees 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 by less than 3 percentage points.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by race and ethnicity, Reporting Year 2022



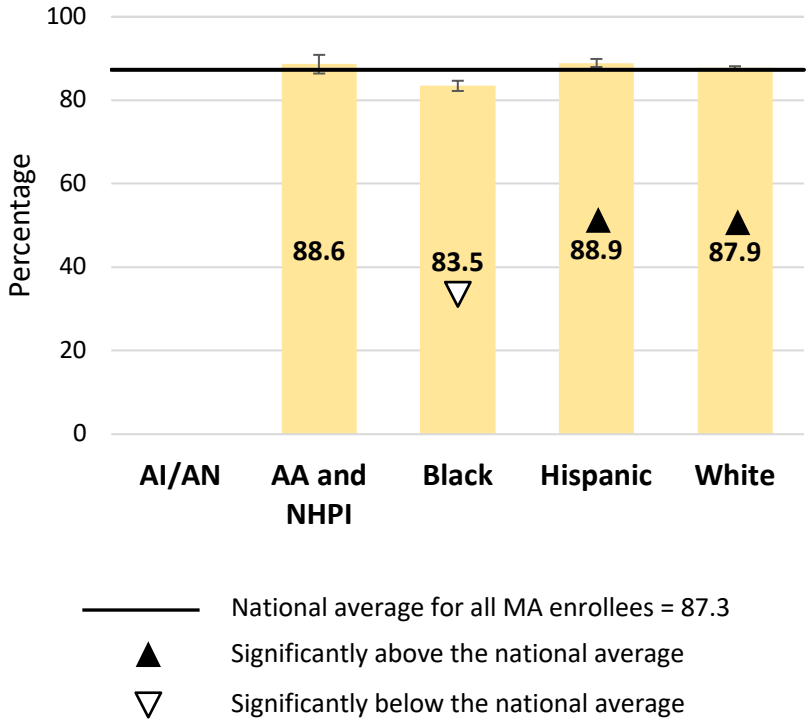
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average.
- The percentage of White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average by less than 3 percentage points.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 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 race and ethnicity, Reporting Year 2022



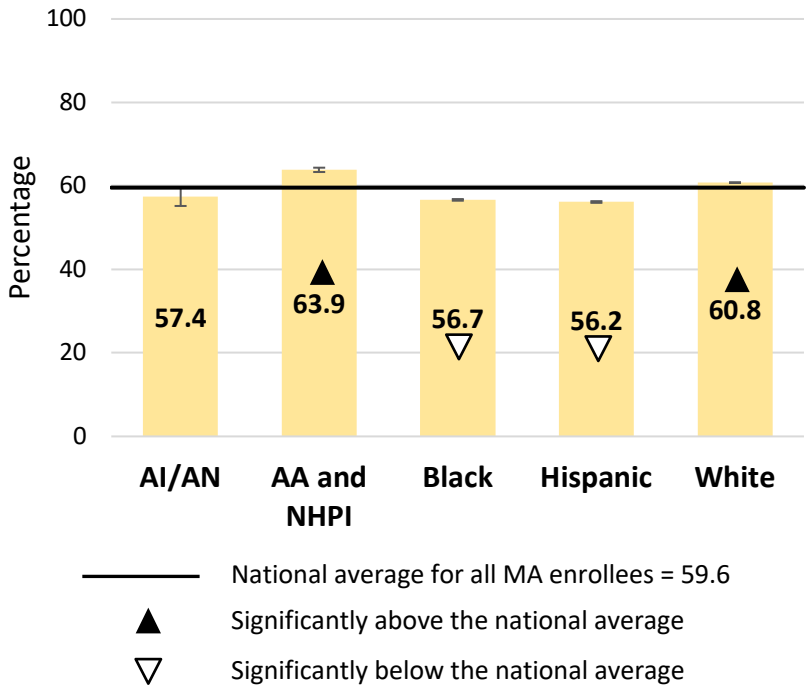
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees 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.
- The percentage of Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average by less than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

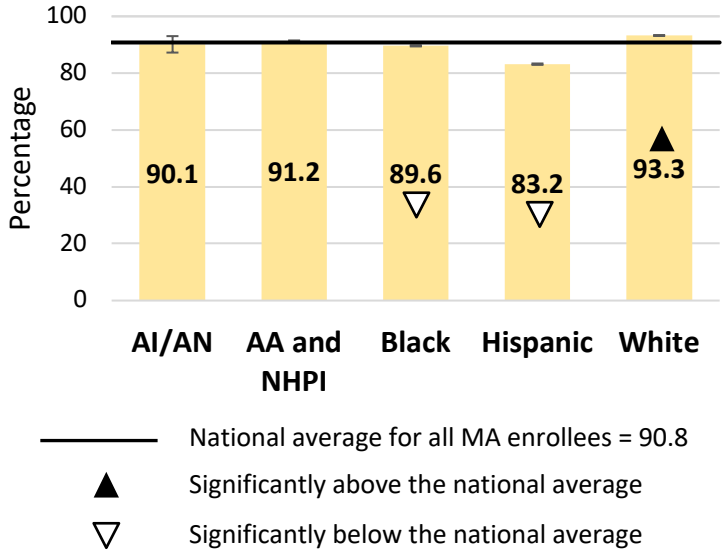
- The percentage of AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **similar to** the national average.
- The percentage of AA and NHPI MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average by more than 3 percentage points.
- The percentage of White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average by less than 3 percentage points.

[†] 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 Medication

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

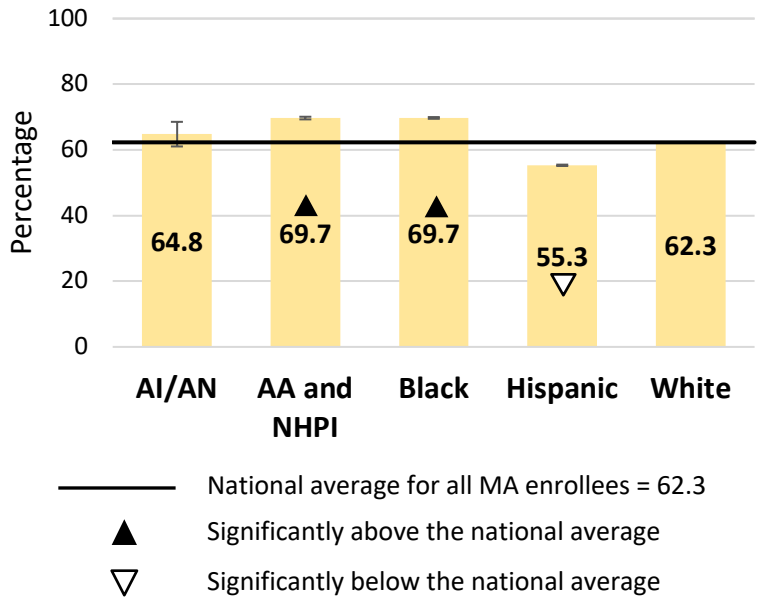
Disparities

- The percentage of older adult AI/AN MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average.
- The percentage of older adult AA and NHPI MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average.
- The percentage of older adult Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average by more than 3 percentage points.
- The percentage of older adult White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average by less 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

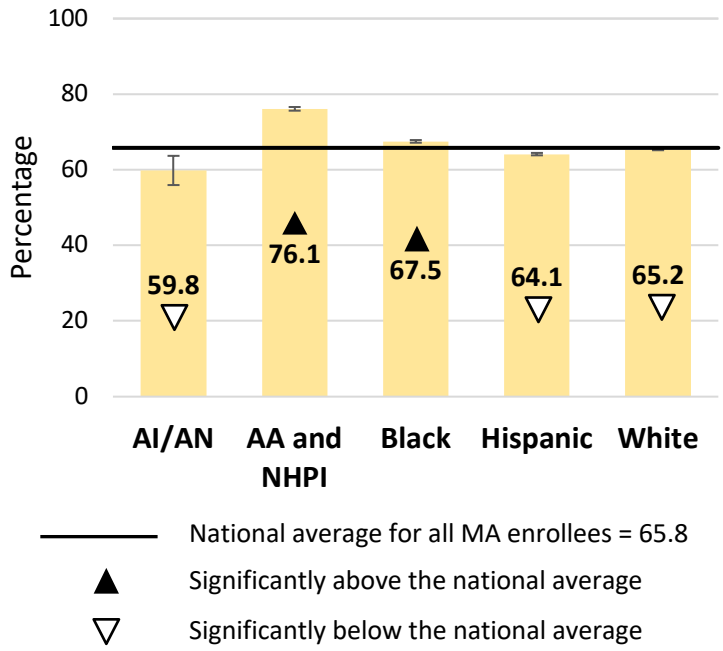
Disparities

- The percentage of older adult AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average.
- The percentage of older adult AA and NHPI MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average by more than 3 percentage points.
- The percentage of older adult Black MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average by more than 3 percentage points.
- The percentage of older adult White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average.

[†] 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

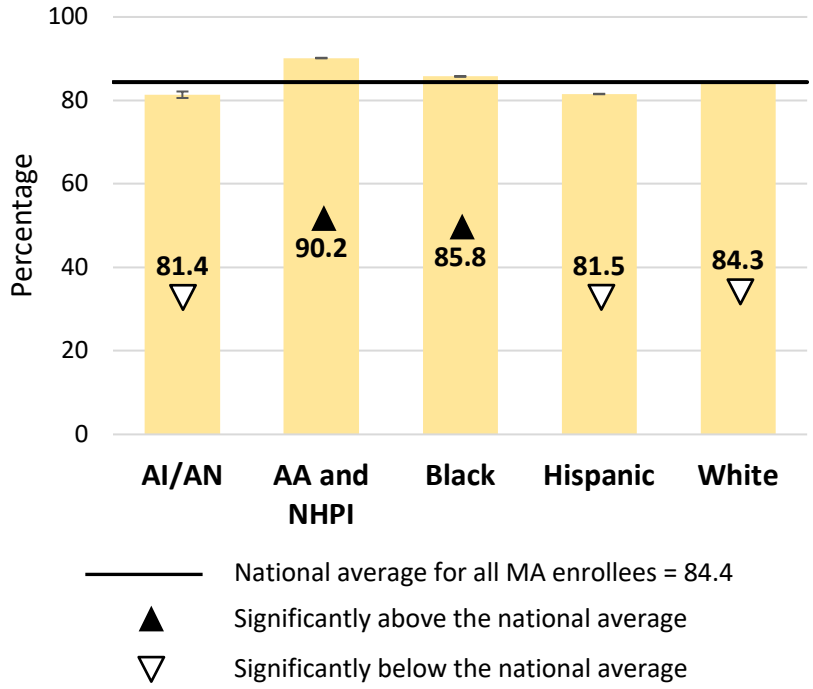
Disparities

- The percentage of older adult AI/AN MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average by more than 3 percentage points.
- The percentage of older adult AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average by more than 3 percentage points.
- The percentage of older adult Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.

[†] This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

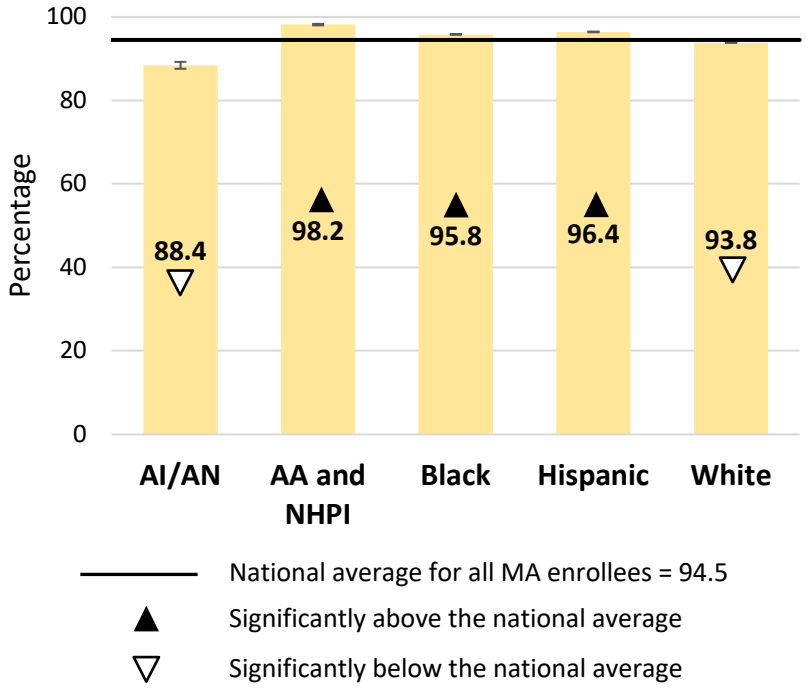
Disparities

- The percentage of older adult AI/AN MA enrollees for whom use of high-risk medications was avoided was **below** the national average by more than 3 percentage points.[†]
- The percentage of older adult AA and NHPI MA enrollees for whom use of high-risk medications was avoided was **above** the national average by more than 3 percentage points.
- The percentage of older adult Black MA enrollees for whom use of high-risk medications was avoided was **above** the national average by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees for whom use of high-risk medications was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult White MA enrollees for whom use of high-risk medications was avoided was **below** the national average by less than 3 percentage points.

[†] Prior to rounding.

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

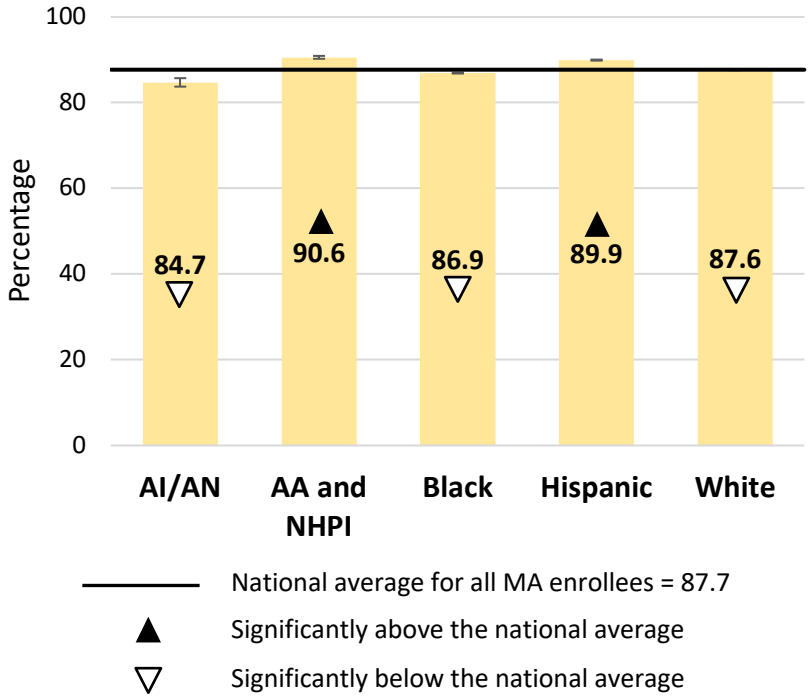
Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average by more than 3 percentage points.
- The percentage of Black MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average 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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

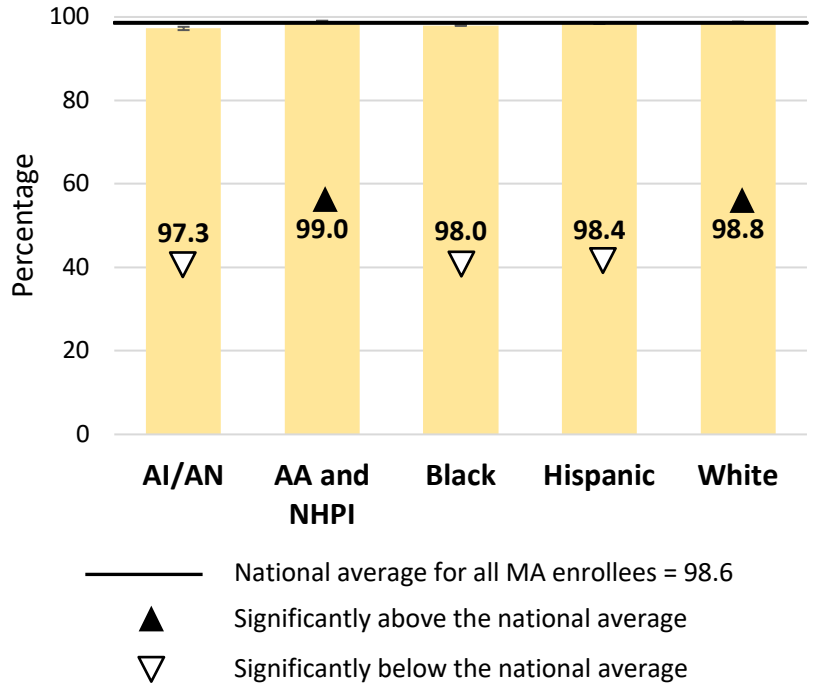
Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average by less than 3 percentage points.[†]
- The percentage of AA and NHPI MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average by less than 3 percentage points.

[†] Prior to rounding.

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 race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

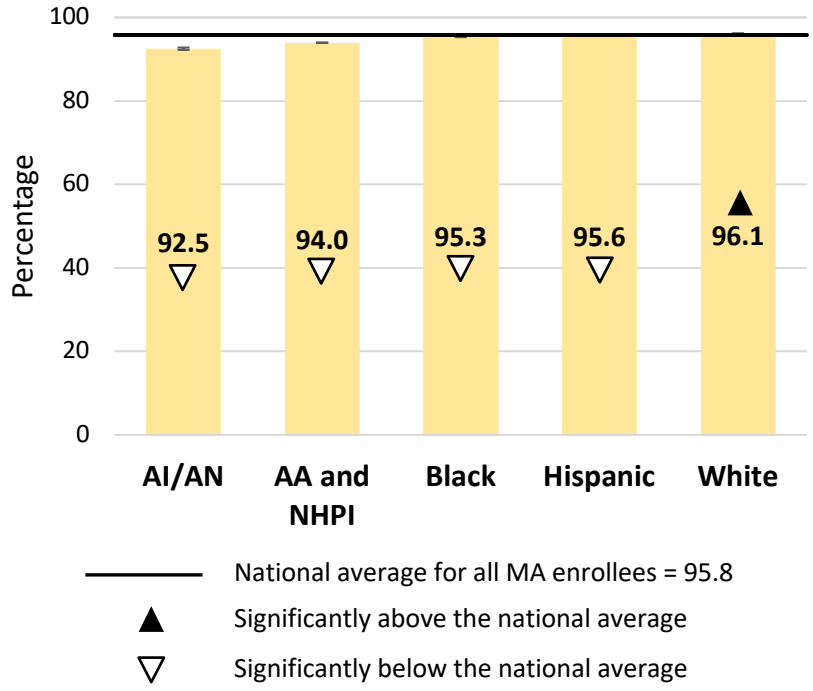
Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average by less than 3 percentage points.
- The percentage of AA and NHPI MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average by less than 3 percentage points.

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by race and ethnicity, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

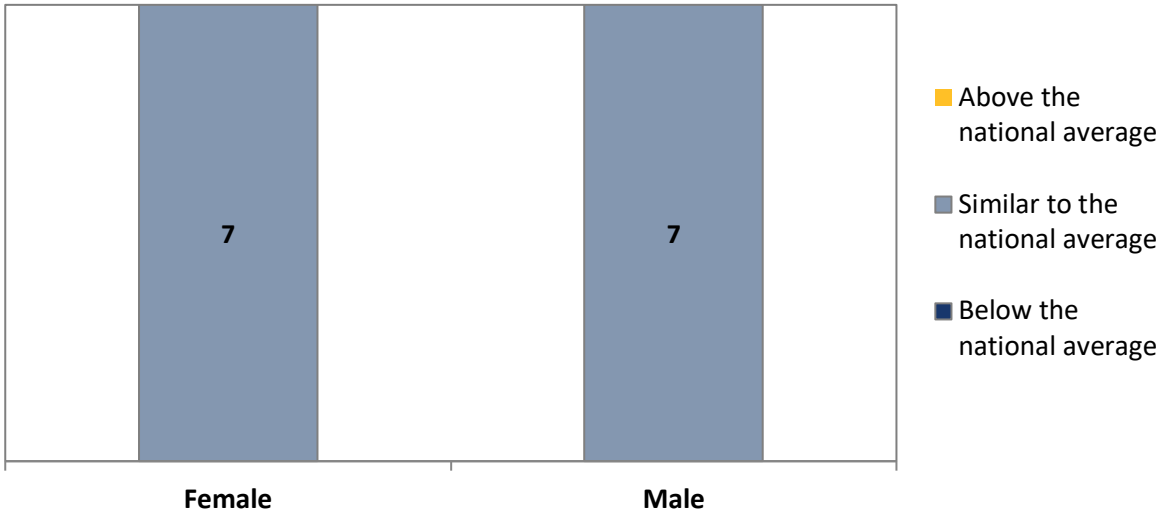
- The percentage of AI/AN MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average by less than 3 percentage points.
- The percentage of Black MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average by less than 3 percentage points.
- The percentage of Hispanic MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average by less than 3 percentage points.
- The percentage of White MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average by less than 3 percentage points.

SECTION II

Disparities in Health Care in Medicare Advantage by Sex

Disparities in Care by Sex:
All Patient Experience Measures

Number of patient experience measures (out of 7) for which female and male MA enrollees reported experiences that were above, similar to, or below the national average in 2021



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.

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

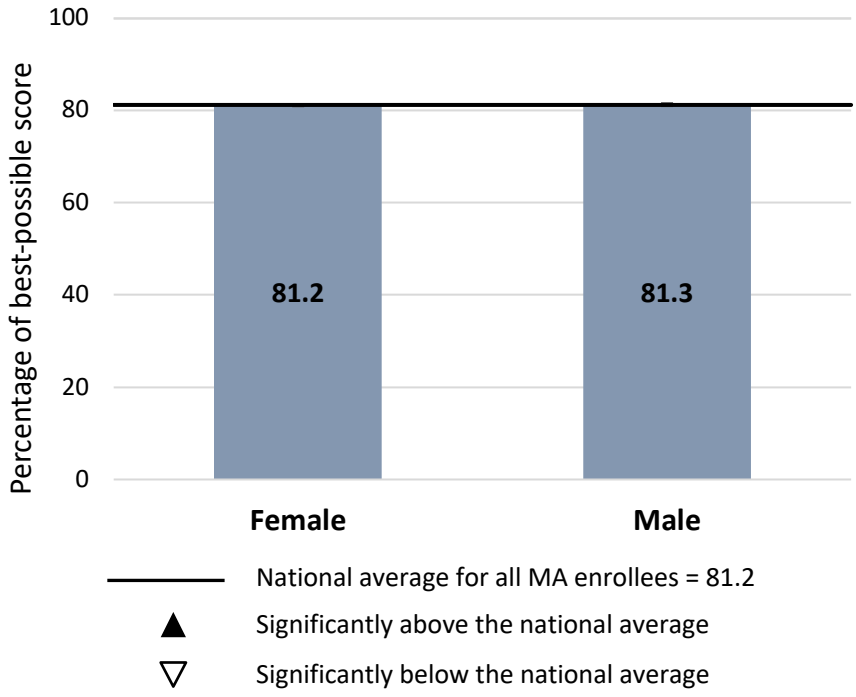
- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points† on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national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

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

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 sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

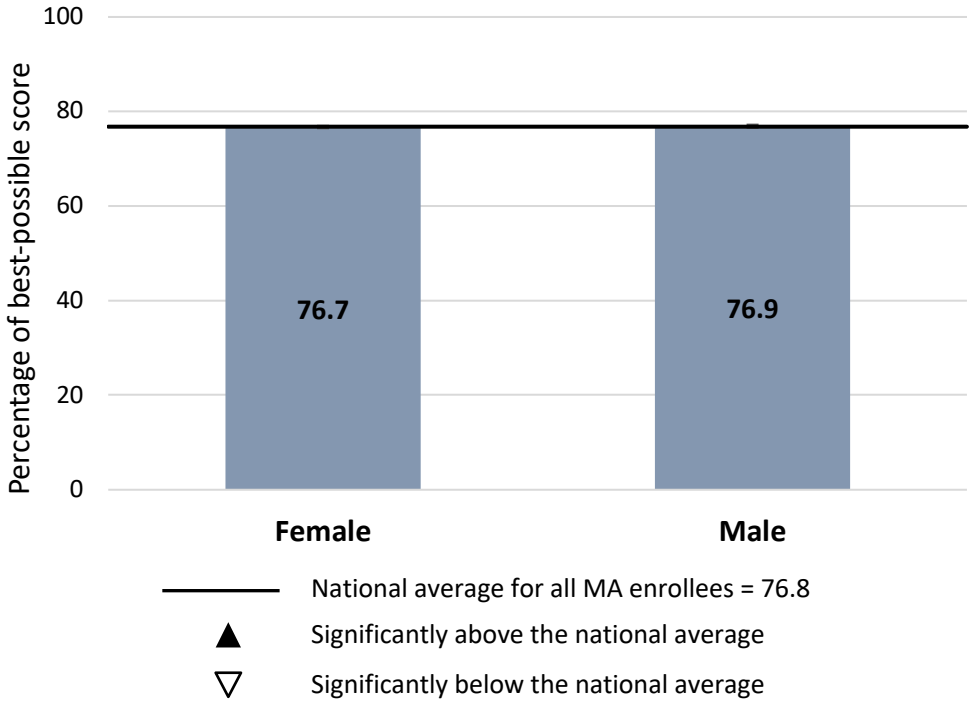
Disparities

- Female MA enrollees reported experiences with getting needed care that were **similar to** the national average.
- Male MA enrollees reported experiences with getting needed care that were **similar to** the national average.

† 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.

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 sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

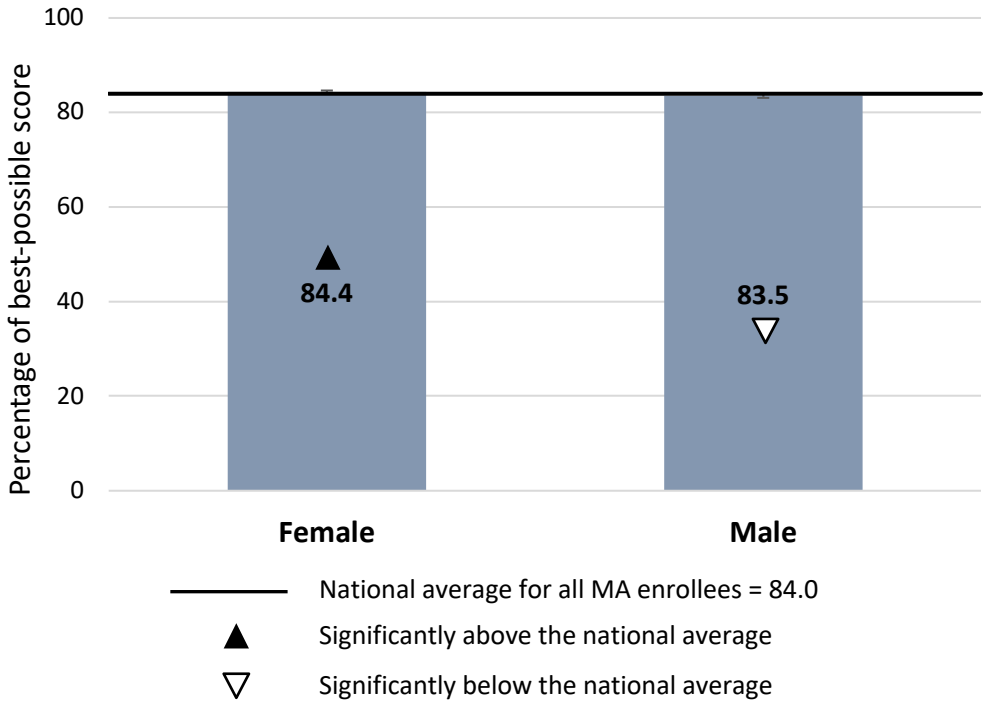
Disparities

- Female MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average.
- Male MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average.

† 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 sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

Disparities

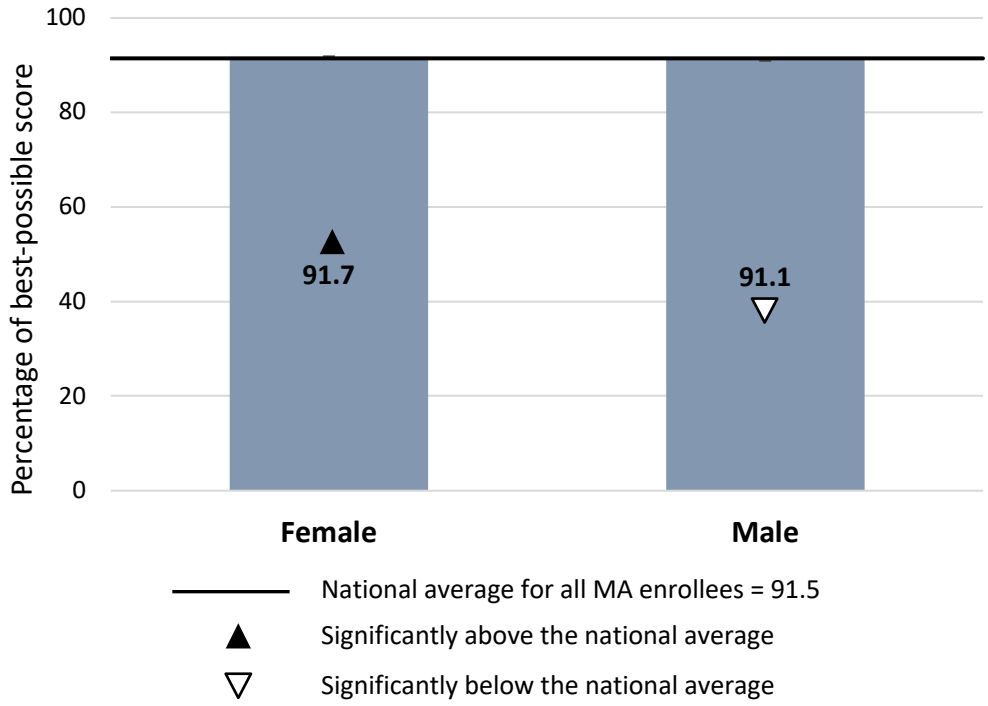
- Female MA enrollees reported experiences with customer service that were **above** the national average by less than 3 points on a 0–100 scale.[‡]
- Male MA enrollees reported experiences with customer service that were **below** the national average by less than 3 points on a 0–100 scale.

[†] 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.

[‡] Unlike on page 61, we describe all statistically significant differences on individual measures as being above or below the national average and note whether those differences are more or less than 3 points.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

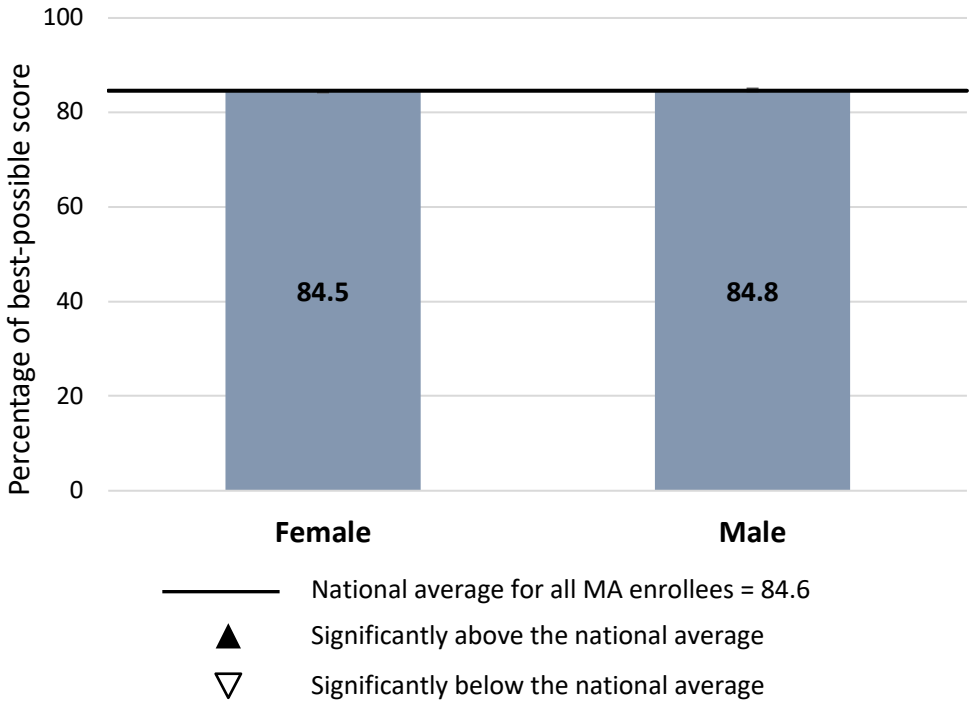
Disparities

- Female MA enrollees reported experiences with doctor communication that were **above** the national average by less than 3 percentage points.
- Male MA enrollees reported experiences with doctor communication that were **below** the national average by less than 3 percentage points.

[†] 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 patient care is coordinated,[†] by sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

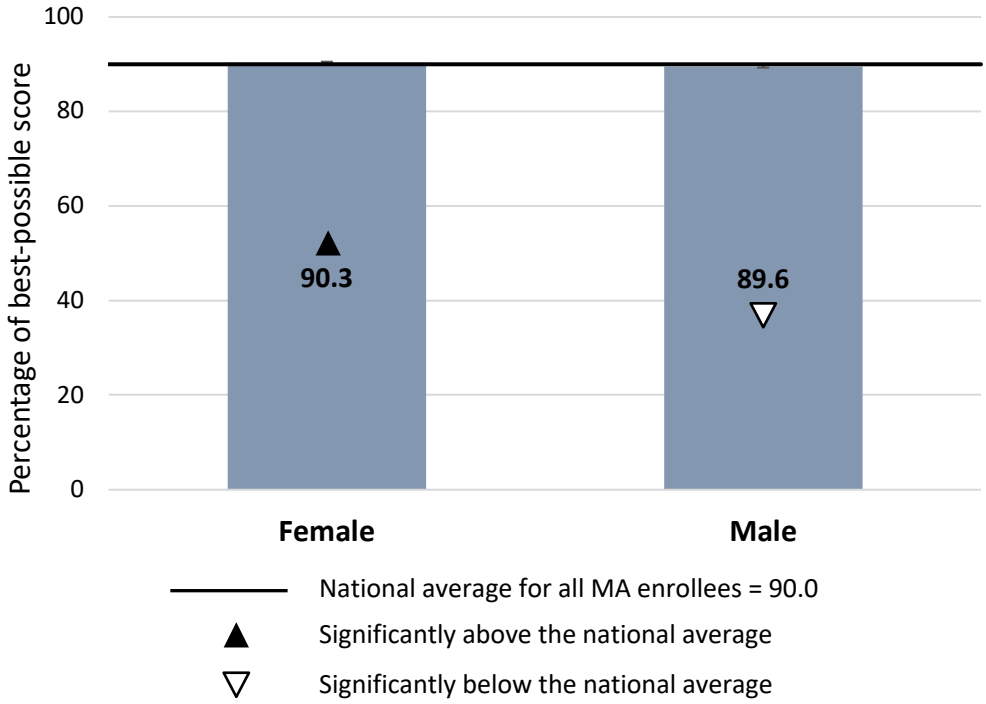
Disparities

- Female MA enrollees reported experiences with care coordination that were **similar to** the national average.
- Male MA enrollees reported experiences with care coordination that were **similar to** the national average.

[†] 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 plans,[†] by sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.

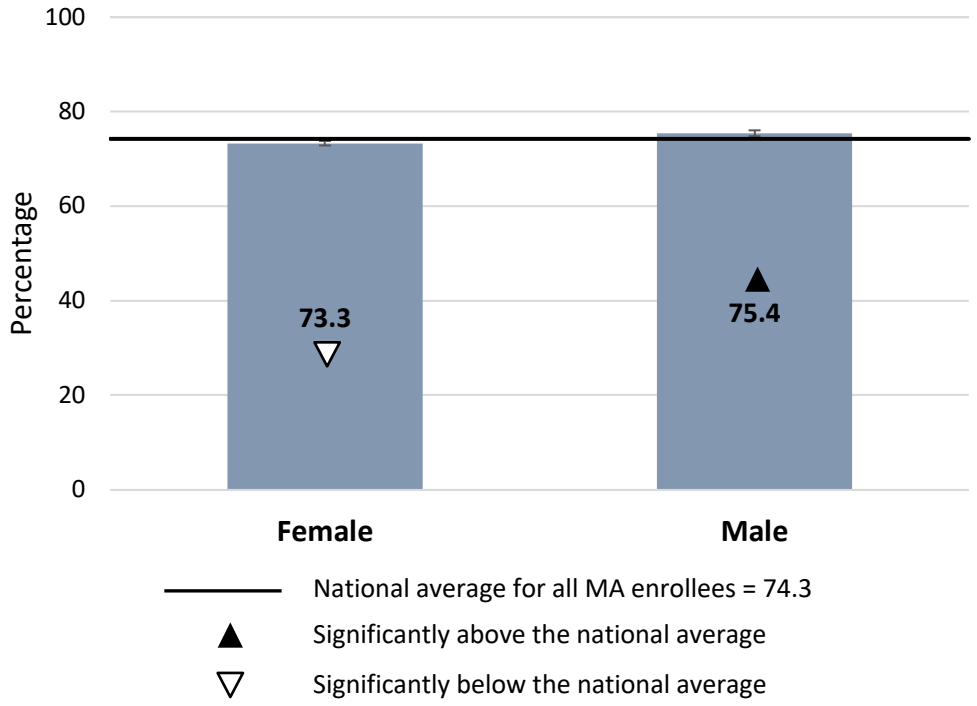
Disparities

- Female MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average by less than 3 percentage points.
- Male MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average by less than 3 percentage points.

[†] 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 sex, 2022



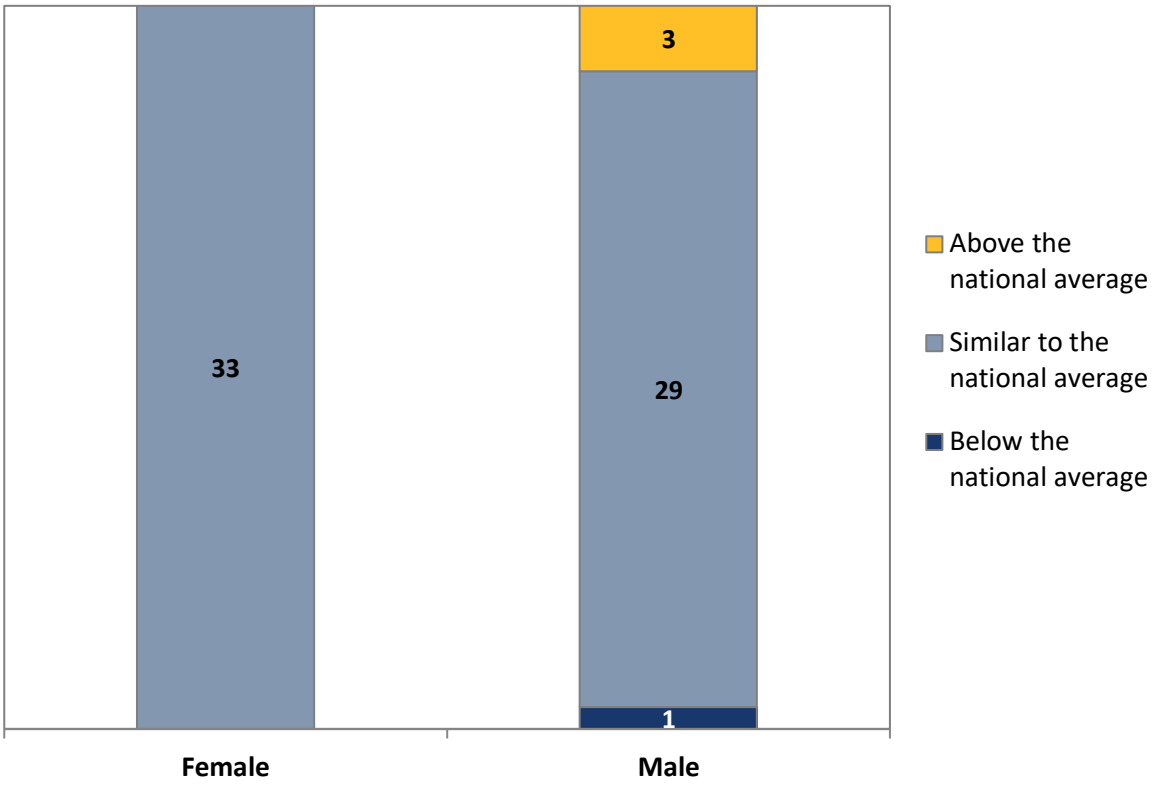
SOURCE: Data are from the Medicare CAHPS survey, 2022.

Disparities

- The percentage of female MA enrollees who received the flu vaccine was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees who received the flu vaccine was **above** the national average by less than 3 percentage points.

Disparities in Care by Sex:
All Clinical Care Measures

Number of clinical care measures (out of 33) for which female and male MA enrollees had results that were above, similar to, or below the national average in Reporting Year 2022



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

NOTES: When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—will always be closer to the overall (national) average than scores for the smaller group.

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

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

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

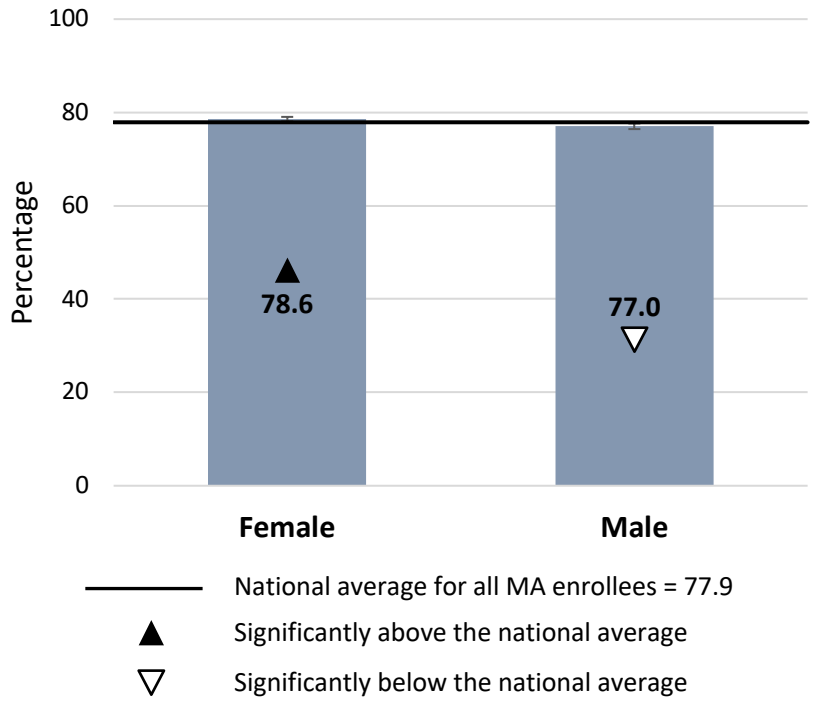
Male MA enrollees had results that were below the national average
• Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Male MA enrollees had results that were above the national average
• 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

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of eligible[†] female MA enrollees who were appropriately screened for colorectal cancer was **above** the national average by less than 3 percentage points.[‡]
- The percentage of eligible male MA enrollees who were appropriately screened for colorectal cancer was **below** the national average by less than 3 percentage points.

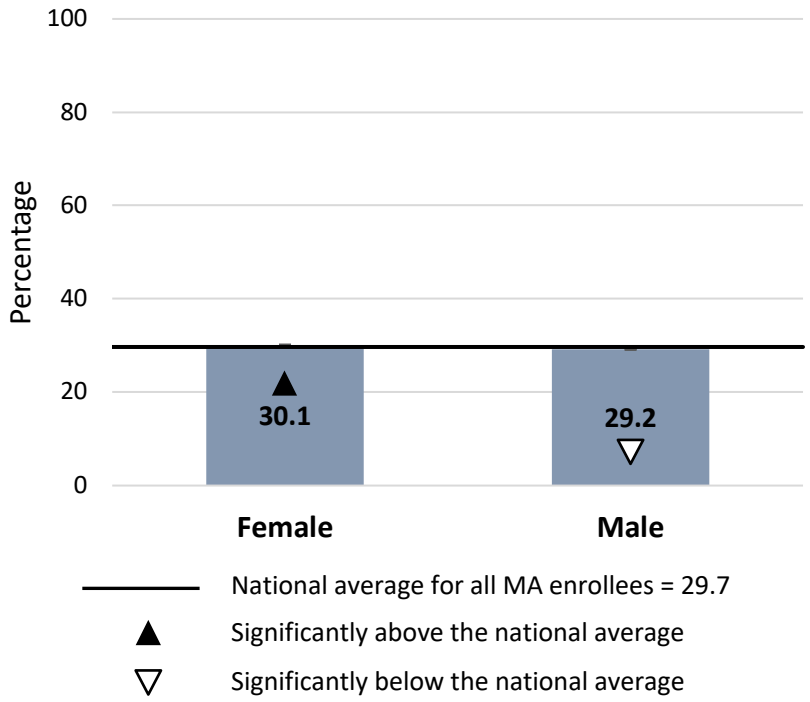
[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (which are specified in the chart subtitle).

[‡] Unlike on page 67, 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.

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 sex, Reporting Year 2022



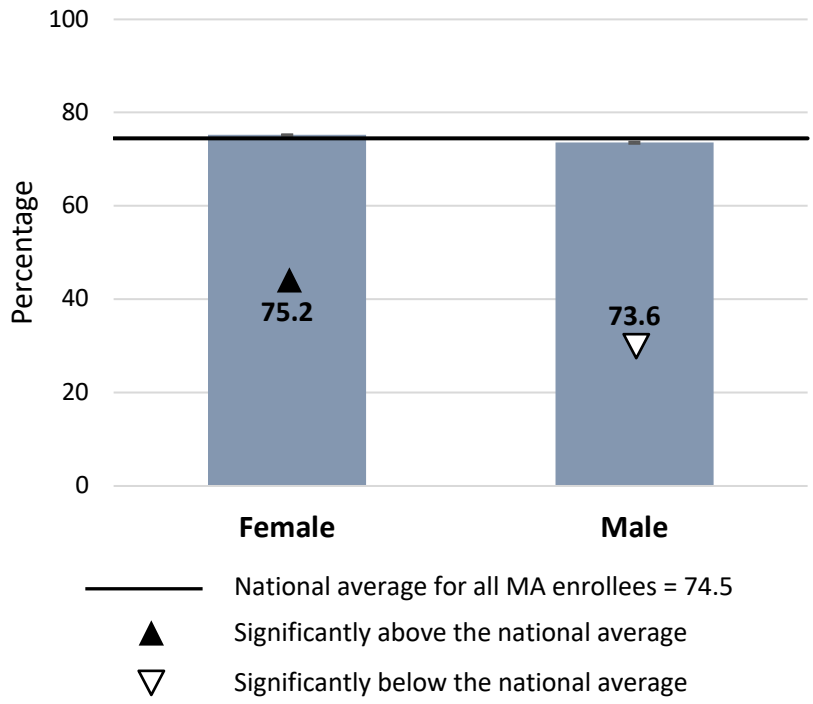
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average by less than 3 percentage points.
- The percentage of eligible male MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average 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 sex, Reporting Year 2022



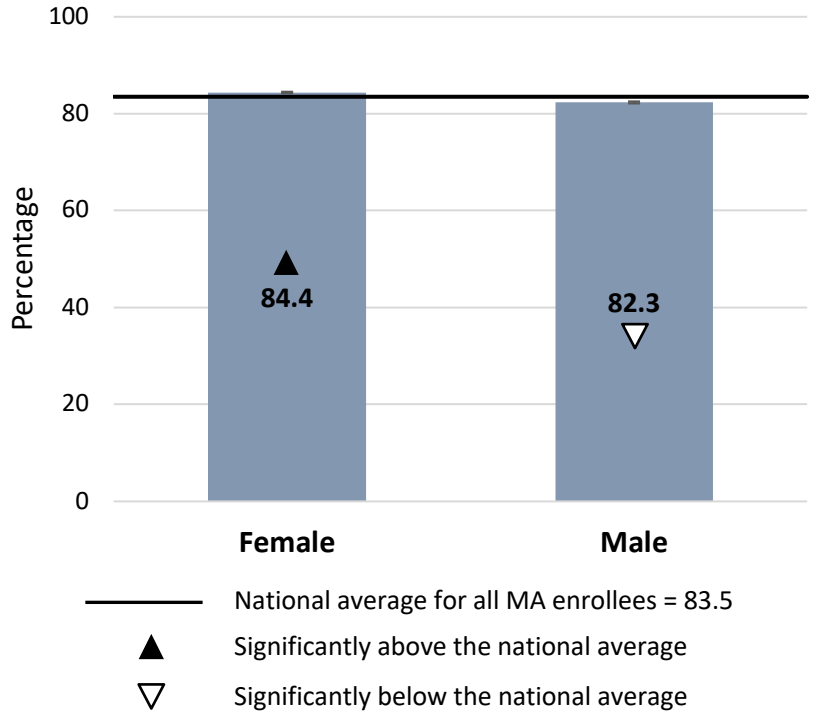
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

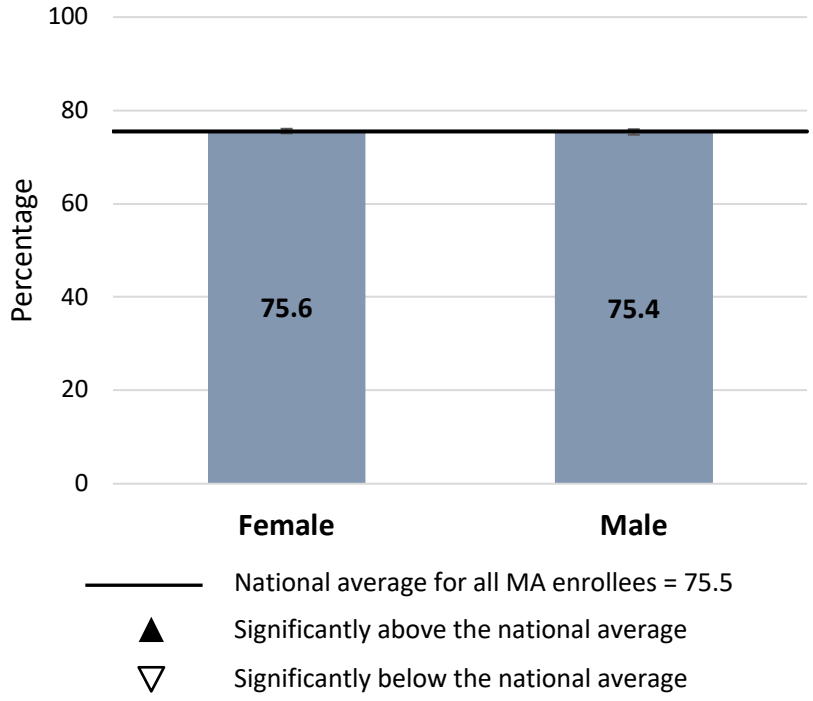
Disparities

- The percentage of eligible female MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

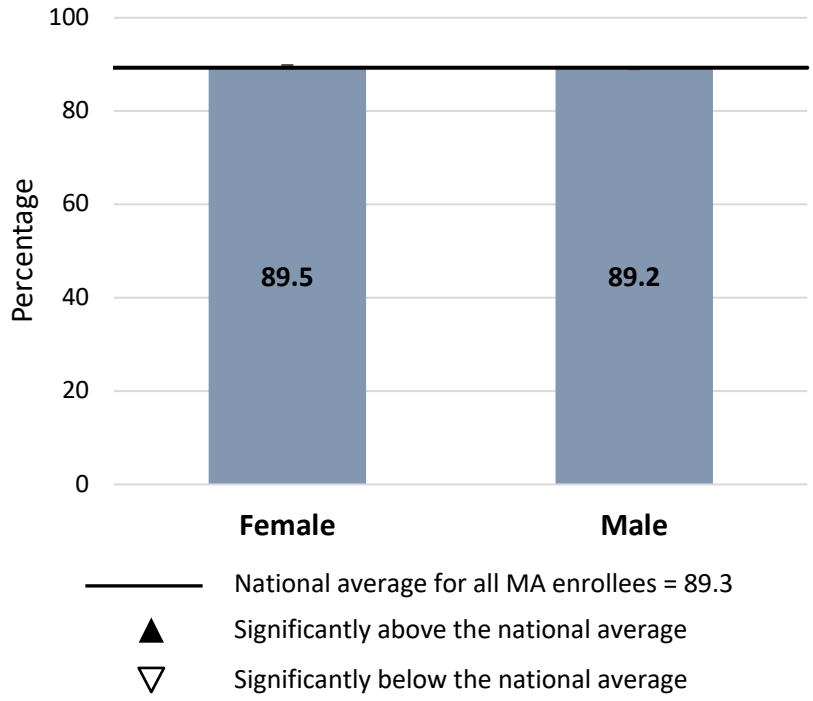
Disparities

- The percentage of eligible female MA enrollees who had their blood pressure adequately controlled was **similar to** the national average.
- The percentage of eligible male MA enrollees who had their blood pressure adequately controlled was **similar to** the national average.

[†] 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 AMI who received continuous beta-blocker treatment for six months after discharge, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

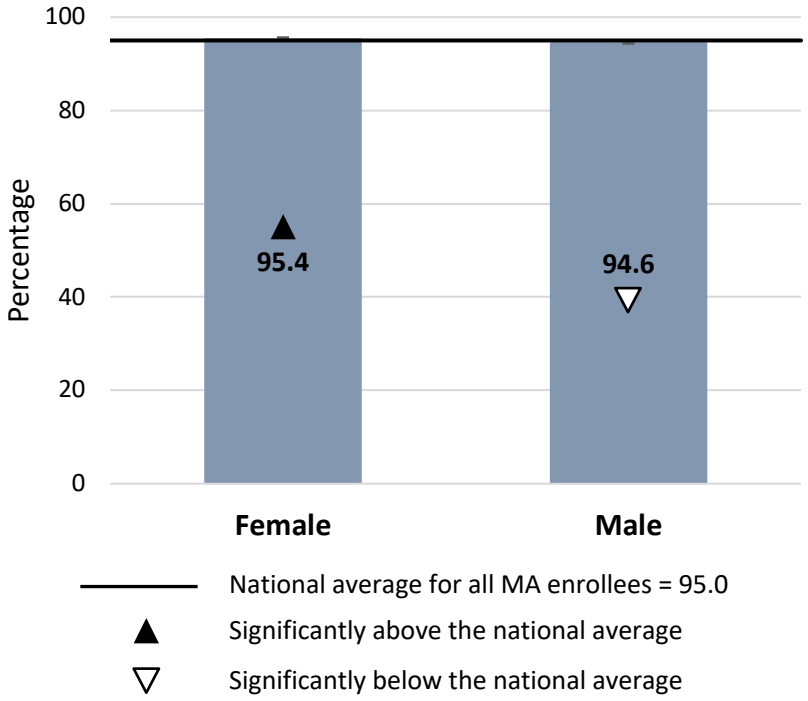
Disparities

- The percentage of eligible female MA enrollees who received continuous beta-blocker treatment was **similar to** the national average.
- The percentage of eligible male MA enrollees who received continuous beta-blocker treatment was **similar to** the national average.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

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



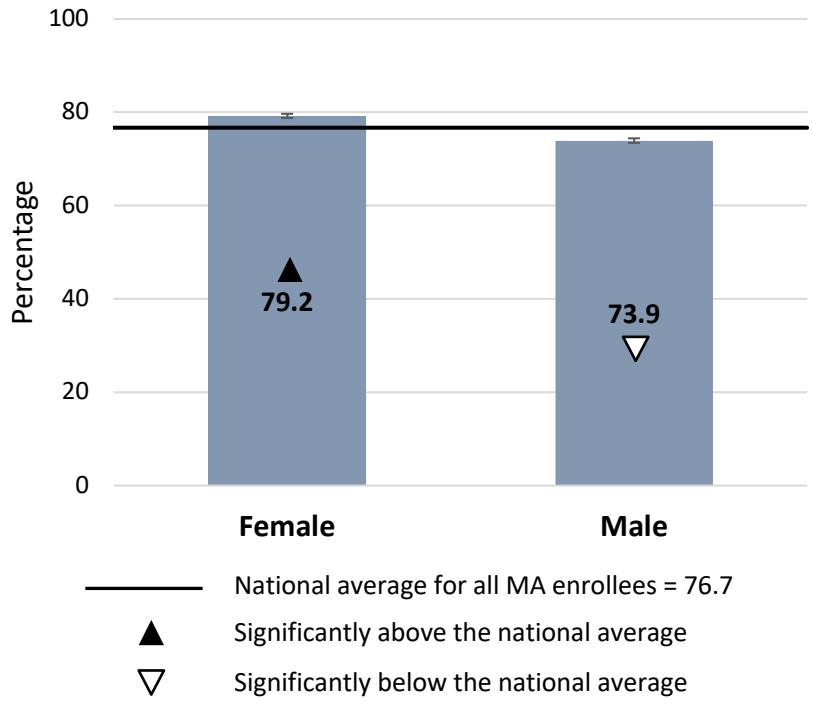
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **below** the national average by less than 3 percentage points.

Diabetes Care—Eye Exam

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



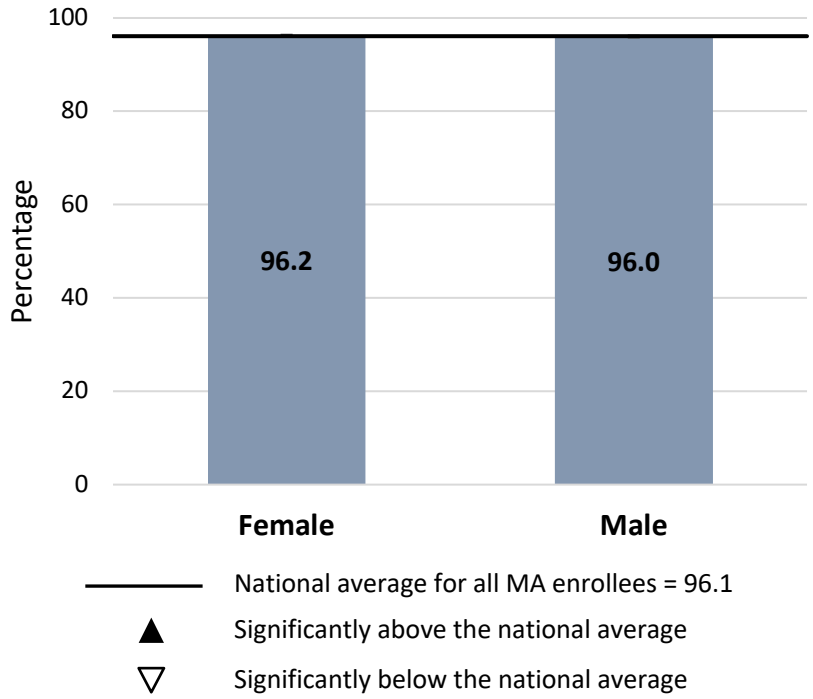
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had an eye exam in the past year was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had an eye exam in the past year was **below** the national average by less than 3 percentage points.

Diabetes Care—Kidney Disease Monitoring

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



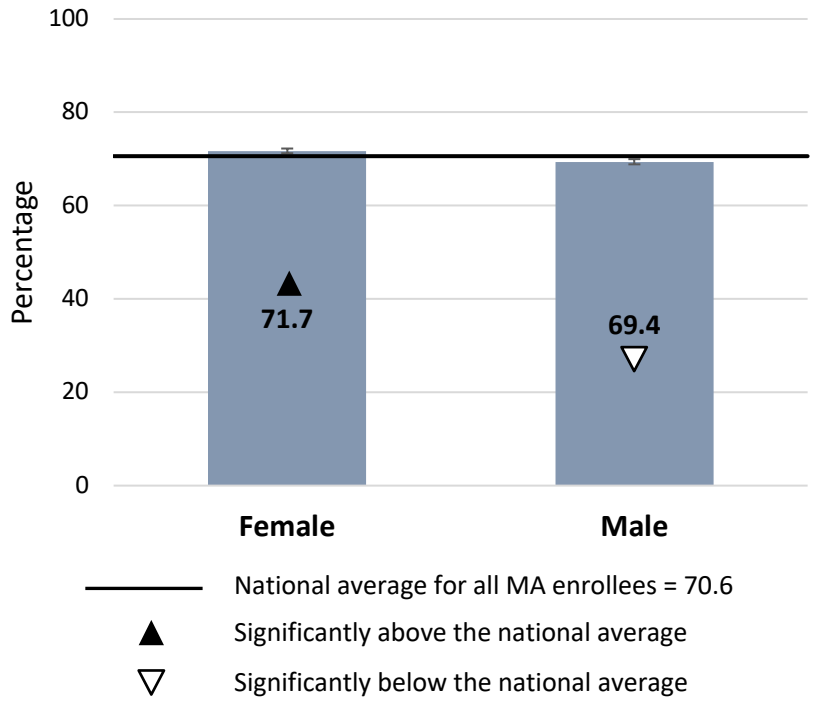
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had medical attention for nephropathy in the past year was **similar to** the national average.
- The percentage of male MA enrollees with diabetes who had medical attention for nephropathy in the past year was **similar to** the national average.

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 sex, Reporting Year 2022



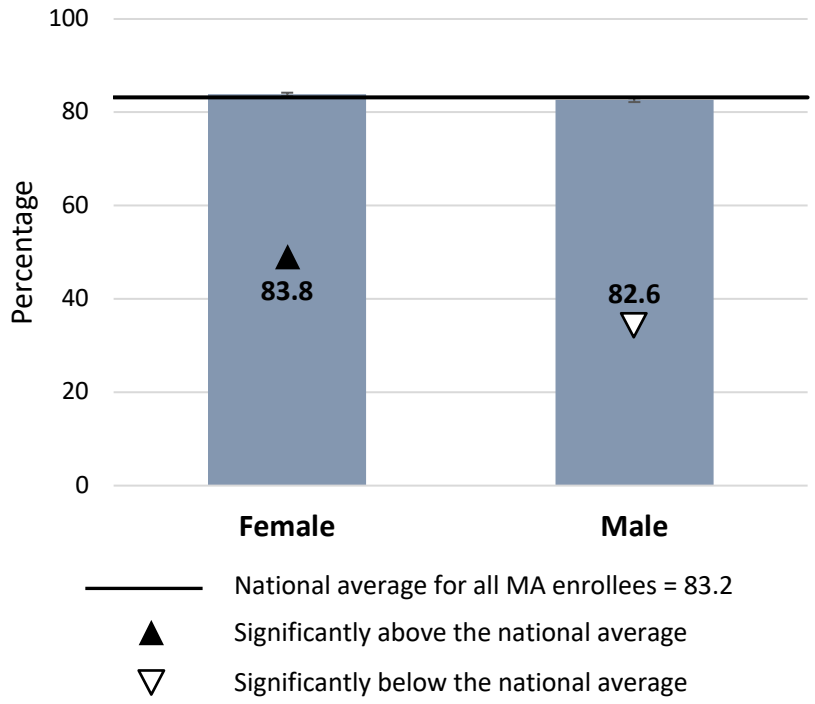
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had their blood pressure under control was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had their blood pressure under control was **below** the national average 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 sex, Reporting Year 2022



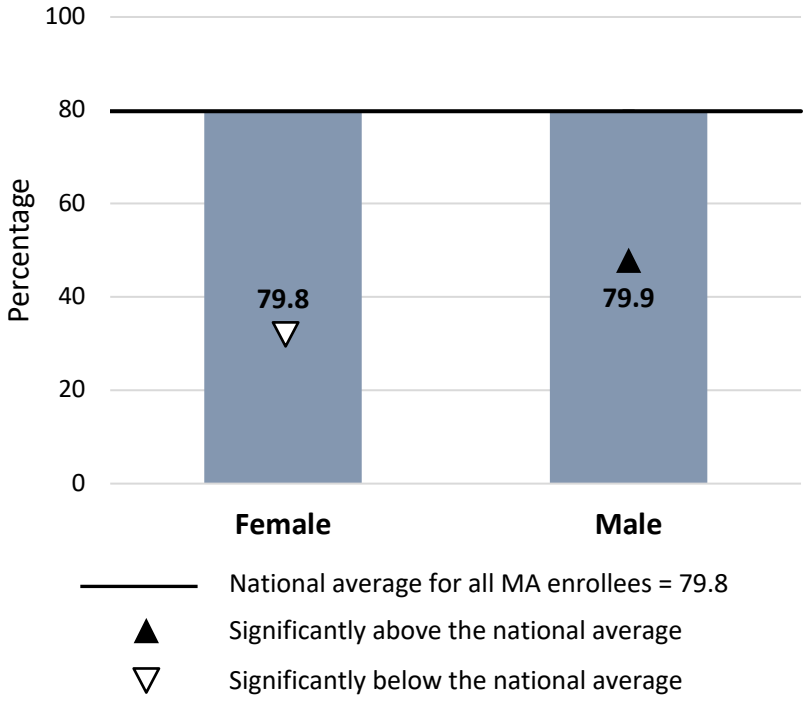
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had their blood sugar level under control was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had their blood sugar level under control was **below** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

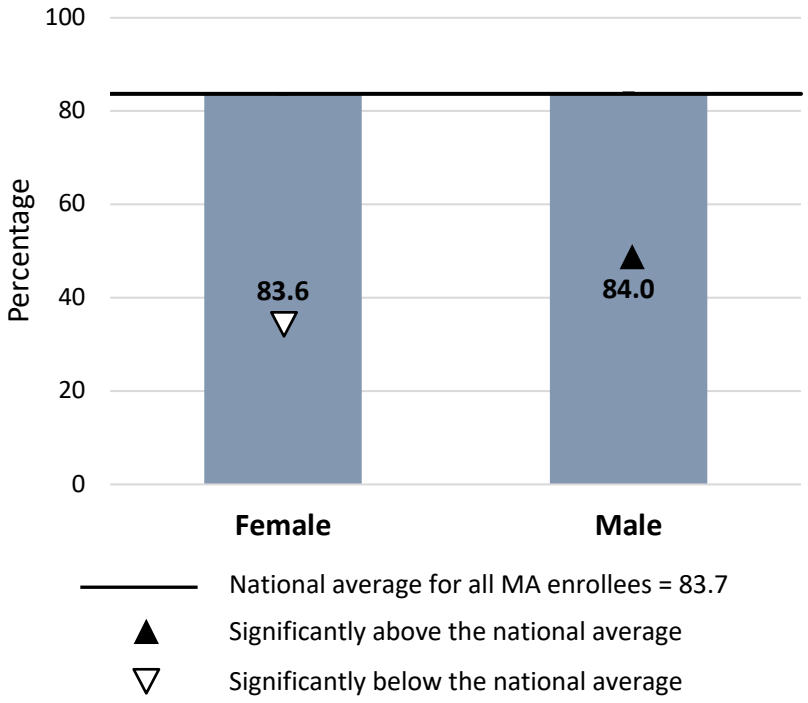
- The percentage of female MA enrollees with diabetes who received statin therapy was **below** the national average by less than 3 percentage points.[‡]
- The percentage of male MA enrollees with diabetes who received statin therapy was **above** the national average by less than 3 percentage points.

[†] Excludes those who also have clinical ASCVD.

[‡] Prior to rounding.

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 who remained on the medication for at least 80 percent of the treatment period, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

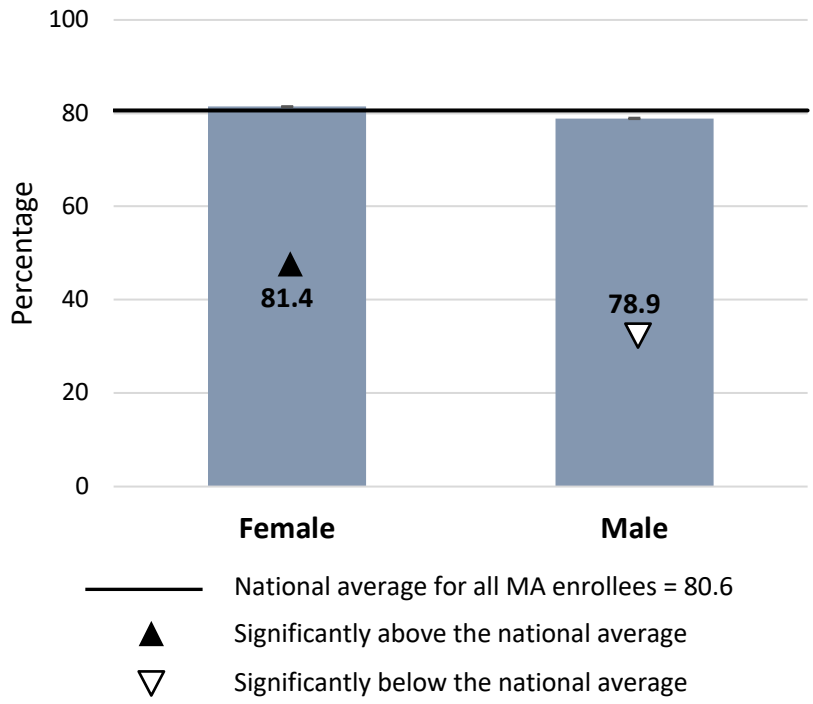
- The percentage of female MA enrollees with diabetes who had proper statin medication adherence was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had proper statin medication adherence was **above** the national average by less than 3 percentage points.

[†] Excludes those who also have clinical ASCVD.

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 sex, Reporting Year 2022



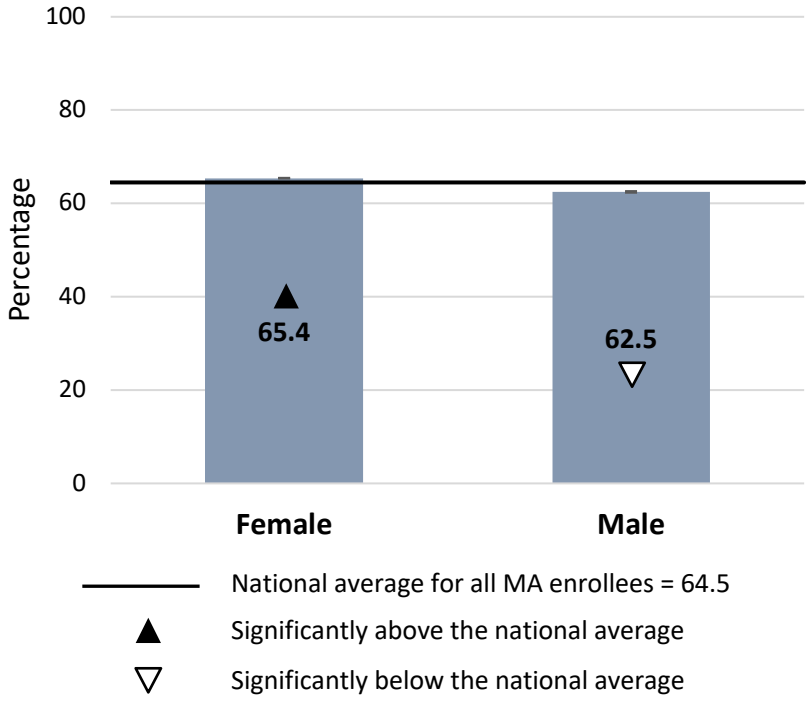
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average by less than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

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



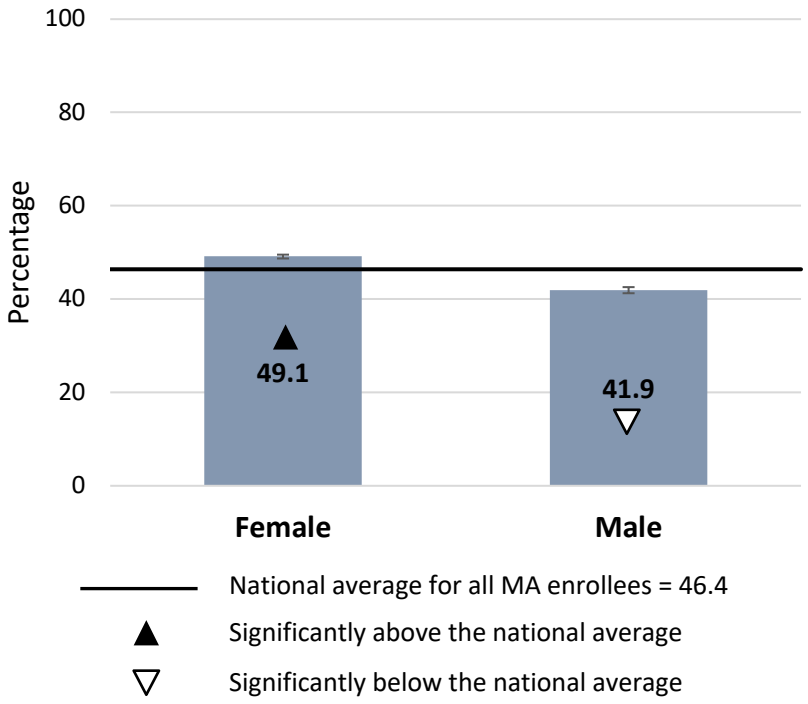
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average by less than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

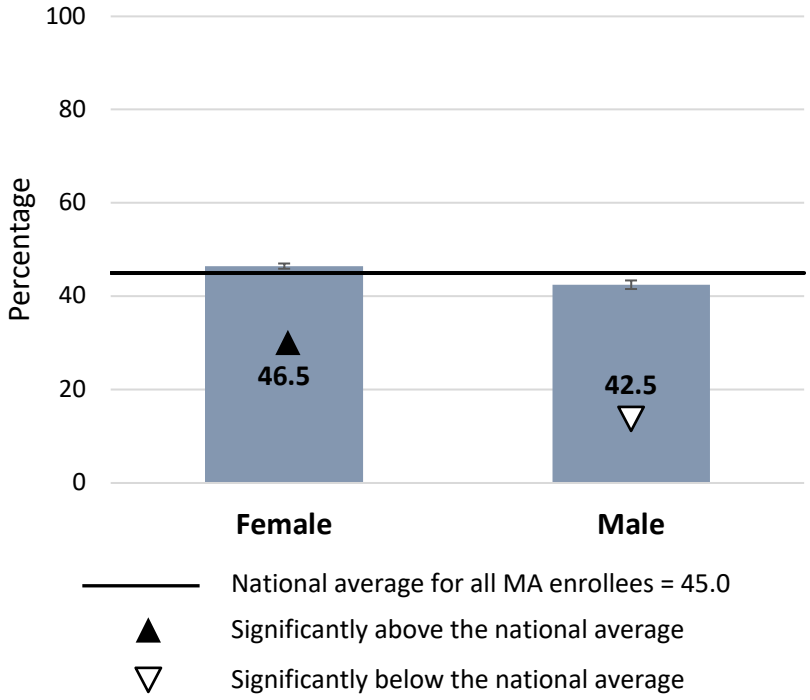
Disparities

- The percentage of female MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average by more than 3 percentage points.

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

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

Percentage of MA enrollees aged 18 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

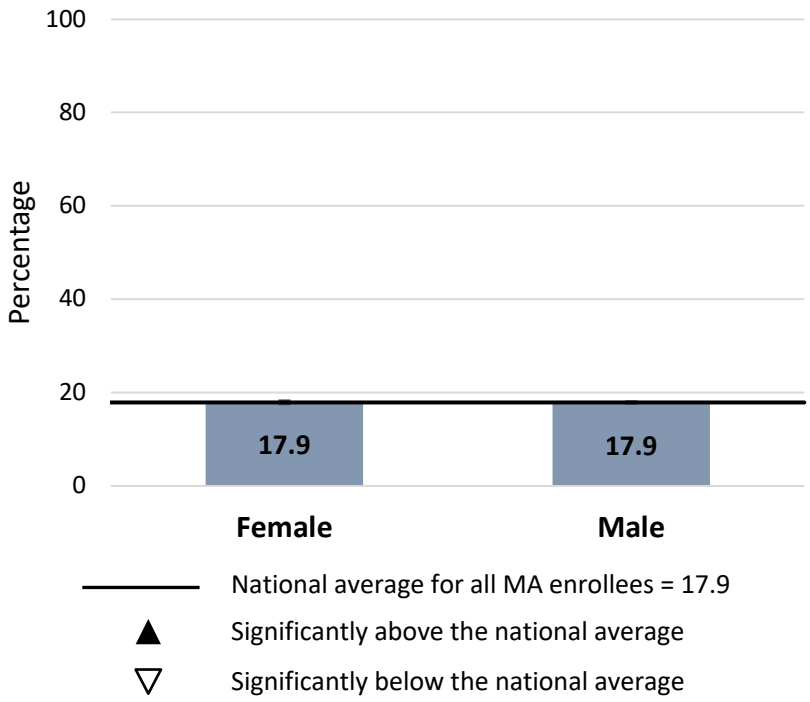
Disparities

- The percentage of female MA enrollees 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 by less than 3 percentage points.
- The percentage of male MA enrollees 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 by less than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

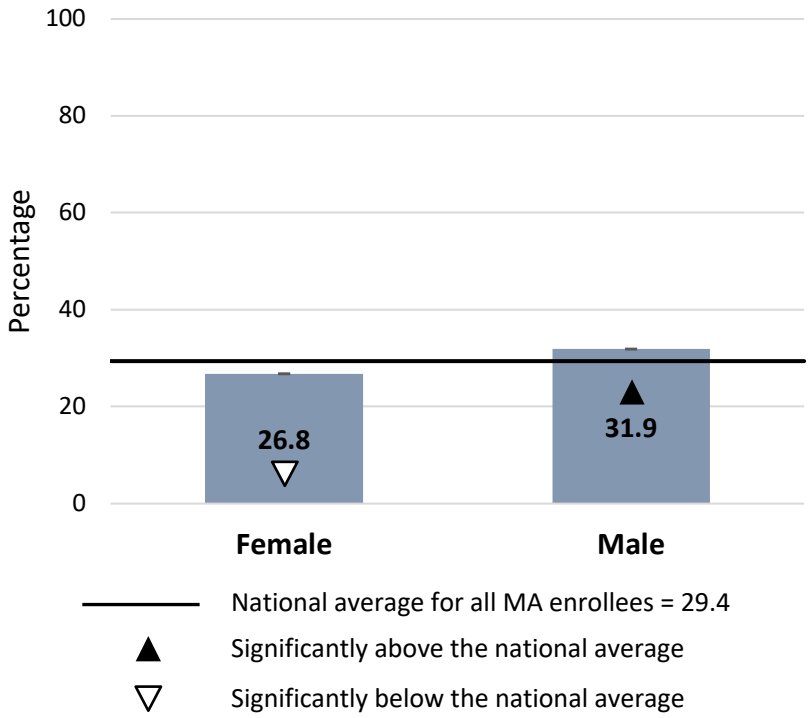
Disparities

- The percentage of female MA enrollees 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.
- The percentage of male MA enrollees 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.

[†] 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 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

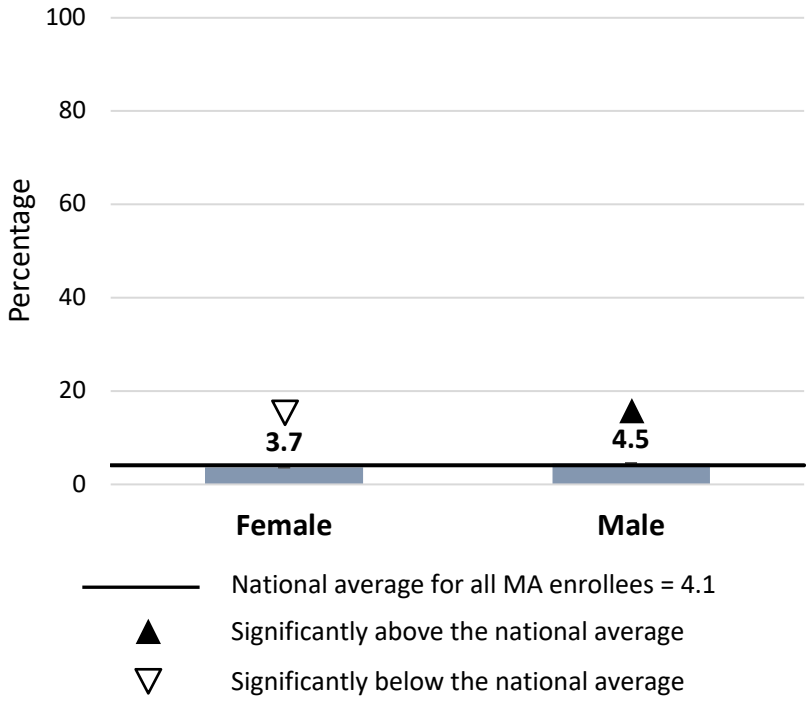
- The percentage of female MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average by less than 3 percentage points.

[†] 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.

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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

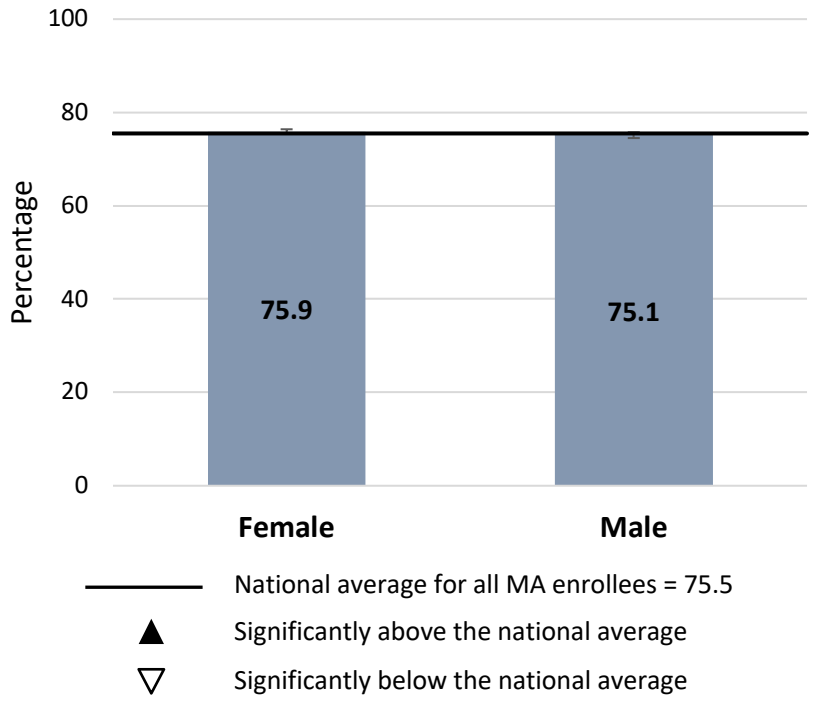
- The percentage of female MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average by less than 3 percentage points.

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

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by sex, Reporting Year 2022



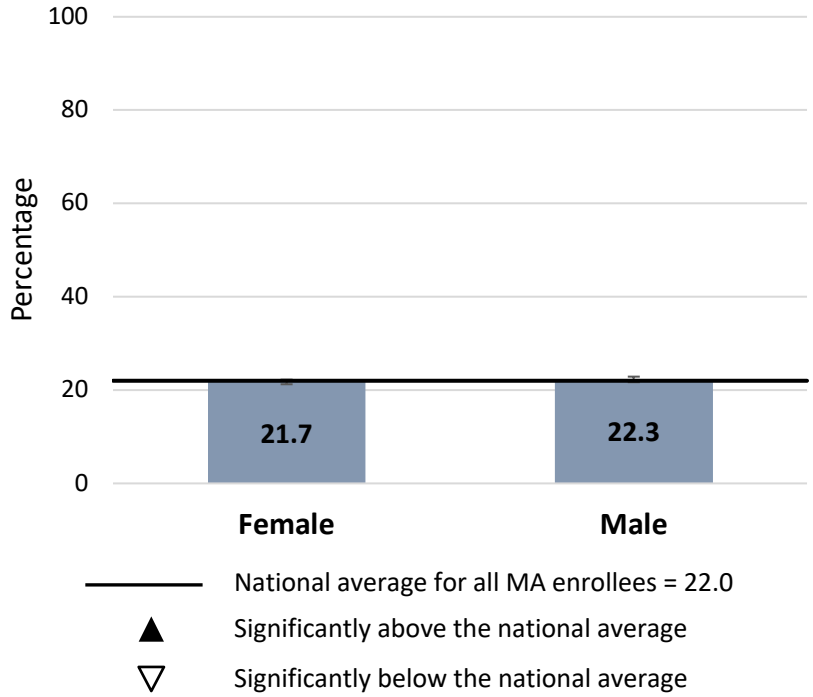
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average.
- The percentage of male MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average.

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 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 sex, Reporting Year 2022



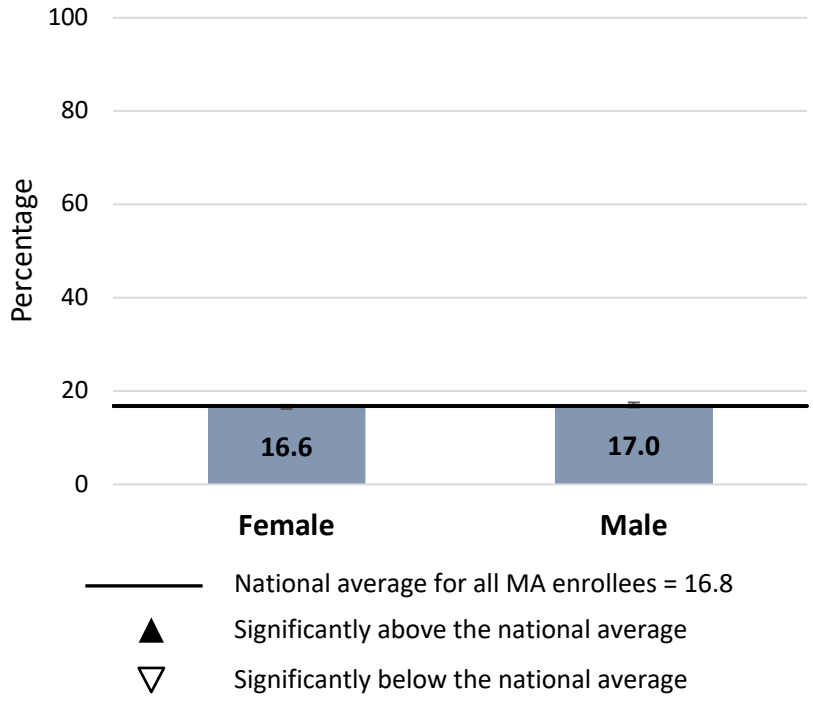
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average.
- The percentage of male MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by sex, Reporting Year 2022



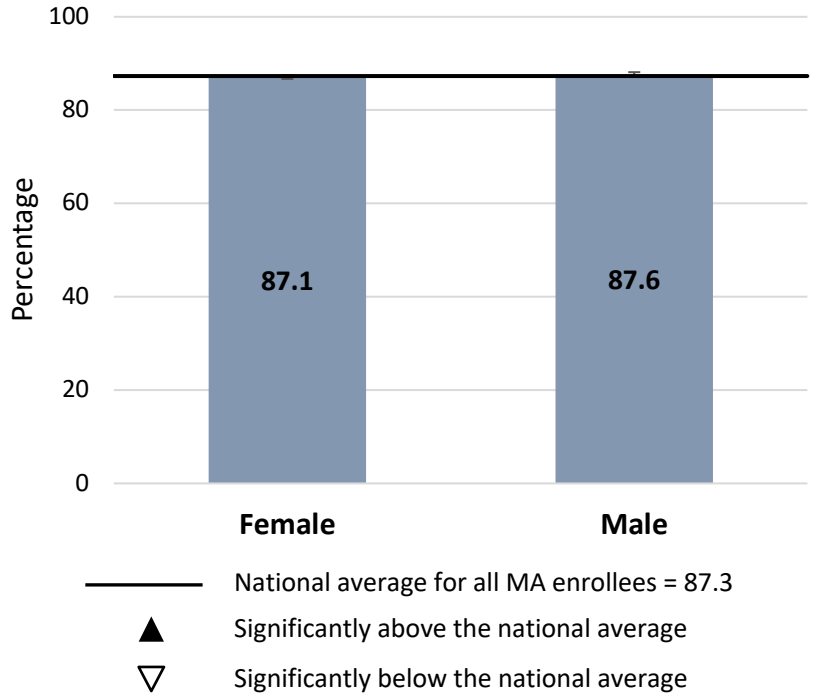
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average.
- The percentage of male MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 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 sex, Reporting Year 2022



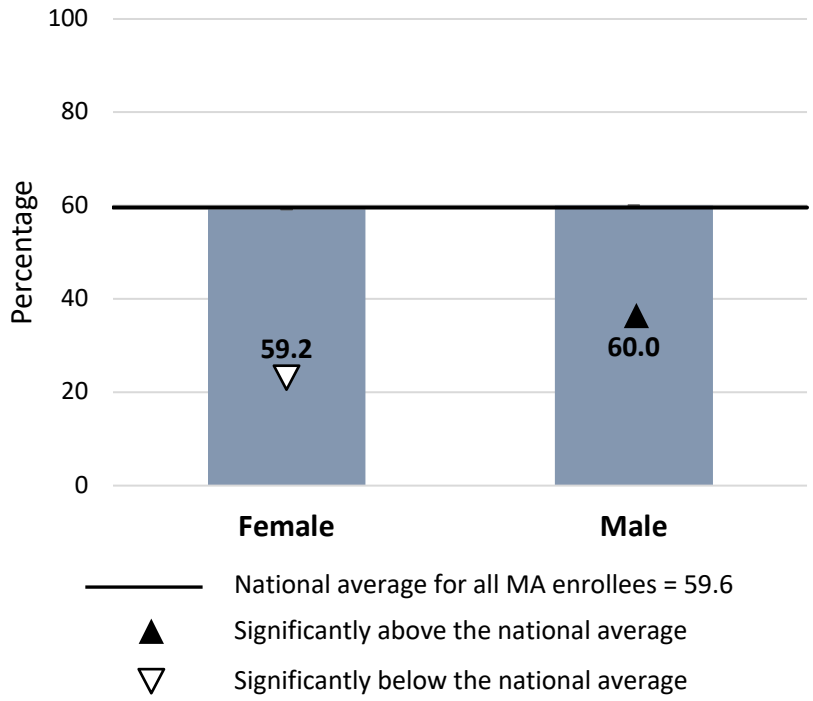
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees 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.
- The percentage of male MA enrollees 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.

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

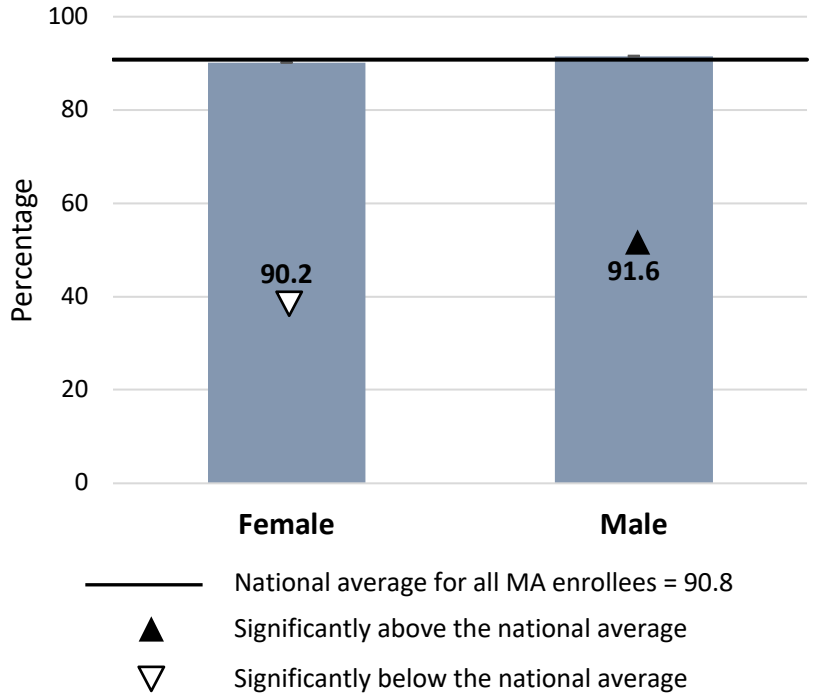
- The percentage of female MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average by less than 3 percentage points.

[†] 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 Medication

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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

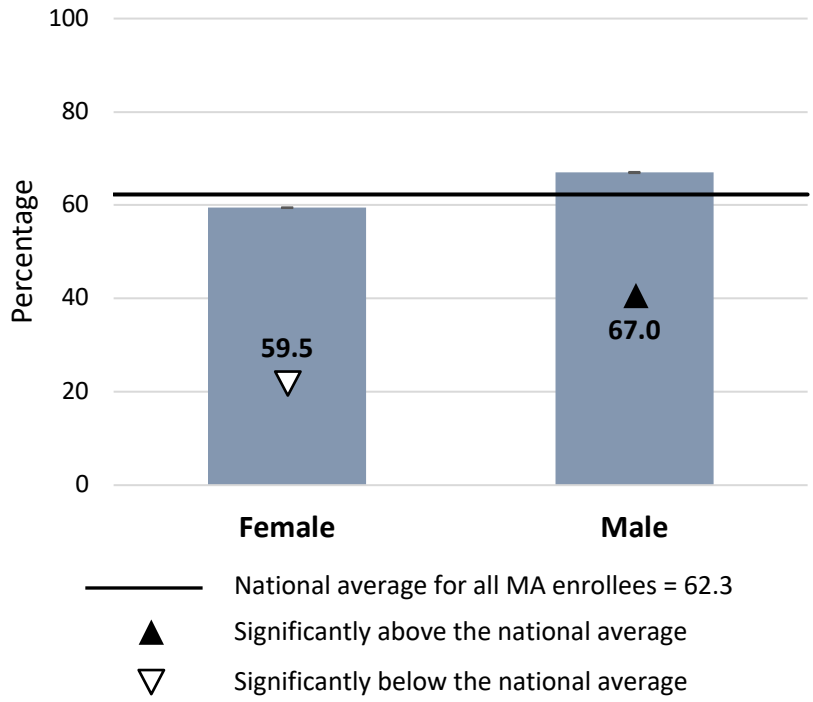
Disparities

- The percentage of older adult female MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult male MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average by less than 3 percentage points.

[†] This includes cyclooxygenase-2 selective 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

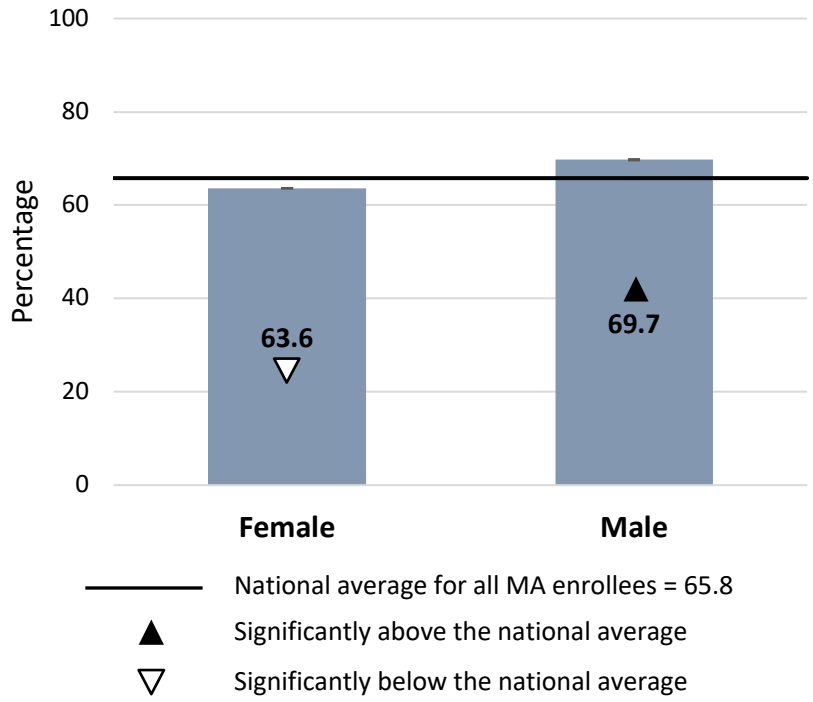
Disparities

- The percentage of older adult female MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult male MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

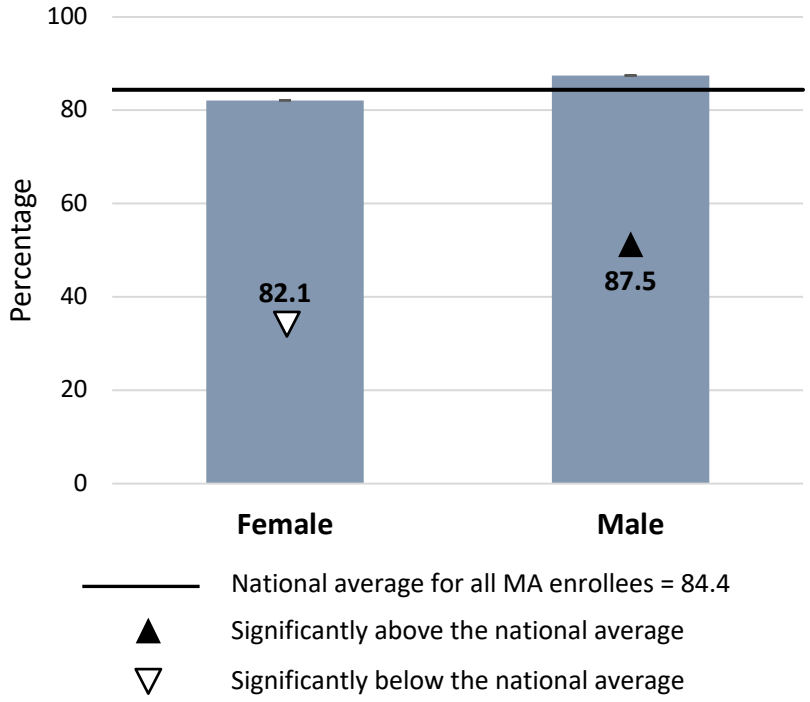
Disparities

- The percentage of older adult female MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult male MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average 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 sex, Reporting Year 2022



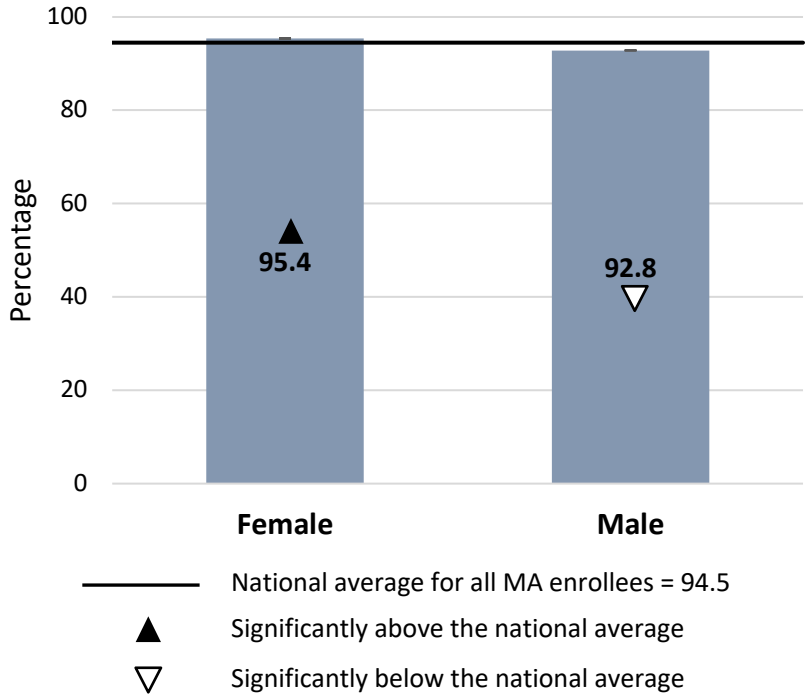
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of older adult female MA enrollees for whom use of high-risk medications was avoided was **below** the national average by less than 3 percentage points.
- The percentage of older adult male MA enrollees for whom use of high-risk medications was avoided was **above** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

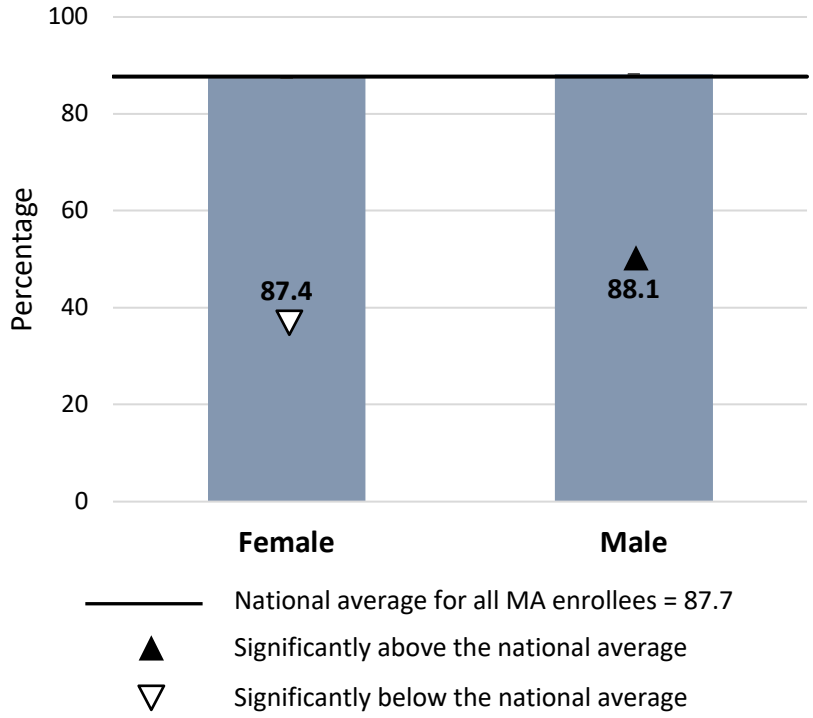
Disparities

- The percentage of female MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average 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 sex, Reporting Year 2022



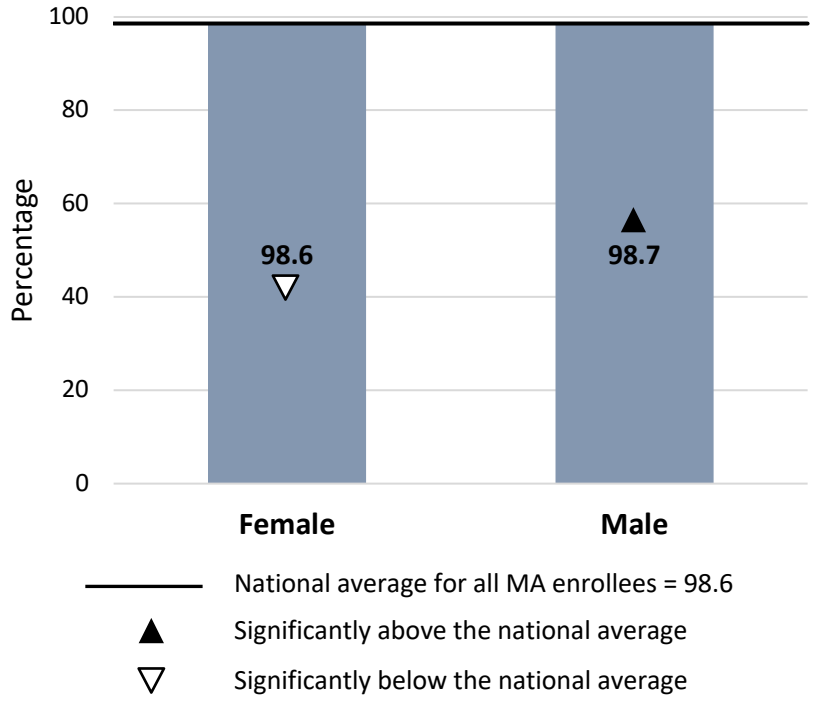
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average by less than 3 percentage points.
- The percentage of male MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average 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 sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

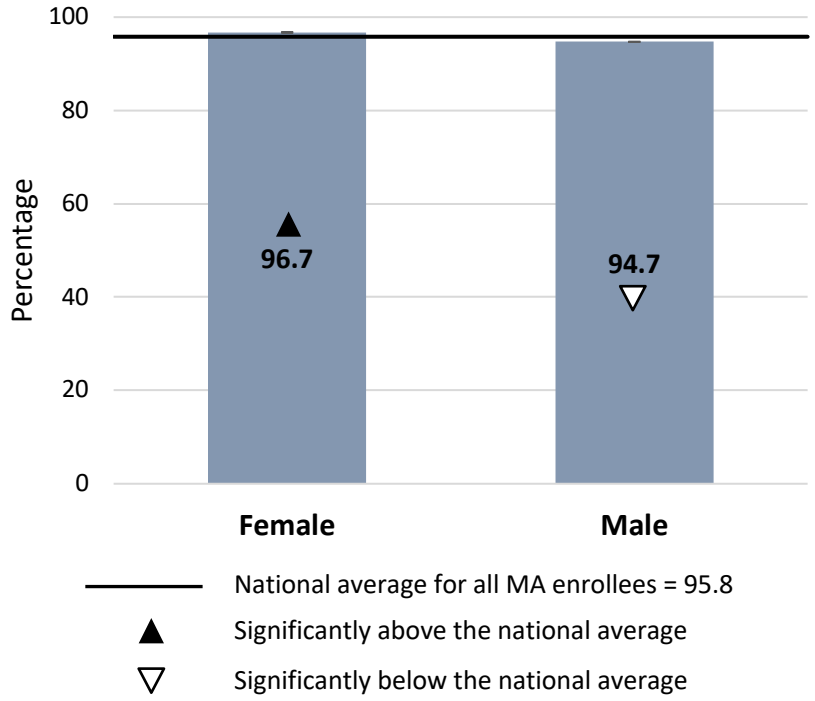
- The percentage of female MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average by less than 3 percentage points.[†]
- The percentage of male MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average by less than 3 percentage points.

[†] Prior to rounding.

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

Disparities

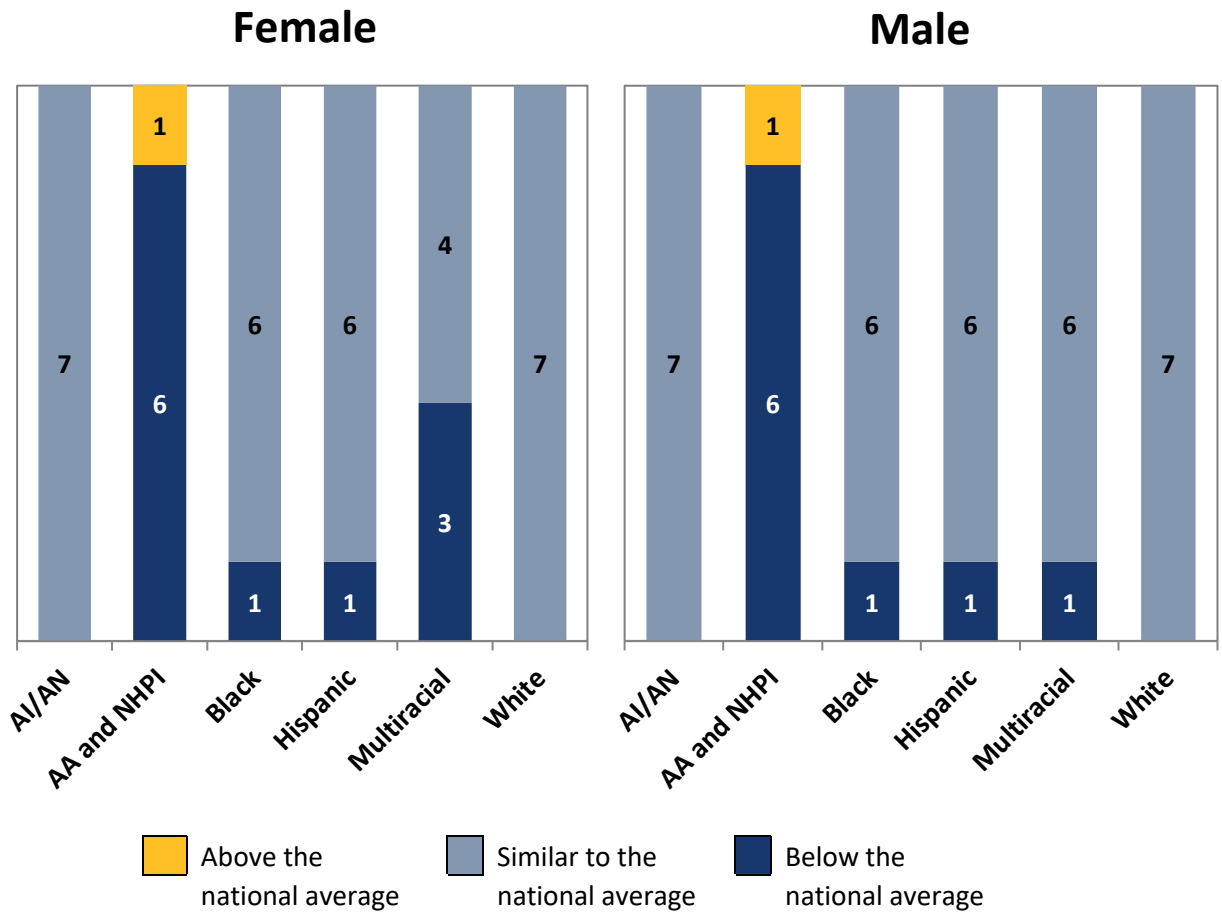
- The percentage of female MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average by less than 3 percentage points.
- The percentage of male MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average by less than 3 percentage points.

SECTION III

Disparities in Health Care in Medicare Advantage by Race and Ethnicity Within Sex

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

Number of patient experience measures (out of 7) for which female or male MA enrollees of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all female or male MA enrollees in 2022



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2022 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Within sex, each racial or ethnic group is compared with the national average for all female/male MA enrollees.

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

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

Female AA and NHPI MA enrollees had results that were below the national average for all female MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Doctors Who Communicate Well • Care Coordination • Getting Needed Prescription Drugs

Female AA and NHPI MA enrollees had results that were above the national average for all female MA enrollees
• Annual Flu Vaccine

Female Black MA enrollees had results that were below the national average for all female MA enrollees
• Annual Flu Vaccine

Female Hispanic MA enrollees had results that were below the national average for all female MA enrollees
• Getting Appointments and Care Quickly

Female Multiracial MA enrollees had results that were below the national average for all female MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Annual Flu Vaccine

Male AA and NHPI MA enrollees had results that were below the national average for all male MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Doctors Who Communicate Well • Care Coordination • Getting Needed Prescription Drugs

Male AA and NHPI MA enrollees had results that were above the national average for all male MA enrollees
• Annual Flu Vaccine

Male Black MA enrollees had results that were below the national average for all male MA enrollees
• Annual Flu Vaccine

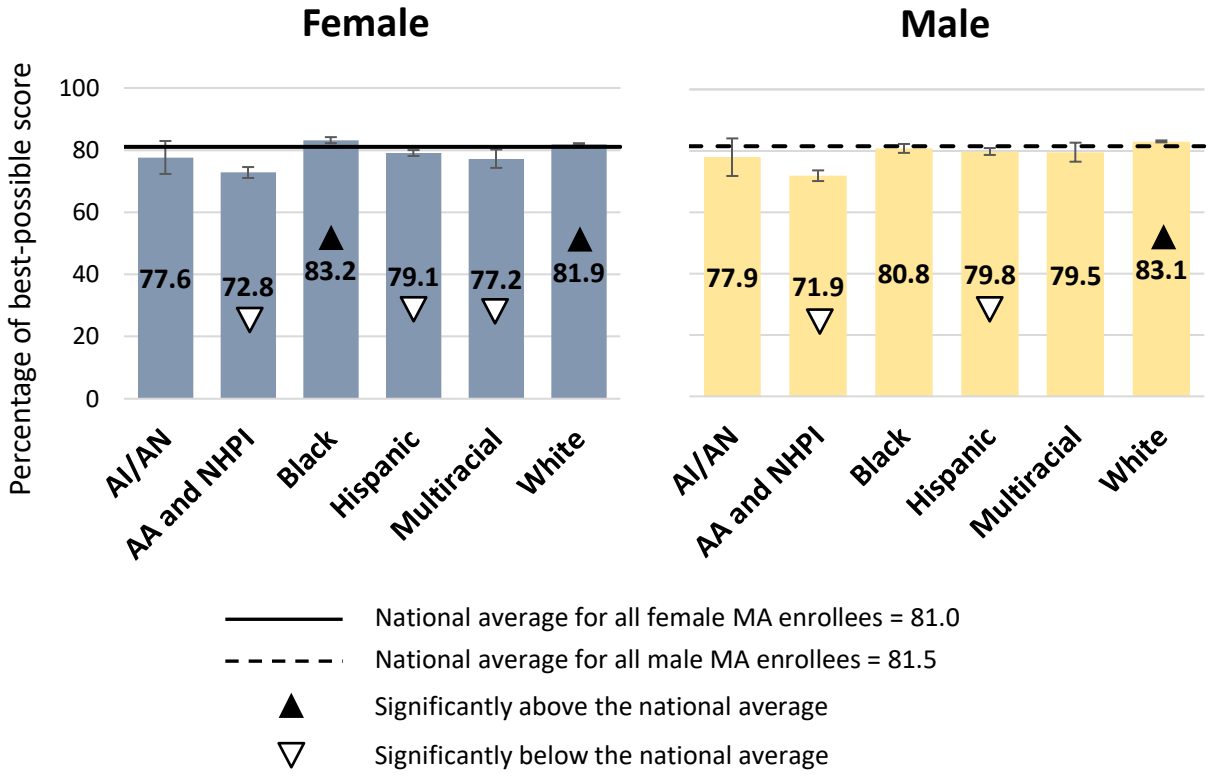
Male Hispanic MA enrollees had results that were below the national average for all male MA enrollees
• Getting Appointments and Care Quickly

Male Multiracial MA enrollees had results that were below the national average for all male MA enrollees
• Annual Flu Vaccine

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Disparities

- Female AI/AN MA enrollees reported experiences with getting needed care that were **similar to** the national average for all female MA enrollees. Female AA and NHPI and Multiracial MA enrollees each reported experiences with getting needed care that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Hispanic MA enrollees reported experiences with getting needed care that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.[§] Female Black and White MA enrollees each reported experiences with getting needed care that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.

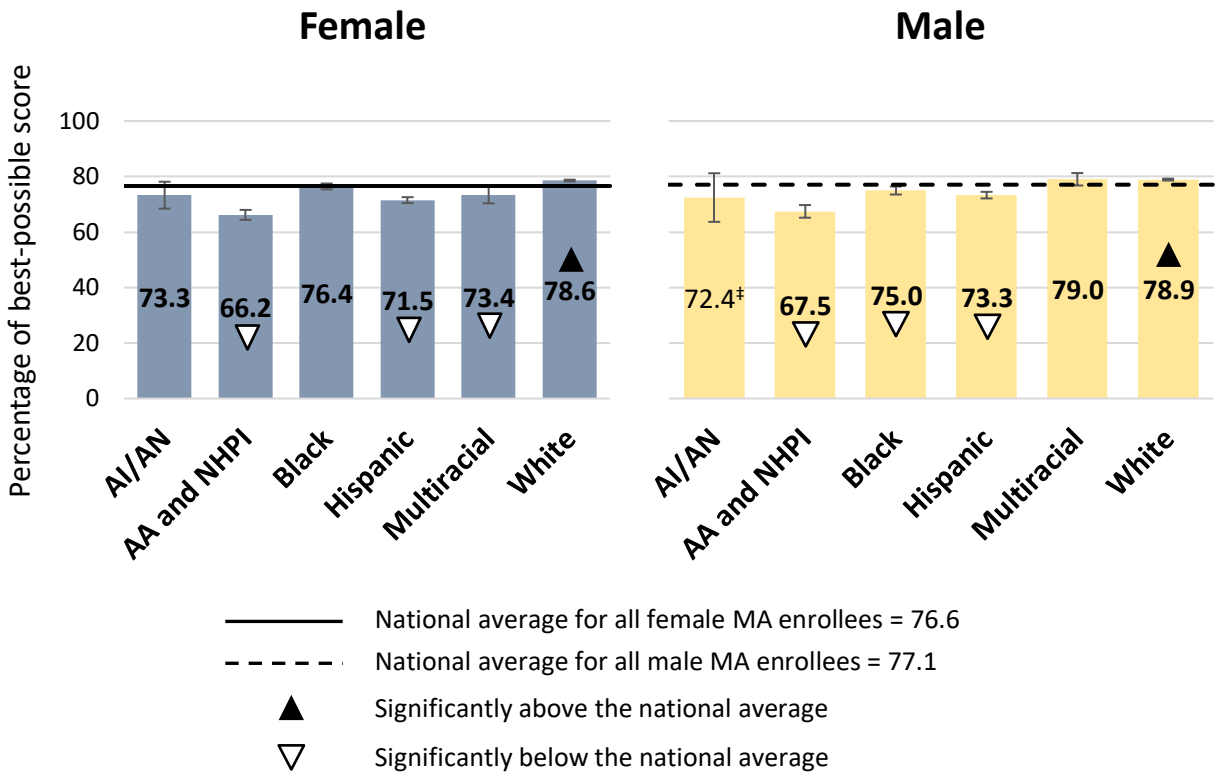
[†] This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

[§] Unlike on pages 103–105, 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.

- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with getting needed care that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with getting needed care that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic MA enrollees reported experiences with getting needed care that were **below** the national average for all male MA enrollees by less than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting needed care that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Disparities

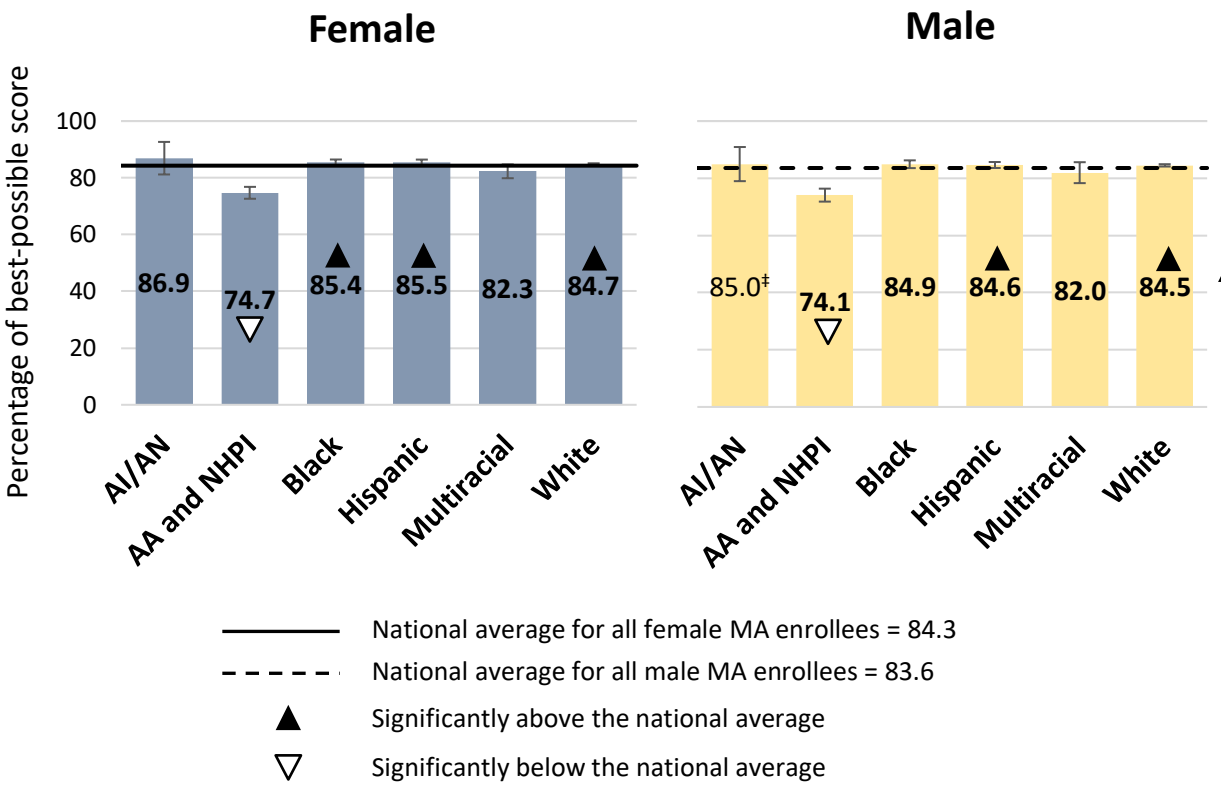
- Female AI/AN and Black MA enrollees each reported experiences with getting appointments and care quickly that were **similar to** the national average for all female MA enrollees. Female AA and NHPI, Hispanic, and Multiracial MA enrollees each reported experiences with getting appointments and care quickly that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average for all female MA enrollees 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.

- Male AI/AN and Multiracial MA enrollees each reported experiences with getting appointments and care quickly that were **similar to** the national average for all male MA enrollees. Male AA and NHPI and Hispanic MA enrollees each reported experiences with getting appointments and care quickly that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Black MA enrollees reported experiences with getting appointments and care quickly that were **below** the national average for all male MA enrollees by less than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average for all male MA enrollees 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 race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Disparities

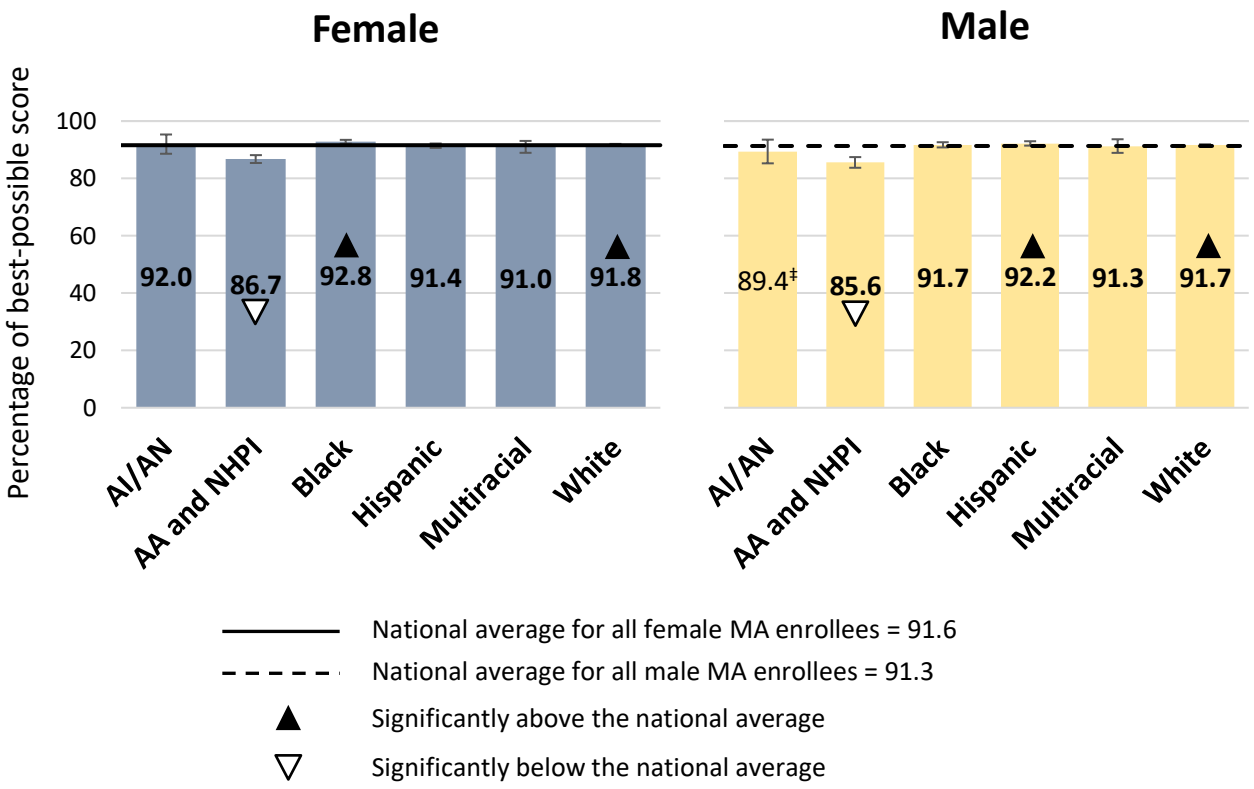
- Female AI/AN and Multiracial MA enrollees each reported experiences with customer service that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Black, Hispanic, and White MA enrollees each reported experiences with customer service that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.

† 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.

- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with customer service that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic and White MA enrollees each reported experiences with customer service that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Disparities

- Female AI/AN, Hispanic, and Multiracial MA enrollees each reported experiences with doctor communication that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with doctor communication that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Black and White MA enrollees each reported experiences with doctor communication that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with doctor communication that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with doctor communication that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic and White MA enrollees each reported experiences with doctor communication that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

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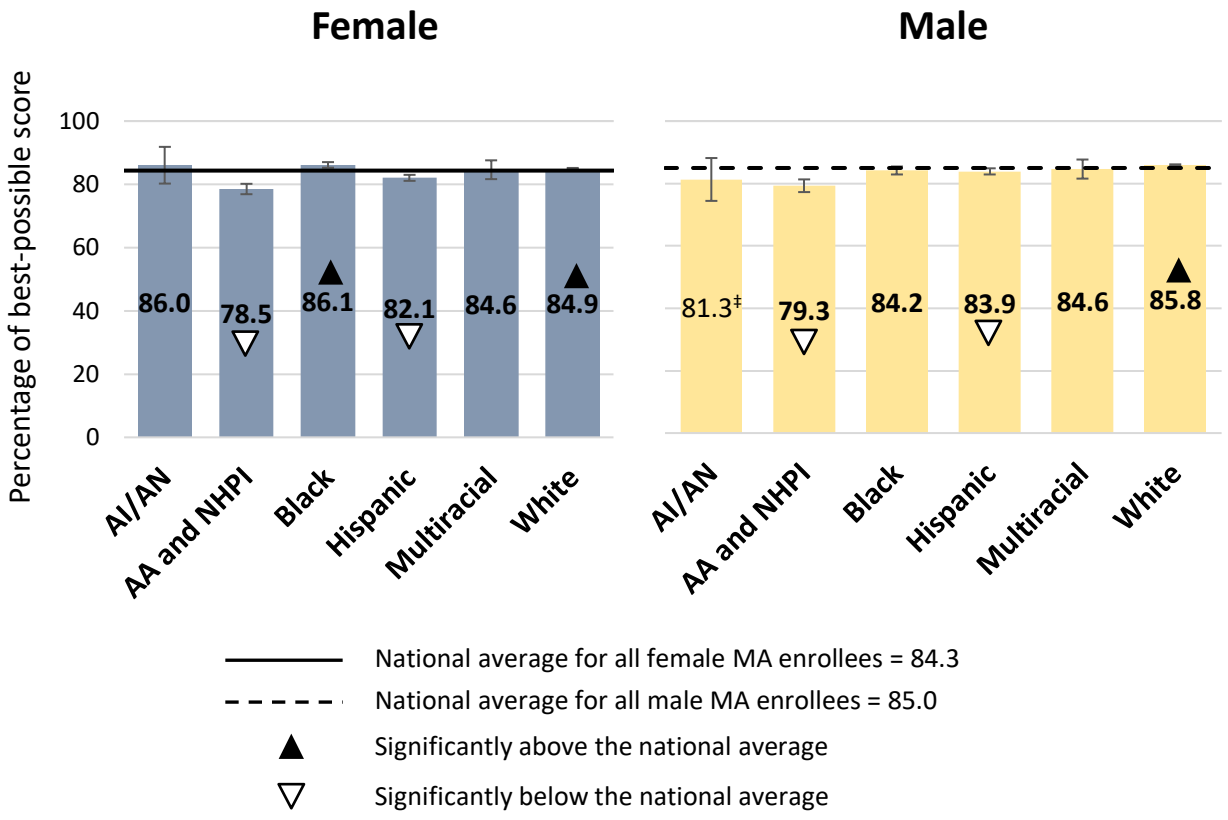
† This includes how often in the last six months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent enough time with patients.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patient care was coordinated,† by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Disparities

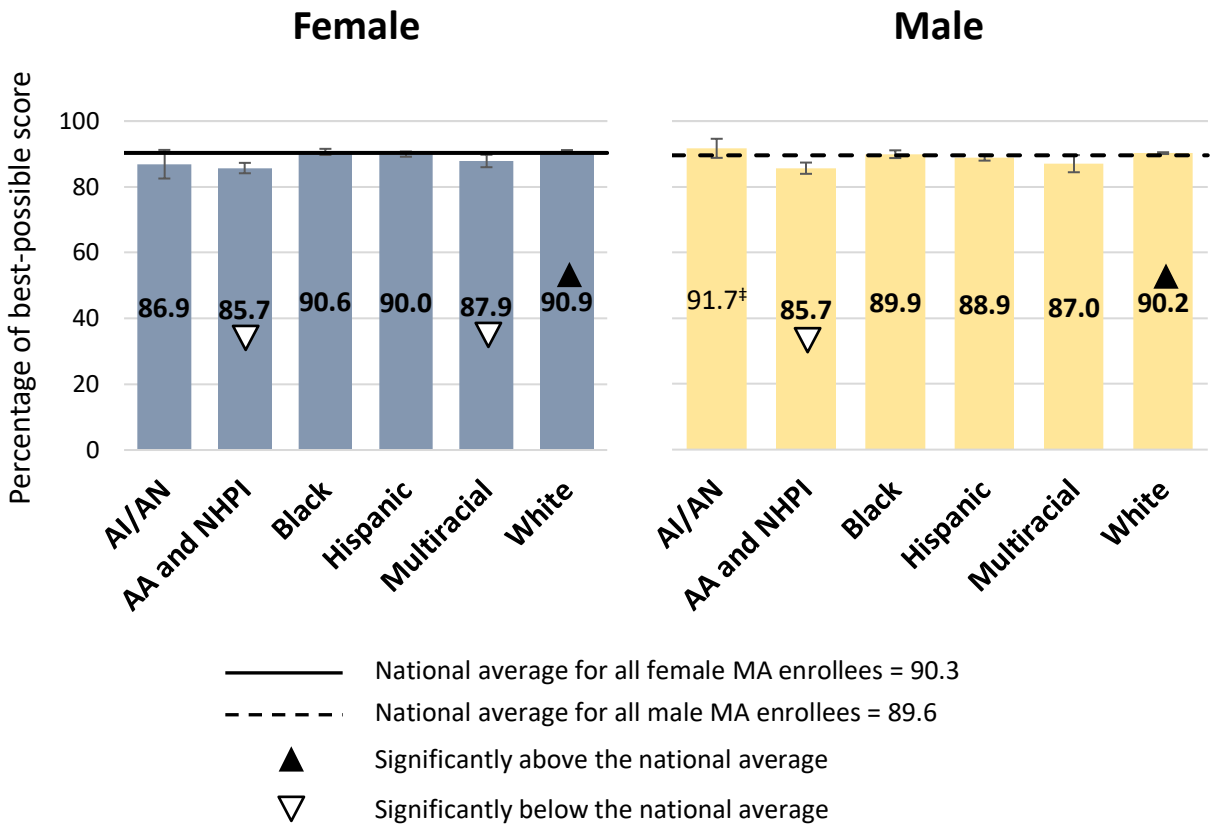
- Female AI/AN and Multiracial MA enrollees each reported experiences with care coordination that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with care coordination that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Hispanic MA enrollees reported experiences with care coordination that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale. Female Black and White MA enrollees each reported experiences with care coordination that were **above** the national average for all female MA enrollees 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.

- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with care coordination that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with care coordination that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic MA enrollees reported experiences with care coordination that were **below** the national average for all male MA enrollees by less than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with care coordination that were **above** the national average for all male MA enrollees 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 plans,† by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Disparities

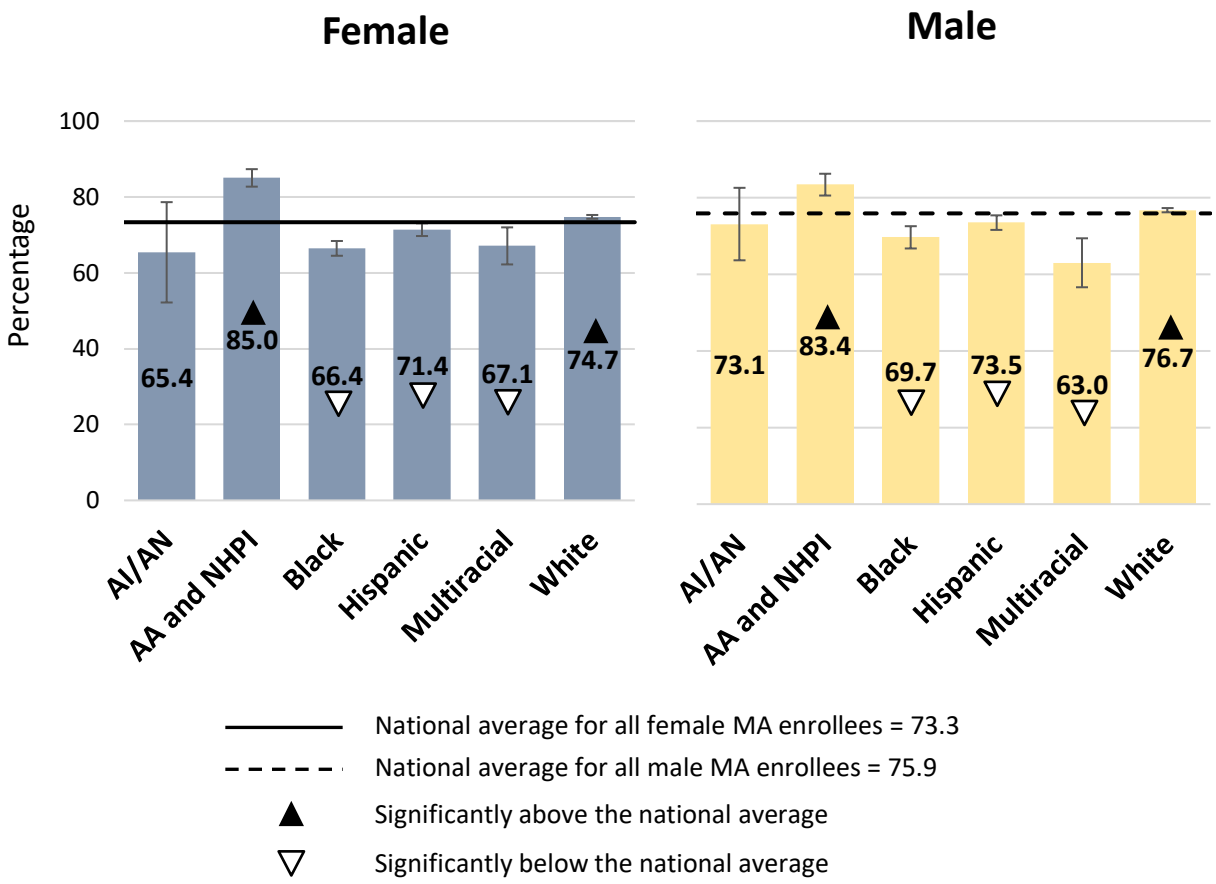
- Female AI/AN, Black, and Hispanic MA enrollees each reported experiences with getting needed prescription drugs that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Multiracial MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale. Female White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.

† 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.

- Male AI/AN, Black, Hispanic, and Multiracial MA enrollees each reported experiences with getting needed prescription drugs that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by race and ethnicity within sex, 2022



SOURCE: Data are from the Medicare CAHPS survey, 2022.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

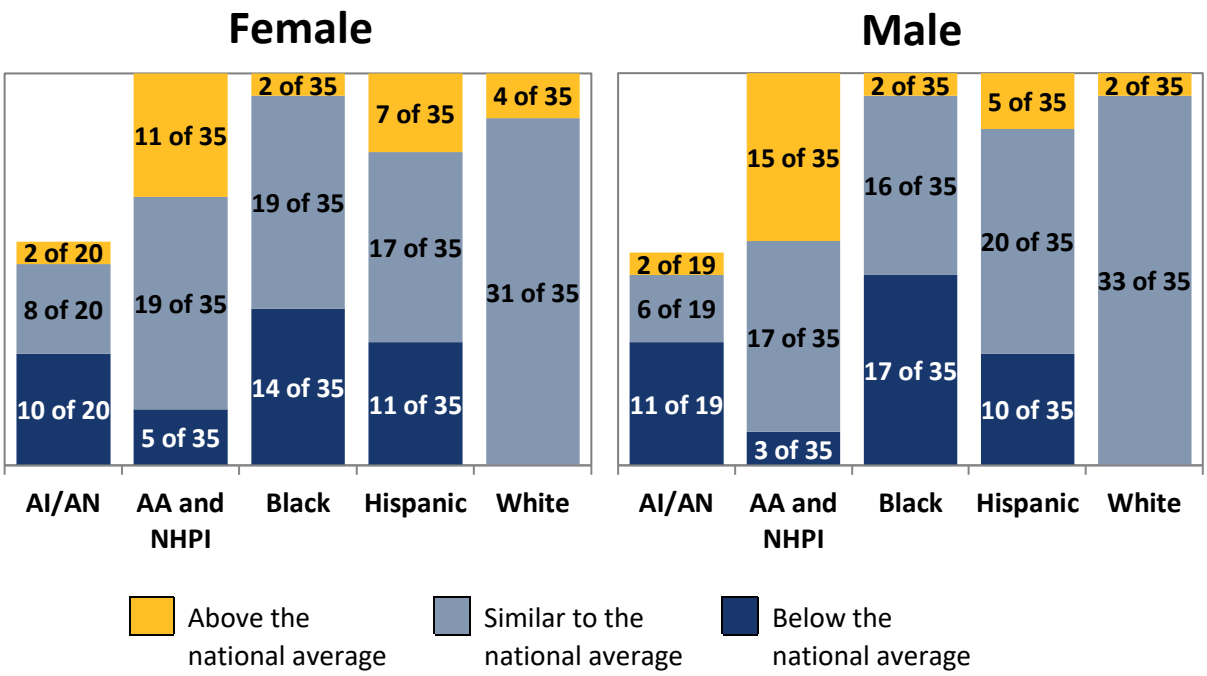
Disparities

- The percentage of female AI/AN MA enrollees who received the flu vaccine was **similar to** the national average for all female MA enrollees. The percentage of female AA and NHPI MA enrollees who received the flu vaccine was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female Black and Multiracial MA enrollees who received the flu vaccine were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees who received the flu vaccine was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female White MA enrollees who received the flu vaccine was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees who received the flu vaccine was **similar to** the national average for all male MA enrollees. The percentage of male AA and NHPI MA enrollees who received the flu vaccine was **above** the national average for all male MA enrollees by more

than 3 percentage points. The percentages of male Black and Multiracial MA enrollees who received the flu vaccine were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male Hispanic MA enrollees who received the flu vaccine was **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees who received the flu vaccine was **above** the national average for all male MA enrollees by less than 3 percentage points.

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

Number of clinical care measures for which female or male MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all female or male MA enrollees in Reporting Year 2022



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (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 for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet standards described on page 4. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Within sex, each racial or ethnic group is compared with the national average for all female and male MA enrollees.

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

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

Female AI/AN MA enrollees had results that were below the national average for all female MA enrollees

- Testing to Confirm COPD
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Avoiding Use of High-Risk Medications in Older Adults
- Avoiding Use of Opioids at High Dosage
- Avoiding Use of Opioids from Multiple Prescribers

Female AI/AN MA enrollees had results that were above the national average for all female MA enrollees

- Initiation of AOD Dependence Treatment
- Engagement of AOD Dependence Treatment

Female AA and NHPI MA enrollees had results that were below the national average for all female MA enrollees

- Testing to Confirm COPD
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Initiation of AOD Dependence Treatment

Female AA and NHPI MA enrollees had results that were above the national average for all female MA enrollees

- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- 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 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

Female Black MA enrollees had results that were below the national average for all female MA enrollees

- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information

Female Black MA enrollees had results that were above the national average for all female MA enrollees

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

Female Hispanic MA enrollees had results that were below the national average for all female MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Continuous Beta-Blocker Treatment After a Heart Attack
- 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
- 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 Use of High-Risk Medications in Older Adults

Female Hispanic MA enrollees had results that were above the national average for all female MA enrollees

- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Transitions of Care—Patient Engagement After Inpatient Discharge

Female White MA enrollees had results that were above the national average for all female enrollees

- 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)
- Initiation of AOD Dependence Treatment

Male AI/AN MA enrollees had results that were below the national average for all male MA enrollees

- Testing to Confirm COPD
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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
- Older Adults' Access to Preventive and Ambulatory Services

Male AI/AN MA enrollees had results that were above the national average for all male MA enrollees

- Initiation of AOD Dependence Treatment
- Engagement of AOD Dependence Treatment

Male AA and NHPI MA enrollees had results that were below the national average for all male MA enrollees

- Testing to Confirm COPD
- Antidepressant Medication Management—Continuation Phase Treatment
- Initiation of AOD Dependence Treatment

Male AA and NHPI MA enrollees had results that were above the national average for all male MA enrollees

- Colorectal Cancer Screening
- Pharmacotherapy Management of COPD Exacerbation—Use of Bronchodilator
- Statin Use in Patients with Cardiovascular Disease
- 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
- 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 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
- Avoiding Use of Opioids at High Dosage

Male Black MA enrollees had results that were below the national average for all male MA enrollees

- Testing to Confirm COPD
- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- 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—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Male Black MA enrollees had results that were above the national average for all male MA enrollees

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

Male Hispanic MA enrollees had results that were below the national average for all male MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Diabetes—Statins
- 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)
- Initiation of AOD Dependence Treatment
- 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

Male Hispanic MA enrollees had results that were above the national average for all male MA enrollees

- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

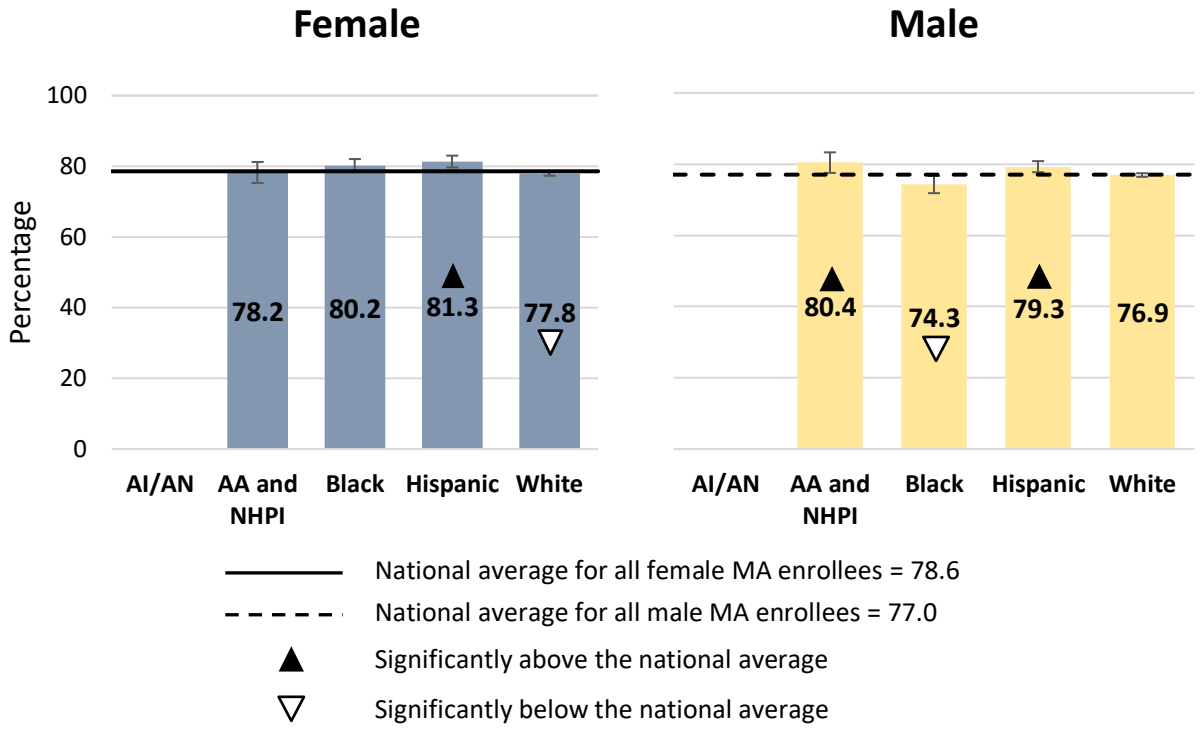
Male White MA enrollees had results that were above the national average for all male MA enrollees

- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Clinical Care: Prevention and Screening

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentages of eligible[†] female AA and NHPI and Black MA enrollees who were appropriately screened for colorectal cancer were **similar to** the national average for all female MA enrollees. The percentage of eligible female Hispanic MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all female MA enrollees by less than 3 percentage points.[‡] The percentage of eligible female White MA enrollees who were appropriately screened for colorectal cancer was **below** the national average for all female MA enrollees by less than 3 percentage points.

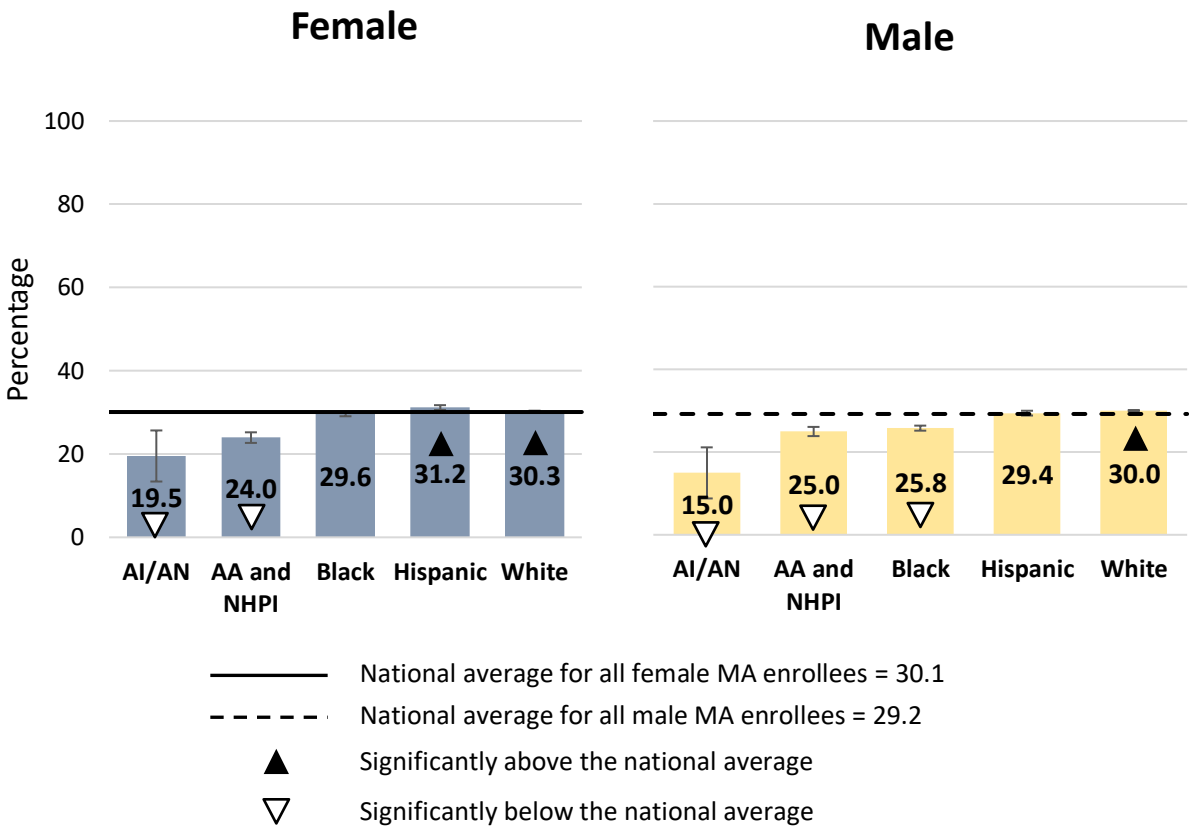
[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (which are specified in the chart subtitle).
[‡] Unlike on the preceding five pages, we describe all statistically 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.

- The percentage of eligible male AA and NHPI MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male Black MA enrollees who were appropriately screened for colorectal cancer was **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of eligible male White MA enrollees who were appropriately screened for colorectal cancer was **similar to** the national average for all male MA enrollees.

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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

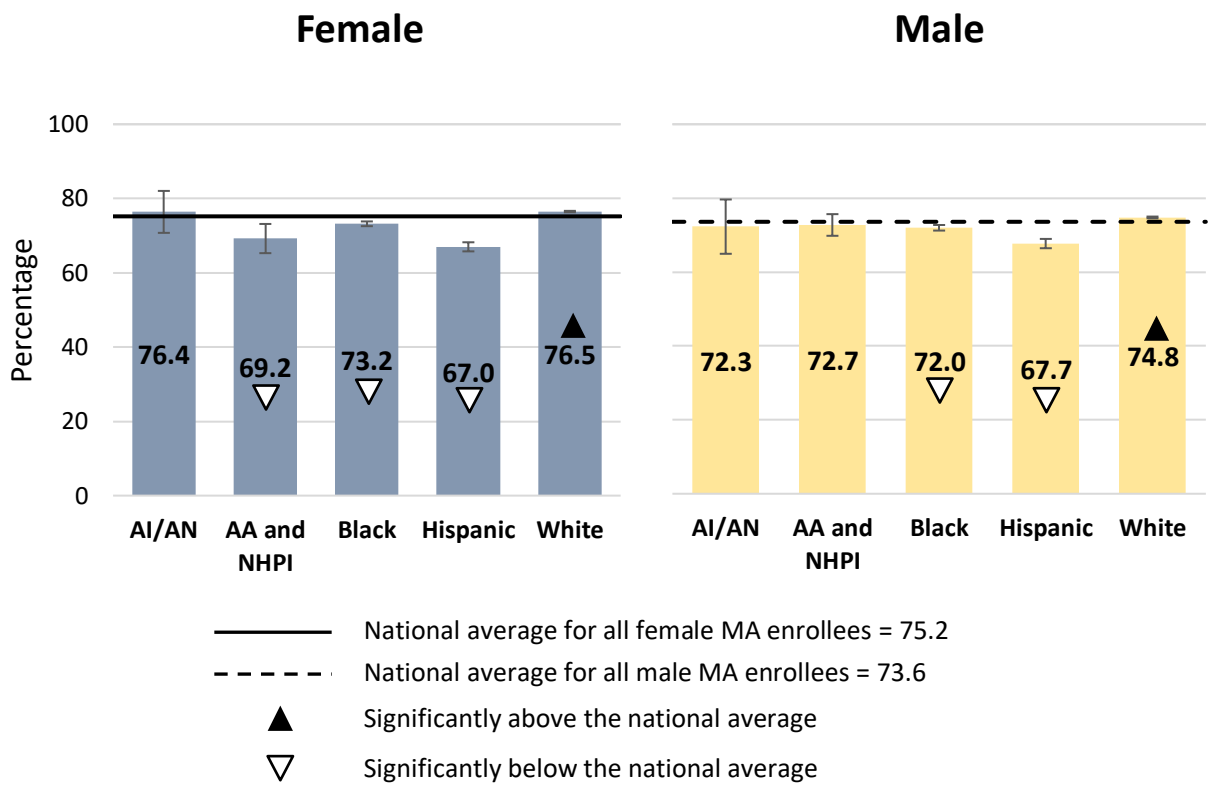
Disparities

- The percentages of eligible female AI/AN and AA and NHPI MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female Black MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **similar to** the national average for all female MA enrollees. The percentages of eligible female Hispanic and White MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **above** the national average for all female MA enrollees by less than 3 percentage points.

- The percentages of eligible male AI/AN, AA and NHPI, and Black MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **similar to** the national average for all male MA enrollees. The percentage of eligible male White MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

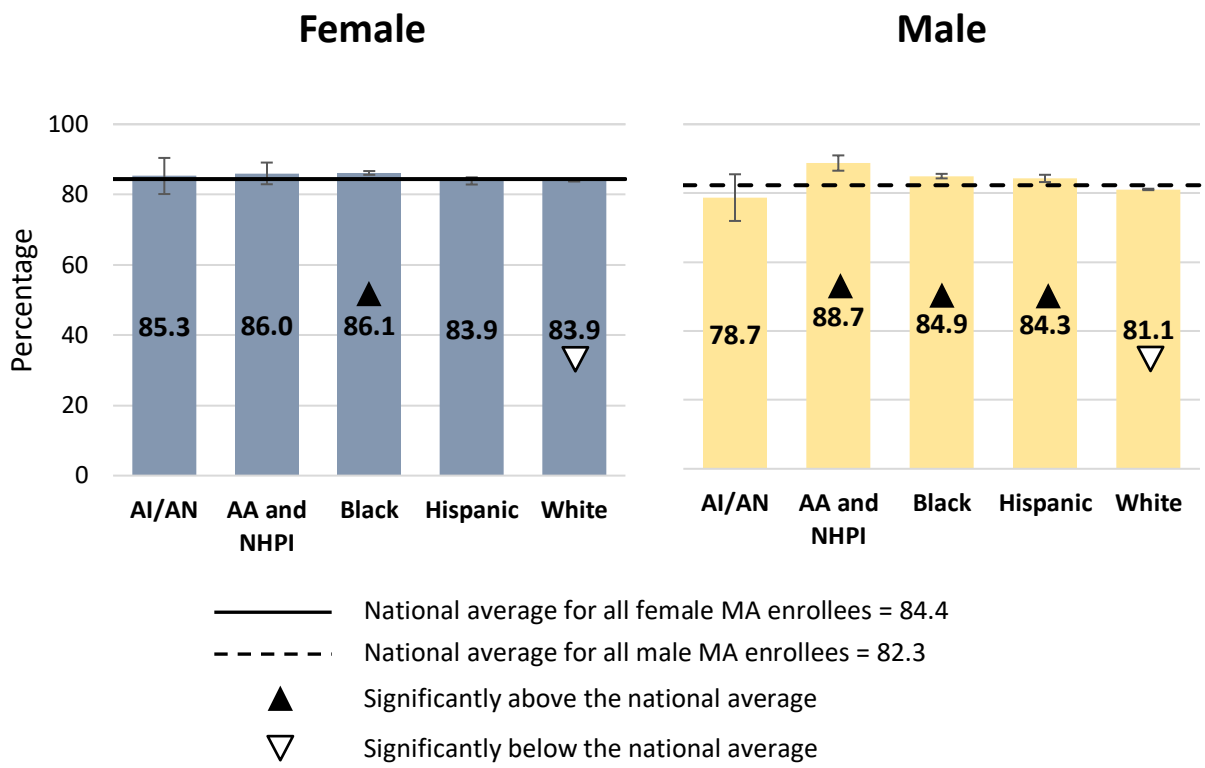
Disparities

- The percentage of eligible female AI/AN MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were **similar to** the national average for all female MA enrollees. The percentages of eligible female AA and NHPI and Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all female MA enrollees by less than 3 percentage points.

- The percentages of eligible male AI/AN and AA and NHPI MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **similar to** the national average for all male MA enrollees. The percentage of eligible male Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

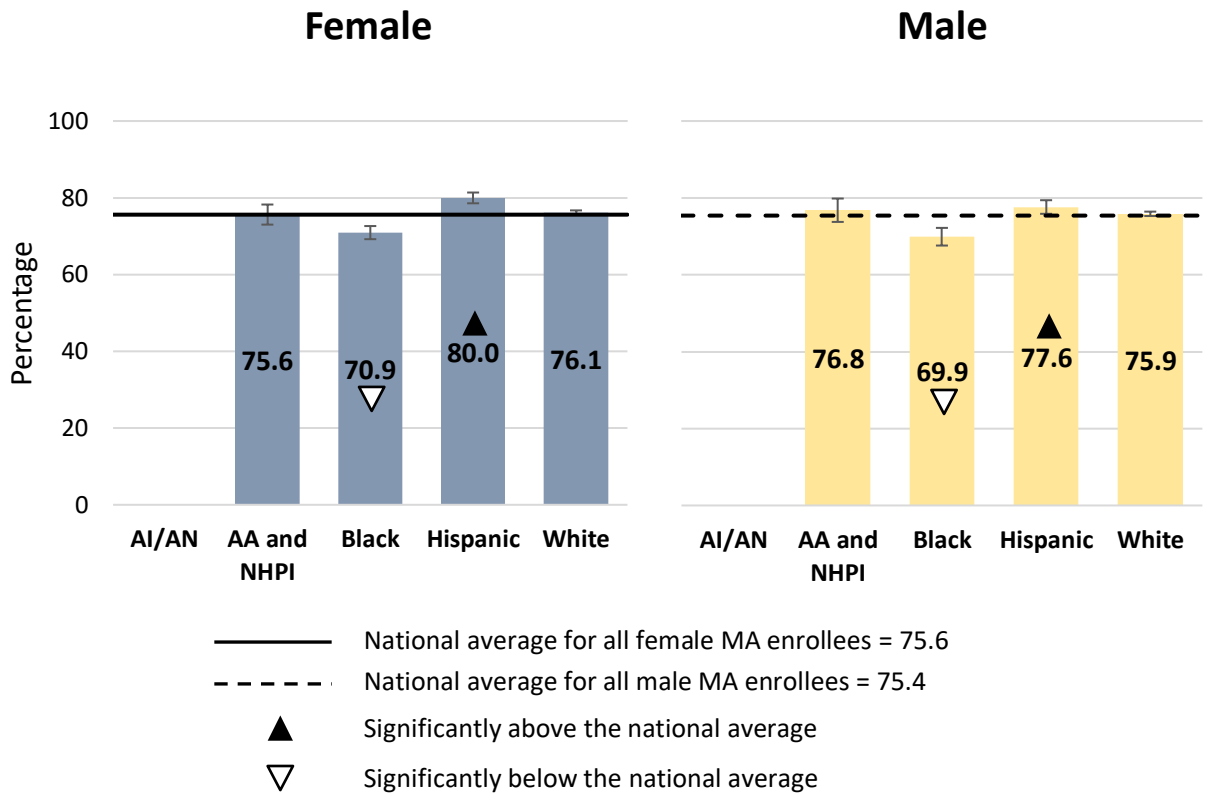
- The percentages of eligible female AI/AN, AA and NHPI, and Hispanic MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation were **similar to** the national average for all female MA enrollees. The percentage of eligible female Black MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all female MA enrollees by less than 3 percentage points.

- The percentage of eligible male AI/AN MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average for all male MA enrollees. The percentage of eligible male AA and NHPI MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of eligible male Black and Hispanic MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation were each **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of eligible male White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

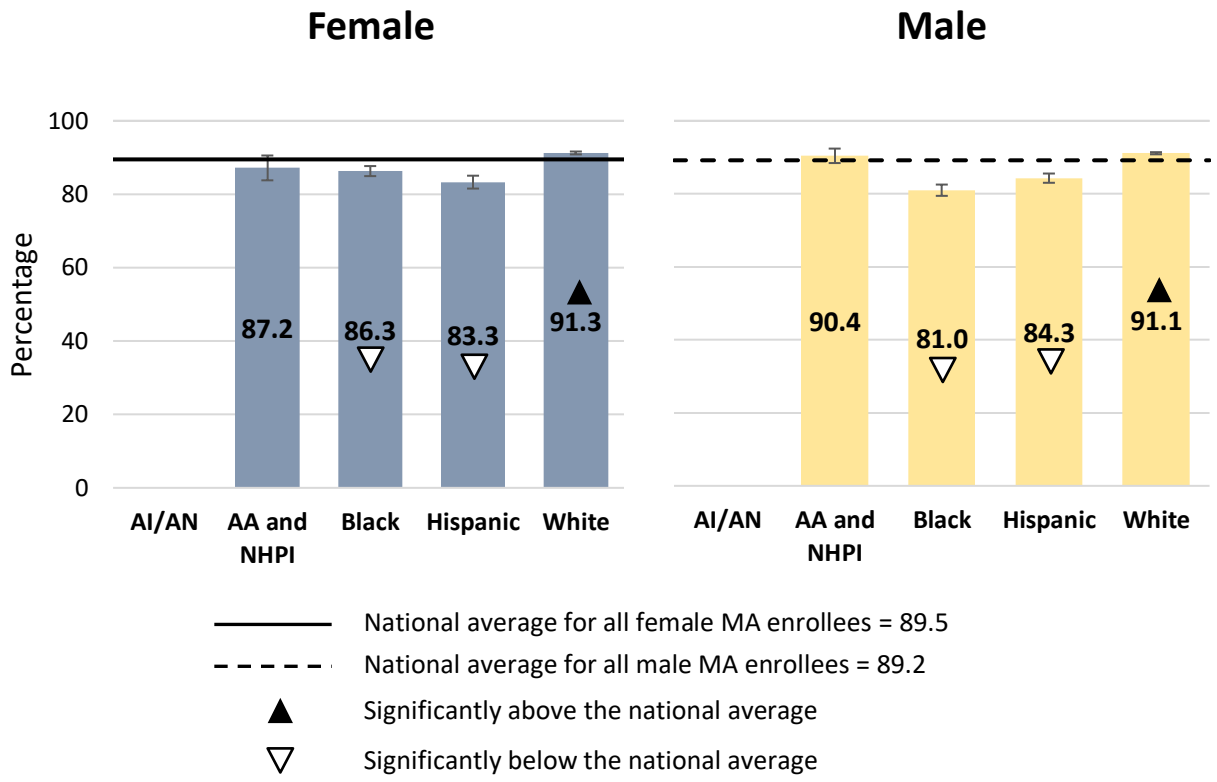
- The percentages of eligible female AA and NHPI and White MA enrollees who had their blood pressure adequately controlled were each **similar to** the national average for all female MA enrollees. The percentage of eligible female Black MA enrollees who had their blood pressure adequately controlled was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female Hispanic MA enrollees who had their blood pressure adequately controlled was **above** the national average for all female MA enrollees by more 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.

- The percentages of eligible male AA and NHPI and White MA enrollees who had their blood pressure adequately controlled were each **similar to** the national average for all male MA enrollees. The percentage of eligible male Black MA enrollees who had their blood pressure adequately controlled was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who had their blood pressure adequately controlled was **above** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



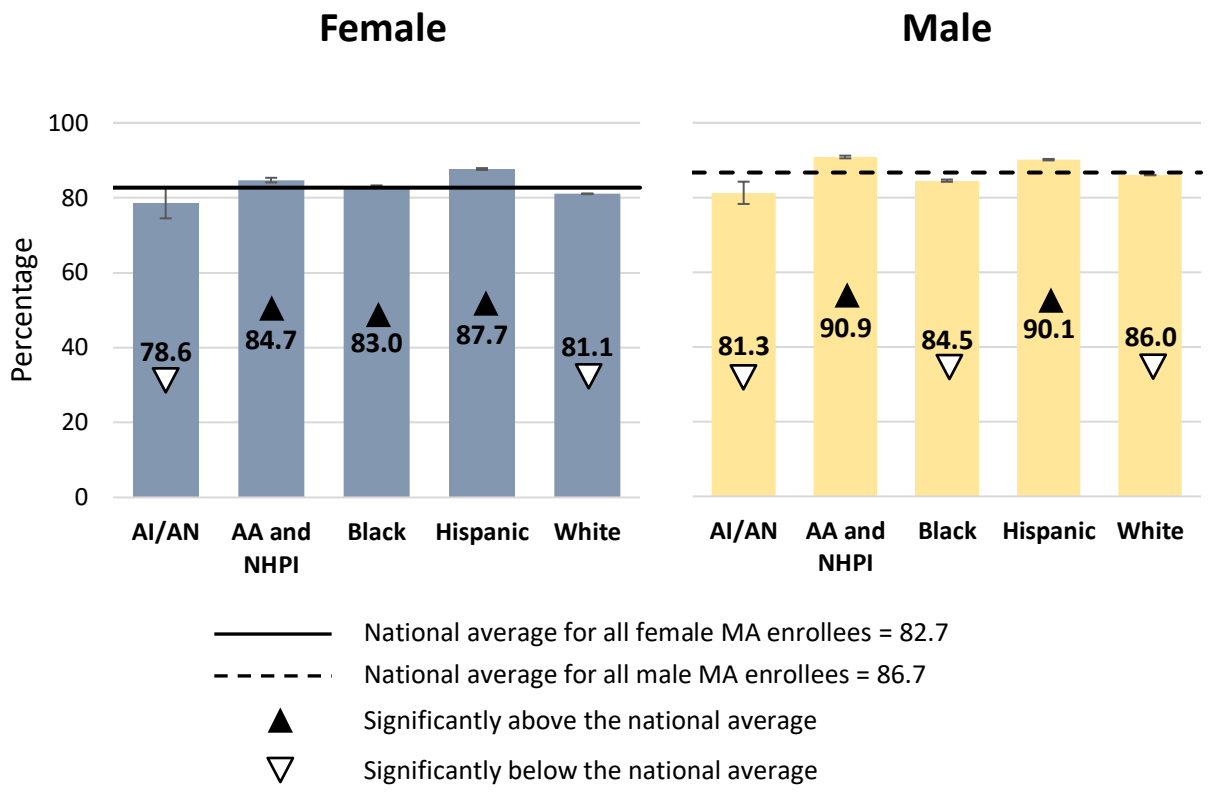
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of eligible female AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all female MA enrollees. The percentages of eligible female Black and Hispanic MA enrollees who received continuous beta-blocker treatment were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who received continuous beta-blocker treatment was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of eligible male AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all male MA enrollees. The percentages of eligible male Black and Hispanic MA enrollees who received continuous beta-blocker treatment were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who received continuous beta blocker treatment was **above** the national average for all male MA enrollees by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of men aged 21 to 75 years enrolled in MA and women aged 40 to 75 years enrolled in MA with clinical ASCVD who received statin therapy, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

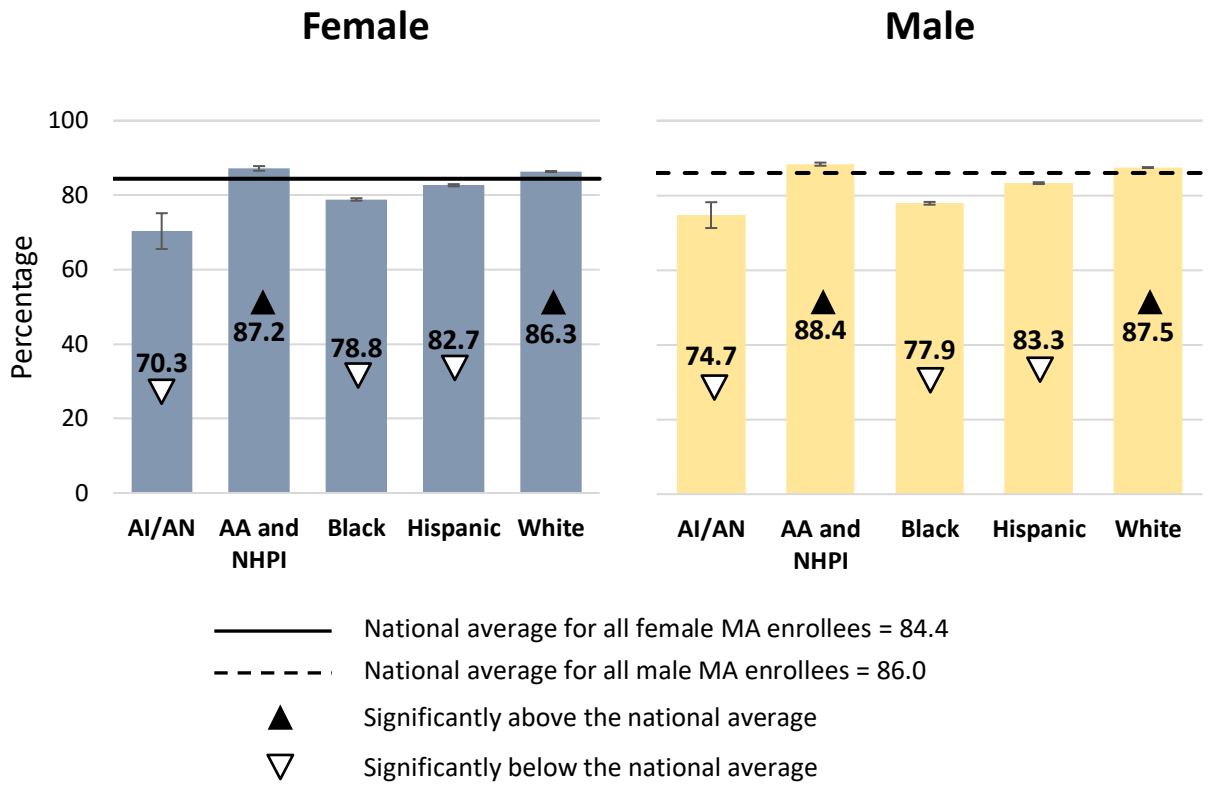
Disparities

- The percentage of female AI/AN MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and Black MA enrollees with clinical ASCVD who received statin therapy were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all female MA enrollees by less than 3 percentage points.

- The percentage of male AI/AN MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees with clinical ASCVD who received statin therapy were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and White MA enrollees with clinical ASCVD who received statin therapy were each **below** the national average for all male MA enrollees 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

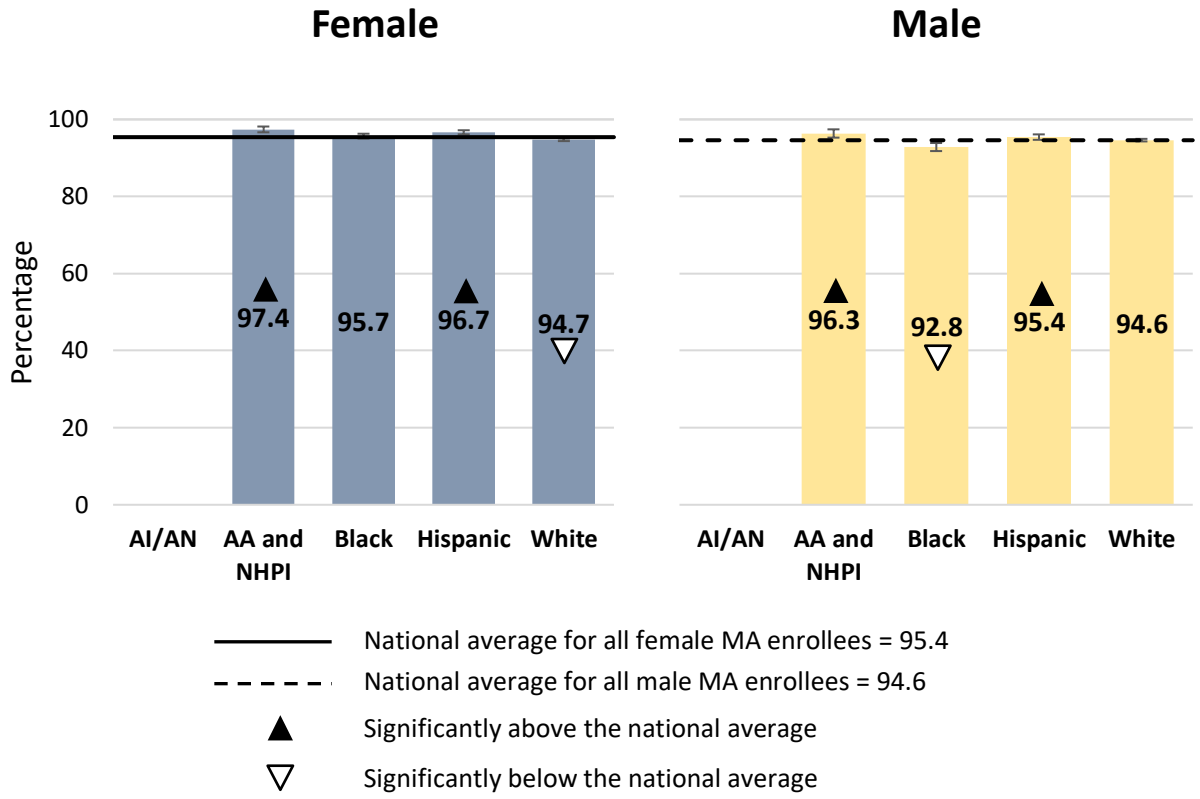
Disparities

- The percentages of female AI/AN and Black MA enrollees with clinical ASCVD who had proper statin medication adherence were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and White MA enrollees with clinical ASCVD who had proper statin medication adherence were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AI/AN and Black MA enrollees with clinical ASCVD who had proper statin medication adherence were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and White MA enrollees with clinical ASCVD who had proper statin medication adherence were each **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all male MA enrollees by less than 3 percentage points.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by race and ethnicity within sex, Reporting Year 2022



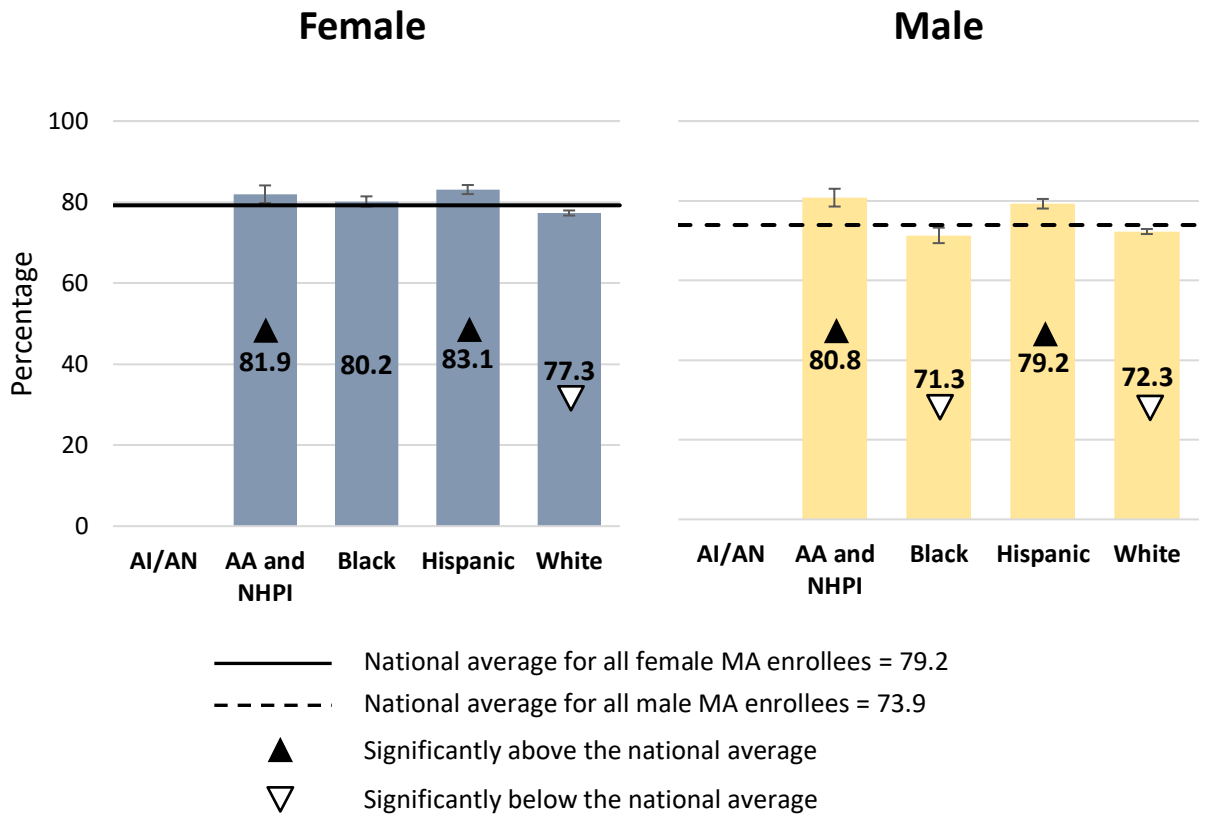
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentages of female AA and NHPI and Hispanic MA enrollees with diabetes who had their blood sugar tested at least once in the past year were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Black MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **similar to** the national average for all female MA enrollees. The percentage of female White MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who had their blood sugar tested at least once in the past year were each **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male Black MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees with diabetes who had their blood sugar tested at least once in the past year was **similar to** the national average for all male MA enrollees.

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 race and ethnicity within sex, Reporting Year 2022



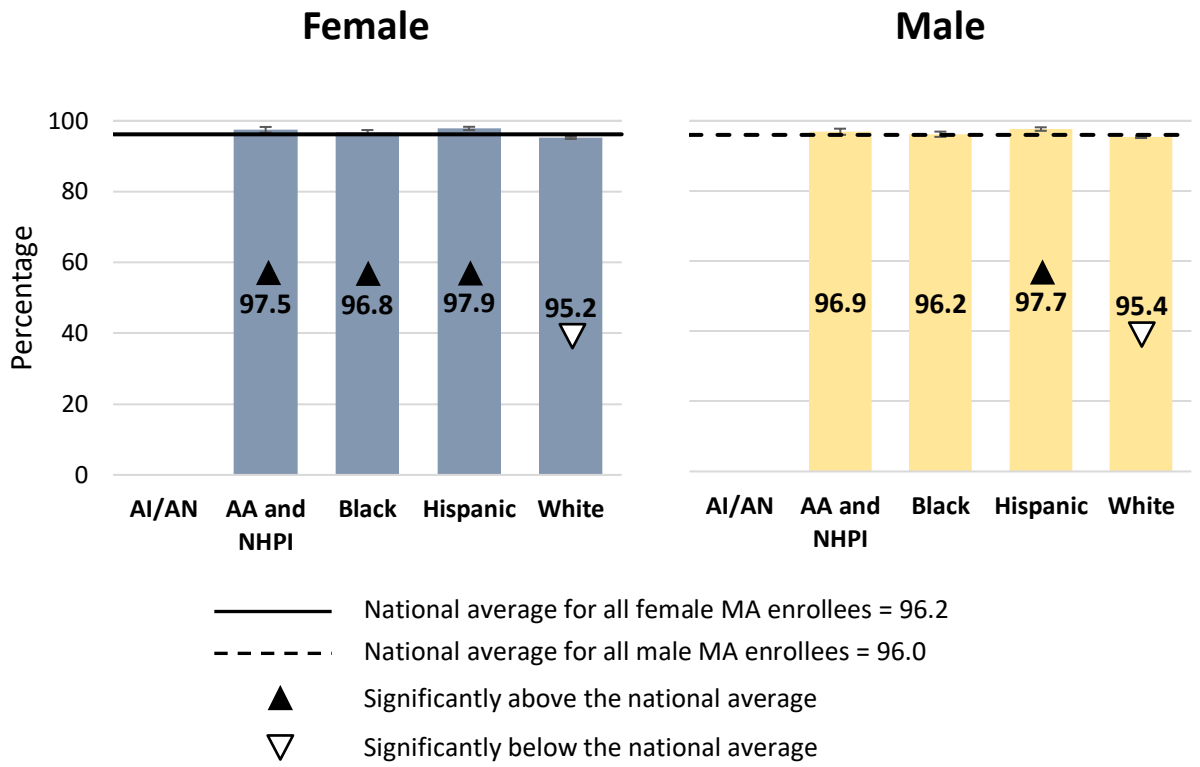
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Black MA enrollees with diabetes who had an eye exam in the past year was **similar to** the national average for all female MA enrollees. The percentage of female Hispanic MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees with diabetes who had an eye exam in the past year was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who had an eye exam in the past year were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and White MA enrollees with diabetes who had an eye exam in the past year were each **below** the national average for all male MA enrollees by less than 3 percentage points.

Diabetes Care—Kidney Disease Monitoring

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by race and ethnicity within sex, Reporting Year 2022



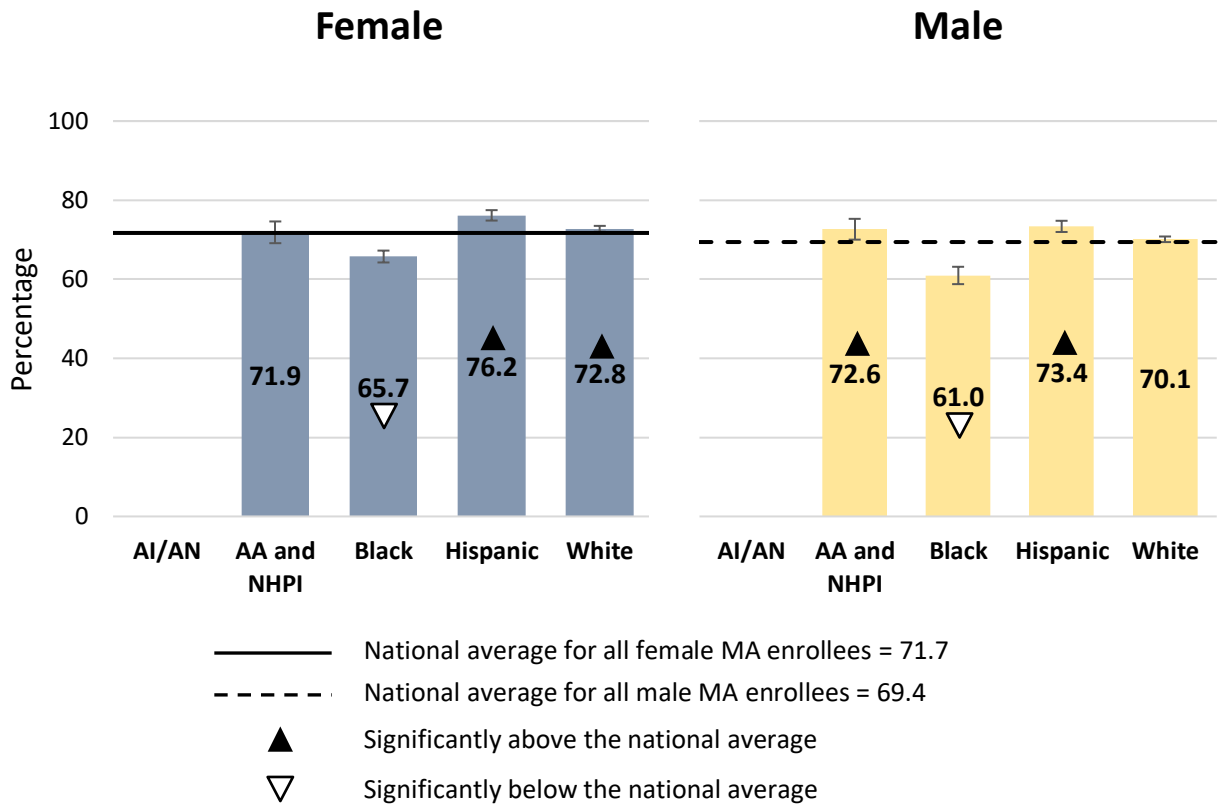
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentages of female AA and NHPI, Black, and Hispanic MA enrollees with diabetes who had medical attention for nephropathy in the past year were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female White MA enrollees with diabetes who had medical attention for nephropathy in the past year was **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AA and NHPI and Black MA enrollees with diabetes who had medical attention for nephropathy in the past year were each **similar to** the national average for all male MA enrollees. The percentage of male Hispanic MA enrollees with diabetes who had medical attention for nephropathy in the past year was **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees with diabetes who had medical attention for nephropathy in the past year was **below** the national average for all male MA enrollees by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

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



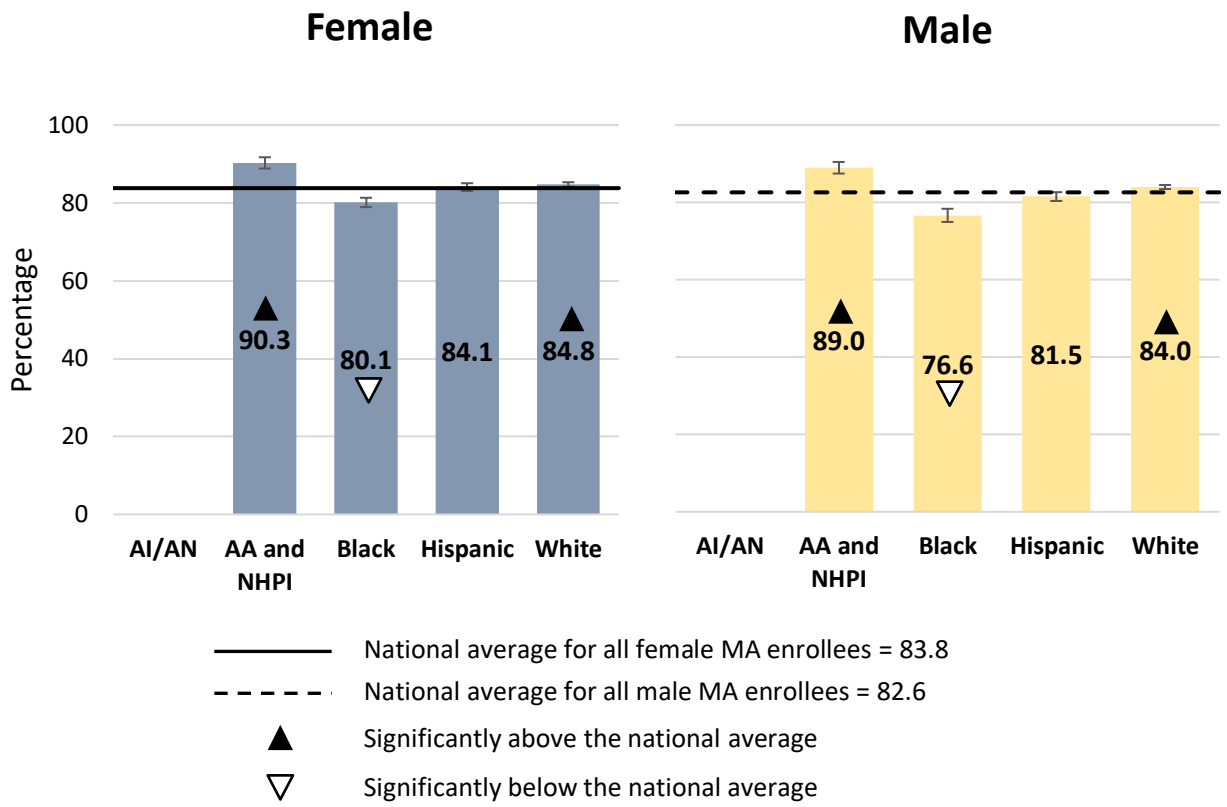
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average for all female MA enrollees. The percentage of female Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees with diabetes who had their blood pressure under control was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees with diabetes who had their blood pressure under control was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who had their blood pressure under control were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average for all male MA enrollees.

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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

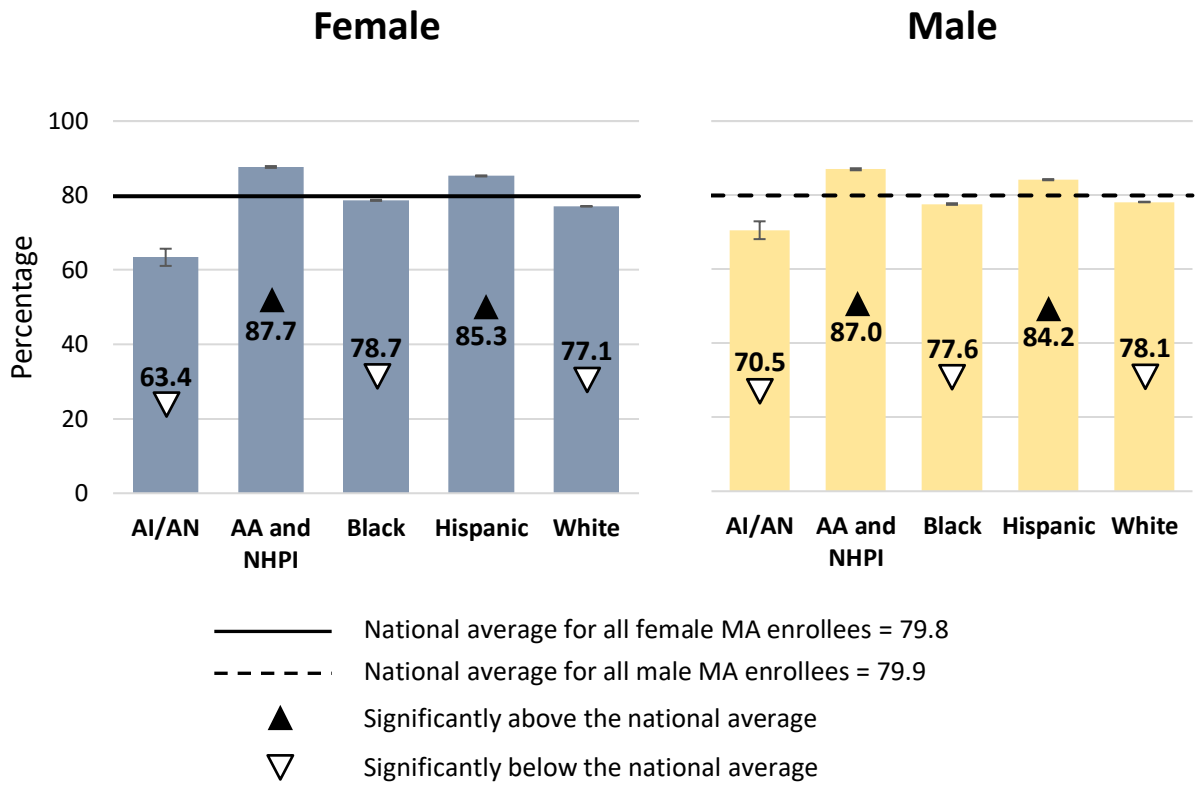
Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees with diabetes who had their blood sugar level under control was **similar to** the national average for all female MA enrollees. The percentage of female White MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all female MA enrollees by less than 3 percentage points.

- The percentage of male AA and NHPI MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male Hispanic MA enrollees with diabetes who had their blood sugar level under control was **similar to** the national average for all male MA enrollees. The percentage of male White MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all male MA enrollees 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

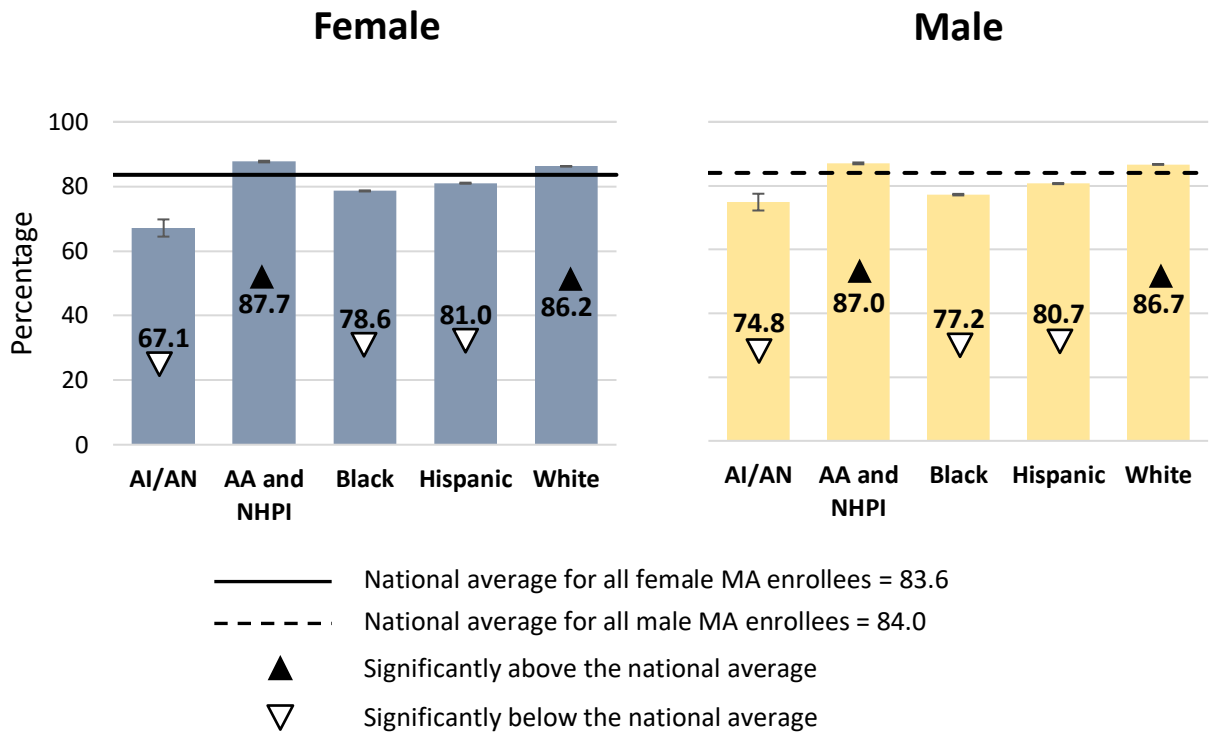
Disparities

- The percentage of female AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees with diabetes who received statin therapy were each **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female Black and White MA enrollees with diabetes who received statin therapy were each **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who received statin therapy were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and White MA enrollees with diabetes who received statin therapy were each **below** the national average for all male MA enrollees 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 who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

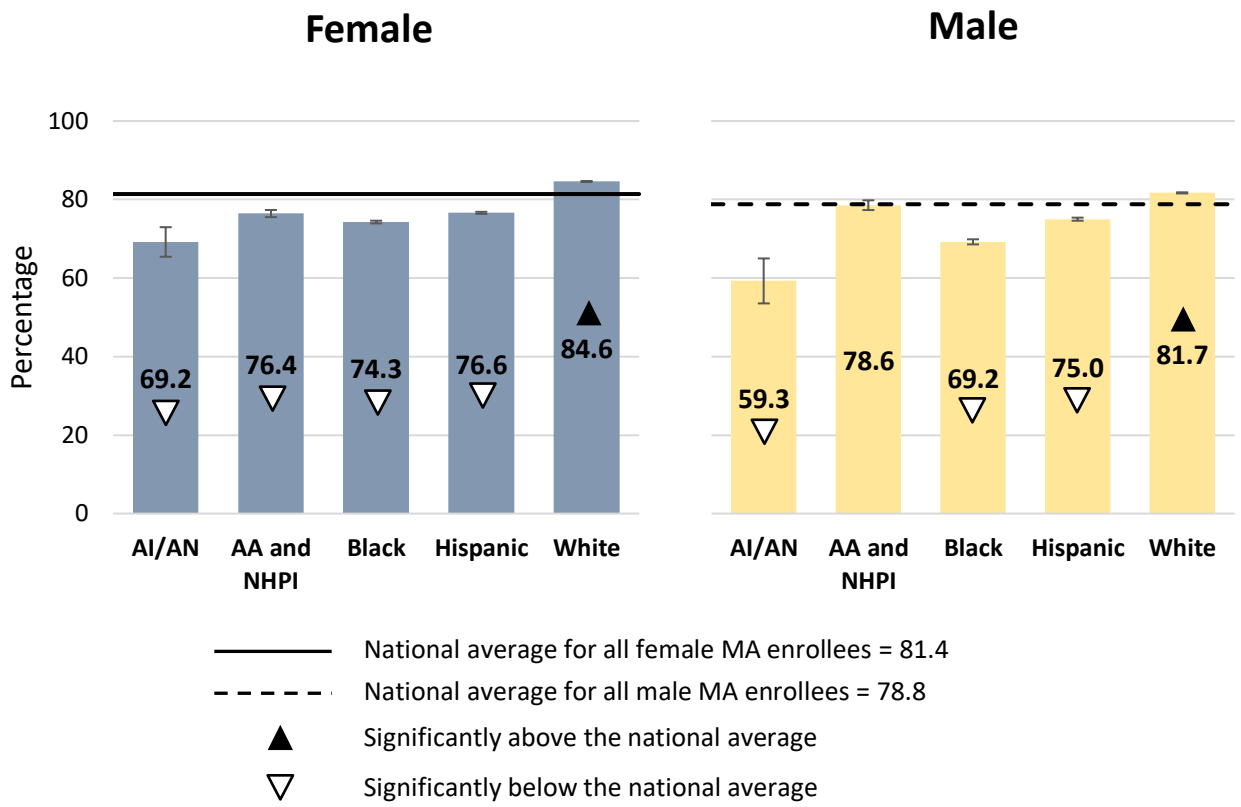
- The percentages of female AI/AN and Black MA enrollees who had proper statin medication adherence were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female AA and NHPI MA enrollees who had proper statin medication adherence was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees who had proper statin medication adherence was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female White MA enrollees who had proper statin medication adherence was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AI/AN, Black, and Hispanic MA enrollees who had proper statin medication adherence were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male AA and NHPI MA enrollees who had proper statin medication adherence was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who had proper statin medication adherence was **above** the national average for all male MA enrollees by less than 3 percentage points.

† Excludes those who also have clinical ASCVD.

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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

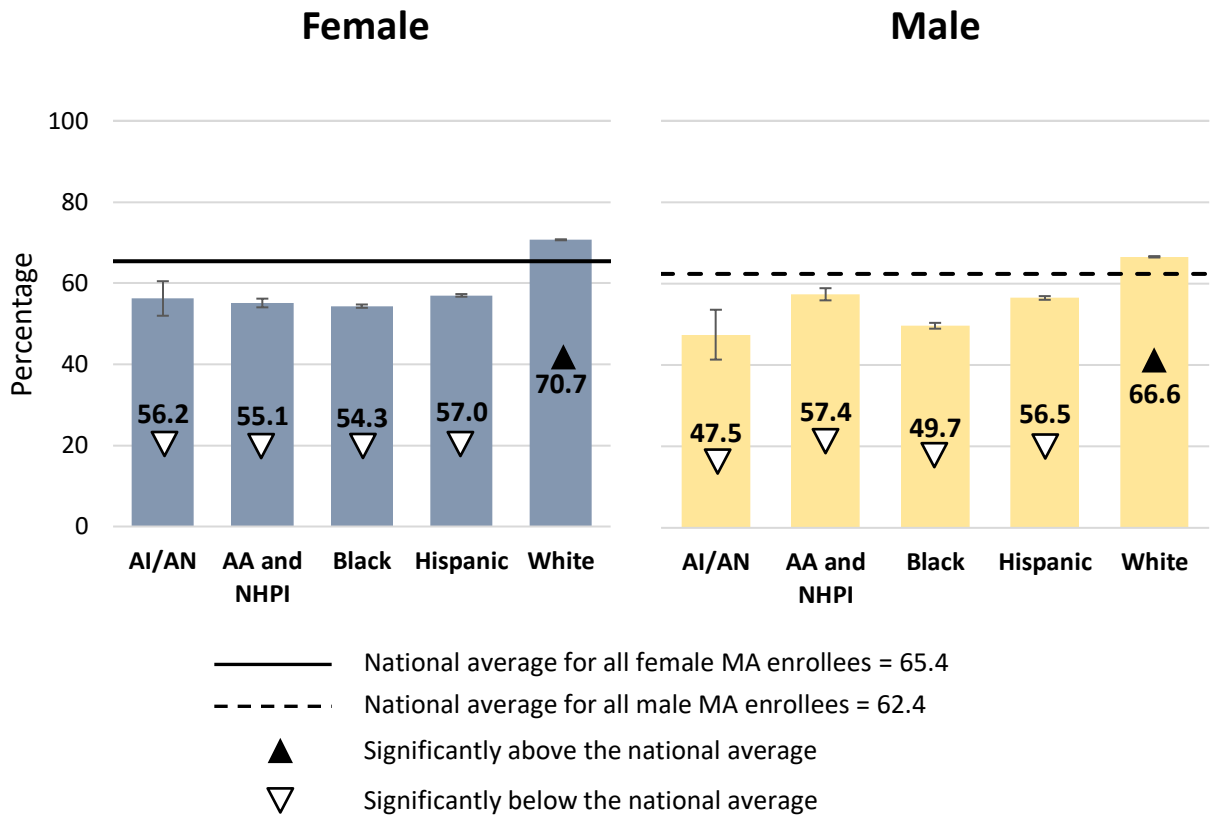
Disparities

- The percentages of eligible female AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all female MA enrollees by more than 3 percentage points.

- The percentages of eligible male AI/AN, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **similar to** the national average for all male MA enrollees. The percentage of eligible male White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all male 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 who remained on antidepressant medication for at least 180 days, by race and ethnicity within sex, Reporting Year 2022



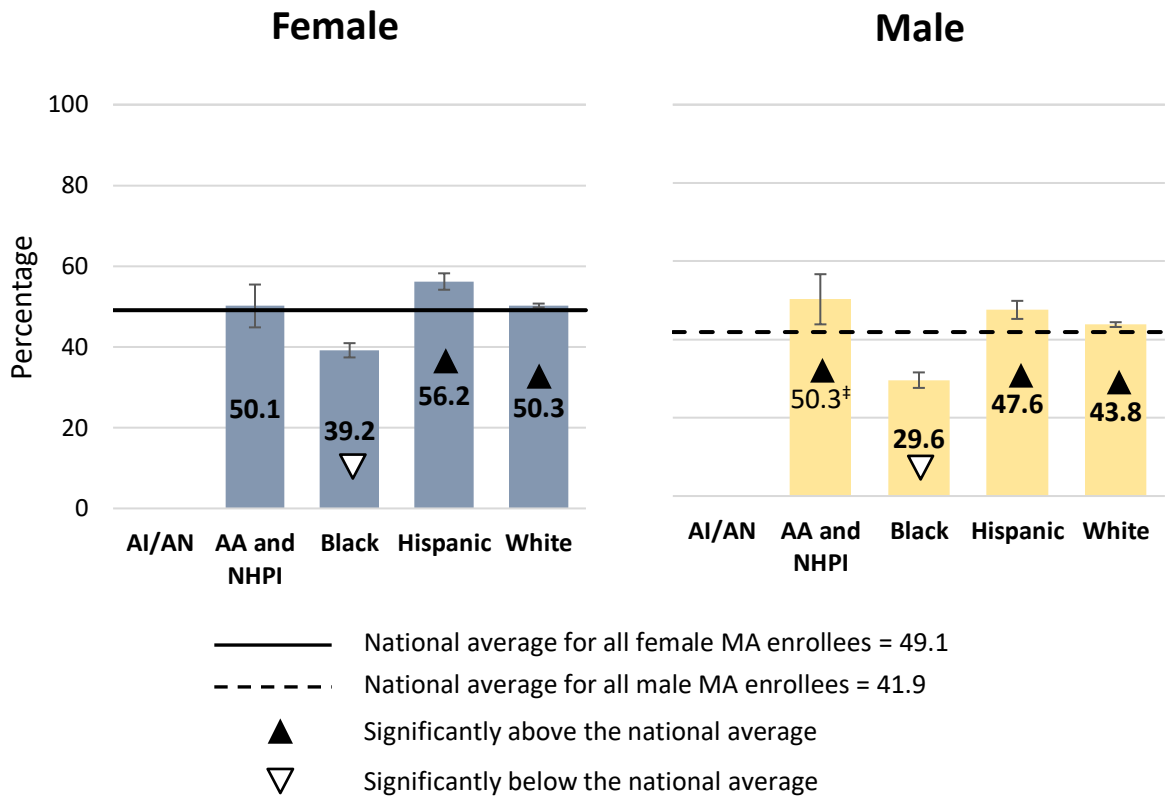
SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of eligible female AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all female MA enrollees by more than 3 percentage points.
- The percentages of eligible male AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all male MA enrollees by more than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

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

Disparities

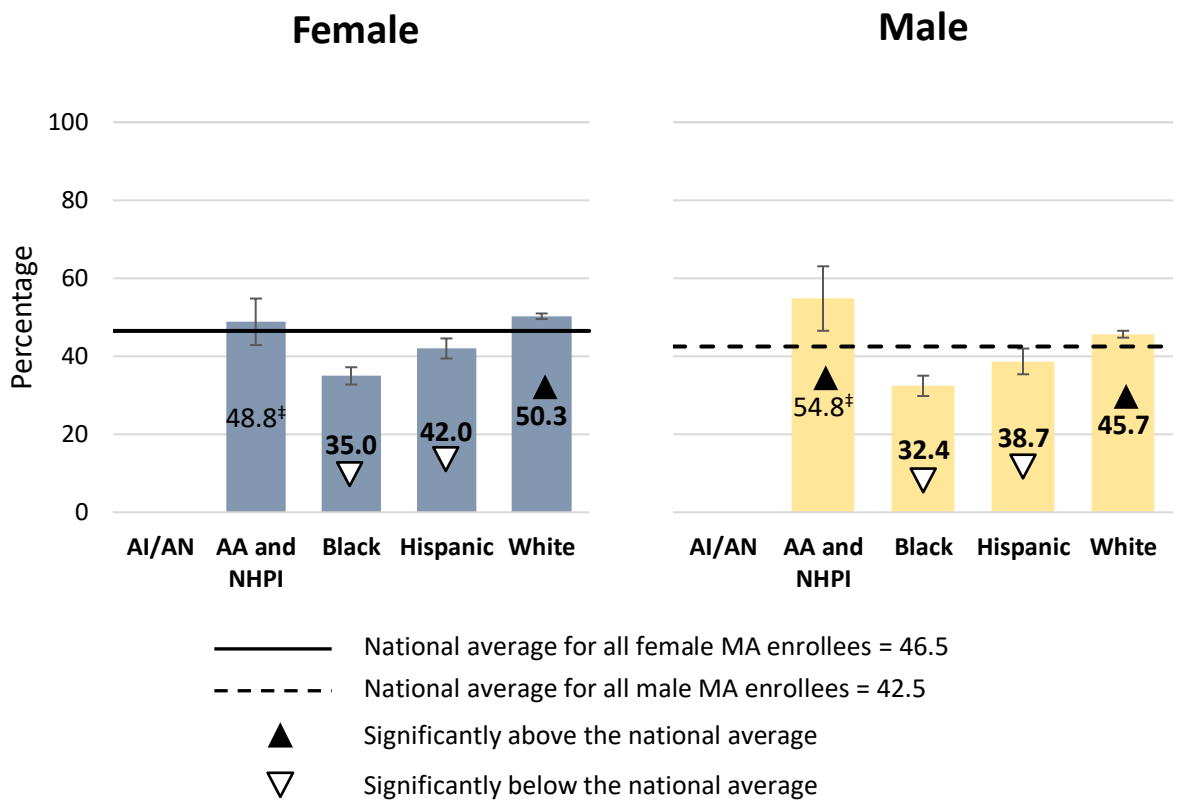
- The percentage of female AA and NHPI MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all female MA enrollees. The percentage of female Black MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees 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 female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees 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 female MA enrollees by less than 3 percentage points.

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

- The percentages of male AA and NHPI and Hispanic MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male Black MA enrollees 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 male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees 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 male MA enrollees by less than 3 percentage points.

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

Percentage of MA enrollees aged 18 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

[‡] These scores are based on fewer than 400 completed measures, and thus their precision might be low.

Disparities

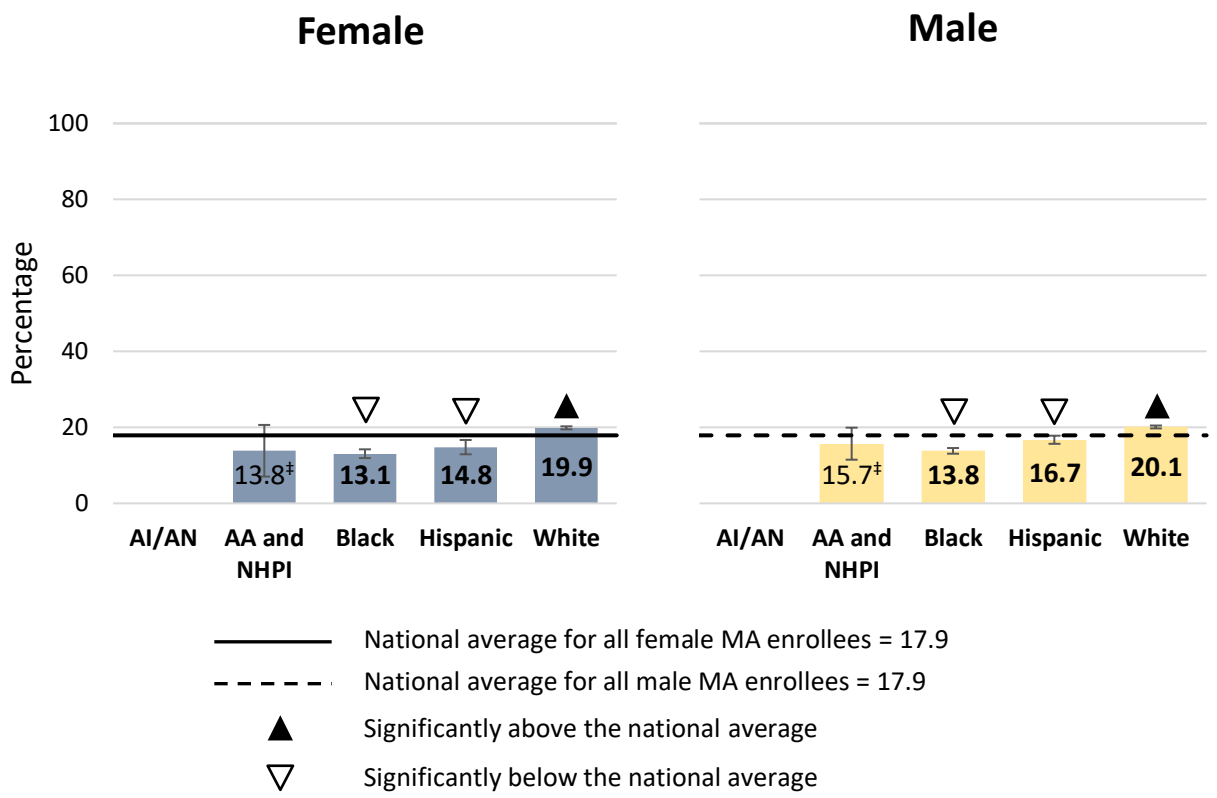
- The percentage of female AA and NHPI MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all female MA enrollees. The percentages of female Black and Hispanic MA enrollees 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 were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees 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 female MA enrollees by more than 3 percentage points.

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

- The percentages of male AA and NHPI and White MA enrollees 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 were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and Hispanic MA enrollees 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 were each **below** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

[‡] These scores are based on fewer than 400 completed measures, and thus their precision might be low.

Disparities

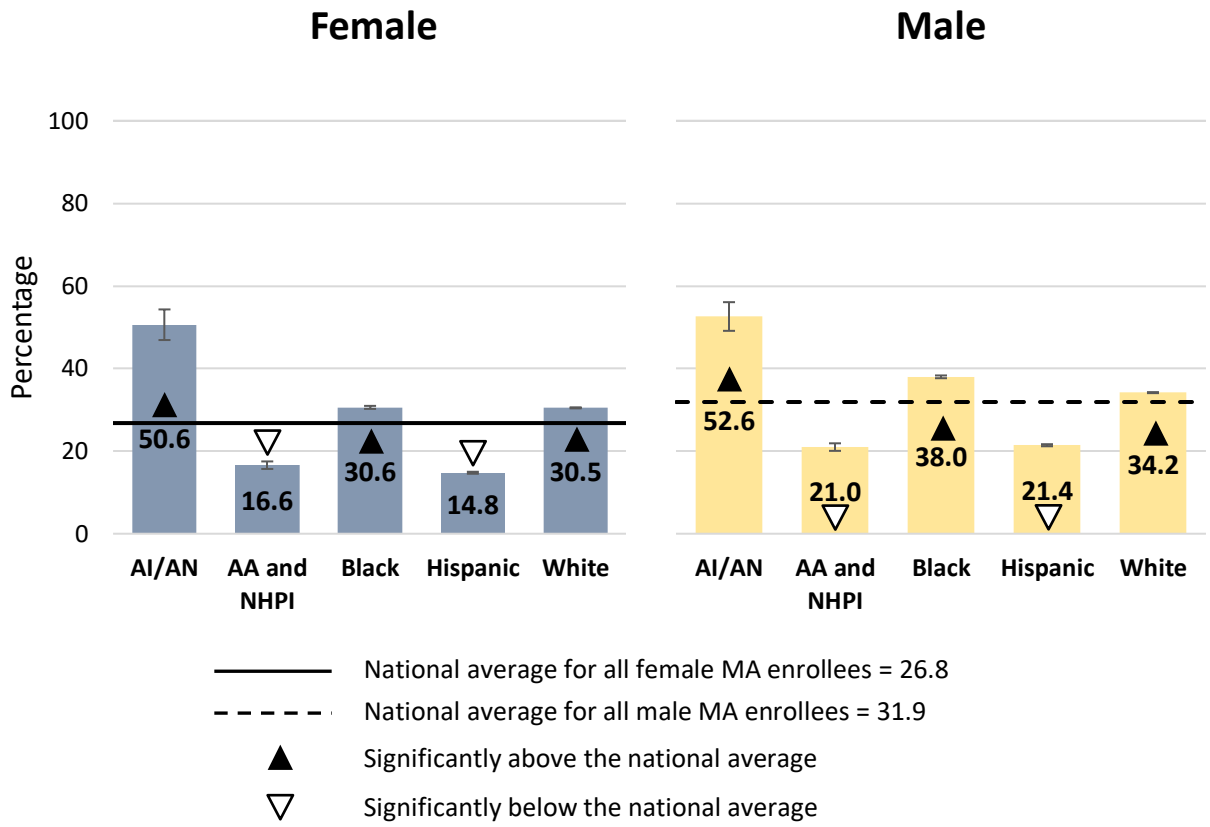
- The percentage of female AA and NHPI MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all female MA enrollees. The percentages of female Black and Hispanic MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence were each **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees 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 female MA enrollees by less than 3 percentage points.

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

- The percentage of male AA and NHPI MA enrollees 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 male MA enrollees. The percentage of male Black MA enrollees 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 male MA enrollees by more than 3 percentage points. The percentage of male Hispanic MA enrollees 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 male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees 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 male MA enrollees by less 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

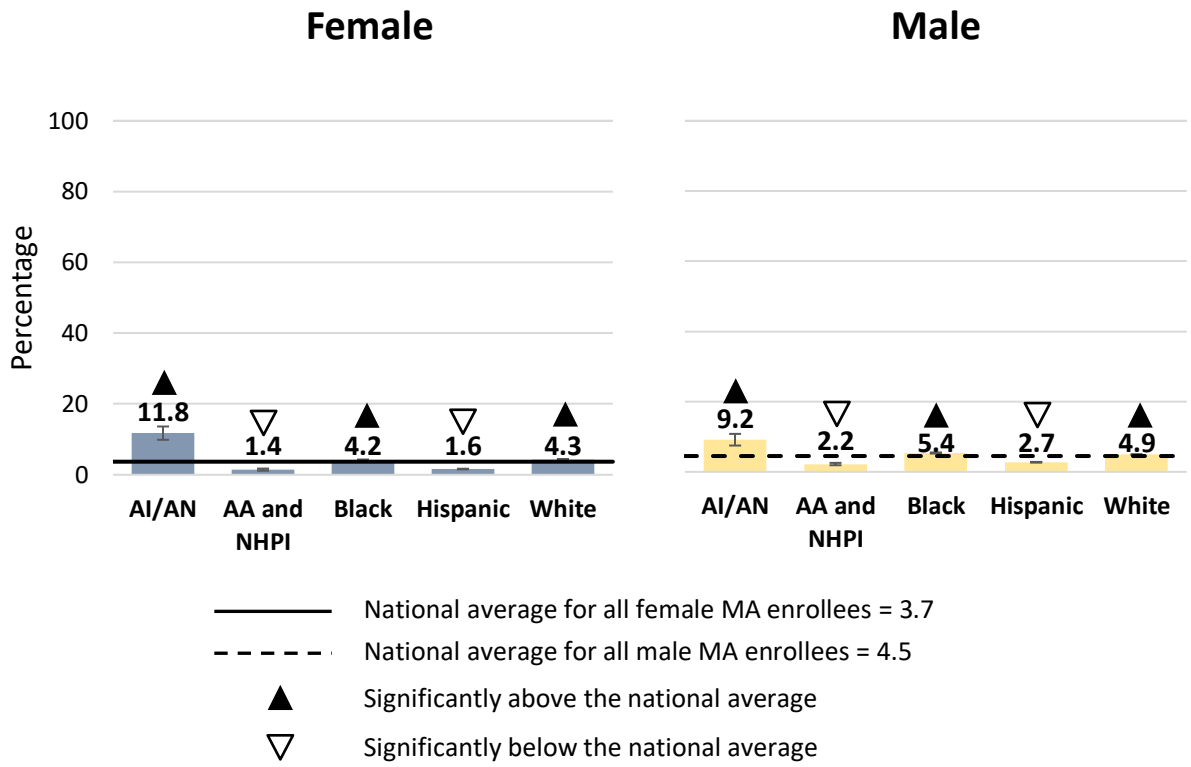
- The percentages of female AI/AN, Black, and White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **below** the national average for all female MA enrollees by more than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.
[‡] Initiation may occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

- The percentages of male AI/AN and Black MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all male MA enrollees by less 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of female AI/AN MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female Black and White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **above** the national average for all female MA enrollees by less than 3 percentage points.

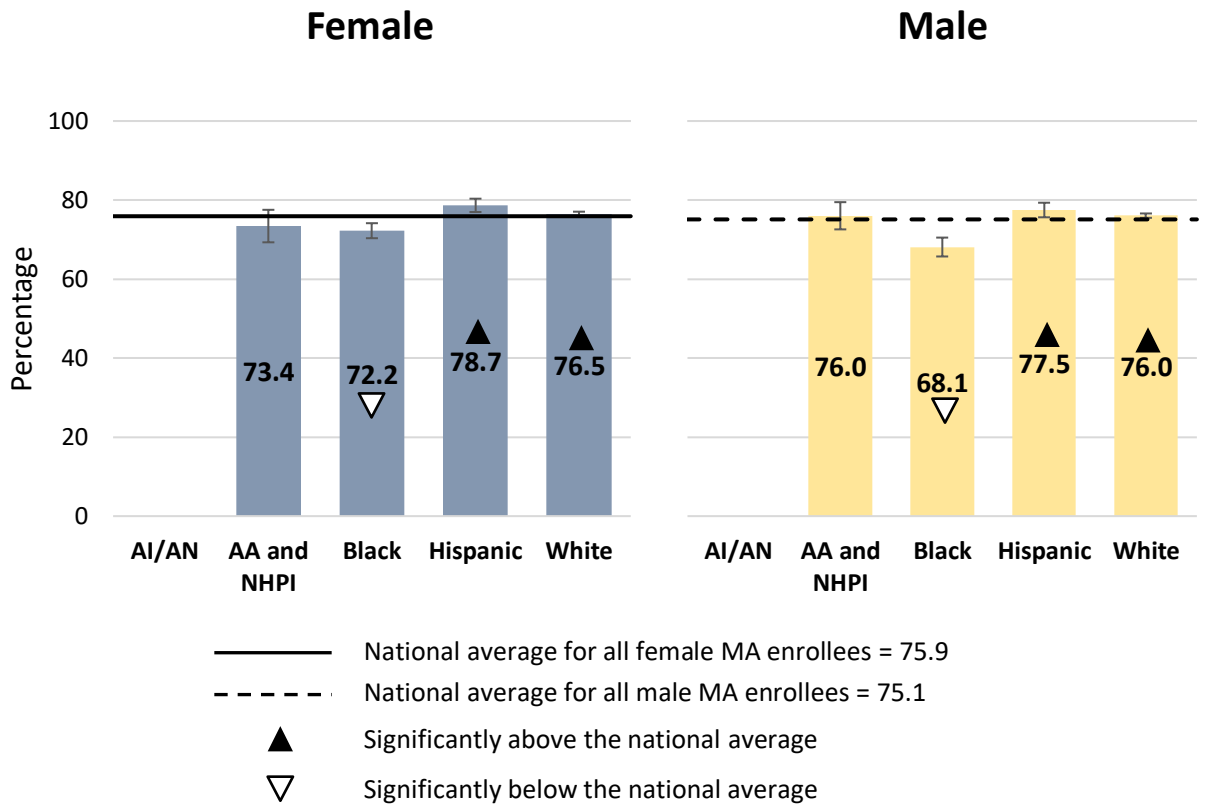
[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

- The percentage of male AI/AN MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentages of male Black and White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **above** the national average for all male MA enrollees by less than 3 percentage points.

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

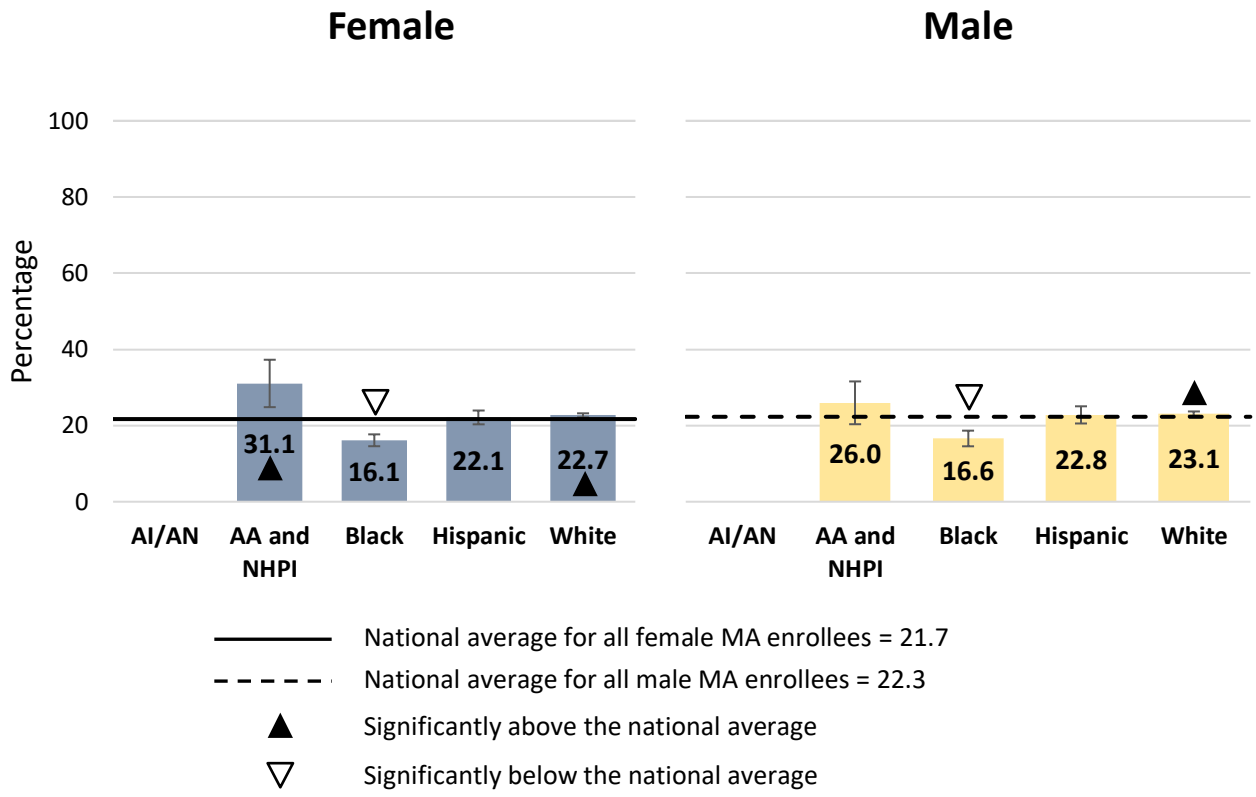
Disparities

- The percentage of female AA and NHPI MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all female MA enrollees. The percentage of female Black MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all female MA enrollees by more than 3 points. The percentages of female Hispanic and White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility were each **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AA and NHPI MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all male MA enrollees. The percentage of male Black MA enrollees who had their medications

reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Hispanic and White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility were each **above** the national average for all male MA enrollees by less than 3 percentage points.

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

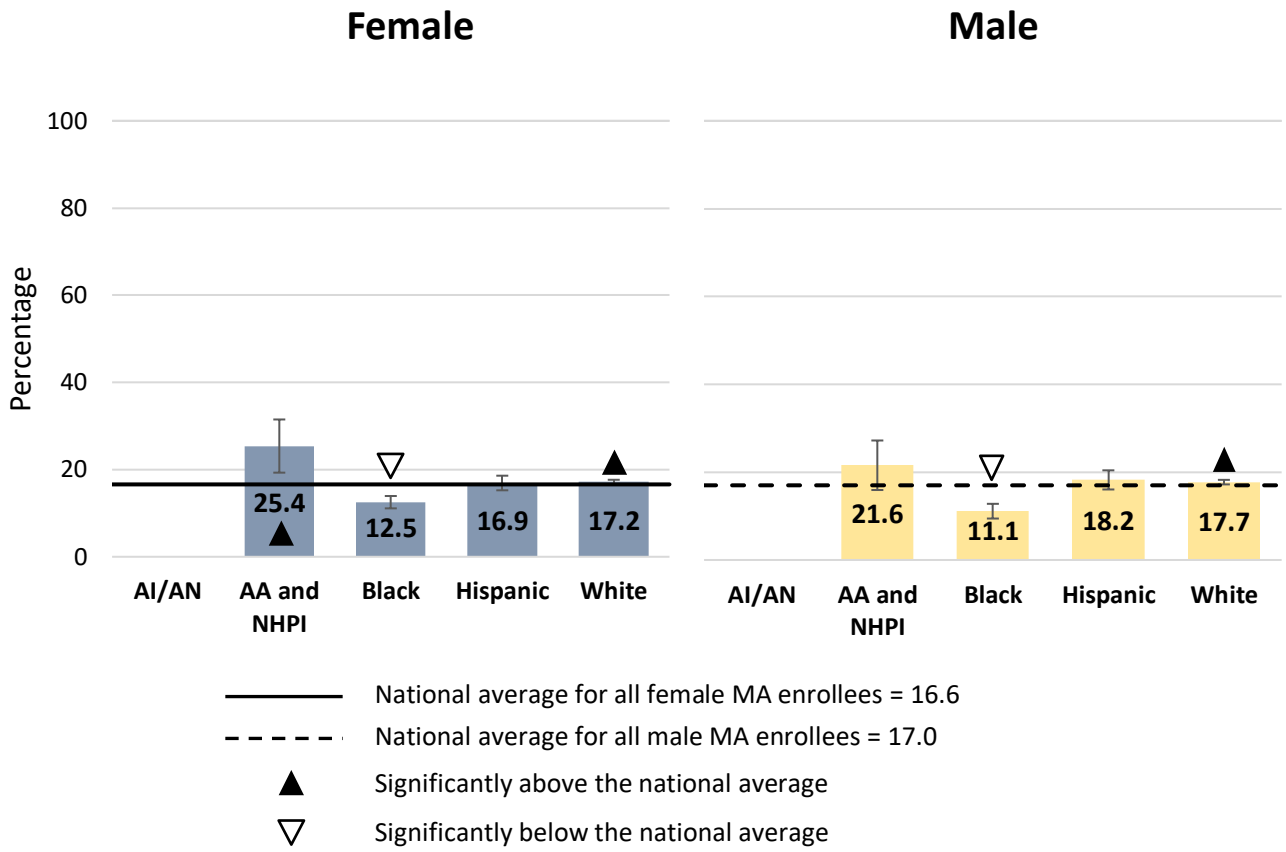
Disparities

- The percentage of female AA and NHPI MA enrollees 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 female MA enrollees by more than 3 percentage points. The percentage of female Black MA enrollees 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 female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all female MA enrollees. The percentage of female White MA enrollees 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 female MA enrollees by less than 3 percentage points.

- The percentages of male AA and NHPI and Hispanic MA enrollees 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 were each **similar to** the national average for all male MA enrollees. The percentage of male Black MA enrollees 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 male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees 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 male MA enrollees by less than 3 percentage points.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

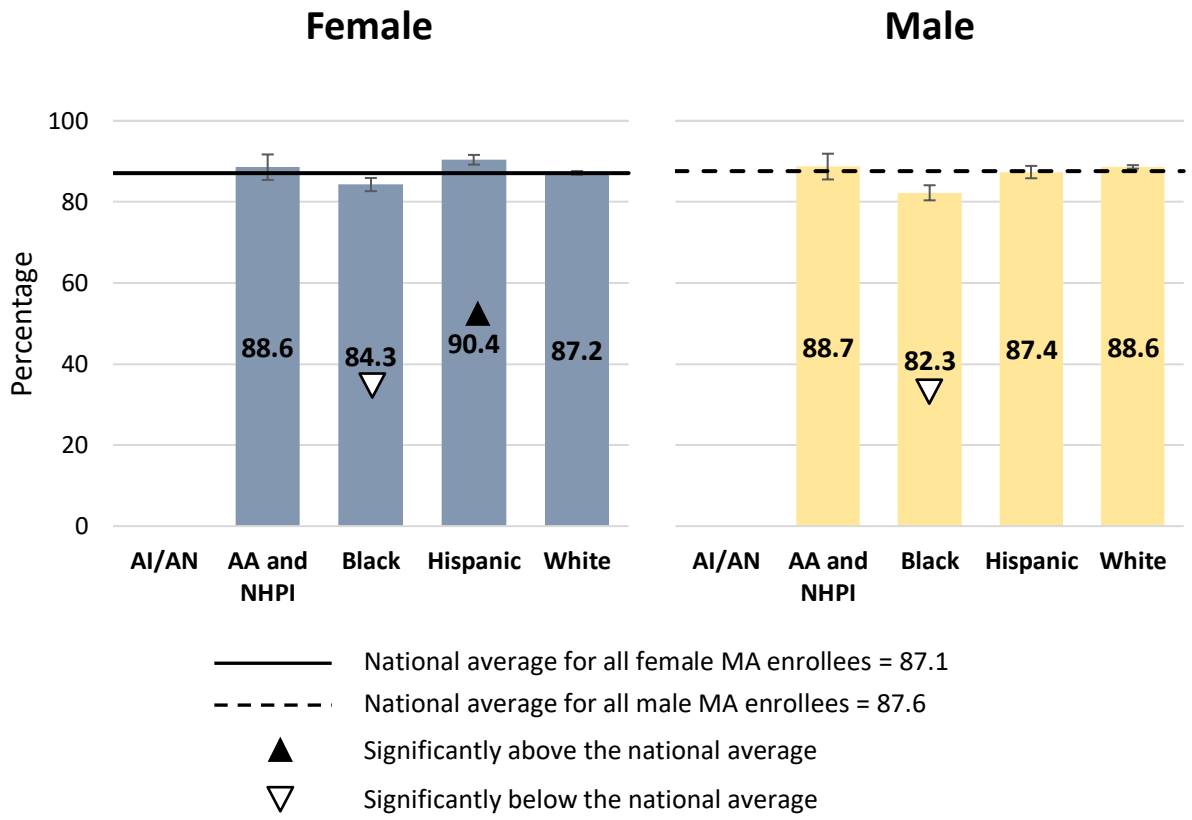
Disparities

- The percentage of female AA and NHPI MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Black MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all female MA enrollees. The percentage of female White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all female MA enrollees by less than 3 percentage points.

- The percentages of male AA and NHPI and Hispanic MA enrollees 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 male MA enrollees. The percentage of male Black MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all male MA enrollees by less than 3 percentage points.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

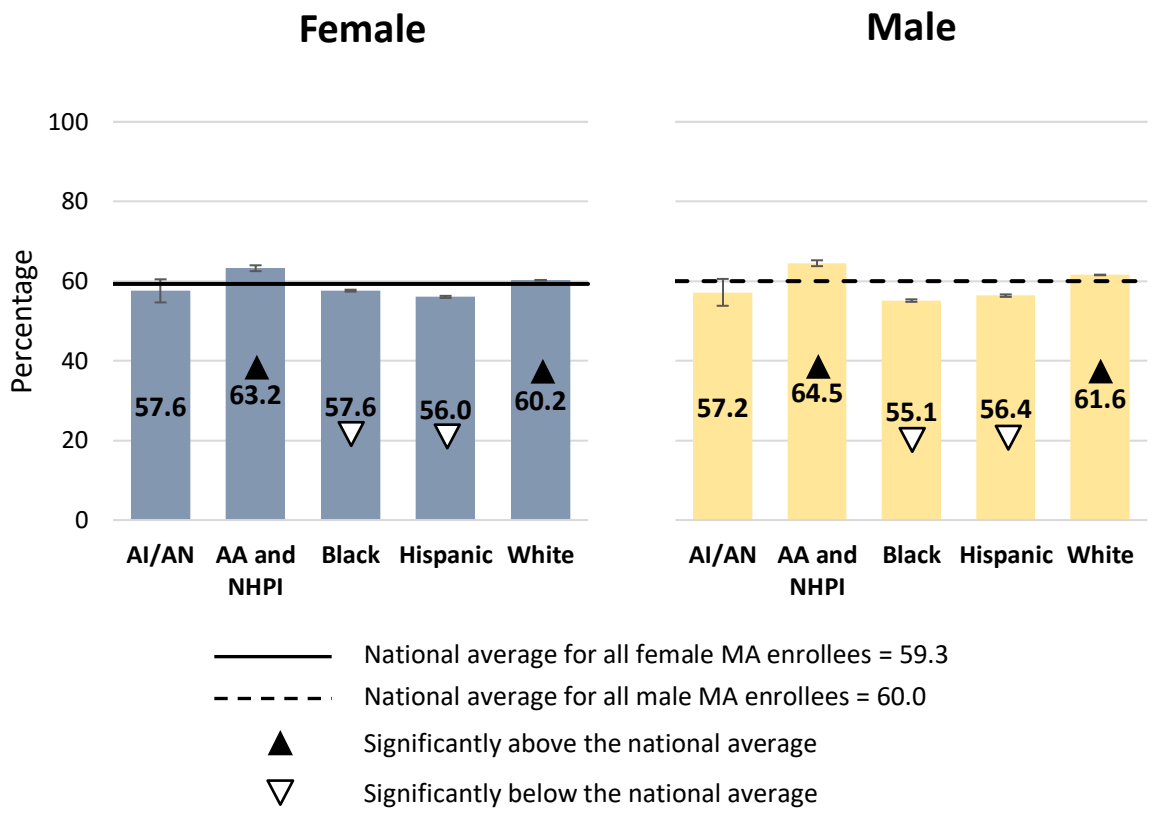
Disparities

- The percentages of female AA and NHPI and White MA enrollees 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 female MA enrollees. The percentage of female Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all female MA enrollees by more than 3 percentage points.

- The percentages of male AA and NHPI, Hispanic, and White MA enrollees 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 male MA enrollees. The percentage of male Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all male MA enrollees by more than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of female AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **similar to** the national average for all female MA enrollees. The percentage of female AA and NHPI MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Black MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all female MA enrollees by less than 3 percentage points.

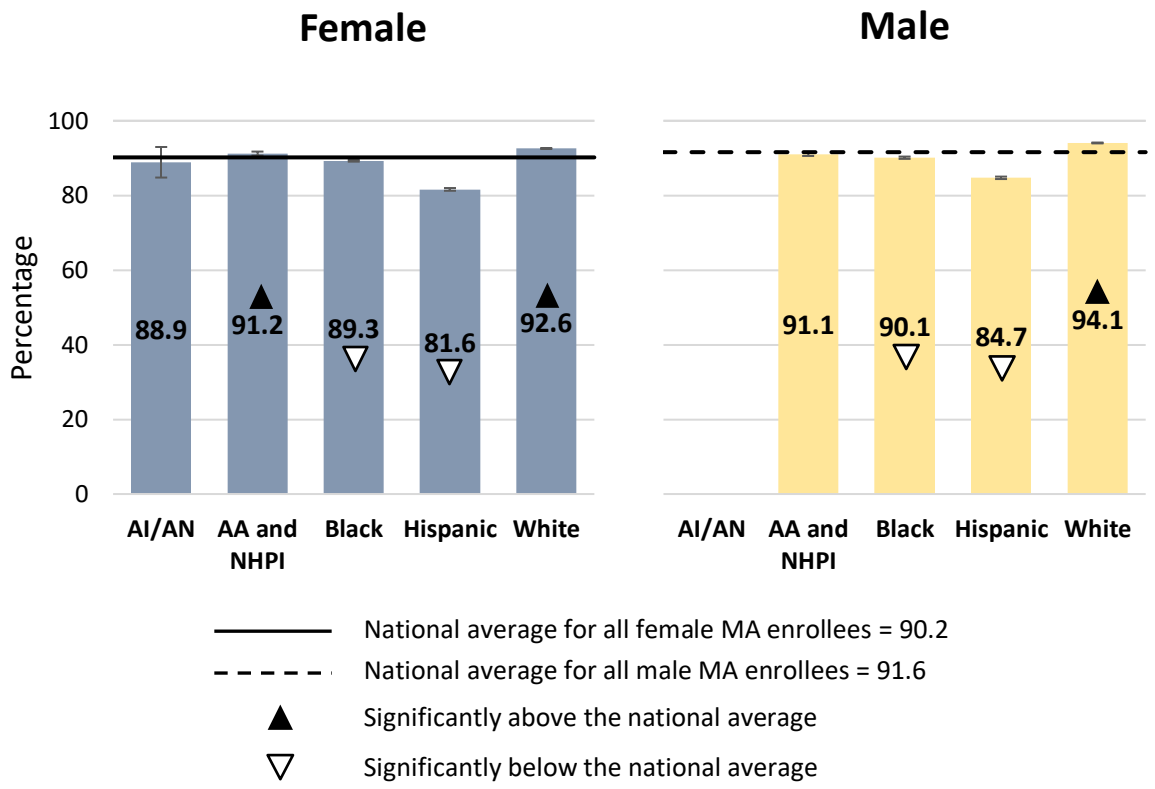
[†] Conditions include COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, AMI, atrial fibrillation, and stroke and transient ischemic attack.

- The percentage of male AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **similar to** the national average for all male MA enrollees. The percentage of male AA and NHPI MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all male MA enrollees by less than 3 percentage points.

Clinical Care: Overuse and Appropriate Use of Medication

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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races. The score for male AI/AN MA enrollees is not accurate enough to report.

Disparities

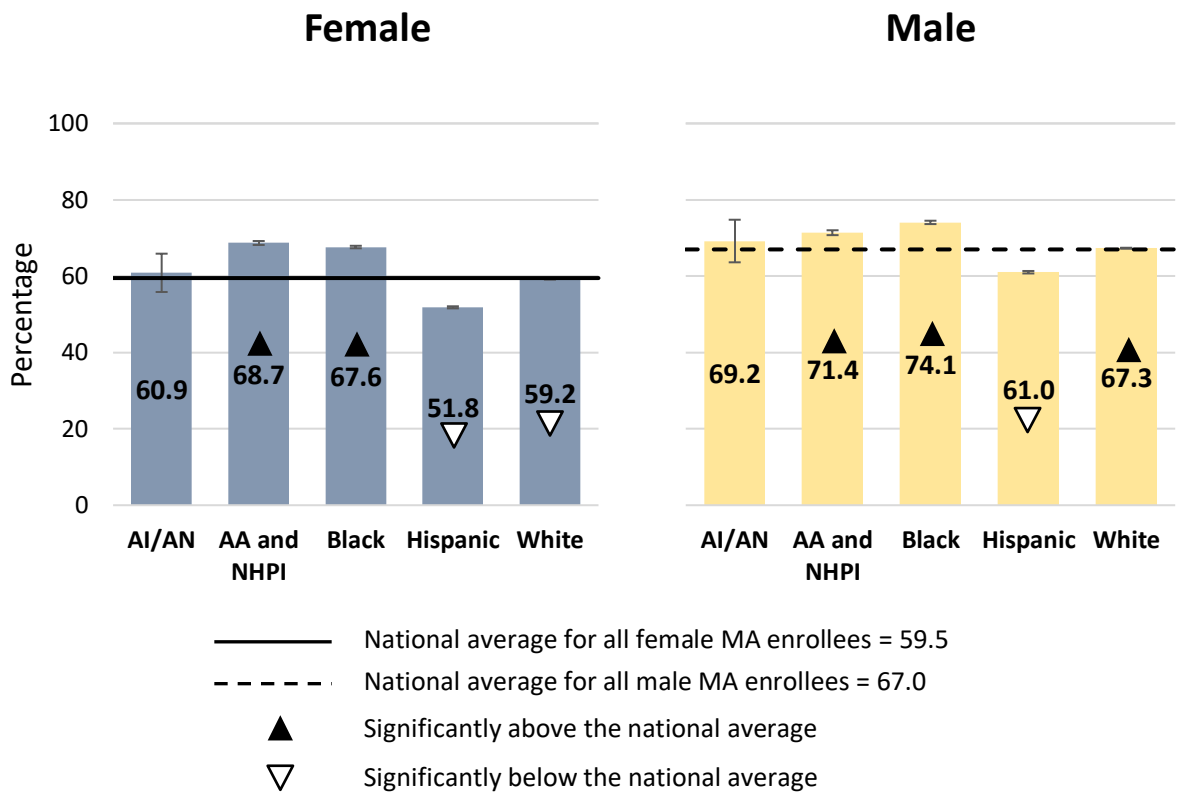
- The percentage of older adult female AI/AN MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average for all female MA enrollees. The percentages of older adult female AA and NHPI and White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of older adult female Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of older adult female Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all female MA enrollees by more than 3 percentage points.

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

- The percentage of older adult male AA and NHPI MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average for all male MA enrollees. The percentage of older adult male Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of older adult male Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of older adult female AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average for all female MA enrollees. The percentages of older adult female AA and NHPI and Black MA enrollees with dementia for whom use of potentially harmful medication was avoided were each **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of older adult female Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all female MA enrollees by less than 3 percentage points.

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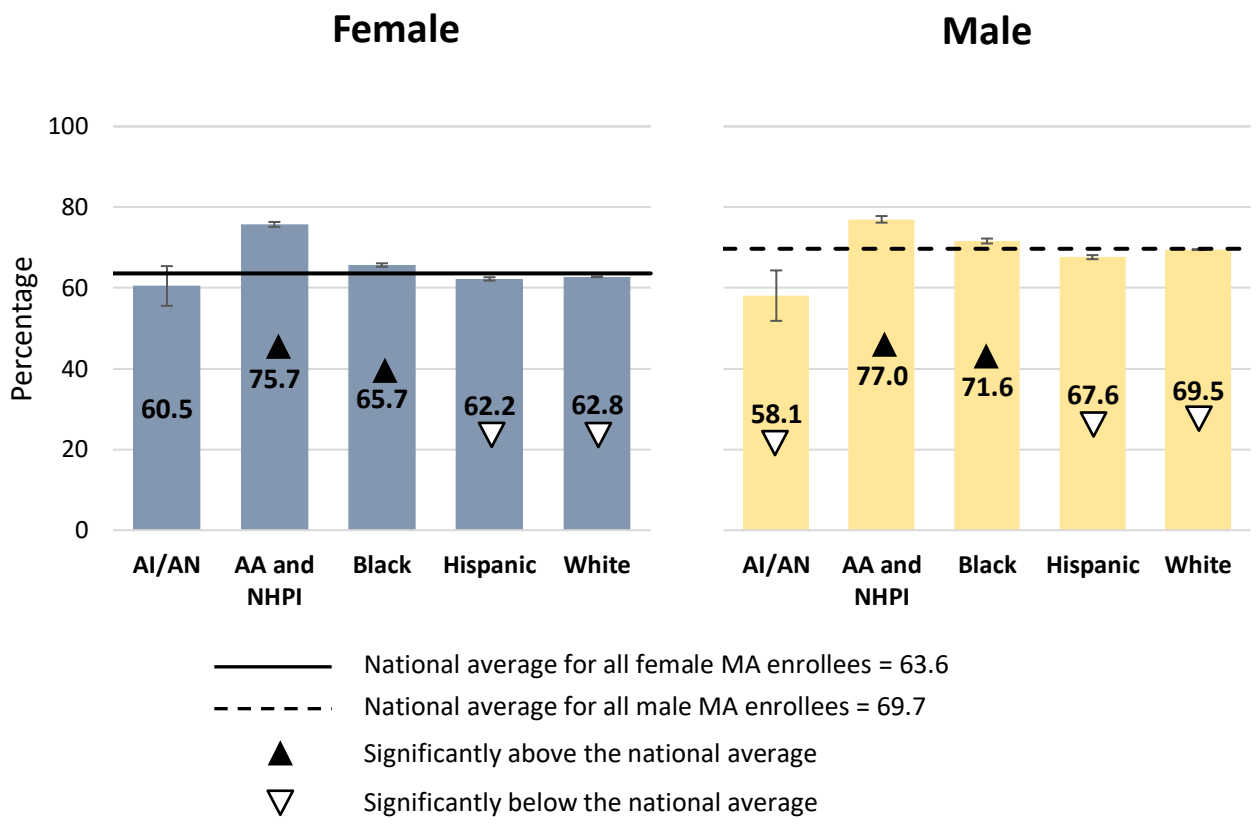
† This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

- The percentage of older adult male AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average for all male MA enrollees. The percentages of older adult male AA and NHPI and Black MA enrollees with dementia for whom use of potentially harmful medication was avoided were each **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of older adult male Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all male MA enrollees by less 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

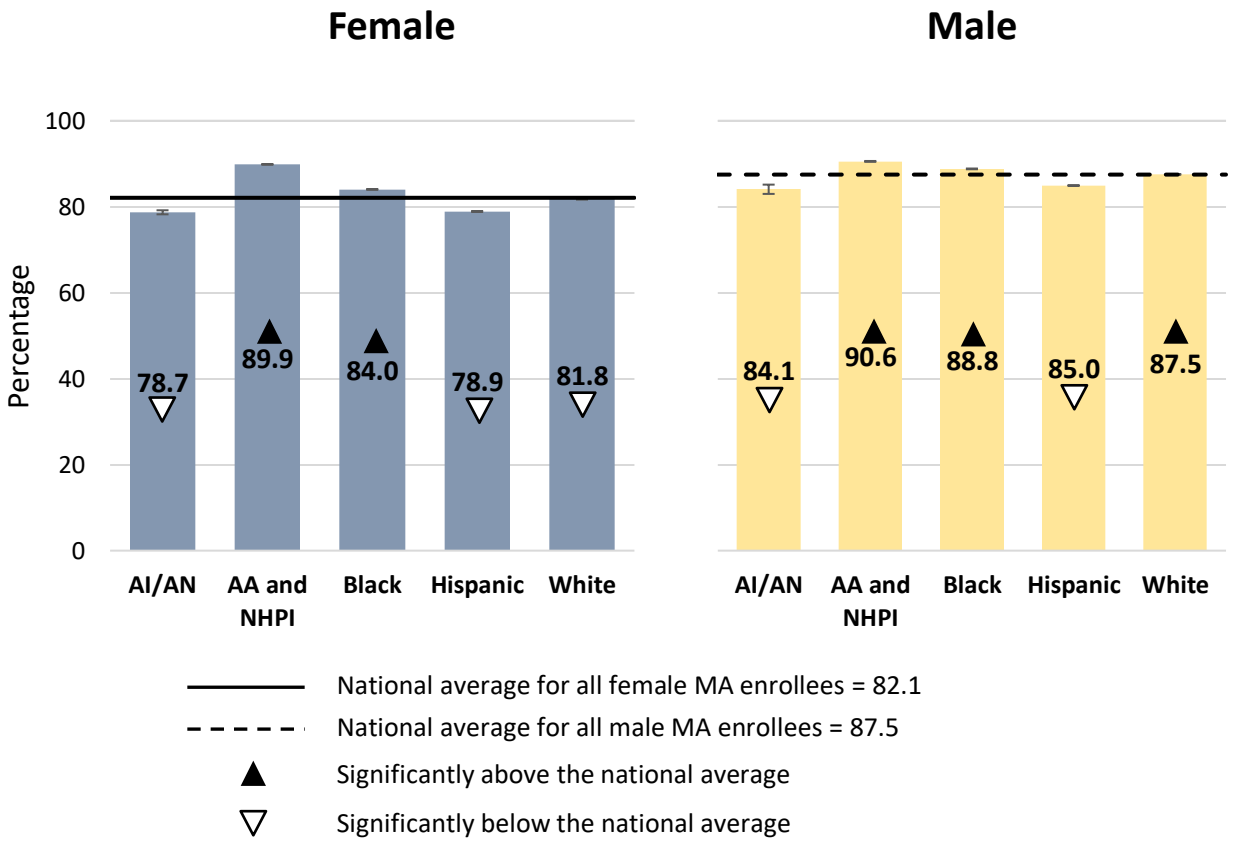
- The percentage of older adult female AI/AN MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **similar to** the national average for all female MA enrollees. The percentage of older adult female AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of older adult female Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all female MA enrollees by less than 3 percentage points. The percentages of older adult female Hispanic and White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points.

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

- The percentage of older adult male AI/AN MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of older adult male AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of older adult male Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all male MA enrollees by less than 3 percentage points. The percentages of older adult male Hispanic and White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points.

Avoiding Use of High-Risk Medications in Older Adults

Percentage of MA enrollees aged 65 years and older who were not prescribed two or more high-risk medications from the same drug class in the past year, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

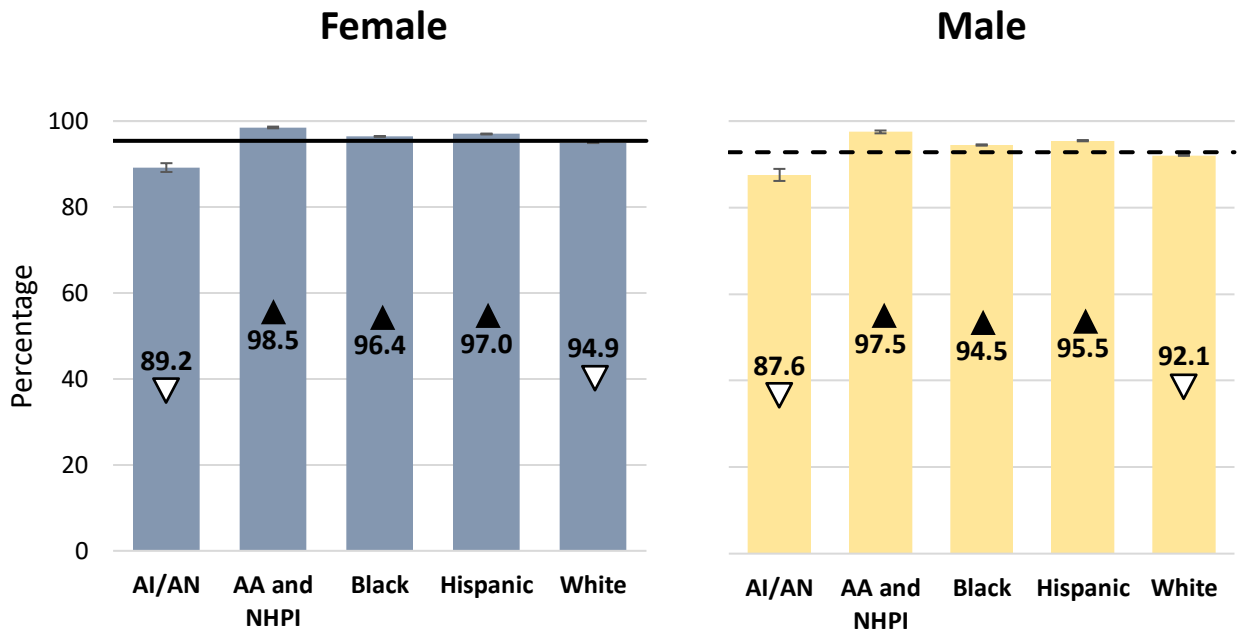
Disparities

- The percentages of older adult female AI/AN and Hispanic MA enrollees for whom use of high-risk medications was avoided were each **below** the national average for all older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female AA and NHPI MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female Black MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all older adult female MA enrollees by less than 3 percentage points. The percentage of older adult female White MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all older adult female MA enrollees by less than 3 percentage points.

- The percentage of older adult male AI/AN MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male AA and NHPI MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all older adult male MA enrollees by more than 3 percentage points. The percentages of older adult male Black and White MA enrollees for whom use of high-risk medications was avoided were each **above** the national average for all older adult male MA enrollees by less than 3 percentage points. The percentage of older adult male Hispanic MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all older adult male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

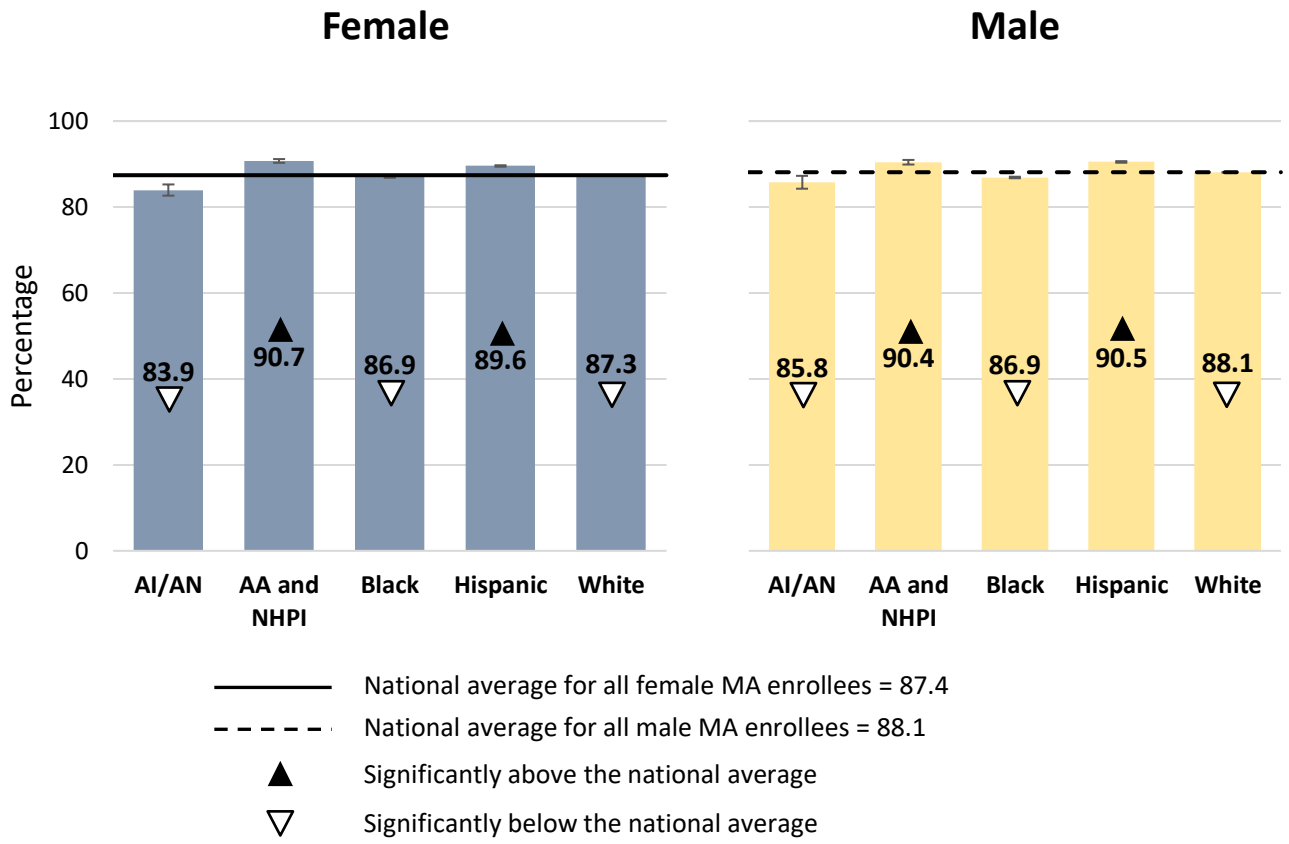
- The percentage of female AI/AN MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female AA and NHPI MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female Black and Hispanic MA enrollees for whom use of opioids at a high dosage was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female White MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all female MA enrollees by less than 3 percentage points.

[†] Average morphine equivalent dose ≥90 mg.

- The percentage of male AI/AN MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male AA and NHPI MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and Hispanic MA enrollees for whom use of opioids at a high dosage was avoided were each **above** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

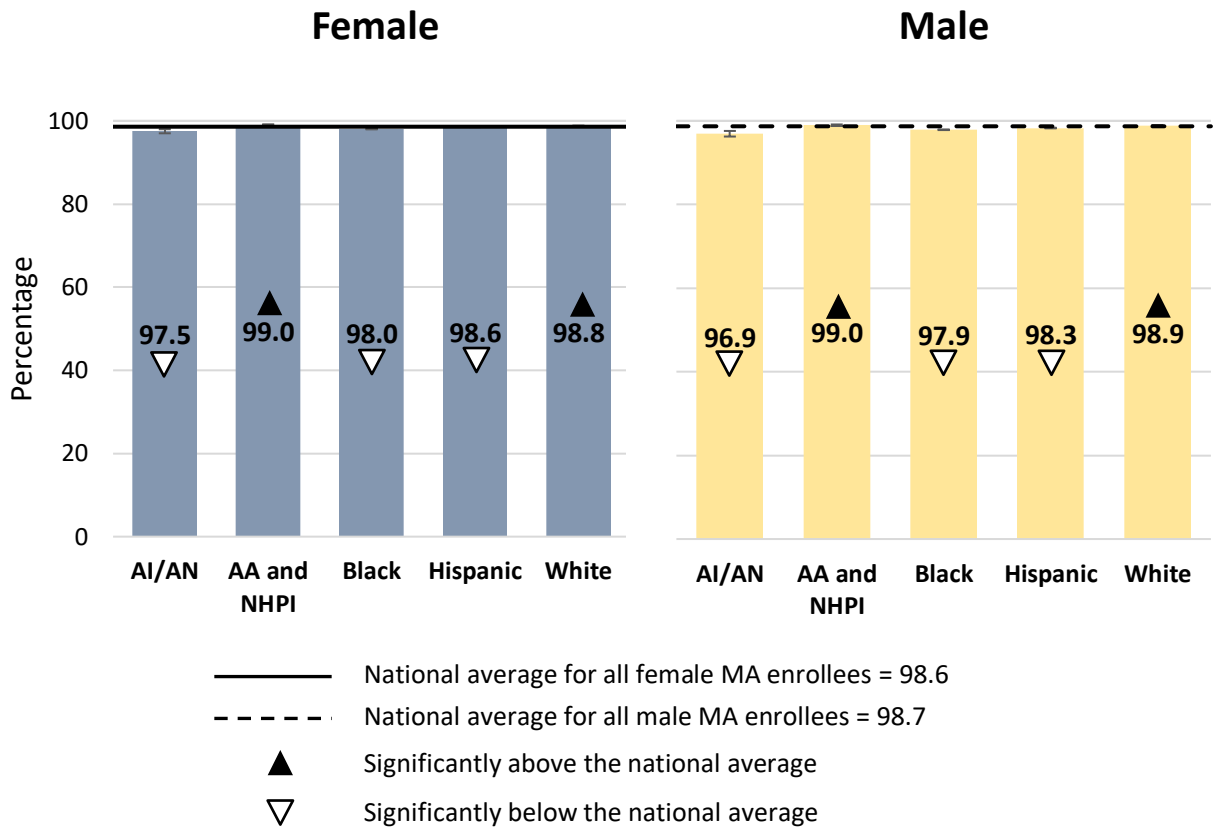
Disparities

- The percentage of female AI/AN MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female AA and NHPI MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentages of female Black and White MA enrollees for whom use of opioids from multiple prescribers was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average for all female MA enrollees by less than 3 percentage points.

- The percentages of male AI/AN, Black, and White MA enrollees for whom use of opioids from multiple prescribers was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided were each **above** the national average for all male 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 race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

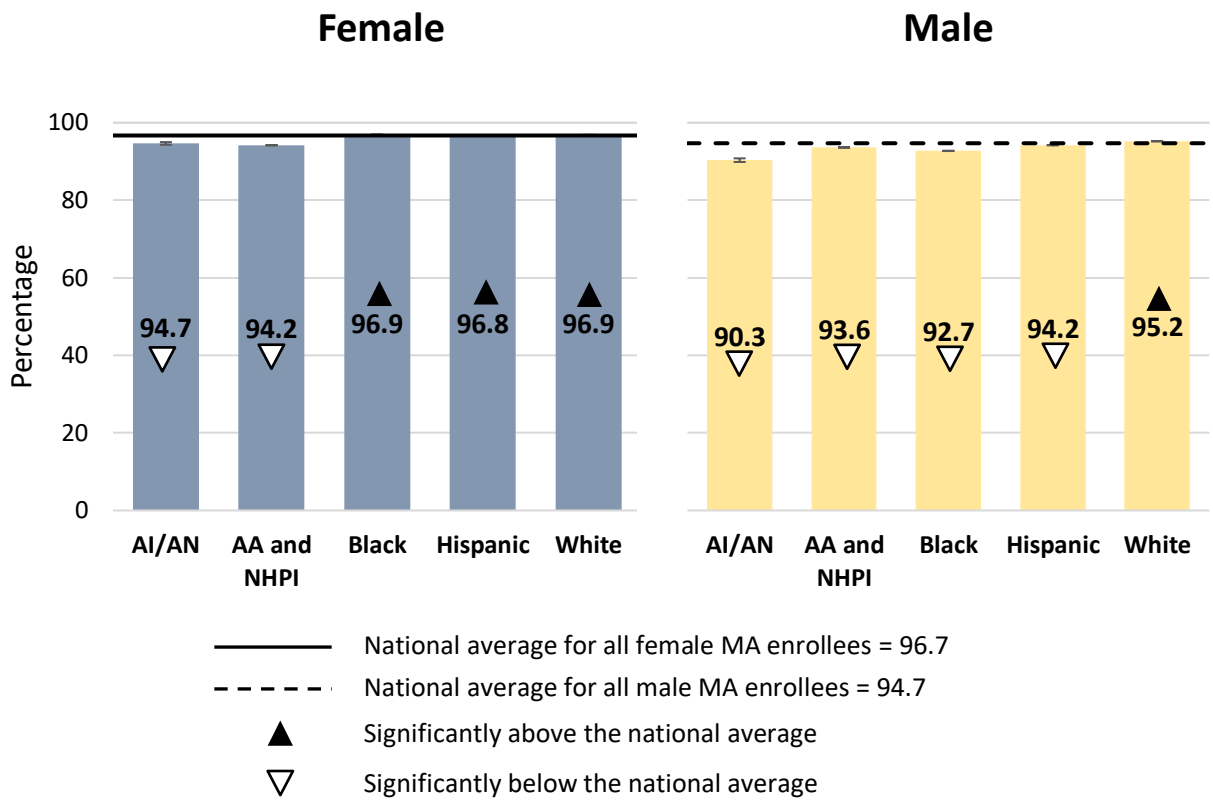
Disparities

- The percentages of female AI/AN, Black, and Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female AA and NHPI and White MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AI/AN, Black, and Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentages of male AA and NHPI and White MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **above** the national average for all male MA enrollees by less than 3 percentage points.

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by race and ethnicity within sex, Reporting Year 2022



SOURCE: Clinical quality data were collected in 2021 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of female AI/AN and AA and NHPI MA enrollees who had an ambulatory or preventive care visit in the past year were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female Black, Hispanic, and White MA enrollees who had an ambulatory or preventive care visit in the past year were each **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI, Black, and Hispanic MA enrollees who had an ambulatory or preventive care visit in the past year were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average for all male MA enrollees by less than 3 percentage points.

Appendix: Data Sources and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems Survey

The MA and PDP CAHPS survey consists of a set of mail surveys with telephone follow-ups based on 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. The 2022 MA and PDP CAHPS survey attempted to contact 1,099,462 people with Medicare and received responses from 370,054, for a 33.7-percent response rate. The 2022 surveys represent all people with Medicare FFS coverage, MA enrollees from 559 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP enrollees from 53 PDP contracts with at least 1,500 eligible enrollees. The data presented in this report pertain only to MA enrollees.

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 2022, there were 713 MA contracts that supplied the 25,045,752 HEDIS measure records used for this report.

Information on Race and Ethnicity

The 2021 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 other Pacific Islander,” and “American Indian or Alaska Native.” We followed a U.S. Census approach, so 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:

- Respondents who endorsed Hispanic ethnicity were classified as Hispanic regardless of races endorsed.
- Non-Hispanic respondents who endorsed two or more races were classified as Multiracial, with a single exception: Those who selected both “Asian” and “Native Hawaiian or other Pacific Islander” 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 analyses of differences by race and ethnicity.

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 with race and ethnicity information that can be inferred from a person's name, address, other demographics, and health plan characteristics (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.

Information on Sex

Information on the sex of MA enrollees is gathered from administrative records.

Analytic Approach

The CAHPS measures presented in this report are composite measures that summarize, through averaging, the answers to two or more related CAHPS survey questions, or items. The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report. This is a single-item measure rather than a composite.

CAHPS estimates for different racial and ethnic groups are from case mix–adjusted linear regression models. Each model was run six times, with AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White MA enrollees successively serving as the focal racial/ethnic group. Each time the model was run, it contained records for MA enrollees of all racial and ethnic groups; what changed were predictors. These linear regression models contained an indicator for the focal racial/ethnic group and the following case-mix adjustors: age, education, self-rated health and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. In keeping with how the measure is officially scored, no case-mix adjustment was made for the annual flu vaccine measure. These models yielded estimates of each group's score and a statistical test of the difference between that score and the score for all others; the statistical test is equivalent to the test of difference from the national average for all MA enrollees.

CAHPS estimates for female and male MA enrollees are from case mix–adjusted linear regression models that contained either an indicator for female sex or an indicator for male sex and the same set of case-mix adjustors used in the racial and ethnic group models. CAHPS estimates for female and male MA enrollees of different racial and ethnic backgrounds are from case mix–adjusted linear regression models, stratified by sex. These models were run in the same manner as the overall racial and ethnic models described earlier. The models for female MA enrollees yielded statistical tests that are the equivalent of tests of each racial and ethnic group's score against the national average for all female MA enrollees. The models for male MA enrollees yielded statistical tests that are the equivalent of tests of each racial and ethnic group's score against the national average for all male MA enrollees.

HEDIS estimates for different racial and ethnic groups are from logistic regression models. Each model was run five times, each time focusing on a single racial/ethnic group: AI/AN, AA and NHPI, Black,

Hispanic, and White. None of the HEDIS measures reported is case mix–adjusted. That is, the sole predictor in these logistic regression models was the MBISG-predicted probability that a person belonged to the focal racial/ethnic group for that model. HEDIS estimates for female and male MA enrollees are from logistic regression models that contained only an indicator for female or male sex. HEDIS estimates for female and male MA enrollees of different racial and ethnic groups are from logistic regression models, stratified by sex, that were run in the same manner as the overall racial and ethnic models described earlier. To estimate the confidence interval for the difference between the score for one group and the national mean, a linear regression that is otherwise similar to the model described earlier (with the racial/ethnic group probability as the sole predictor) was run, retaining the standard error of the log-odds for the group identifier. This standard error was multiplied by the proportion of MA enrollees not in the group to estimate the standard error for the difference, which was then used to construct the confidence interval.

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 3 percentage points (HEDIS) are further denoted as practically significant. In the summary charts that appear in the Executive Summary and at the beginning of each section showing 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 the bullet-point summaries that appear below these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

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