

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



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# Preface

This report presents summary information on the performance of Medicare Advantage (MA) plans on specific measures of quality of health care reported in 2019, which corresponds to care received in 2018. Specifically, this report compares the quality of clinical care for dual-eligible (DE) beneficiaries (i.e., beneficiaries who qualify for both Medicare and Medicaid) and Medicare beneficiaries who are eligible for a Part D Low-Income Subsidy (LIS) with the quality of care for beneficiaries who are neither DE nor LIS. We refer to the former group as *DE/LIS beneficiaries* and the latter group as *non-DE/LIS beneficiaries*. We also refer to *DE/LIS status*, which indicates whether a beneficiary is DE/LIS. In addition to examining overall differences by DE/LIS status, we look at how differences by DE/LIS status vary across racial and ethnic groups and between rural and urban areas.

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# Executive Summary



This report presents summary information on the performance of Medicare Advantage (MA) plans on specific measures of quality of health care reported in 2019 (hereafter, “Reporting Year 2019”), which corresponds to care received in 2018 (also referred to as “Measurement Year 2018”). Specifically, this report compares the quality of clinical care for dual-eligible (DE) beneficiaries (i.e., beneficiaries who qualify for both Medicare and Medicaid) and Medicare beneficiaries who are eligible for a Low-Income Subsidy (LIS)<sup>1</sup> with the quality of care for beneficiaries who are neither DE nor LIS-eligible. We refer to the former group as *DE/LIS beneficiaries* and the latter group as *non-DE/LIS beneficiaries*. We also refer to *DE/LIS status*, which indicates whether a beneficiary is DE/LIS. In addition to examining overall differences by DE/LIS status, the report looks at how differences by DE/LIS status vary across racial and ethnic groups and between rural and urban areas.

The report is based on an analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data on the quality of care delivered to Medicare beneficiaries enrolled in MA plans. HEDIS is composed of information collected from medical records and administrative data on the clinical quality of care that MA beneficiaries receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease.

### ***Disparities in Health Care in Medicare Advantage by DE/LIS Status***

DE/LIS disparities in clinical care were widespread: DE/LIS MA beneficiaries had worse results than non-DE/LIS MA beneficiaries for 54 percent of measures, similar results for 41 percent of measures, and better results for 5 percent of measures (see Figure 1, which is also shown at the beginning of Section I of this report).<sup>2</sup> Differences between DE/LIS and non-DE/LIS beneficiaries were largest in the areas of follow-up after hospitalization for mental illness (an 11-percentage-point deficit for DE/LIS beneficiaries) and avoiding potentially harmful drug-disease interactions in elderly patients with dementia and a history of falls (in each case, a 9-percentage-point deficit for DE/LIS beneficiaries).

### ***DE/LIS Disparities by Race and Ethnicity in Health Care in Medicare Advantage***

Although the pattern of generally worse results for DE/LIS beneficiaries than for non-DE/LIS beneficiaries held for all four racial and ethnic groups examined, the pattern was less consistent for Hispanic beneficiaries than for other groups (see Figure 2, which is also shown at the beginning of Section II of this report). Among Asian or Pacific Islander (API), Black, and White beneficiaries, those who were DE/LIS had worse results on clinical care measures much more often than they had better results on those measures.

- Among API beneficiaries, those who were DE/LIS had worse results on 33 percent of measures and better results on 3 percent of measures. Differences between API DE/LIS beneficiaries and API non-DE/LIS beneficiaries were largest in the areas of avoiding potentially harmful drug-disease interactions in elderly patients with dementia and a history of falls (15-percentage-point and 9-percentage-point deficits, respectively, for DE/LIS beneficiaries) and osteoporosis management for women who had a fracture (11-percentage-point deficit for DE/LIS beneficiaries).
- Among Black beneficiaries, those who were DE/LIS had worse results on 38 percent of measures and better results on 5 percent of measures. Differences between Black DE/LIS beneficiaries and Black non-DE/LIS beneficiaries were largest in the areas of blood pressure

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<sup>1</sup> The LIS is available under the Medicare Part D prescription drug program.

<sup>2</sup> Here, we use *similar* to characterize differences that are not statistically significant, fall below a magnitude threshold, or both, as described in the appendix. We use *worse* and *better* to characterize differences that are statistically significant and reach or exceed a magnitude threshold.

control for patients with diabetes (a 13-percentage-point deficit for DE/LIS beneficiaries), avoiding potentially harmful drug-disease interactions in elderly patients with dementia (an 11-percentage-point deficit for DE/LIS beneficiaries), and use of bronchodilators in the management of chronic obstructive pulmonary disease (COPD) (a 10-percentage-point deficit for non-DE/LIS beneficiaries).

- Among White beneficiaries, those who were DE/LIS had worse results on 56 percent of measures and better results on 5 percent of measures. Differences between White DE/LIS beneficiaries and White non-DE/LIS beneficiaries were largest in the areas of breast cancer screening (a 12–percentage point deficit for DE/LIS beneficiaries) and avoiding potentially harmful drug-disease interactions in elderly patients with dementia and a history of falls (12–percentage point and 13–percentage point deficits, respectively, for DE/LIS beneficiaries).
- Among Hispanic beneficiaries, those who were DE/LIS had worse results on 23 percent of measures and better results on 18 percent of measures. Differences between Hispanic DE/LIS beneficiaries and Hispanic non-DE/LIS beneficiaries were largest in the areas of use of bronchodilators and corticosteroids in the management of COPD (18-percentage-point and 15-percentage-point deficits, respectively, for non-DE/LIS beneficiaries) and follow-up after hospitalization for mental illness (a 13-percentage-point deficit for DE/LIS beneficiaries).

### ***DE/LIS Disparities in Health Care in Medicare Advantage in Urban and Rural Areas<sup>3</sup>***

Disparities in clinical care by DE/LIS status were observed more often in urban areas than in rural areas (see Figure 3, which is also shown at the beginning of Section III of this report). In urban areas, DE/LIS beneficiaries had worse results than non-DE/LIS beneficiaries on 56 percent of clinical care measures and better results on 5 percent of clinical care measures. In rural areas, DE/LIS beneficiaries had worse results than non-DE/LIS beneficiaries on one-third of clinical care measures and better results on 8 percent of clinical care measures. Differences between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries were largest in the areas of follow-up after hospitalization for mental illness (a 9-percentage-point deficit for DE/LIS beneficiaries) and avoiding potentially harmful drug-disease interactions in elderly patients with dementia and a history of falls (10-percentage-point and 9-percentage-point deficits, respectively, for DE/LIS beneficiaries). Differences between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries were largest in the areas of follow-up after hospitalization for mental illness (a 20-percentage-point deficit for DE/LIS beneficiaries), initiation of alcohol or other drug (AOD) treatment (a 17-percentage-point deficit for non-DE/LIS beneficiaries), and use of bronchodilators in the management of COPD (a 12-percentage-point deficit for non-DE/LIS beneficiaries).

### ***Conclusion***

In evaluating differences by DE/LIS status in the quality of health care received in 2018 by MA beneficiaries at the national level, this report found that DE/LIS beneficiaries often received worse clinical care than non-DE/LIS beneficiaries. Future research is needed to understand the causes of this pattern. Disparities for DE/LIS beneficiaries were less common among Hispanic beneficiaries than among API, Black, and White beneficiaries. Of these three racial/ethnic groups, DE/LIS disparities were most

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<sup>3</sup> Beneficiaries were classified as living in a rural or urban area according to the ZIP code of their mailing address and the corresponding U.S. Census Bureau core-based statistical area (CBSA). CBSAs consist of the county or counties associated with at least one core urban area plus adjacent counties with a high degree of social and economic integration with the core area. Metropolitan statistical areas contain a core urban area with a population of 50,000 or more. Micropolitan statistical areas contain a core urban area of at least 10,000 but less than 50,000 people. For this report, any beneficiary residing within a metropolitan statistical area was classified as an urban resident; any beneficiary living in a micropolitan statistical area or outside a CBSA was classified as a rural resident.

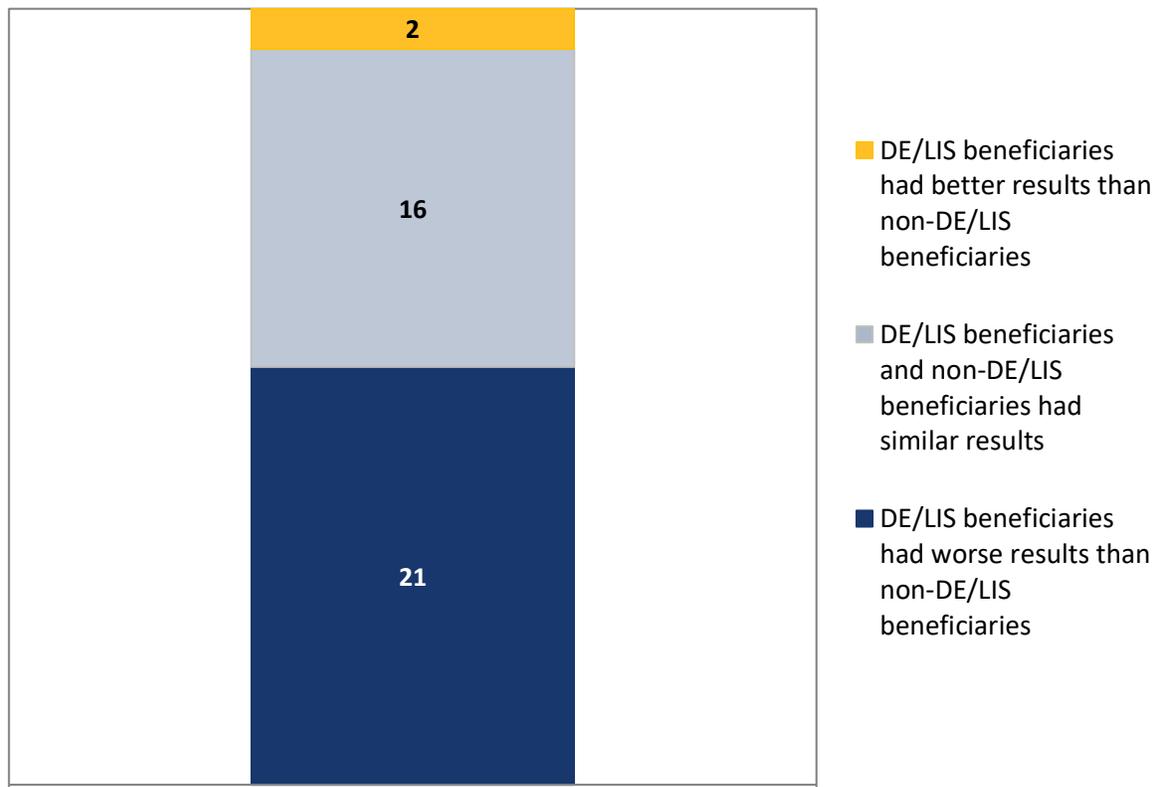
common among White beneficiaries. Future research should examine the extent to which the relatively smaller disparities for Hispanic beneficiaries might involve the widespread availability of linguistically appropriate care for Hispanic DE/LIS beneficiaries (Anhang Price et al., 2015).<sup>4</sup> For some measures, it may be that a small difference or no difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries reflects poor quality of care for Hispanic non-DE/LIS beneficiaries. Finally, this analysis revealed more-pronounced disparities in clinical care for DE/LIS beneficiaries in urban than in rural areas. Additional research is needed to better understand the mechanisms for this finding, including whether DE/LIS beneficiaries experience challenges in accessing the best providers in urban areas or whether DE/LIS and non-DE/LIS beneficiaries have different experiences with the same providers.

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<sup>4</sup> Anhang Price et al., 2015, found smaller disparities in Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for Hispanic beneficiaries in contracts with higher proportions of Hispanic and Spanish-preferring beneficiaries and suggested that linguistically appropriate care might be a mechanism for this finding. It is also the case that Hispanic DE/LIS beneficiaries are more likely than Hispanic non-DE/LIS beneficiaries to be enrolled in plans with a high concentration of Hispanic beneficiaries (Weinick et al., 2014), including Dual Eligible Special Needs Plans. Thus, Hispanic DE/LIS beneficiaries may be more likely than Hispanic non-DE/LIS beneficiaries to be in a plan with appropriate linguistic services. This may provide a benefit not seen for other DE/LIS groups.

## Figure 1. Summary of Disparities in Clinical Care by DE/LIS Status

Number of clinical care measures for which DE/LIS beneficiaries had results that were worse than, similar to, or better than results for non-DE/LIS beneficiaries in Reporting Year 2019



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

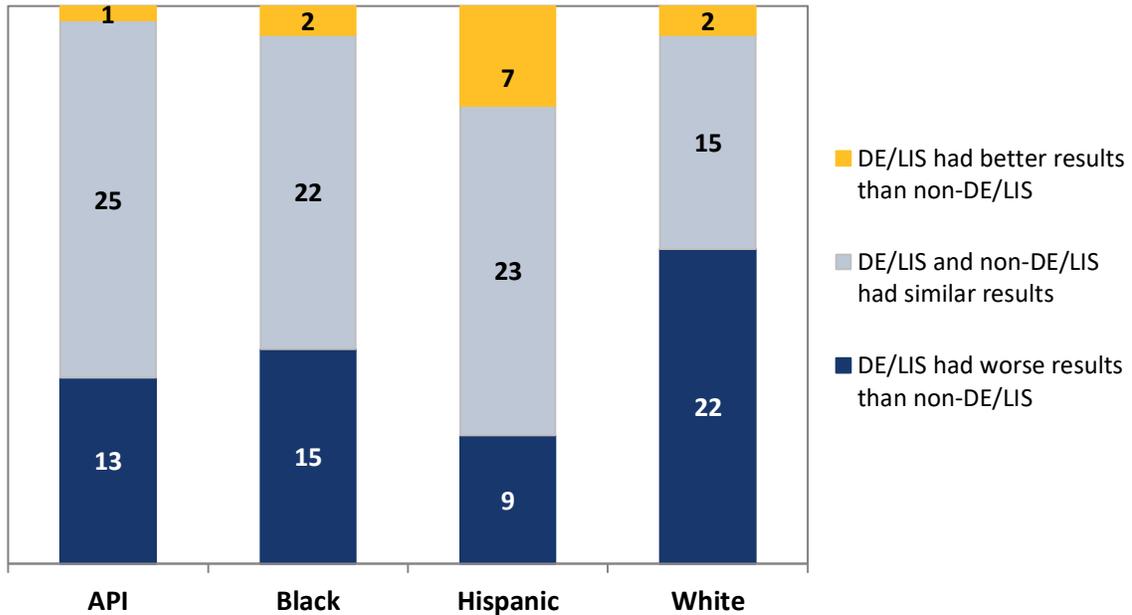
The relative difference between DE/LIS and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

## Figure 2. Summary of Disparities in Clinical Care by DE/LIS Status Within Racial and Ethnic Groups

Number of clinical care measures for which DE/LIS beneficiaries of selected racial and ethnic groups had results that were worse than, similar to, or better than results for non-DE/LIS beneficiaries in Reporting Year 2019



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races. Three of the values reported in this chart had low precision; one is among the 13 instances in which API DE/LIS beneficiaries had worse results than API non-DE/LIS beneficiaries, while the other two are among the 25 instances in which API DE/LIS and API non-DE/LIS beneficiaries had similar results.

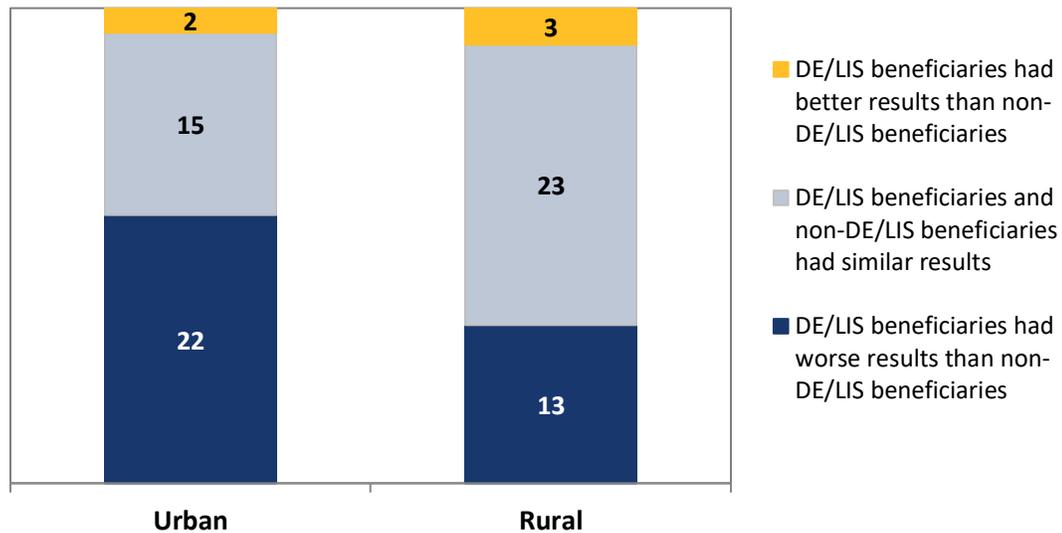
Within each racial or ethnic group, the relative difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

### Figure 3. Summary of DE/LIS Disparities in Clinical Care Within Urban and Rural Areas

Number of clinical care measures for which urban and rural residents who were DE/LIS had results that were worse than, similar to, or better than results for urban and rural residents who were not DE/LIS in Reporting Year 2019



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.  
**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

Within urban and rural areas, the relative difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

# Clinical Care Measures Included in This Report<sup>5</sup>

## *Prevention and Screening*

- Adult Body Mass Index (BMI) Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening

## *Respiratory Conditions*

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

## *Cardiovascular Conditions*

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

## *Diabetes*

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

## *Musculoskeletal Conditions*

- Rheumatoid Arthritis Management
- Osteoporosis Management in Women Who Had a Fracture

## *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 Abuse or Dependence (within 30 days of discharge)
- Initiation of Alcohol or Other Drug Treatment
- Engagement of Alcohol or Other Drug Treatment

## *Medication Management and Care Coordination*

- Medication Reconciliation After Hospital 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

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<sup>5</sup> This report considers all HEDIS measures that meet the measurement criteria and is not limited to the CMS Part C and D Star Ratings program.

*Overuse/Appropriate Use*

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

*Access/Availability of Care*

- Older Adults' Access to Preventive/Ambulatory Services

# Abbreviations Used in This Report

AMI	acute myocardial infarction
AOD	alcohol or other drug
API	Asian or Pacific Islander
ASCVD	atherosclerotic cardiovascular disease
BMI	body mass index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBSA	core-based statistical area
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
DE	dual-eligible
DE/LIS	dual-eligible or eligible for a Low-Income Subsidy
DMARD	disease-modifying anti-rheumatic drug
ED	emergency department
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
LIS	Low-Income Subsidy
MA	Medicare Advantage
non-DE/LIS	neither dual-eligible nor eligible for a Low-Income Subsidy
NSAID	nonsteroidal anti-inflammatory drug
QMB	Qualified Medicare Beneficiaries

# Overview and Methods



## Overview

This report presents summary information on the performance of Medicare Advantage (MA) plans on specific measures of quality of health care reported in 2019 (hereafter, “Reporting Year 2019”), which corresponds to care received in 2018 (also referred to as “Measurement Year 2018”).<sup>1</sup> The report focuses on 39 measures of clinical care, which describe the extent to which patients receive appropriate screening and treatment for specific health conditions.

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 socioeconomic status, race, and ethnicity. Since 2015, the CMS Office of Minority Health (OMH) has issued reports highlighting racial and ethnic differences in the quality of health care received by Medicare beneficiaries nationwide. In 2017, OMH began issuing reports comparing the quality of health care for male and female beneficiaries nationwide and looking at racial and ethnic differences separately among male and female beneficiaries. In 2018, OMH initiated a series of annual reports comparing the quality of health care for Medicare beneficiaries residing in rural versus urban areas nationwide; these reports have also looked at how racial and ethnic differences vary between rural and urban areas and how rural and urban differences vary across racial and ethnic groups.

This report focuses on comparing quality of care for dual-eligible (DE) beneficiaries (i.e., beneficiaries who qualify for both Medicare and Medicaid benefits)<sup>2</sup> and Medicare beneficiaries who are eligible for a Low-Income Subsidy (LIS)<sup>3</sup> with quality of care for beneficiaries who are neither dual-eligible nor LIS-eligible. Although it also is an indicator of high medical need, dual eligibility often is used as a proxy for low socioeconomic position (National Academies of Sciences, Engineering, and Medicine, 2016) and is a known predictor of many health-related processes and outcomes (Office of the Assistant Secretary for Planning and Evaluation, 2016).

In this report, three sets of comparisons are presented. In the first set, DE/LIS beneficiaries are compared with non-DE/LIS beneficiaries overall (i.e., irrespective of other beneficiary characteristics). In the second set, quality of care for DE/LIS beneficiaries is compared with quality of care for non-DE/LIS beneficiaries separately within four different racial and ethnic groups: Asian or Pacific Islander (API), Black, Hispanic, and White beneficiaries.<sup>4</sup> In the third set, quality of care for DE/LIS beneficiaries is compared with quality of care for non-DE/LIS beneficiaries separately within urban and rural areas.<sup>5</sup> The

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<sup>1</sup> Two measures reported herein—Adult BMI Assessment and Breast Cancer Screening—pertain to care received in the past two years.

<sup>2</sup> In this report, all DE individuals (i.e., those who would be considered full benefit, partial benefit, and Qualified Medicare Beneficiaries [QMBs]) are included in this group.

<sup>3</sup> In 2021, Medicare beneficiaries may qualify for the LIS if they have up to \$19,320 in yearly income (\$26,130 for a married couple) and up to \$14,790 in resources (\$29,520 for a married couple).

<sup>4</sup> For reporting Healthcare Effectiveness Data and Information Set (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from Centers for Medicare & Medicaid Services (CMS) administrative data, surname, and residential location. This methodology—which is called Medicare Bayesian Improved Surname Geocoding (MBISG)—is recommended for estimating racial and ethnic disparities for API, Black, Hispanic, and White beneficiaries (Haas et al., 2019). It is not currently recommended for estimating disparities for multiracial beneficiaries. The use of this methodology for American Indian and Alaska Native beneficiaries is under evaluation.

<sup>5</sup> Beneficiaries were classified as living in a rural or urban area according to the ZIP code of their mailing address and the corresponding U.S. Census Bureau core-based statistical area (CBSA). CBSAs consist of the county or counties associated with at least one core urban area plus adjacent counties with a high degree of social and economic integration with the core. Metropolitan statistical areas contain a core urban area with a population of

three sets of comparisons just described—which might be of interest to Medicare beneficiaries, MA organizations, Medicare Part D sponsors, health care researchers, and federal policymakers—are presented in a single report to provide a more-comprehensive understanding of the ways in which care differs by socioeconomic position, race and ethnicity, rurality, and the intersection of these characteristics. The focus of this report is on differences that exist at the national level. Interested readers can find information about health care quality for specific Medicare plans at Medicare.gov (Medicare.gov, undated).

### ***Data Sources***

Data on the 39 clinical care measures included in this report were gathered through medical records and insurance claims or encounter data for hospitalizations, medical office visits, and procedures. These data, which are collected each year from MA plans nationwide, are part of the 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, and access and availability of care. The 2019 HEDIS data reported here pertain to care received from January to December 2018.

Table 1 shows the distribution of beneficiaries by DE/LIS status, race and ethnicity, and urban and rural status in the 2019 MA population, and, for comparison, in the Medicare fee-for-service (FFS) population. In 2019, 34 percent of all Medicare beneficiaries were enrolled in MA. In general, DE/LIS beneficiaries were more likely to be enrolled in MA than were non-DE/LIS beneficiaries, racial and ethnic minority beneficiaries were more likely to be enrolled in MA than were White beneficiaries, and urban residents were more likely to be enrolled in MA than were rural residents.

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50,000 or more. Micropolitan statistical areas contain a core urban area of at least 10,000 but less than 50,000 people. For the purposes of this report, any beneficiary residing within a metropolitan statistical area was classified as an urban resident, while any beneficiary living in a micropolitan statistical area or outside a CBSA was classified as a rural resident.

Table 1. Distribution of the 2019 MA Population Compared with the Medicare FFS Population

Beneficiary Characteristic	MA (%)	Medicare FFS (%)
DE/LIS status		
DE/LIS	21.0	15.5
Non-DE/LIS	79.0	84.5
Race or ethnicity		
American Indian or Alaska Native*	0.4	0.7
Asian or Pacific Islander	4.0	3.6
Black	11.0	8.6
Hispanic	12.8	6.1
White	69.5	79.1
Multiracial*	2.3	2.0
Place of residence		
Urban	84.4	78.5
Rural	15.6	21.5

NOTE: DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

\* The American Indian and Alaska Native and multiracial groups are not included in this report because they are less reliably measured than the other groups listed in this table.

### Reportability of Information

Sample size criteria were used to determine whether a score on a measure was reportable for a particular group. Scores based on 400 or more observations across all contracts were considered sufficiently precise for reporting. Scores based on more than 99 but fewer than 400 observations were considered low in precision and were flagged as such. In this report, 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.<sup>6</sup>

### Disparities in Health Care in Medicare Advantage by DE/LIS Status

Section I of the report begins with a stacked bar chart showing the number of clinical care measures (out of 39) for which DE/LIS beneficiaries had results that were worse than, similar to, or better than results for non-DE/LIS beneficiaries.<sup>7</sup> Following the stacked bar charts are separate, unstacked bar charts for each clinical care measure. These unstacked bar charts show the percentage of DE/LIS and non-DE/LIS MA beneficiaries whose care met the standard called for by the specific measure (e.g., receiving a clinically indicated test or treatment).

<sup>6</sup> If a score were based on 99 or fewer observations, it would have been suppressed (i.e., not reported); however, no score fit that description for this report.

<sup>7</sup> Here, *similar* is used to characterize differences that are not statistically significant, fall below a magnitude threshold, or both, as described in the appendix. *Worse* and *better* are used to characterize differences that are statistically significant and reach or exceed a magnitude threshold.

### ***DE/LIS Disparities by Race and Ethnicity in Health Care in Medicare Advantage***

Section II of the report shows how differences in care for DE/LIS and non-DE/LIS beneficiaries vary from one racial or ethnic group to another. Section II begins with a set of stacked bar charts that show, separately for API, Black, Hispanic, and White MA beneficiaries, the number of clinical care measures for which results for DE/LIS beneficiaries were worse than, similar to, or better than results for non-DE/LIS beneficiaries. Following the stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for API, Black, Hispanic, and White MA beneficiaries, the percentage of DE/LIS and non-DE/LIS beneficiaries whose care met the standard called for by the measure.

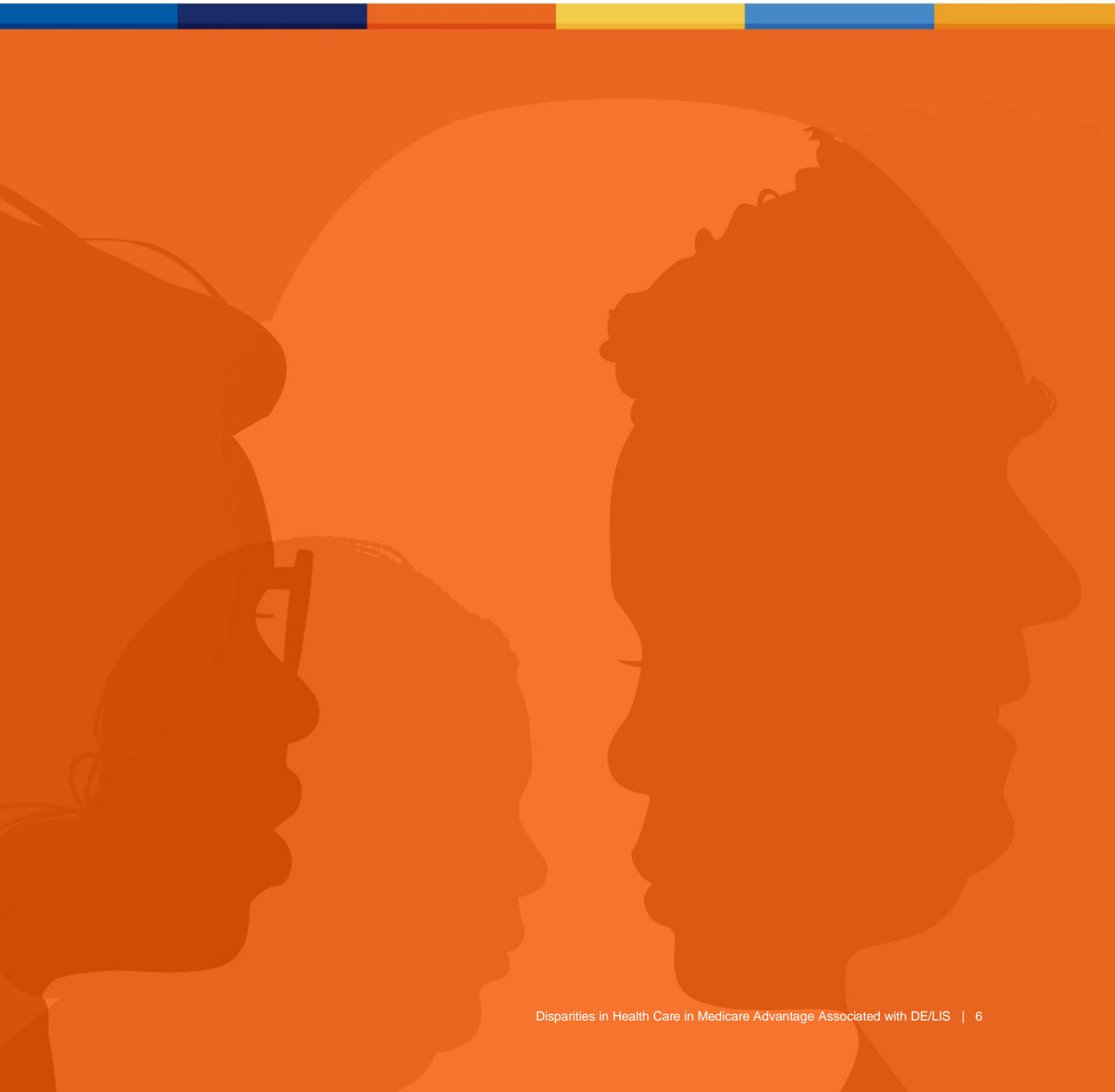
### ***DE/LIS Disparities in Health Care in Medicare Advantage Within Urban and Rural Areas***

Section III of the report shows how differences in care for DE/LIS and non-DE/LIS beneficiaries vary between urban and rural areas. Section III begins with a pair of stacked bar charts that show, separately for residents of urban and rural areas, the number of clinical care measures for which results for DE/LIS beneficiaries were worse than, similar to, or better than results for non-DE/LIS beneficiaries. Following the stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for residents of urban and rural areas, the percentage of DE/LIS and non-DE/LIS beneficiaries whose care met the standard called for by the measure.

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

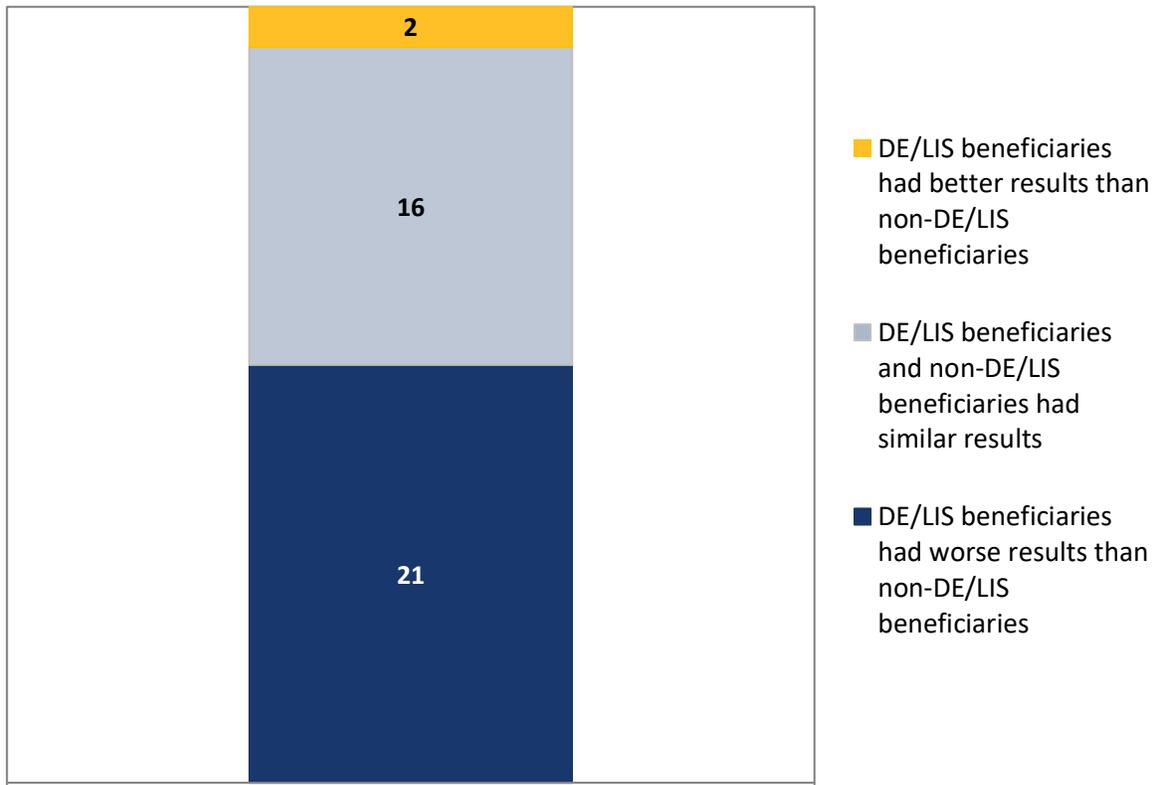
SECTION I:

# DE/LIS Disparities in Health Care in Medicare Advantage



## Summary of Disparities in Clinical Care by DE/LIS Status

Number of clinical care measures for which DE/LIS beneficiaries had results that were worse than, similar to, or better than results for non-DE/LIS beneficiaries in Reporting Year 2019



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

The relative difference between DE/LIS and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

**DE/LIS beneficiaries had worse results than non-DE/LIS beneficiaries**

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Osteoporosis Management in Women Who Had a Fracture
- 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)
- Medication Reconciliation After Hospital 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 Elderly Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medications in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers

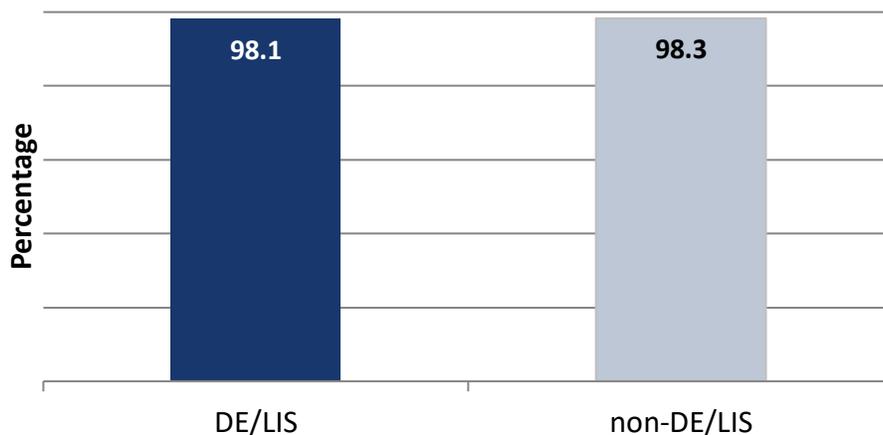
**DE/LIS beneficiaries had better results than non-DE/LIS beneficiaries**

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Initiation of Alcohol or Other Drug Treatment

## Prevention and Screening

### Adult Body Mass Index (BMI) Assessment

Percentage of MA beneficiaries aged 18 to 74 years who had an outpatient visit whose BMI was documented in the past two years, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

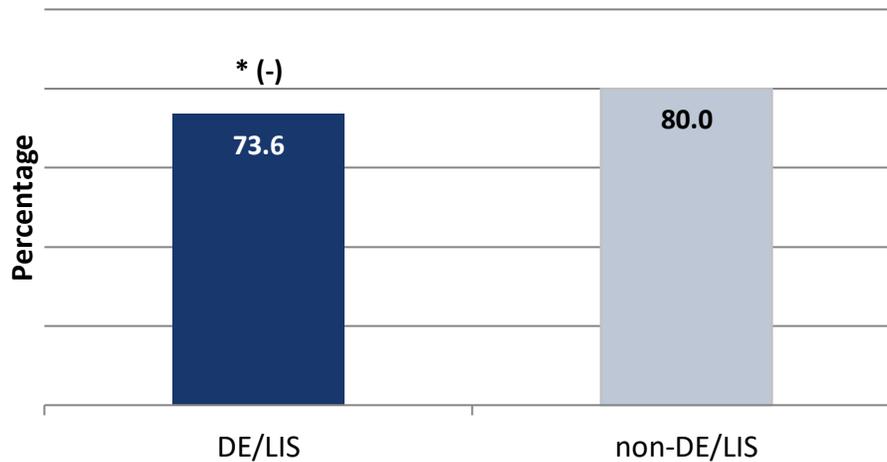
**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries were about as likely as non-DE/LIS beneficiaries to have had their BMIs documented.

## Breast Cancer Screening

Percentage of female MA beneficiaries aged 50 to 74 years who had appropriate screening for breast cancer in the past two years, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Female DE/LIS beneficiaries were less likely than female non-DE/LIS beneficiaries to have been appropriately screened for breast cancer. The difference between female DE/LIS beneficiaries and female non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

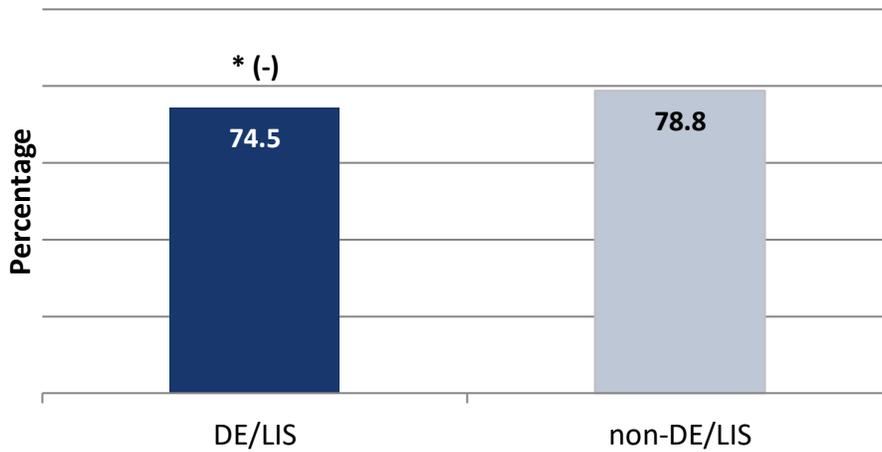
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Colorectal Cancer Screening

Percentage of MA beneficiaries aged 50 to 75 years who had appropriate screening for colorectal cancer, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries were less likely than non-DE/LIS beneficiaries to have been appropriately screened for colorectal cancer. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

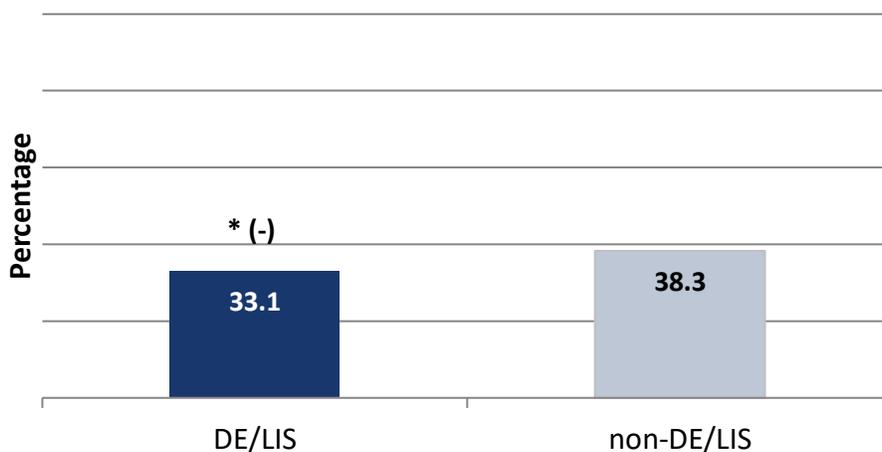
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Respiratory Conditions

### Testing to Confirm COPD

Percentage of MA beneficiaries aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries with a new diagnosis of COPD or newly active COPD were less likely than non-DE/LIS beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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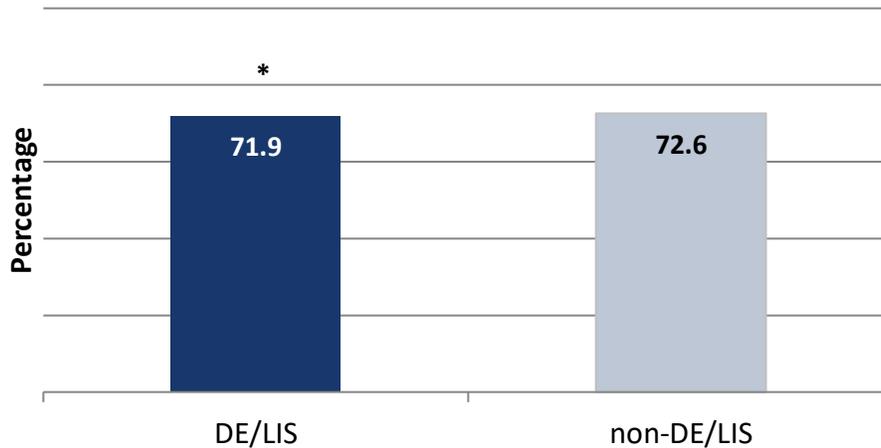
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who experienced a COPD exacerbation were less likely than non-DE/LIS beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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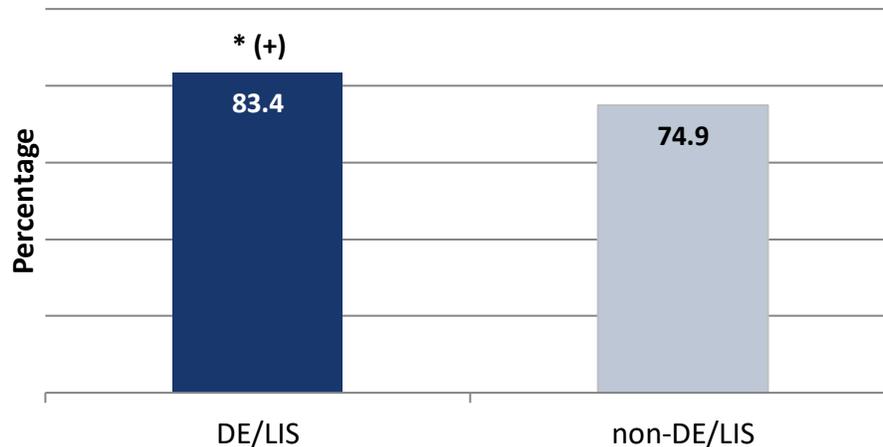
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who experienced a COPD exacerbation were more likely than non-DE/LIS beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

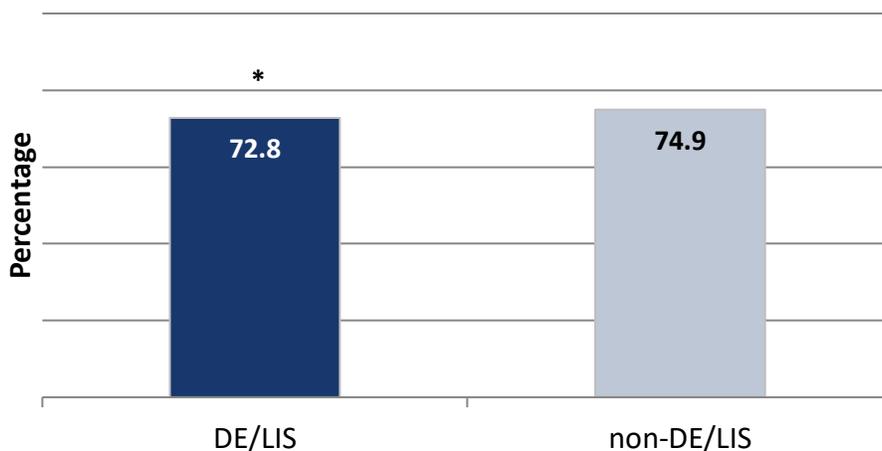
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Cardiovascular Conditions

### Controlling High Blood Pressure

Percentage of MA beneficiaries aged 18 to 85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled<sup>†</sup> during the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries who had a diagnosis of hypertension were less likely than non-DE/LIS beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

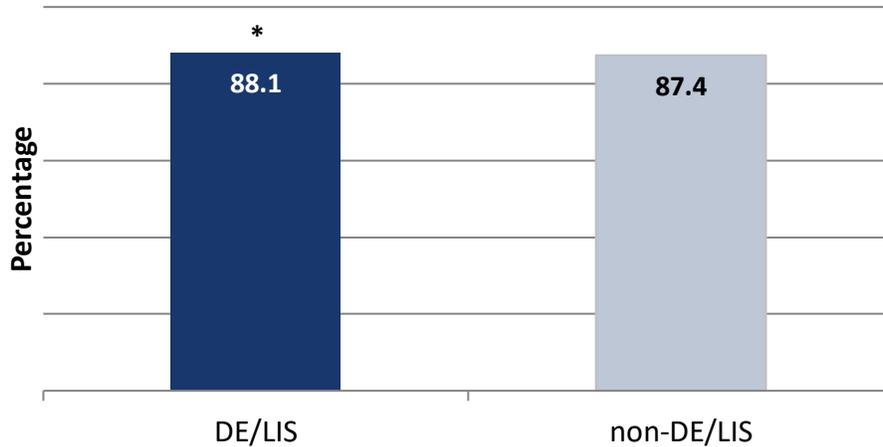
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Less than 140/90 for those 18 to 59 years of age and for those 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for those 60 to 85 years of age without a diagnosis of diabetes.

## Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA beneficiaries aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who were hospitalized for a heart attack were more likely than non-DE/LIS beneficiaries who were hospitalized for a heart attack to have received continuous beta-blocker treatment. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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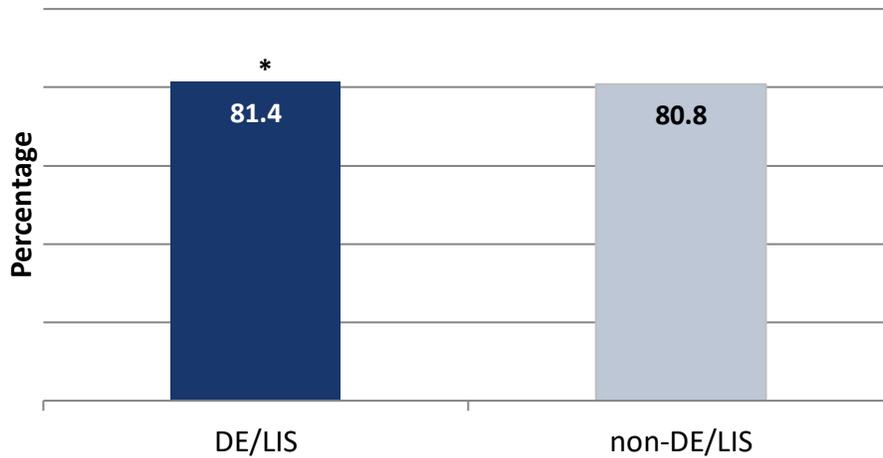
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Cardiovascular Disease

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with ASCVD were more likely than non-DE/LIS beneficiaries with ASCVD to have received statin therapy. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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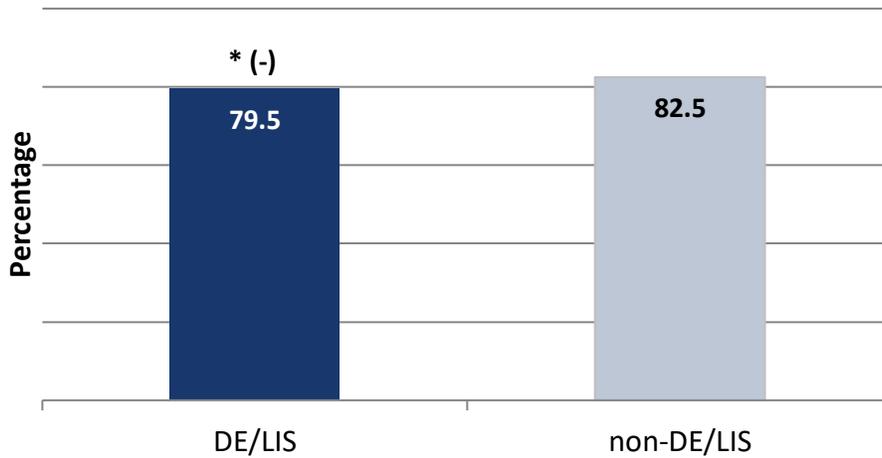
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with ASCVD were less likely than non-DE/LIS beneficiaries with ASCVD to have had proper statin medication adherence. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points (before rounding).

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

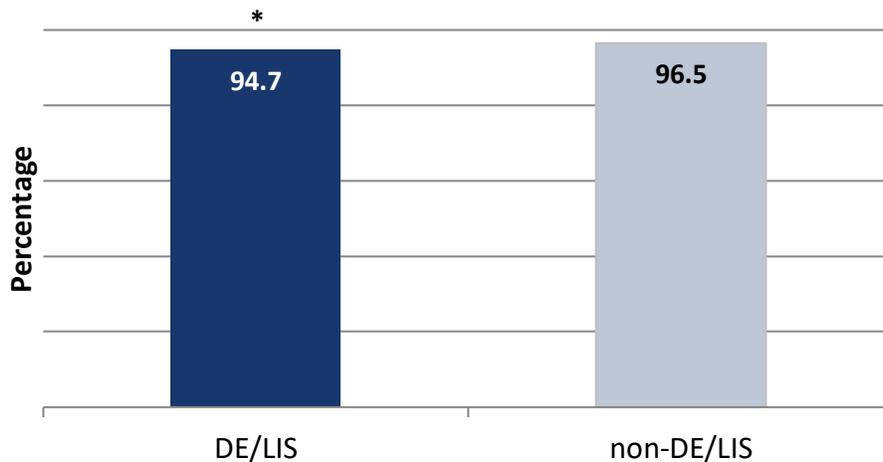
For differences that are statistically significant, the following symbols are also used when applicable:

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- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

# Diabetes

## Diabetes Care—Blood Sugar Testing

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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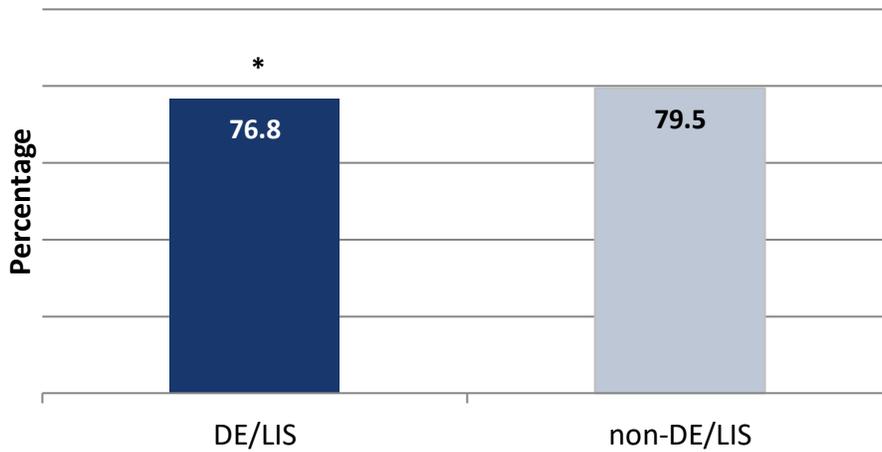
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Eye Exam

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had an eye exam in the past year. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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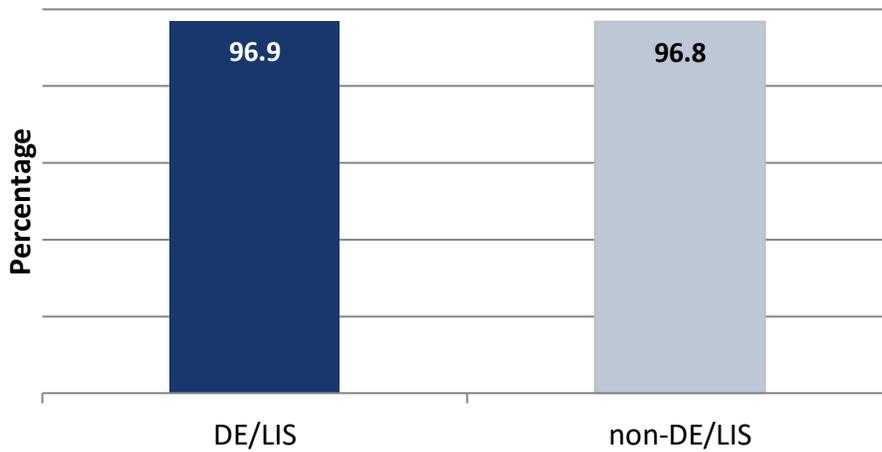
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Kidney Disease Monitoring

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

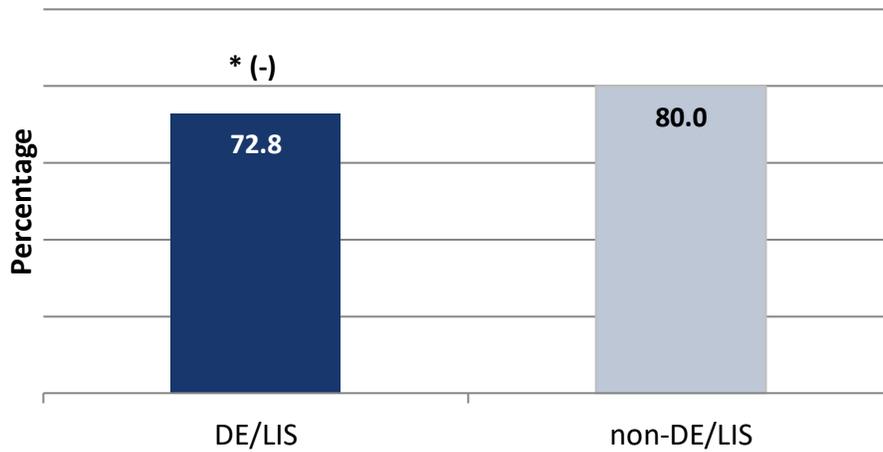
**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were about as likely as non-DE/LIS beneficiaries with diabetes to have had medical attention for nephropathy in the past year.

## Diabetes Care—Blood Pressure Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had their blood pressure under control. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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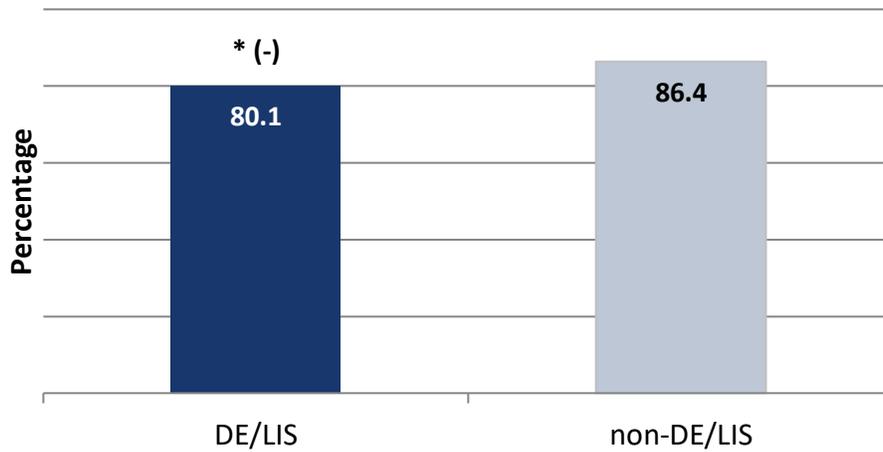
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Blood Sugar Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had their blood sugar levels under control. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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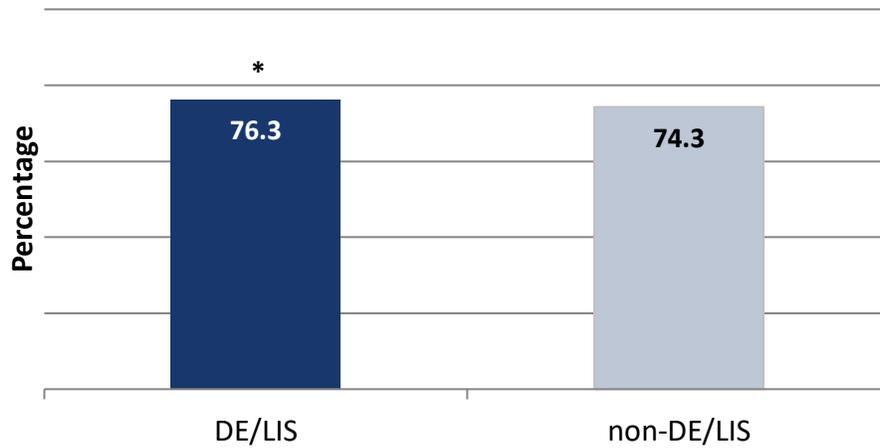
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Diabetes

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who received statin therapy, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were more likely than non-DE/LIS beneficiaries with diabetes to have received statin therapy. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

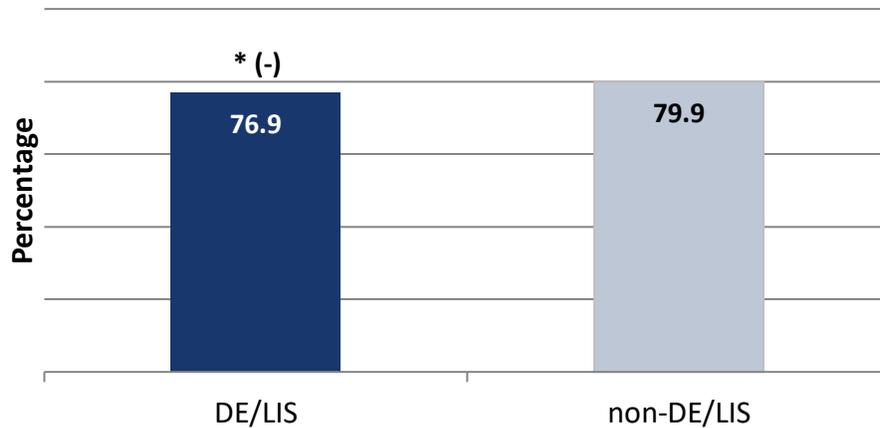
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

## Medication Adherence for Diabetes—Statins

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had proper statin medication adherence. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

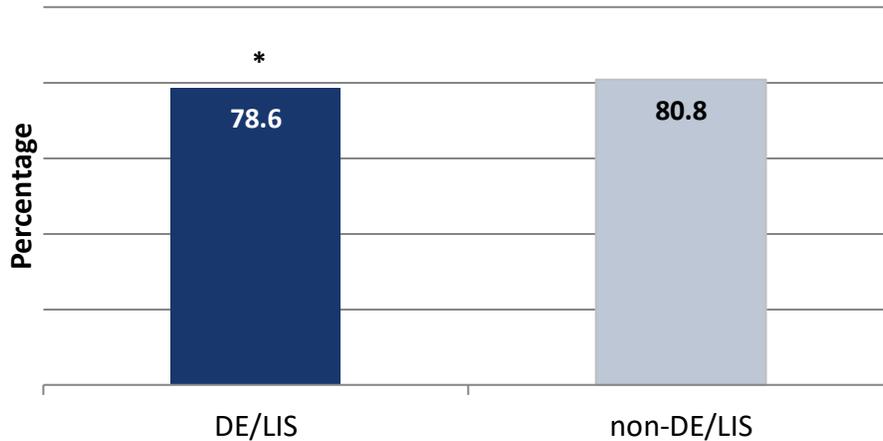
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

# Musculoskeletal Conditions

## Rheumatoid Arthritis Management

Percentage of MA beneficiaries aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD), by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who were diagnosed with rheumatoid arthritis were less likely than non-DE/LIS beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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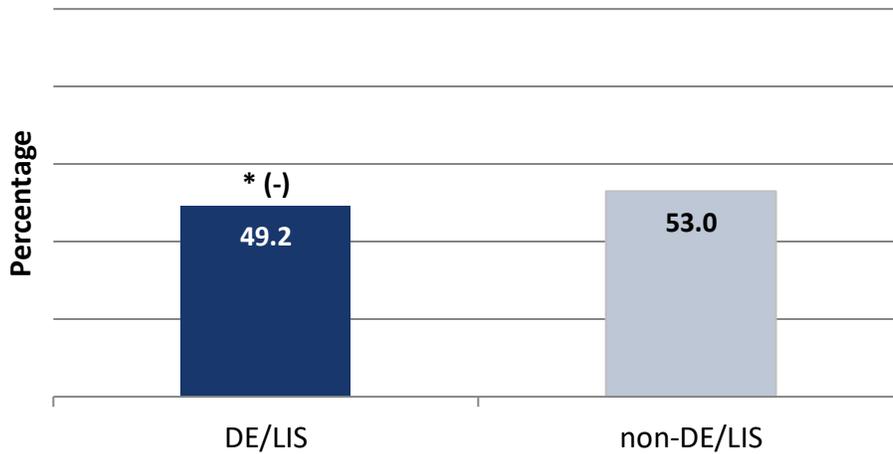
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA beneficiaries aged 65 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Female DE/LIS beneficiaries who suffered a fracture were less likely than female non-DE/LIS beneficiaries women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between female DE/LIS beneficiaries and female non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

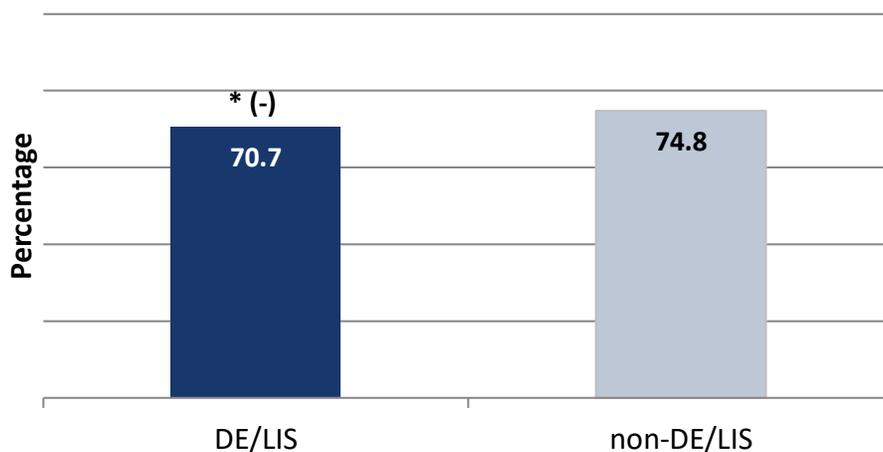
For differences that are statistically significant, the following symbols are also used when applicable:

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- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Behavioral Health

### Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries diagnosed with a new episode of major depression were less likely than non-DE/LIS beneficiaries diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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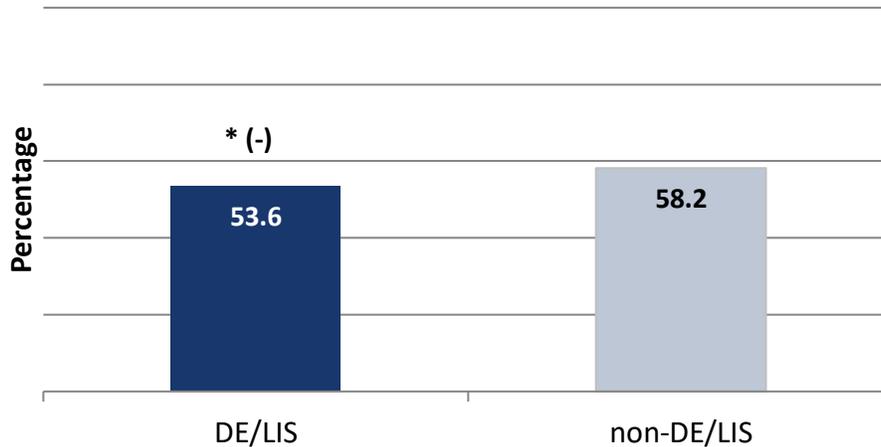
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries diagnosed with a new episode of major depression were less likely than non-DE/LIS beneficiaries diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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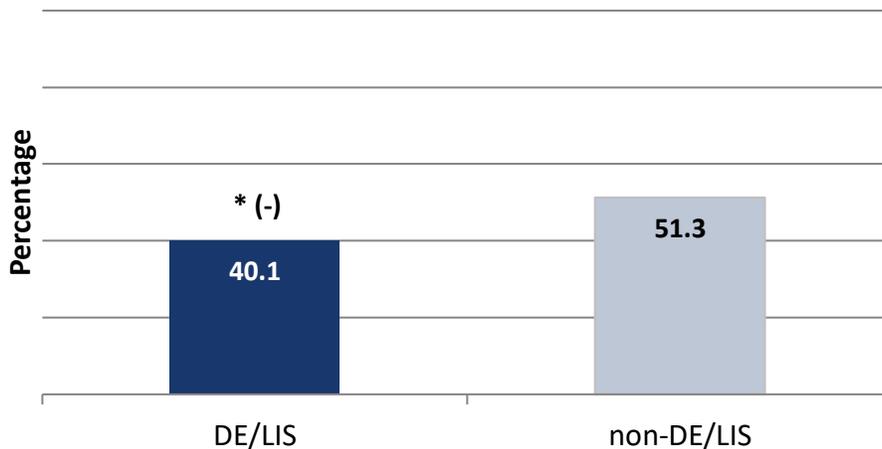
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who were hospitalized for a mental health disorder were less likely than non-DE/LIS beneficiaries who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

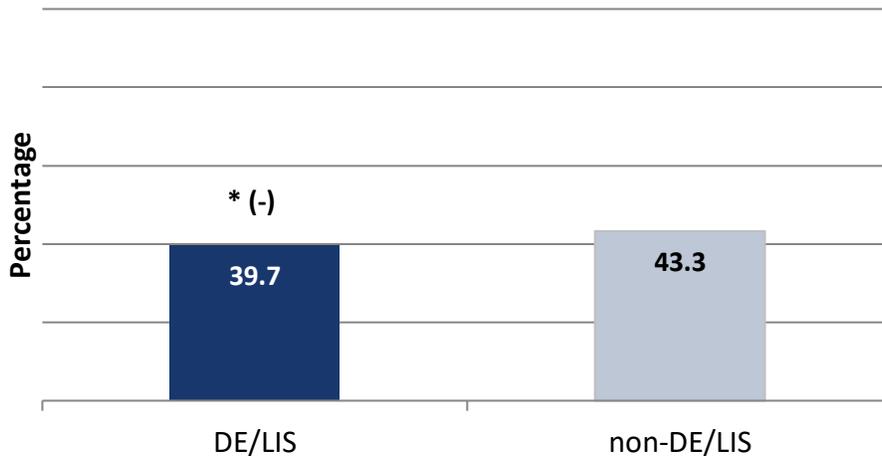
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Follow-Up After Emergency Department Visit for Mental Illness (within 30 days of discharge)

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit for the 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 the ED visit, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who had an ED visit for a mental health disorder were less likely than non-DE/LIS beneficiaries who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

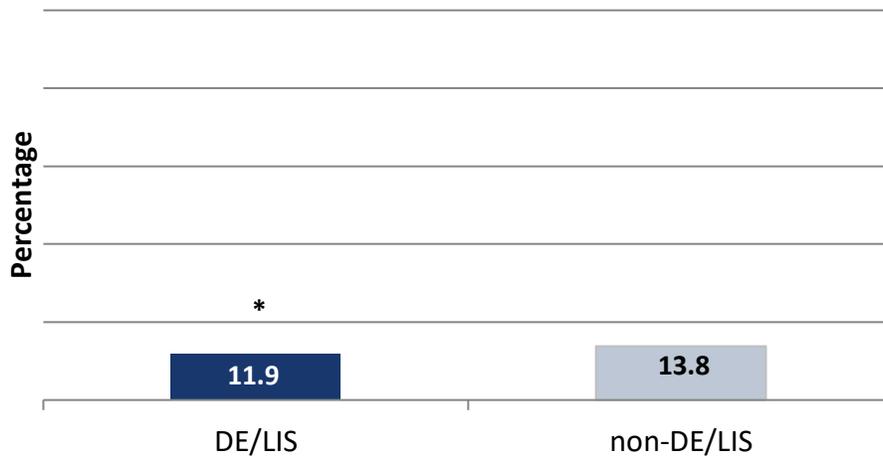
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

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

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit for alcohol and other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who had an ED visit for AOD abuse or dependence were less likely than non-DE/LIS beneficiaries who had an ED visit for AOD abuse or dependence to have had a follow-up visit for AOD abuse or dependence within 30 days of being discharged. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

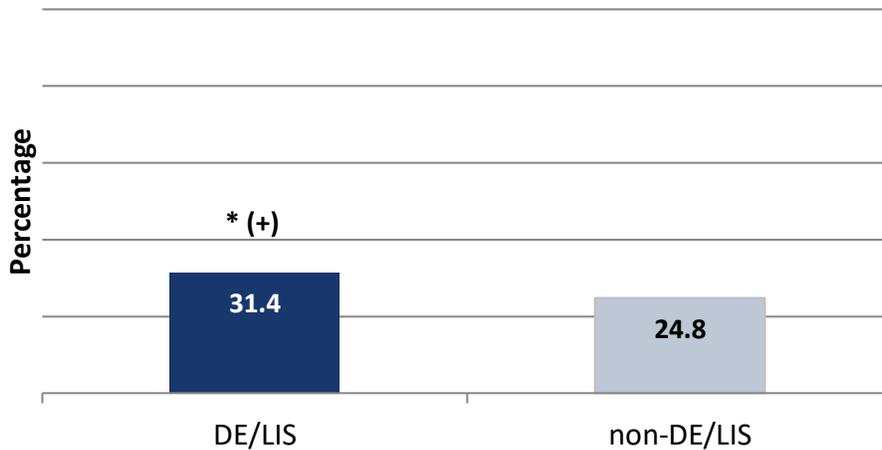
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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 Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated<sup>‡</sup> treatment within 14 days of the diagnosis, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with a new episode of AOD dependence were more likely than non-DE/LIS beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

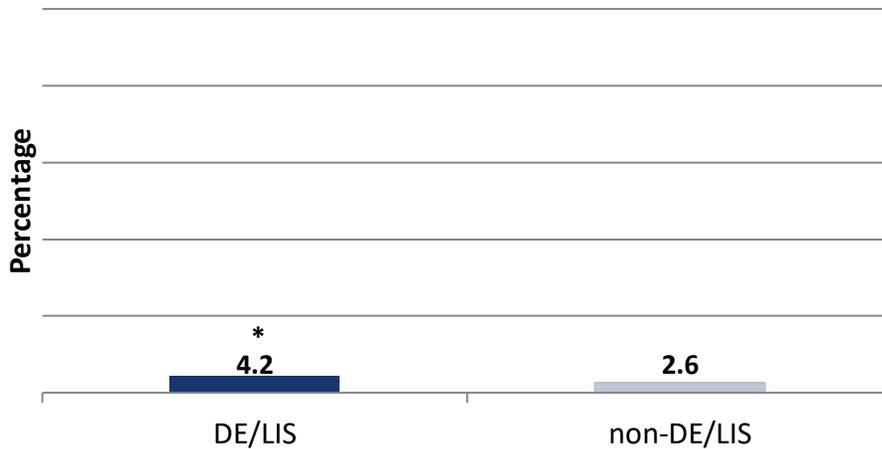
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

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

## Engagement of Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Documented performance for this measure was very low, indicating a need for improvement in this aspect of care and its documentation. DE/LIS beneficiaries with a new episode of AOD dependence who initiated treatment were more likely than non-DE/LIS beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of their initial visit for treatment. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

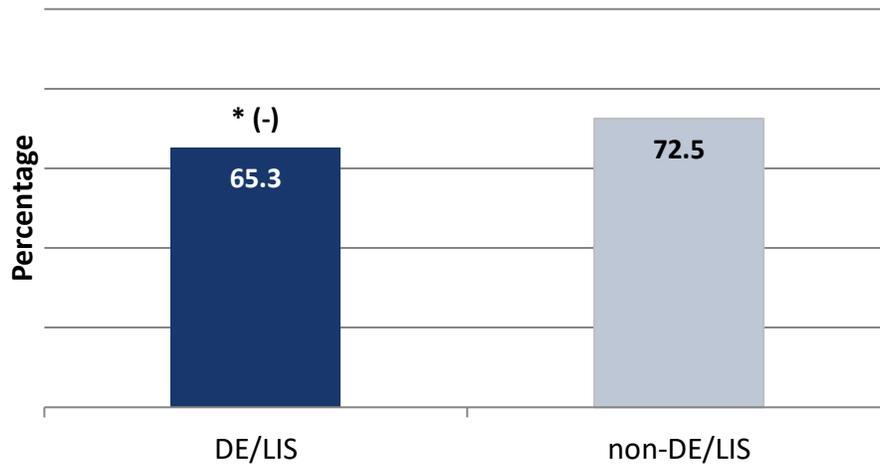
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Medication Management and Care Coordination

### Medication Reconciliation After Hospital Discharge

Percentage of MA beneficiaries aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

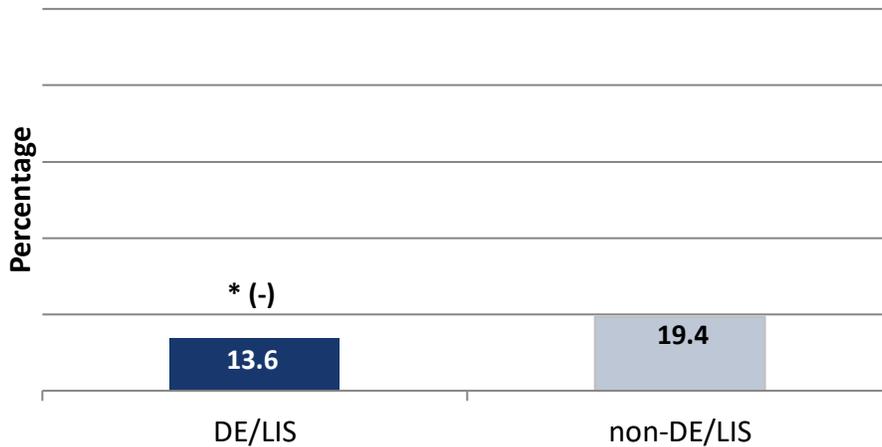
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Notification of Inpatient Admission

Percentage of MA beneficiaries 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 DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- The primary or ongoing care providers of DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than the primary or ongoing care providers of non-DE/LIS beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. The difference between these groups was greater than 3 percentage points.

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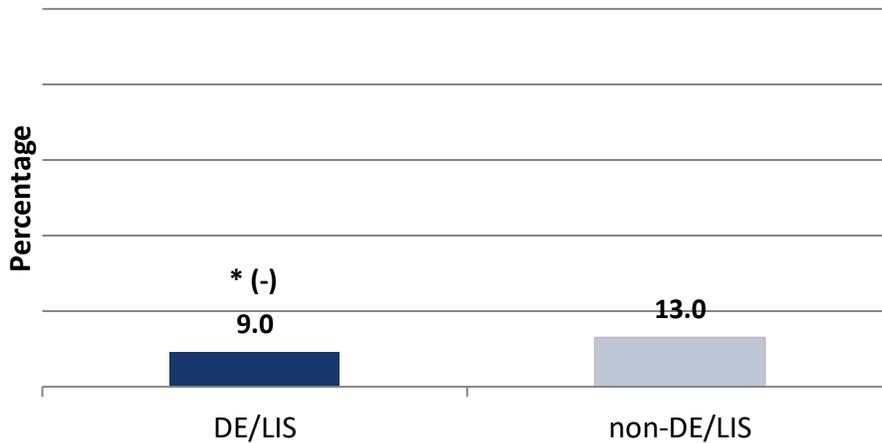
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Receipt of Discharge Information

Percentage of MA beneficiaries 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 DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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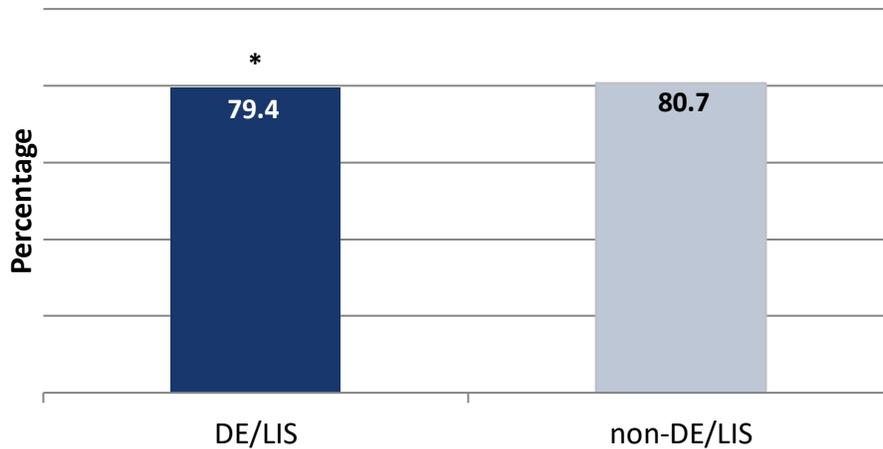
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA beneficiaries 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 DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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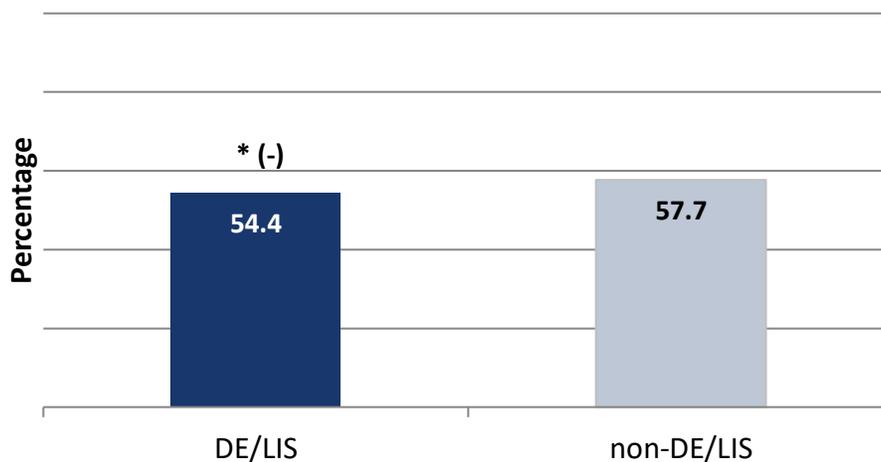
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA beneficiaries aged 18 years and older with multiple high-risk chronic conditions<sup>†</sup> who received follow-up care within seven days of an ED visit, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- DE/LIS beneficiaries with multiple high-risk chronic conditions were less likely than non-DE/LIS beneficiaries with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

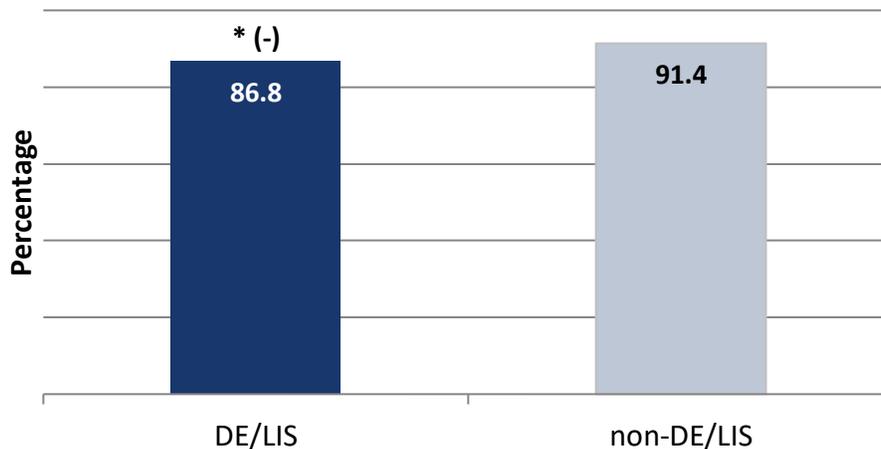
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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.

## Overuse/Appropriateness

### Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of MA beneficiaries aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- Use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with chronic renal failure than for elderly non-DE/LIS beneficiaries with chronic renal failure. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

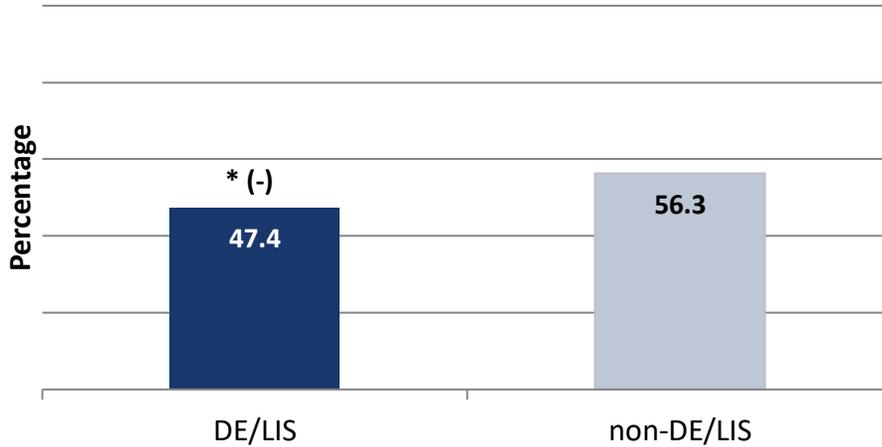
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) or nonaspirin NSAIDs.

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

Percentage of MA beneficiaries aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with dementia than for elderly non-DE/LIS beneficiaries with dementia. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

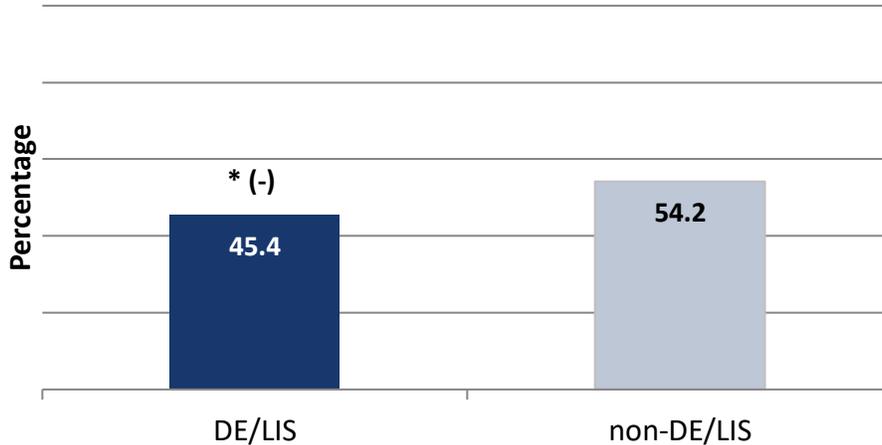
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of MA beneficiaries aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with a history of falls than for elderly non-DE/LIS beneficiaries with a history of falls. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

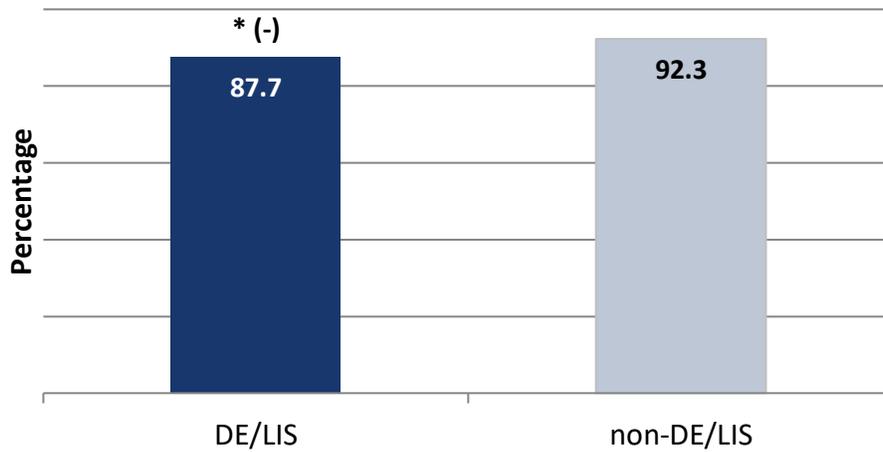
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA beneficiaries aged 65 years and older who were not prescribed a high-risk medication, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of high-risk medication was avoided less often for elderly DE/LIS beneficiaries than for elderly non-DE/LIS beneficiaries. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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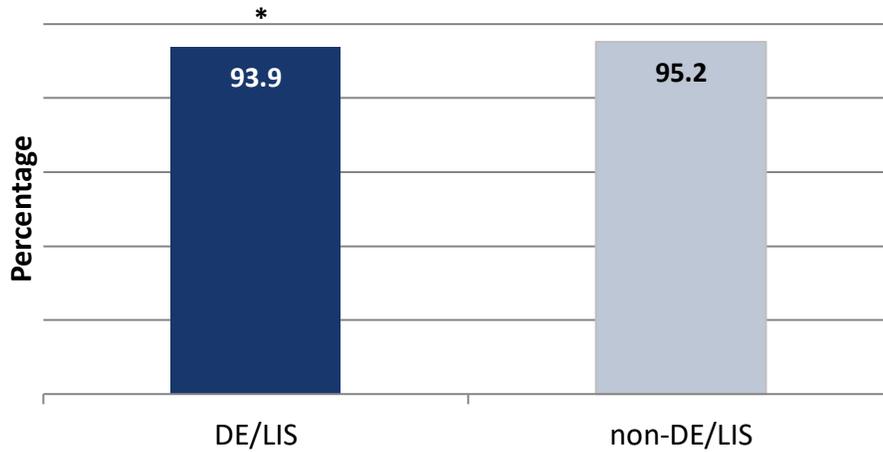
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids at High Dosage

Percentage of MA beneficiaries aged 18 years and older who were not prescribed opioids at a high dosage<sup>†</sup> for more than 14 days, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of opioids at a high dosage for more than 14 days was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

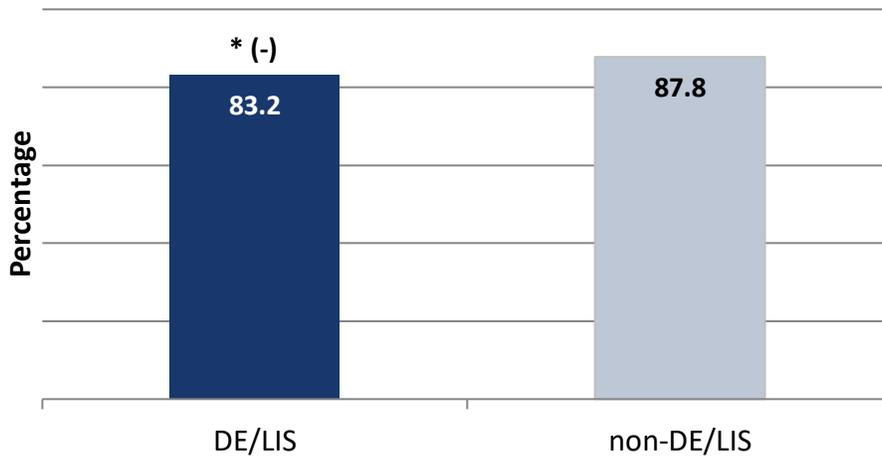
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Average morphine equivalent dose > 120 mg.

## Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of opioids from multiple prescribers was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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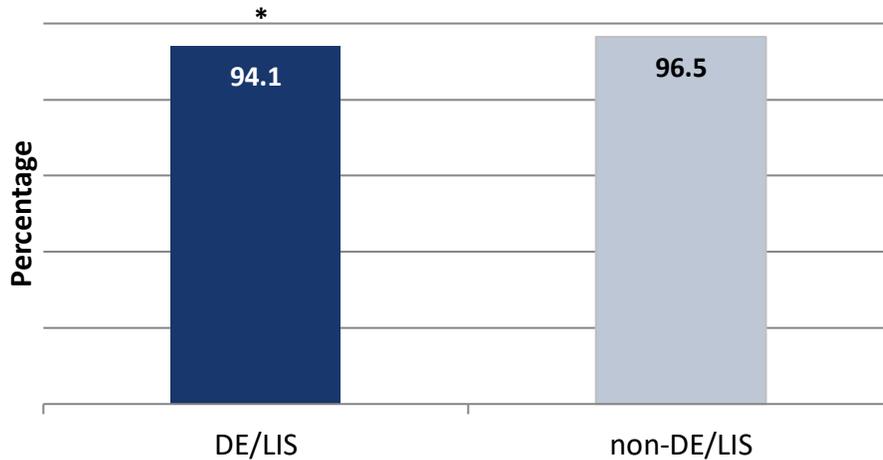
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- Use of opioids from multiple pharmacies was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

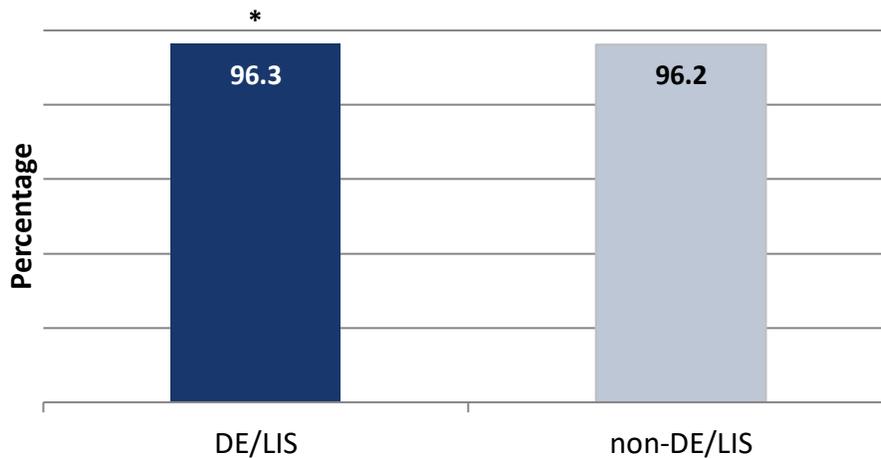
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Access/Availability of Care

### Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA beneficiaries aged 65 years and older who had an ambulatory or preventive care visit in the past year, by DE/LIS status, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- DE/LIS beneficiaries were more likely than non-DE/LIS beneficiaries to have had an ambulatory or preventive care visit. The difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

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

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

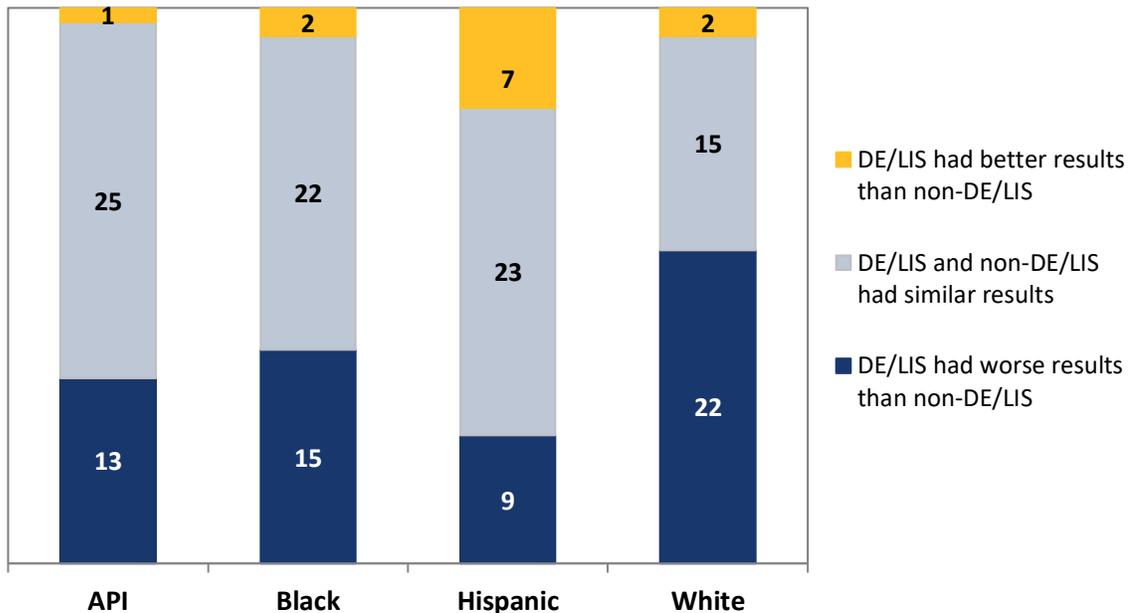
SECTION II:

DE/LIS Disparities by Race  
and Ethnicity in Health Care  
in Medicare Advantage



## Summary of Disparities in Clinical Care by DE/LIS Status Within Racial and Ethnic Groups

Number of clinical care measures for which DE/LIS beneficiaries of selected racial and ethnic groups had results that were worse than, similar to, or better than results for non-DE/LIS beneficiaries in Reporting Year 2019



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races. Three of the values reported in this chart had low precision; one is among the 13 instances in which API DE/LIS beneficiaries had worse results than API non-DE/LIS beneficiaries, while the other two are among the 25 instances in which API DE/LIS and API non-DE/LIS beneficiaries had similar results.

Within each racial or ethnic group, the relative difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

**API DE/LIS beneficiaries had worse results than API non-DE/LIS beneficiaries**

- Breast Cancer Screening
- Testing to Confirm COPD
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Medication Reconciliation After Hospital Discharge
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medication in the Elderly

**API DE/LIS beneficiaries had better results than API non-DE/LIS beneficiaries**

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

**Black DE/LIS beneficiaries had worse results than Black non-DE/LIS beneficiaries**

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Medication Reconciliation After Hospital Discharge
- Transitions of Care—Notification of Inpatient Admission
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medication in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers
- Avoiding Use of Opioids from Multiple Pharmacies

**Black DE/LIS beneficiaries had better results than Black non-DE/LIS beneficiaries**

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Initiation of Alcohol or Other Drug Treatment

### Hispanic DE/LIS beneficiaries had worse results than Hispanic non-DE/LIS beneficiaries

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medications in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers

### Hispanic DE/LIS beneficiaries had better results than Hispanic non-DE/LIS beneficiaries

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Diabetes
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Initiation of Alcohol or Other Drug Treatment
- Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions

### White DE/LIS beneficiaries had worse results than White non-DE/LIS beneficiaries

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Rheumatoid Arthritis Management
- Osteoporosis Management in Women Who Had a Fracture
- 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)
- Medication Reconciliation After Hospital Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medications in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers

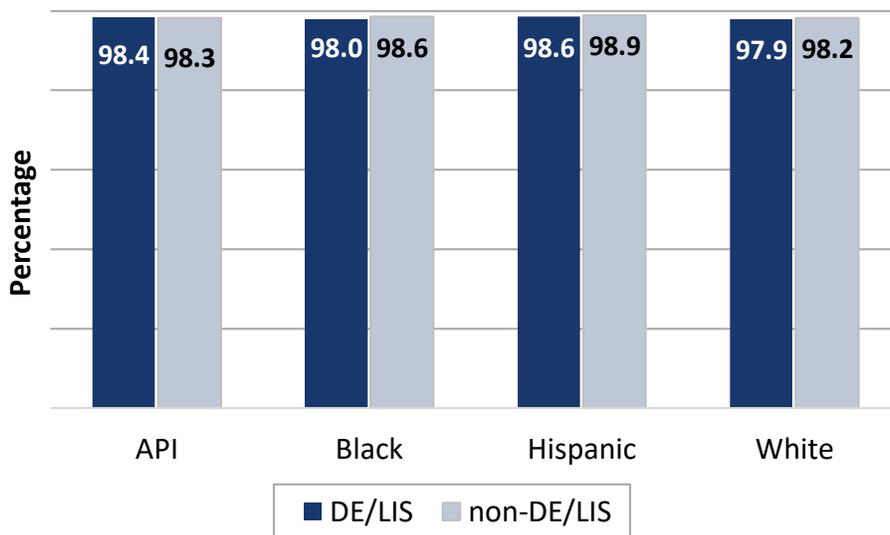
**White DE/LIS beneficiaries had better results than White non-DE/LIS beneficiaries**

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Initiation of Alcohol or Other Drug Treatment

## Prevention and Screening

### Adult Body Mass Index (BMI) Assessment

Percentage of Medicare beneficiaries aged 18 to 74 years who had an outpatient visit and whose BMIs were documented in the past two years, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

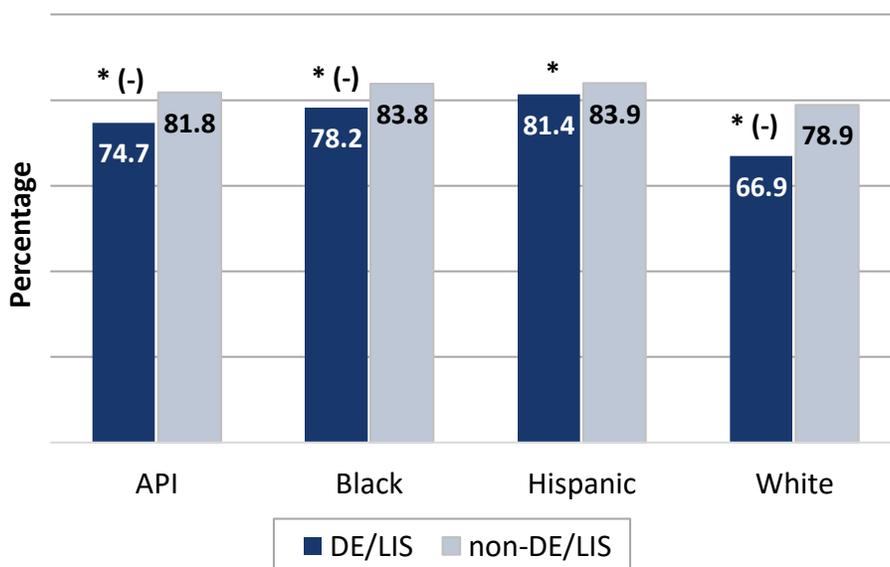
**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among API, Black, Hispanic, and White beneficiaries, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had their BMIs documented.

## Breast Cancer Screening

Percentage of female MA beneficiaries aged 50 to 74 years who had appropriate screening for breast cancer in the past two years, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among female API, Black, Hispanic, and White beneficiaries, those who were DE/LIS were less likely than those who were non-DE/LIS to have been appropriately screened for breast cancer. The difference between female API DE/LIS and female API non-DE/LIS beneficiaries was greater than 3 percentage points, as were the differences between female Black DE/LIS and female Black non-DE/LIS beneficiaries and between female White DE/LIS and female White non-DE/LIS beneficiaries. The difference between female Hispanic DE/LIS and female Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

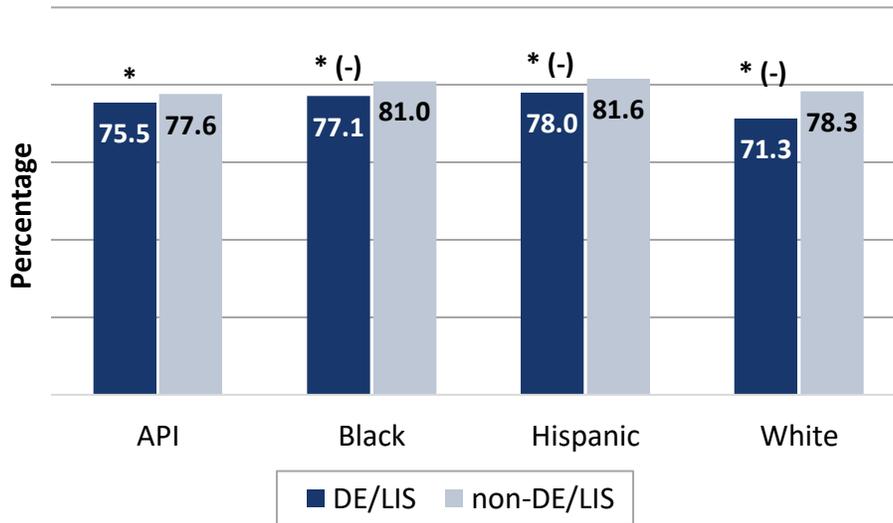
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Colorectal Cancer Screening

Percentage of MA beneficiaries aged 50 to 75 years who had appropriate screening for colorectal cancer, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries, those who were DE/LIS were less likely to have been appropriately screened for colorectal cancer than those who were non-DE/LIS. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was greater than 3 percentage points, as were the differences between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries and between White DE/LIS and White non-DE/LIS beneficiaries.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

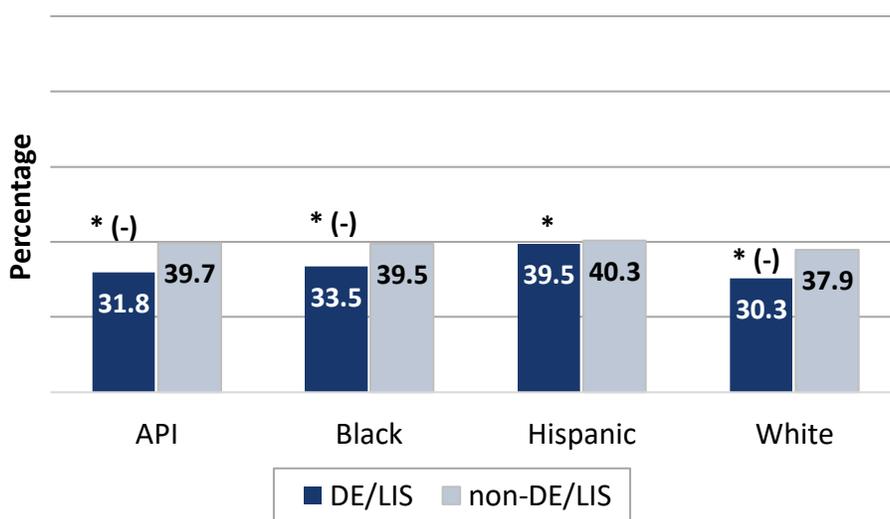
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Respiratory Conditions

### Testing to Confirm COPD

Percentage of MA beneficiaries aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among API, Black, Hispanic, and White beneficiaries with a new diagnosis of COPD or newly active COPD, those who were DE/LIS were less likely than those who were non-DE/LIS to have received a spirometry test to confirm the diagnosis. The difference between API DE/LIS beneficiaries and API non-DE/LIS beneficiaries was greater than 3 percentage points, as were the differences between Black DE/LIS beneficiaries and Black non-DE/LIS beneficiaries and between White DE/LIS beneficiaries and White non-DE/LIS beneficiaries. The difference between Hispanic DE/LIS beneficiaries and Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

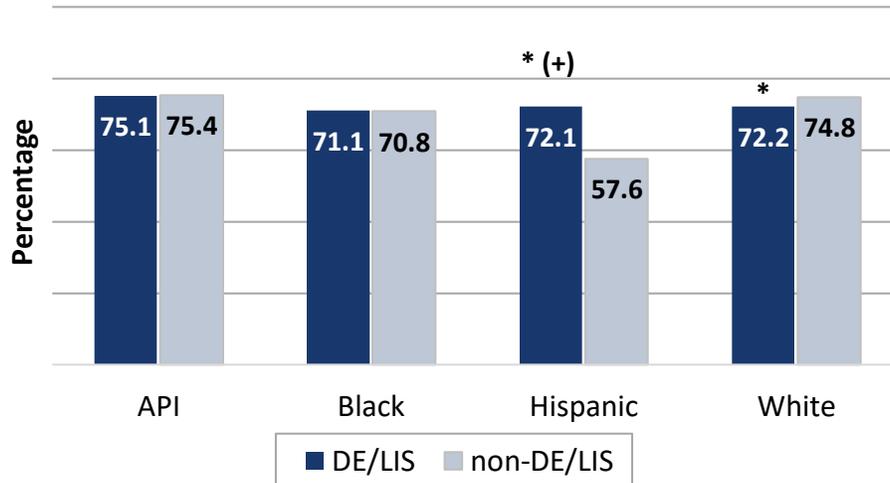
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

**Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by DE/LIS status within race and ethnicity, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API and Black beneficiaries who experienced a COPD exacerbation, those who were DE/LIS were about as likely as those who were non-DE/LIS to have been dispensed a systemic corticosteroid within 14 days of the event.
- Among Hispanic beneficiaries who experienced a COPD exacerbation, those who were DE/LIS were more likely than those who were non-DE/LIS to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among White beneficiaries who experienced a COPD exacerbation, those who were DE/LIS were less likely than those who were non-DE/LIS to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between White DE/LIS and White non-DE/LIS beneficiaries was less than 3 percentage points.

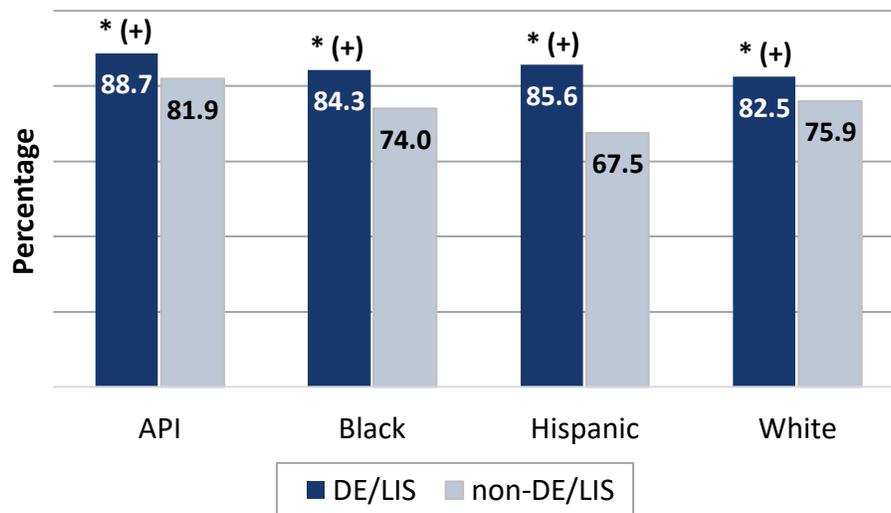
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries who experienced a COPD exacerbation, those who were DE/LIS were more likely than those who were non-DE/LIS to have been dispensed a bronchodilator within 30 days of the event. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

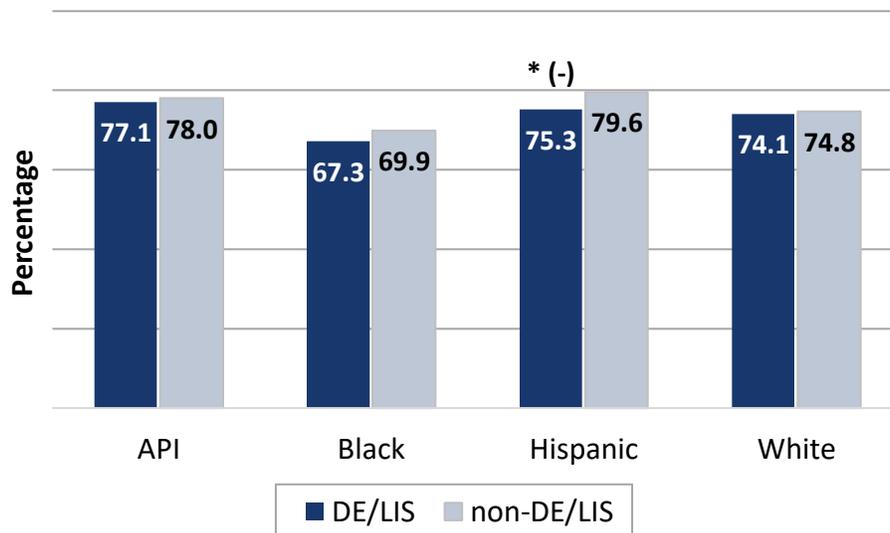
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Cardiovascular Conditions

### Controlling High Blood Pressure

Percentage of MA beneficiaries aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled<sup>†</sup> during the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among API, Black, and White beneficiaries who had a diagnosis of hypertension, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had their blood pressure adequately controlled.
- Among Hispanic beneficiaries who had a diagnosis of hypertension, those who were DE/LIS were less likely than those who were non-DE/LIS to have had their blood pressure adequately controlled. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

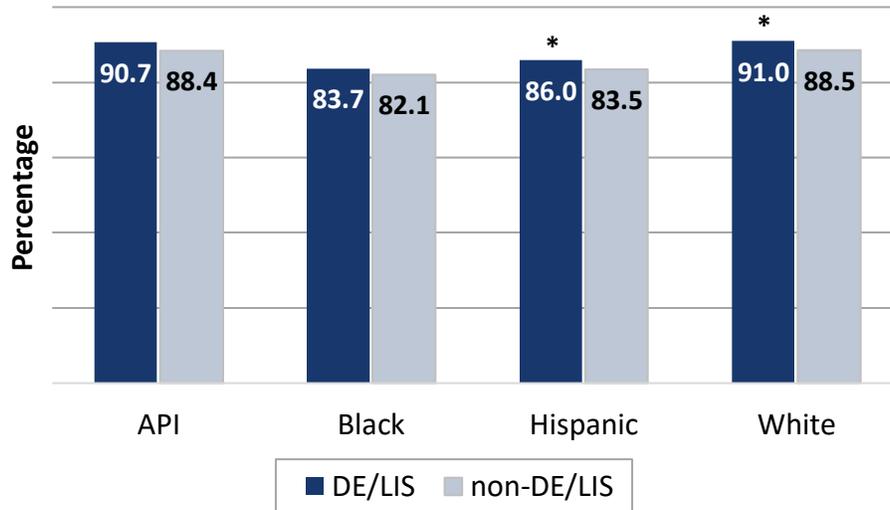
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Less than 140/90 for those 18 to 59 years of age and for those 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for those 60 to 85 years of age without a diagnosis of diabetes.

## Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA beneficiaries 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 DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API and Black beneficiaries who were hospitalized for a heart attack, those who were DE/LIS were about as likely as those who were non-DE/LIS to have received continuous beta-blocker treatment.
- Among Hispanic and White beneficiaries who were hospitalized for a heart attack, those who were DE/LIS were more likely than those who were non-DE/LIS to have received continuous beta-blocker treatment. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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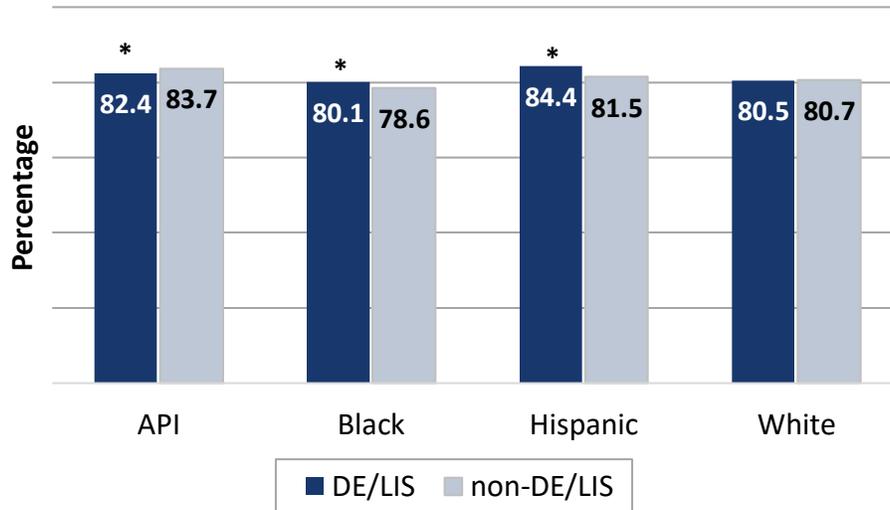
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Cardiovascular Disease

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical ASCVD who received statin therapy, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries with ASCVD, those who were DE/LIS were less likely than those who were non-DE/LIS to have received statin therapy. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points.
- Among Black and Hispanic beneficiaries with ASCVD, those who were DE/LIS were more likely than those who were non-DE/LIS to have received statin therapy. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.
- Among White beneficiaries with ASCVD, those who were DE/LIS were about as likely as those who were non-DE/LIS to have received statin therapy.

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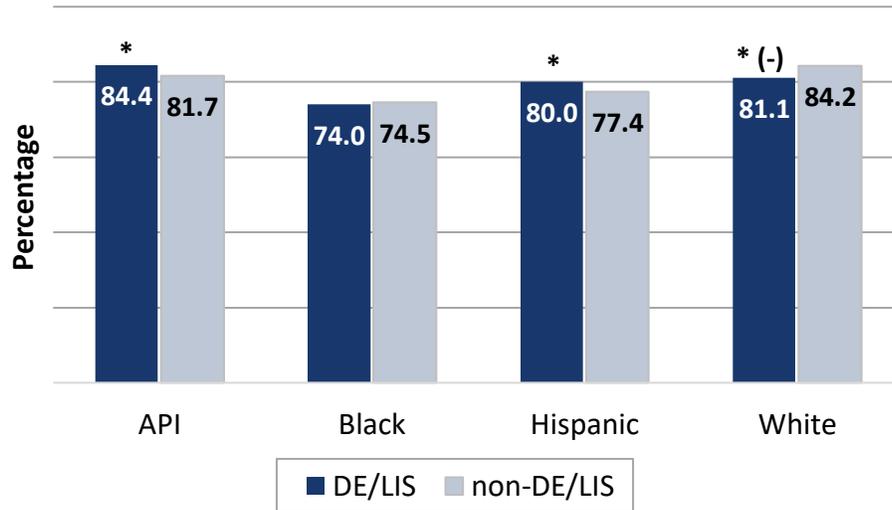
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

- Among API and Hispanic beneficiaries with ASCVD, those who were DE/LIS were more likely than those who were non-DE/LIS to have had proper statin medication adherence. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.
- Among Black beneficiaries with ASCVD, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had proper statin medication adherence.
- Among White beneficiaries with ASCVD, those who were DE/LIS were less likely than those who were non-DE/LIS to have had proper statin medication adherence. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

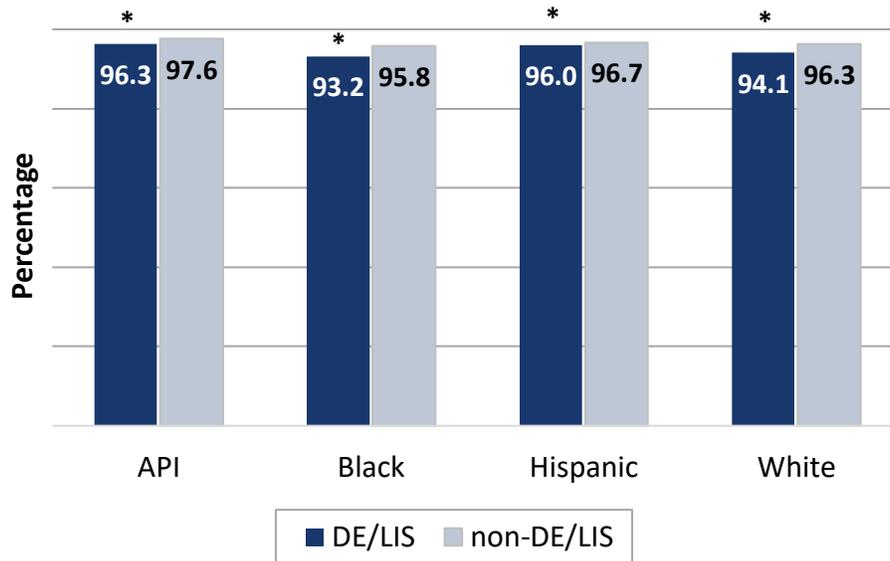
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

# Diabetes

## Diabetes Care—Blood Sugar Testing

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries with diabetes, those who were DE/LIS were less likely than those who were non-DE/LIS to have had their blood sugar tested at least once in the past year. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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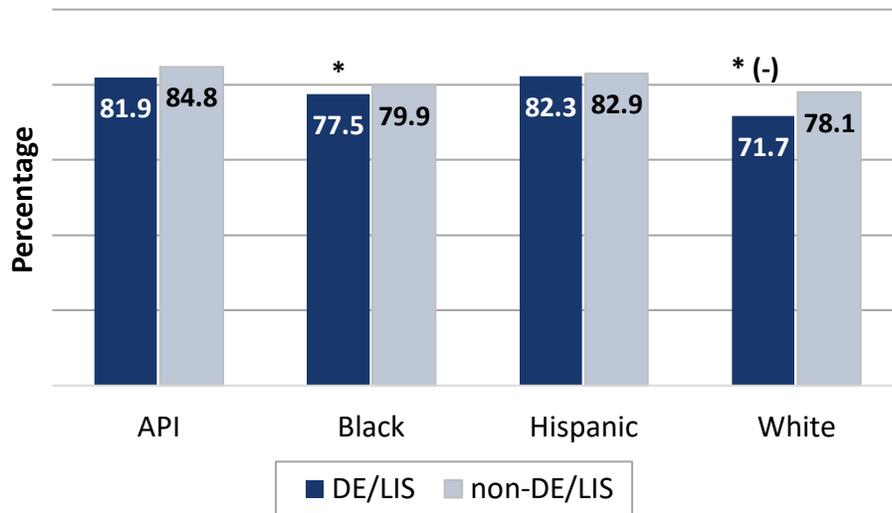
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Eye Exam

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API and Hispanic beneficiaries with diabetes, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had an eye exam in the past year.
- Among Black and White beneficiaries with diabetes, those who were DE/LIS were less likely than those who were non-DE/LIS to have had an eye exam in the past year. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.

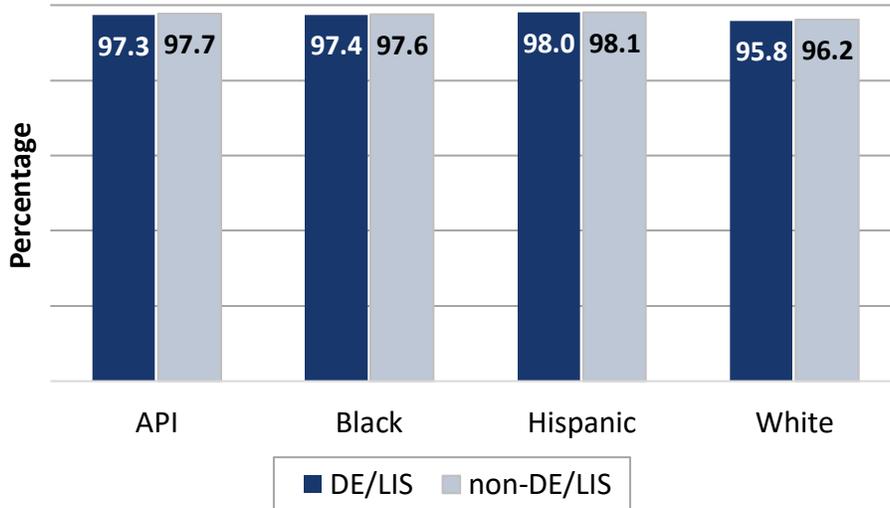
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Kidney Disease Monitoring

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

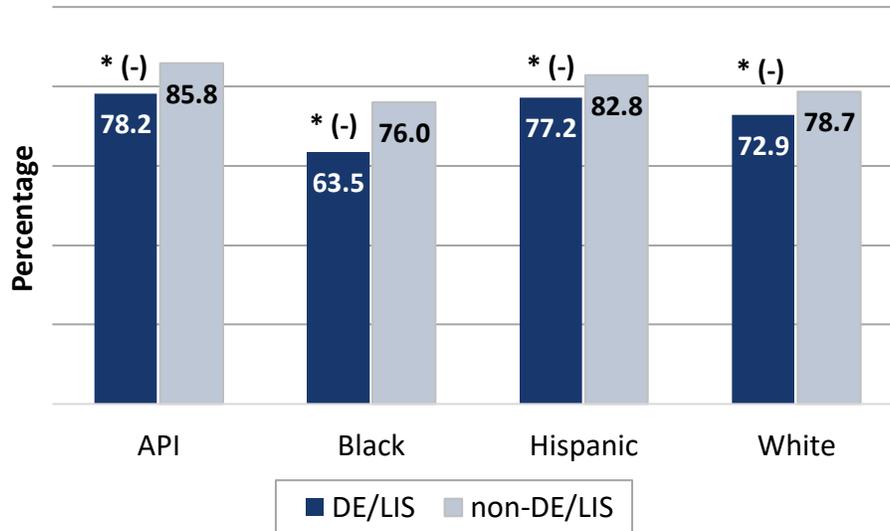
**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries with diabetes, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had medical attention for nephropathy in the past year.

## Diabetes Care—Blood Pressure Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries with diabetes, those who were DE/LIS were less likely than those who were non-DE/LIS to have their blood pressure under control. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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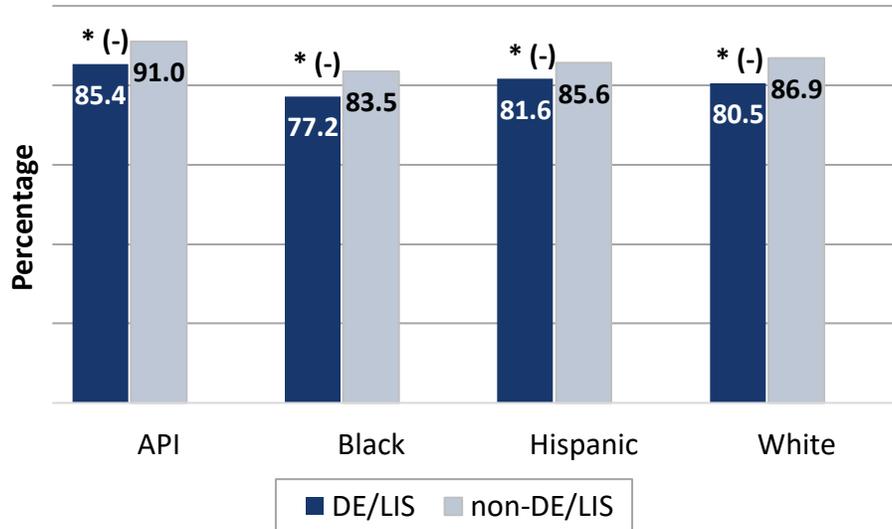
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Blood Sugar Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries with diabetes, those who were DE/LIS were less likely than those who were non-DE/LIS to have their blood sugar level under control. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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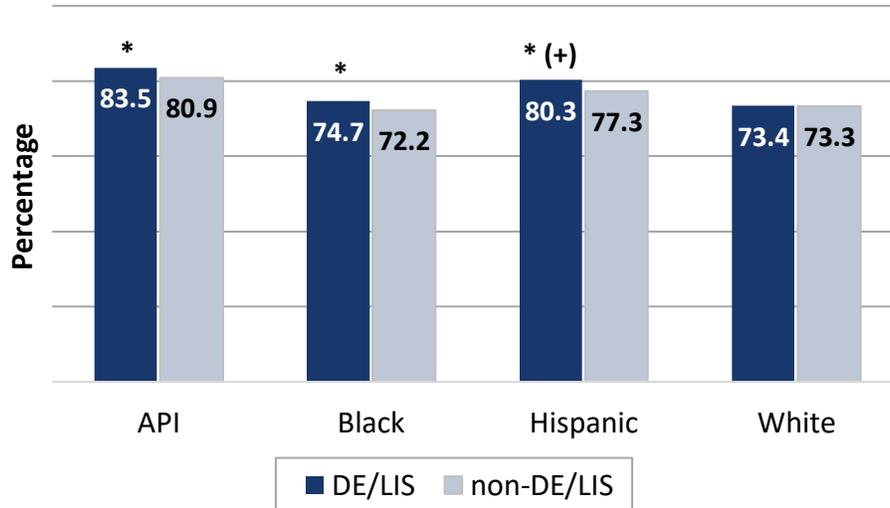
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Diabetes

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who received statin therapy, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and Hispanic beneficiaries with diabetes, those who were DE/LIS were more likely than those who were non-DE/LIS to have received statin therapy. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points, as was the difference between Black DE/LIS and Black non-DE/LIS beneficiaries. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among White beneficiaries with diabetes, those who were DE/LIS were about as likely as those who were non-DE/LIS to have received statin therapy.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

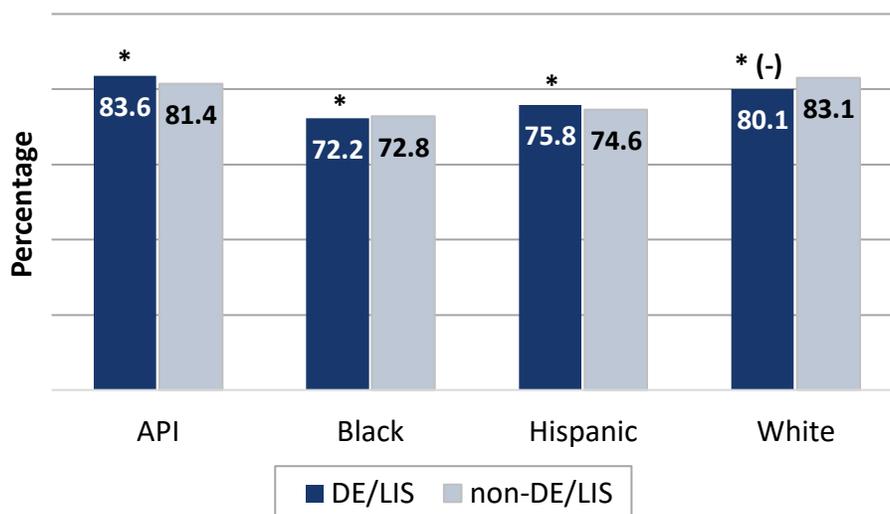
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

## Medication Adherence for Diabetes—Statins

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API and Hispanic beneficiaries with diabetes, those who were DE/LIS were more likely than those who were non-DE/LIS to have had proper statin medication adherence. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.
- Among Black and White beneficiaries with diabetes, those who were DE/LIS were less likely than those who were non-DE/LIS to have had proper statin medication adherence. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

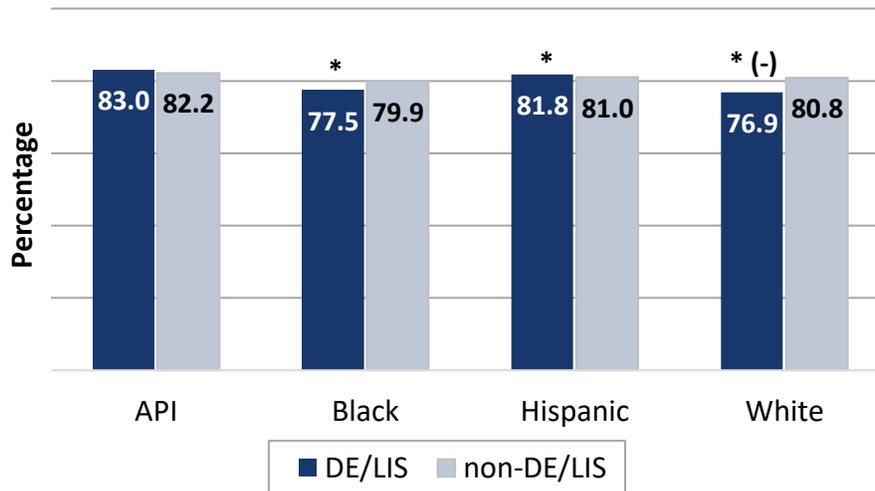
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

# Musculoskeletal Conditions

## Rheumatoid Arthritis Management

Percentage of MA beneficiaries aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a DMARD, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries who were diagnosed with rheumatoid arthritis, those who were DE/LIS were about as likely as those who were non-DE/LIS to have been dispensed at least one DMARD.
- Among Black and White beneficiaries who were diagnosed with rheumatoid arthritis, those who were DE/LIS were less likely than those who were non-DE/LIS to have been dispensed at least one DMARD. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries who were diagnosed with rheumatoid arthritis, those who were DE/LIS were more likely than those who were non-DE/LIS to have been dispensed at least one DMARD. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

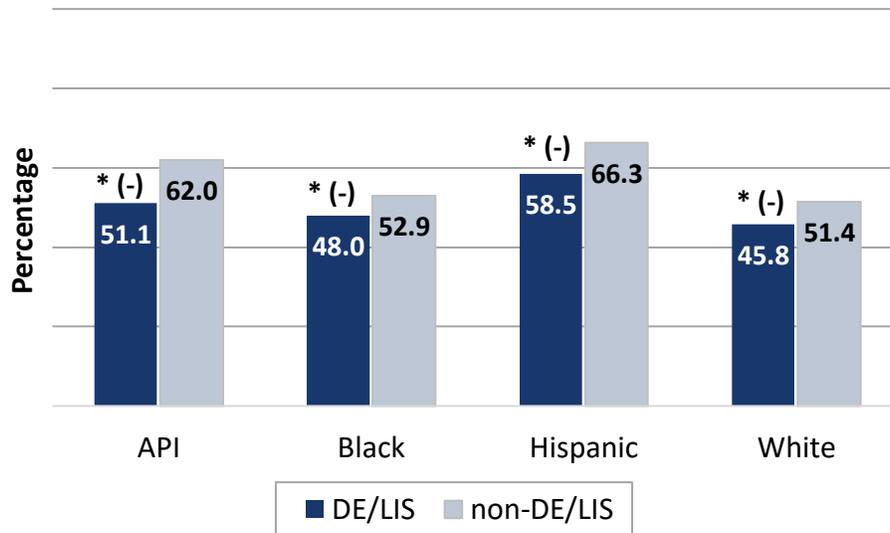
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA beneficiaries aged 65 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among female API, Black, Hispanic, and White beneficiaries who suffered a fracture, those who were DE/LIS were less likely than those who were non-DE/LIS to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. In each case, the difference between female DE/LIS beneficiaries and female non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

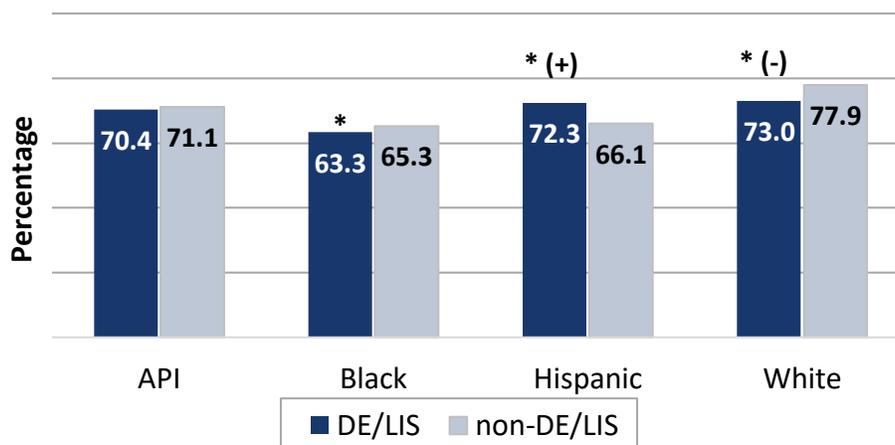
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Behavioral Health

### Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among API beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were about as likely as those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days.
- Among Black and White beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were less likely than those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were more likely than those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.

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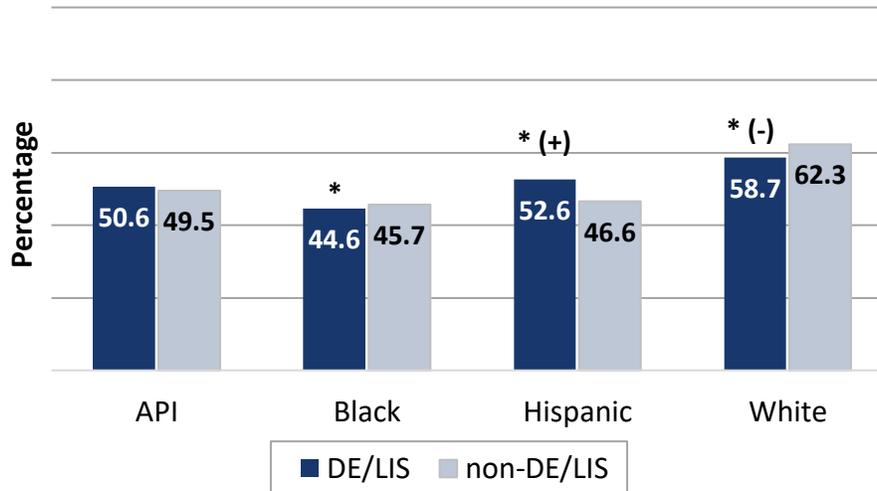
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were about as likely as those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days.
- Among Black and White beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were less likely than those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries diagnosed with a new episode of major depression, those who were DE/LIS were more likely than those who were non-DE/LIS to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.

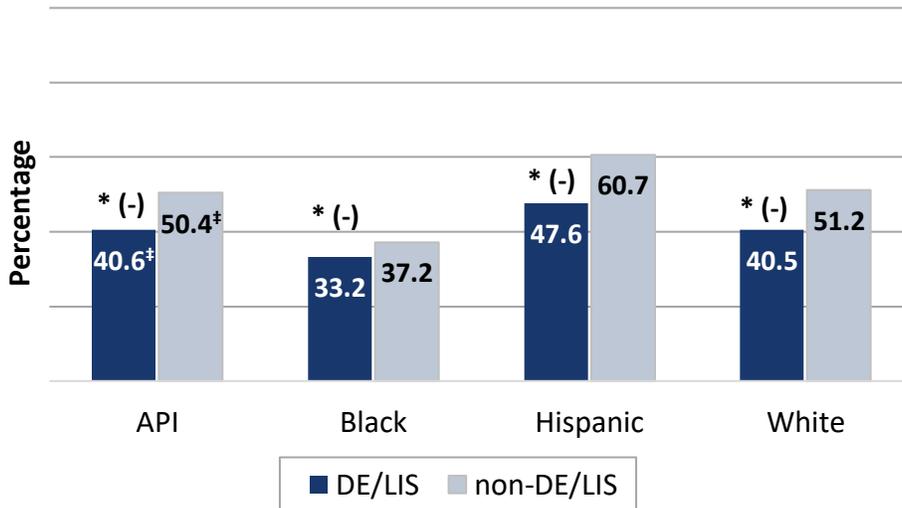
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

<sup>‡</sup> This score is based on fewer than 400 completed measures, and thus its precision is low.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries who were hospitalized for a mental health disorder, those who were DE/LIS were less likely than those who were non-DE/LIS to have had appropriate follow-up care within 30 days of discharge. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

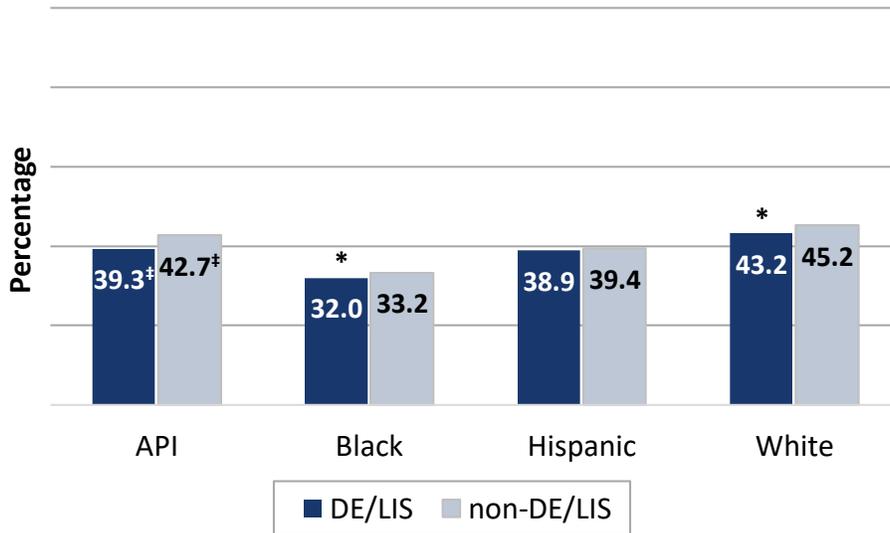
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Follow-Up After Emergency Department Visit for Mental Illness (within 30 days of discharge)

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit for the 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 the ED visit, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

<sup>‡</sup> This score is based on fewer than 400 completed measures, and thus its precision is low.

### Disparities

- Among API and Hispanic beneficiaries who had an ED visit for a mental health disorder, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit.
- Among Black and White beneficiaries who had an ED visit for a mental health disorder, those who were DE/LIS were less likely than those who were non-DE/LIS to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

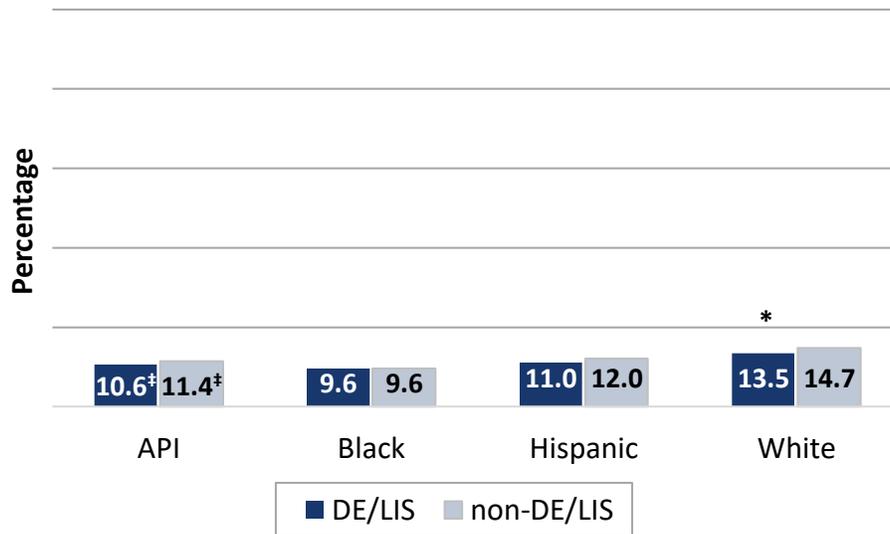
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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 Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days of discharge)

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

<sup>†</sup> This score is based on fewer than 400 completed measures, and thus its precision is low.

### Disparities

- Among API, Black, and Hispanic beneficiaries who had an ED visit for AOD abuse or dependence, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit.
- Among White beneficiaries who had an ED visit for AOD abuse or dependence, those who were DE/LIS were less likely than those who were non-DE/LIS to have had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit. The difference between White DE/LIS and White non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

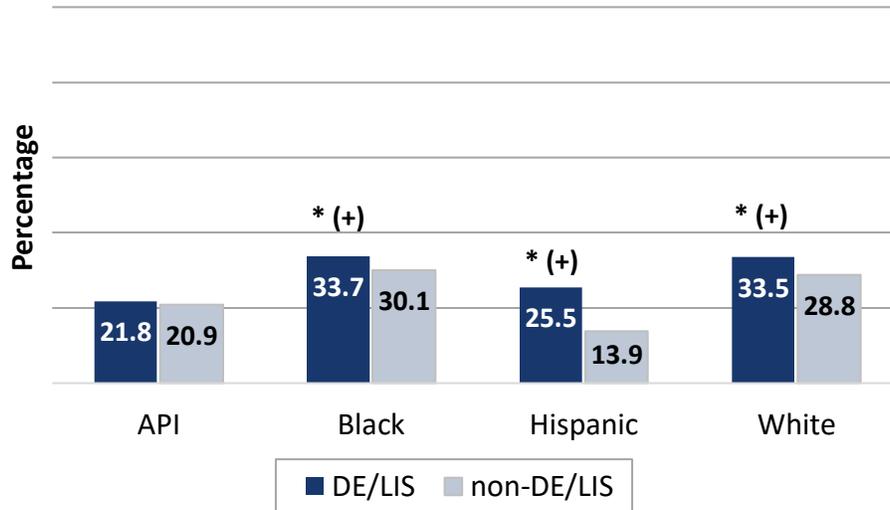
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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 Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated<sup>‡</sup> treatment within 14 days of the diagnosis, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries with a new episode of AOD dependence, those who were DE/LIS were about as likely as those who were non-DE/LIS to have initiated treatment within 14 days of the diagnosis.
- Among Black, Hispanic, and White beneficiaries with a new episode of AOD dependence, those who were DE/LIS were more likely than those who were non-DE/LIS to have initiated treatment within 14 days of the diagnosis. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

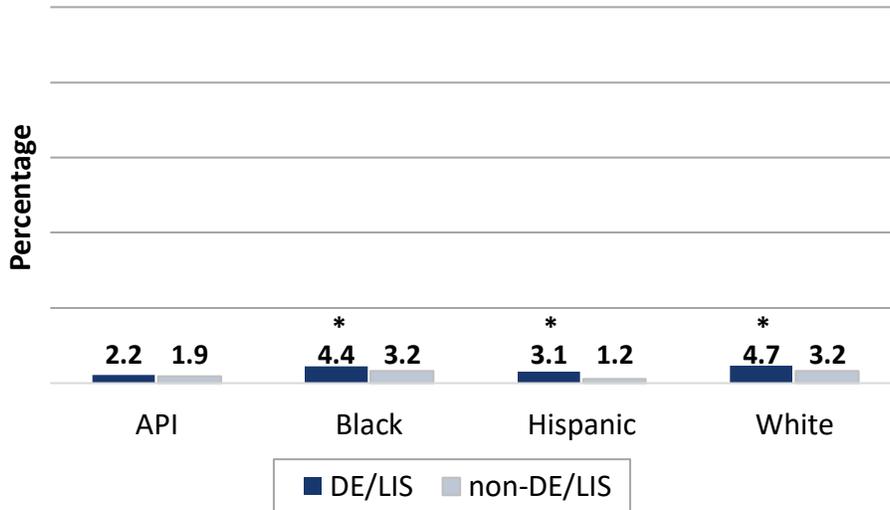
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

<sup>‡</sup> Initiation might occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

## Engagement of Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries with a new episode of AOD dependence who initiated treatment, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had two or more additional services within 30 days of the initiation visit.
- Among Black, Hispanic, and White beneficiaries with a new episode of AOD dependence who initiated treatment, those who were DE/LIS were more likely than those who were non-DE/LIS to have had two or more additional services within 30 days of the initiation visit. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

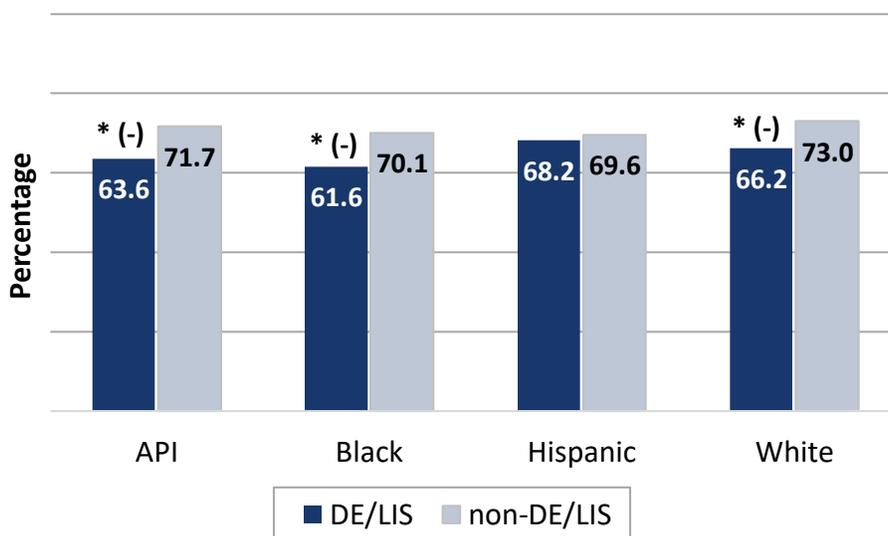
- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

# Medication Management and Care Coordination

## Medication Reconciliation After Hospital Discharge

Percentage of MA beneficiaries aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and White beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were less likely than those who were non-DE/LIS to have had their medications reconciled within 30 days. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points
- Among Hispanic beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were about as likely as those who were non-DE/LIS to have had their medications reconciled within 30 days.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

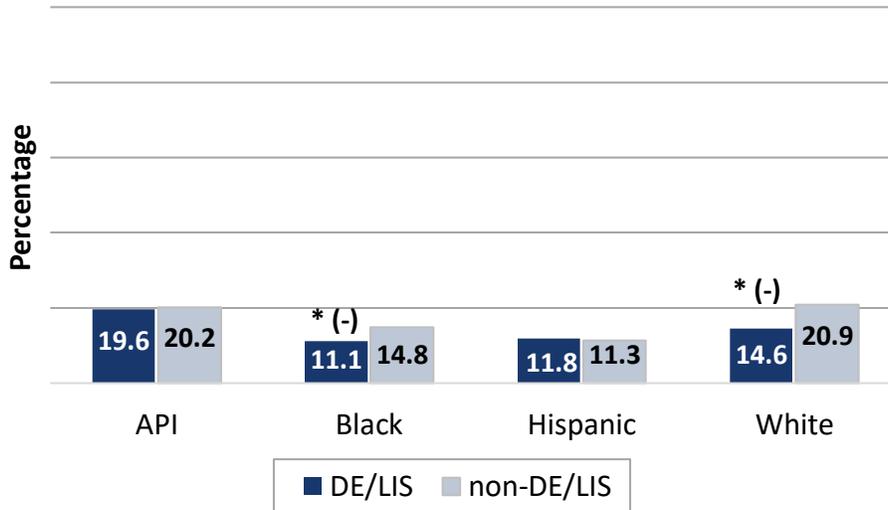
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Notification of Inpatient Admission

Percentage of MA beneficiaries 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 DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- The primary or ongoing care providers of API and Hispanic DE/LIS beneficiaries who were discharged from an inpatient facility were, respectively, about as likely as the primary or ongoing care providers of API and Hispanic non-DE/LIS beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission.
- The primary or ongoing care providers of Black and White DE/LIS beneficiaries who were discharged from an inpatient facility were, respectively, less likely than the primary or ongoing care providers of Black and White non-DE/LIS beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. In each case, the difference was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

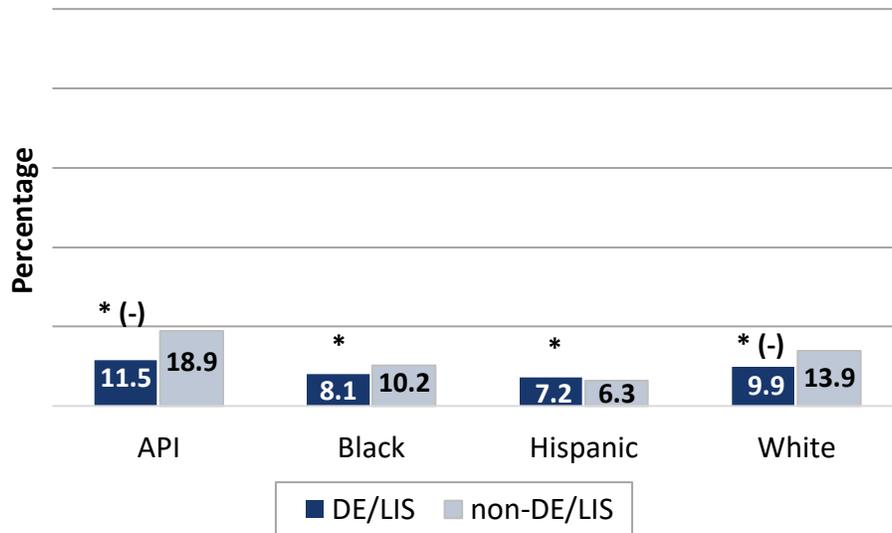
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Receipt of Discharge Information

Percentage of MA beneficiaries 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 DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and White beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were less likely than those who were non-DE/LIS to have received discharge information on the day of or the day following discharge. The difference between API DE/LIS and API non-DE/LIS beneficiaries was greater than 3 percentage points, as was the difference between White DE/LIS and White non-DE/LIS beneficiaries. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points.
- Among Hispanic beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were more likely than those who were non-DE/LIS to have received discharge information on the day of or the day following discharge. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

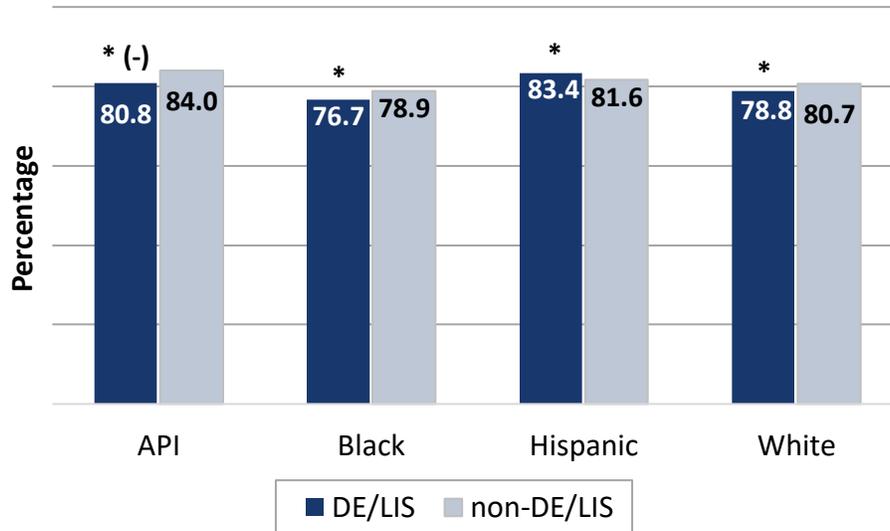
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA beneficiaries 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 DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and White beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were less likely than those who were non-DE/LIS to have had an office visit, home visit, or to have received telehealth services within 30 days of discharge. The difference between API DE/LIS and API non-DE/LIS beneficiaries was greater than 3 percentage points. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was less than 3 percentage points, as was the difference between White DE/LIS and White non-DE/LIS beneficiaries.
- Among Hispanic beneficiaries who were discharged from an inpatient facility, those who were DE/LIS were more likely than those who were non-DE/LIS to have had an office visit, home visit, or to have received telehealth services within 30 days of discharge. The difference between Hispanic DE/LIS and non-DE/LIS beneficiaries was less than 3 percentage points.

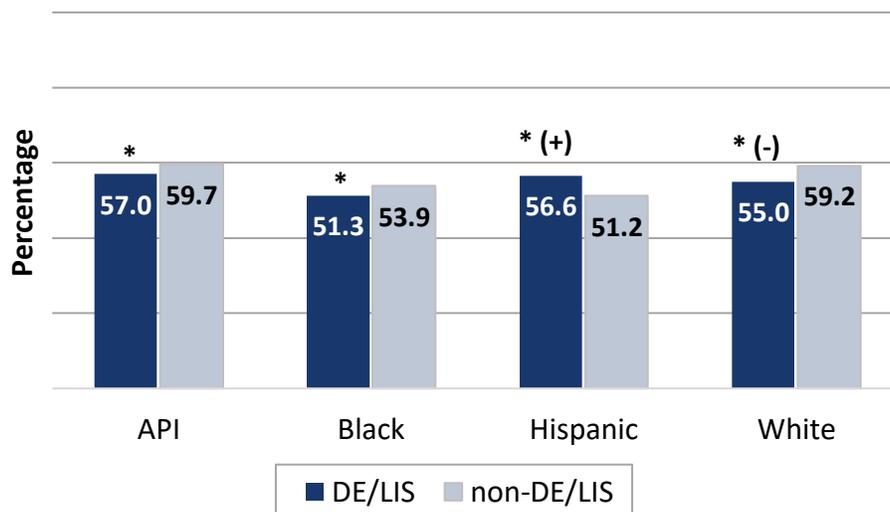
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA beneficiaries aged 18 years and older with multiple high-risk chronic conditions<sup>†</sup> who received follow-up care within 7 days of an ED visit, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and White beneficiaries with multiple high-risk chronic conditions, those who were DE/LIS were less likely than those who were non-DE/LIS to have received follow-up care within 7 days of an ED visit. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points, as was the difference between Black DE/LIS and Black non-DE/LIS beneficiaries. The difference between White DE/LIS and White non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries with multiple high-risk chronic conditions, those who were DE/LIS were more likely than those who were non-DE/LIS to have received follow-up care within 7 days of an ED visit. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

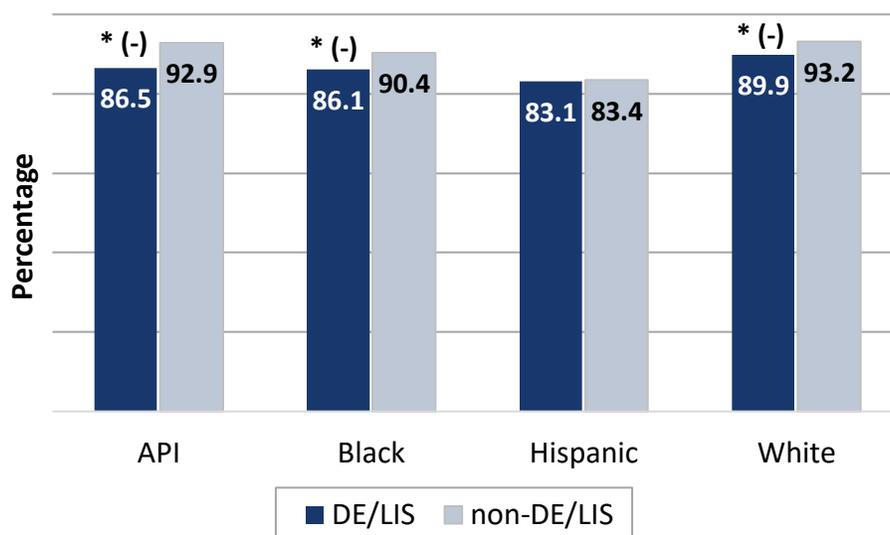
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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.

## Overuse/Appropriateness

### Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of MA beneficiaries aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among elderly API, Black, and White beneficiaries with chronic renal failure, use of potentially harmful medication was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among elderly Hispanic beneficiaries with chronic renal failure, use of potentially harmful medication was avoided about as often for those who were DE/LIS as for those who were non-DE/LIS.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

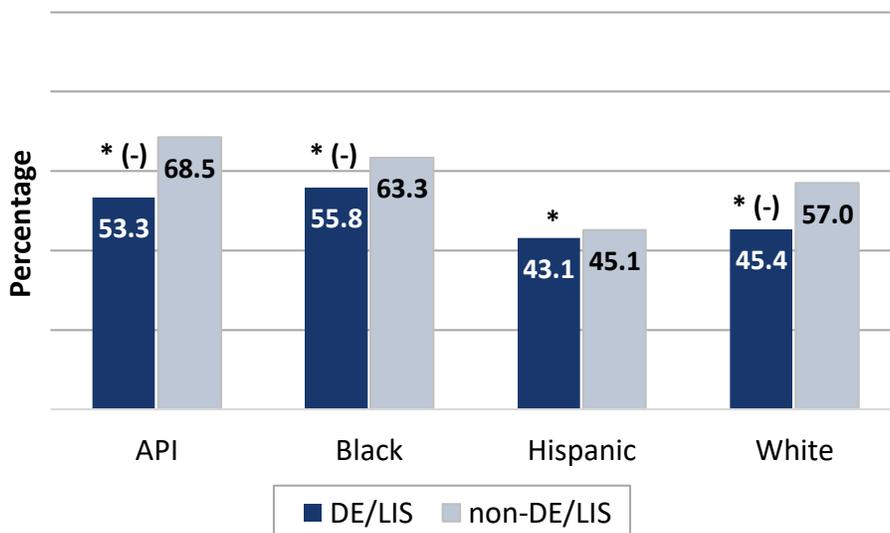
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> This includes cyclooxygenase-2 selective NSAIDs or nonaspirin NSAIDs.

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

**Percentage of MA beneficiaries aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within race and ethnicity, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among elderly API, Black, Hispanic, and White beneficiaries with dementia, use of potentially harmful medication was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. The difference between API DE/LIS and API non-DE/LIS beneficiaries was greater than 3 percentage points, as were the differences between Black DE/LIS and Black non-DE/LIS beneficiaries and between White DE/LIS and White non-DE/LIS beneficiaries. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

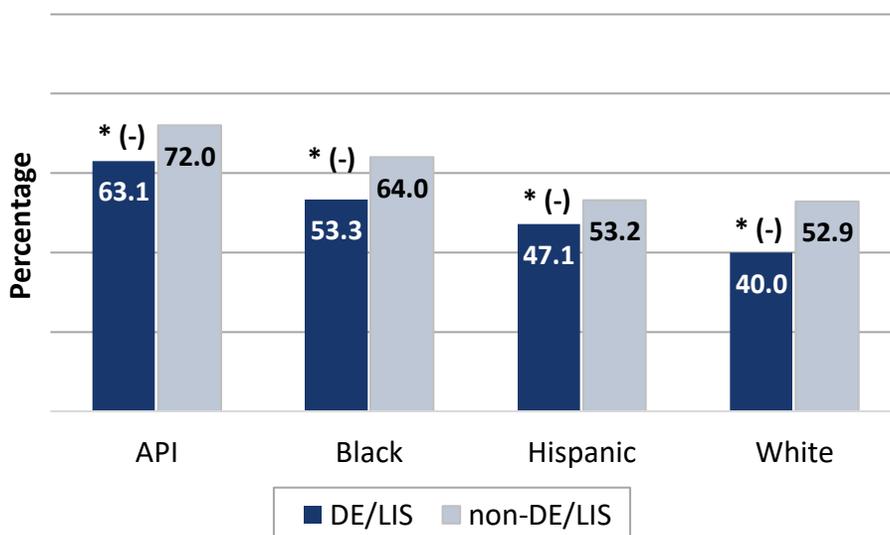
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of MA beneficiaries aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among elderly API, Black, Hispanic, and White beneficiaries with a history of falls, use of potentially harmful medication was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

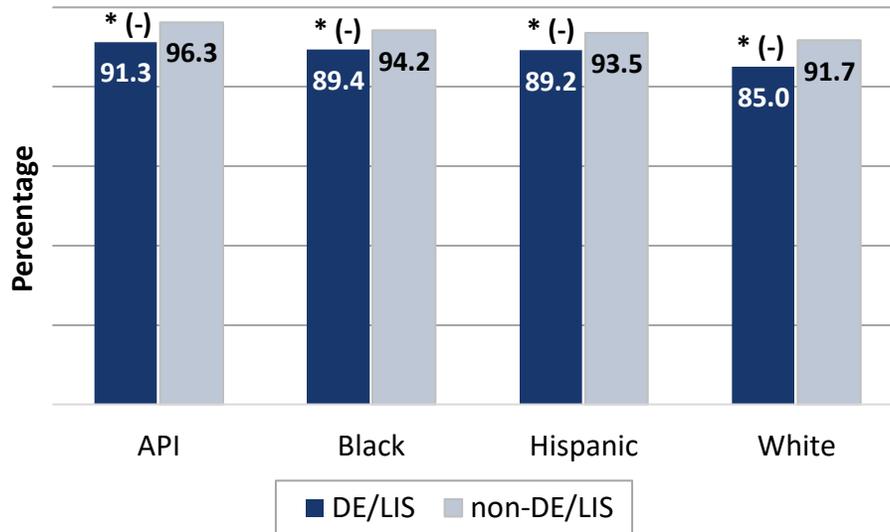
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

## Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA beneficiaries aged 65 years and older who were not prescribed a high-risk medication, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among elderly API, Black, Hispanic, and White beneficiaries, use of high-risk medication was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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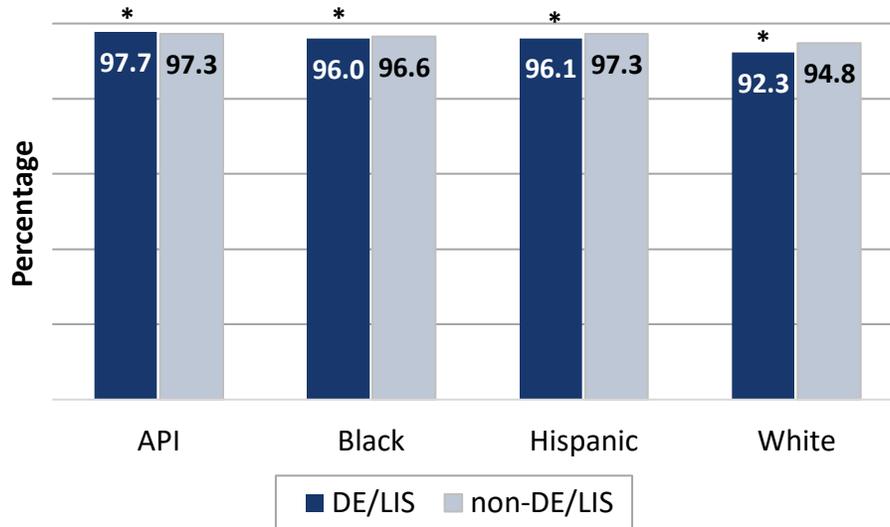
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids at High Dosage

Percentage of MA beneficiaries aged 18 years and older who were not prescribed opioids at a high dosage<sup>†</sup> for more than 14 days, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API beneficiaries, use of opioids at a high dosage for more than 14 days was avoided more often for those who were DE/LIS than for those who were non-DE/LIS. The difference between API DE/LIS beneficiaries and API non-DE/LIS beneficiaries was less than 3 percentage points.
- Among Black, Hispanic, and White beneficiaries, use of opioids at a high dosage for more than 14 days was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

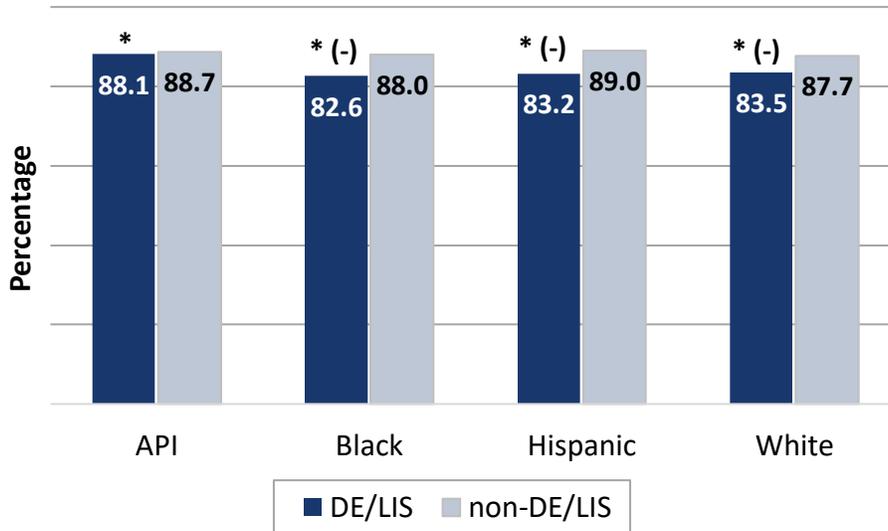
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Average morphine equivalent dose > 120 mg.

## Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, Hispanic, and White beneficiaries, use of opioids from multiple prescribers was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was greater than 3 percentage points, as were the differences between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries and between White DE/LIS and White non-DE/LIS beneficiaries.

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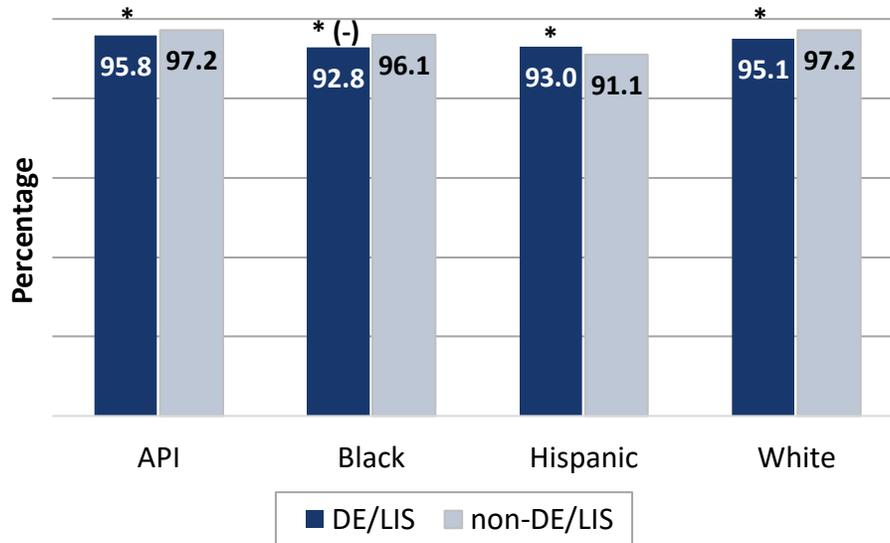
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids from Multiple Pharmacies

**Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

### Disparities

- Among API, Black, and White beneficiaries, use of opioids from multiple pharmacies was avoided less often for those who were DE/LIS than for those who were non-DE/LIS. The difference between API DE/LIS and API non-DE/LIS beneficiaries was less than 3 percentage points, as was the difference between White DE/LIS and White non-DE/LIS beneficiaries. The difference between Black DE/LIS and Black non-DE/LIS beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries, use of opioids from multiple pharmacies was avoided more often for those who were DE/LIS than for those who were non-DE/LIS. The difference between Hispanic DE/LIS and Hispanic non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

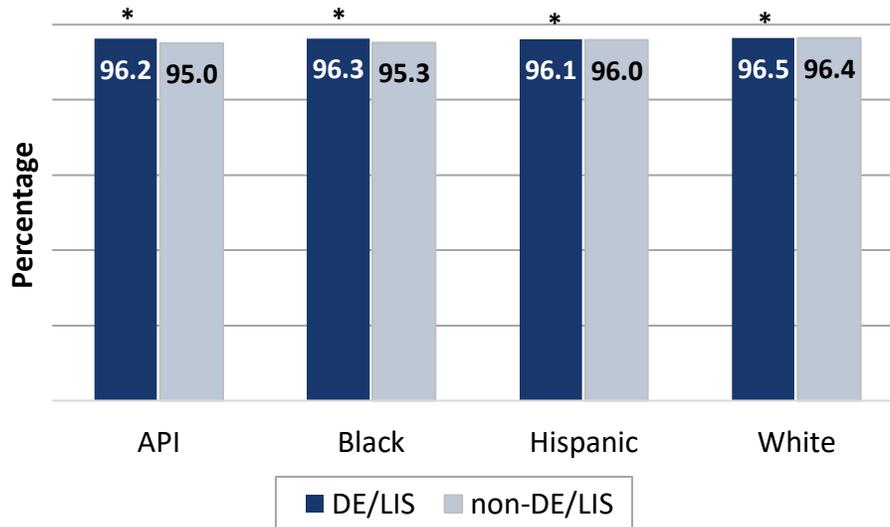
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Access/Availability of Care

### Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA beneficiaries aged 65 years and older who had an ambulatory or preventive care visit in the past year, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** API = Asian or Pacific Islander. DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS. The racial groups, API, Black, and White, are non-Hispanic. Hispanic ethnicity includes all races.

#### Disparities

- Among API, Black, Hispanic, and White beneficiaries, those who were DE/LIS were more likely than those who were non-DE/LIS to have had an ambulatory or preventive care visit. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same racial or ethnic group, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

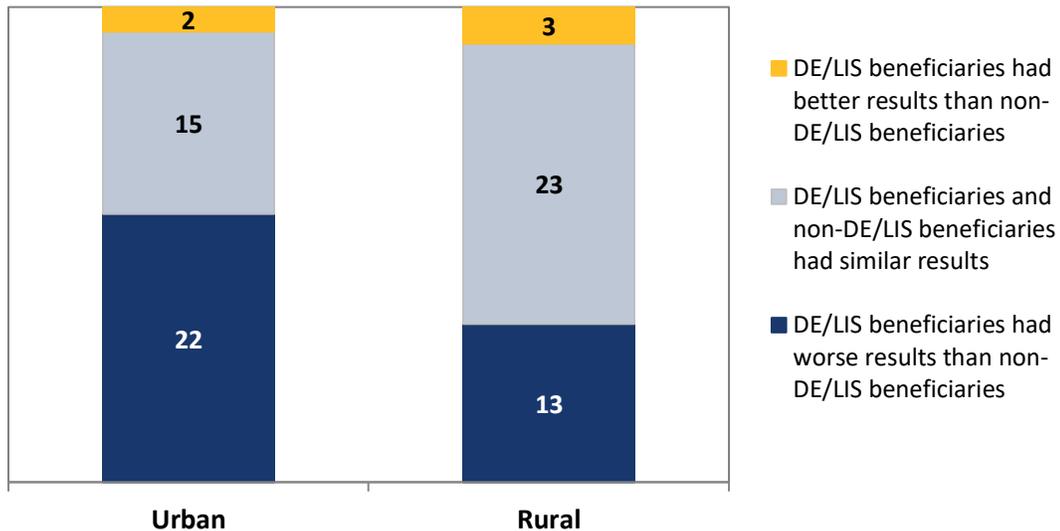
SECTION III:

DE/LIS Disparities in Health  
Care in Medicare Advantage  
Within Urban and Rural Areas



## Summary of DE/LIS Disparities in Clinical Care Within Urban and Rural Areas

**Number of clinical care measures for which urban and rural residents who were DE/LIS had results that were worse than, similar to, or better than results for urban and rural residents who were not DE/LIS in Reporting Year 2019**



**SOURCE:** This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.  
**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

Within urban and rural areas, the relative difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries is used to assess disparities.

- **Better** = Results for DE/LIS beneficiaries were better than results for non-DE/LIS beneficiaries. Differences are statistically significant ( $p < 0.05$ ), are equal to or larger than 3 points<sup>†</sup> on a 0–100 scale, and favor DE/LIS beneficiaries.
- **Similar** = Results were similar for DE/LIS and non-DE/LIS beneficiaries. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Results for DE/LIS beneficiaries were worse than results for non-DE/LIS beneficiaries. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor non-DE/LIS beneficiaries.

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

#### Urban DE/LIS beneficiaries had worse results than urban non-DE/LIS beneficiaries

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Osteoporosis Management in Women Who Had a Fracture
- 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)
- Medication Reconciliation After Hospital 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 Elderly Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medication in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers
- Avoiding Use of Opioids from Multiple Pharmacies

#### Urban DE/LIS beneficiaries had better results than urban non-DE/LIS beneficiaries

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Initiation of Alcohol or Other Drug Treatment

#### Rural DE/LIS beneficiaries had worse results than rural non-DE/LIS beneficiaries

- Breast Cancer Screening
- Colorectal Cancer Screening
- Testing to Confirm COPD
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Rheumatoid Arthritis Management
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days of discharge)
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
- Avoiding Use of High-Risk Medication in the Elderly
- Avoiding Use of Opioids from Multiple Prescribers

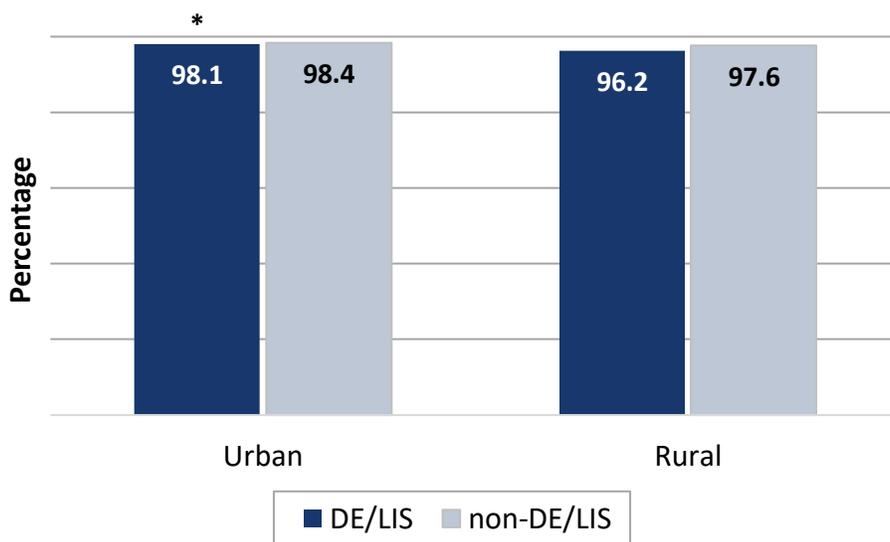
**Rural DE/LIS beneficiaries had better results than rural non-DE/LIS beneficiaries**

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Initiation of Alcohol or Other Drug Treatment

## Prevention and Screening

### Adult Body Mass Index (BMI) Assessment

Percentage of Medicare beneficiaries aged 18 to 74 years who had an outpatient visit whose BMIs were documented in the past two years, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, DE/LIS beneficiaries were less likely than non-DE/LIS beneficiaries to have had their BMIs documented. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points.
- In rural areas, DE/LIS beneficiaries were about as likely as non-DE/LIS beneficiaries to have had their BMIs documented.

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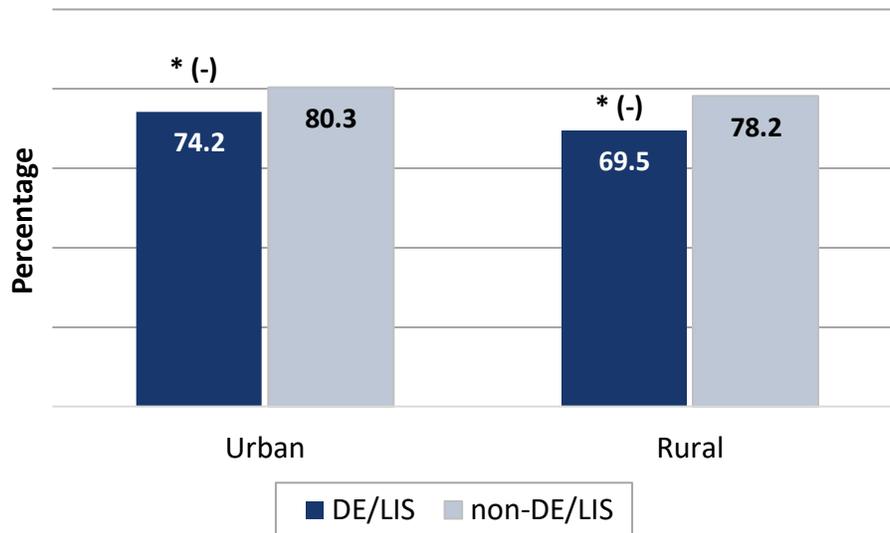
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Breast Cancer Screening

Percentage of female MA beneficiaries aged 50 to 74 years who had appropriate screening for breast cancer in the past two years, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, female DE/LIS beneficiaries were less likely than female non-DE/LIS beneficiaries to have been appropriately screened for breast cancer. In each case, the difference between female DE/LIS beneficiaries and female non-DE/LIS beneficiaries was greater than 3 percentage points.

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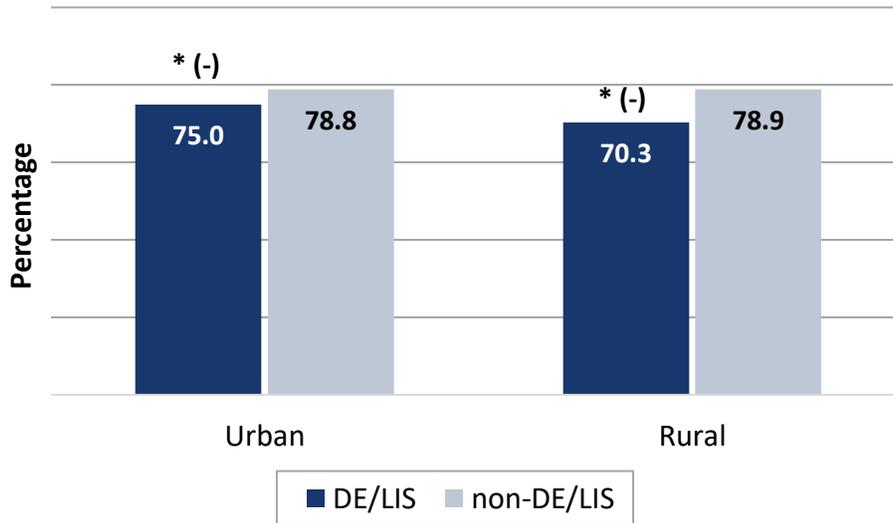
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Colorectal Cancer Screening

Percentage of MA beneficiaries aged 50 to 75 years who had appropriate screening for colorectal cancer, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries were less likely than non-DE/LIS beneficiaries to have been appropriately screened for colorectal cancer. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

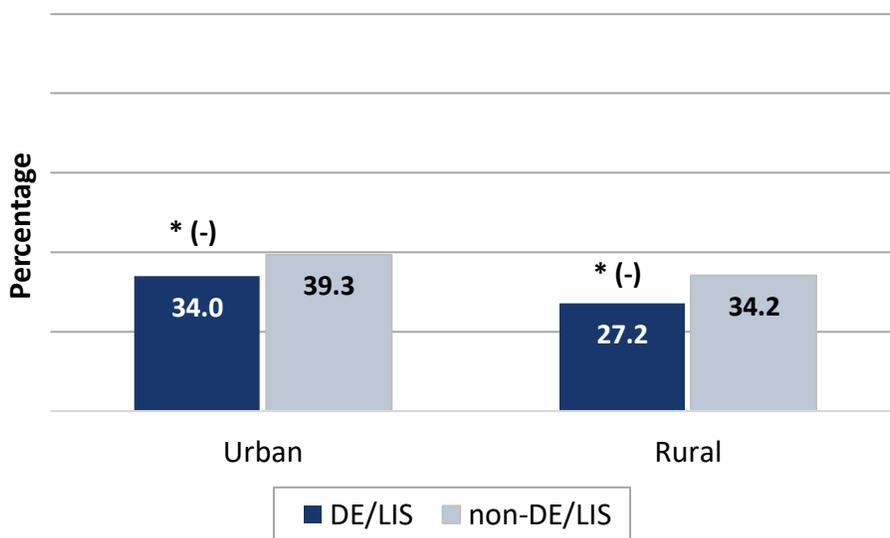
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Respiratory Conditions

### Testing to Confirm COPD

Percentage of MA beneficiaries aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with a new diagnosis of COPD or newly active COPD were less likely than non-DE/LIS beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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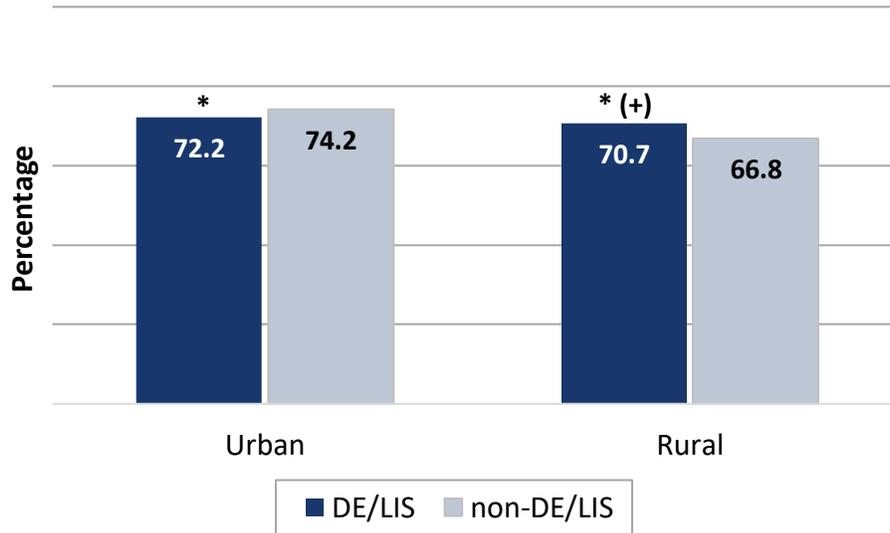
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

**Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by DE/LIS status within urban and rural areas, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries who experienced a COPD exacerbation were less likely than non-DE/LIS beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points.
- In rural areas, DE/LIS beneficiaries who experienced a COPD exacerbation were more likely than non-DE/LIS beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was greater than 3 percentage points.

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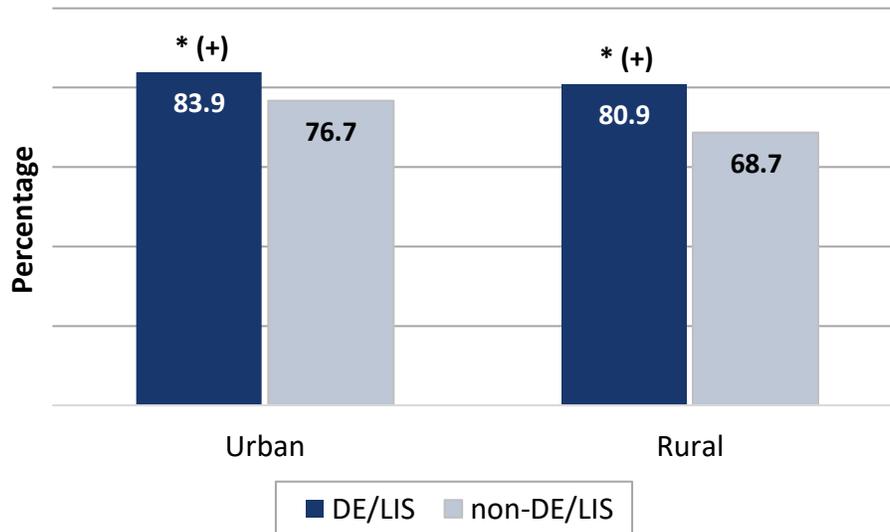
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA beneficiaries aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who experienced a COPD exacerbation were more likely than non-DE/LIS beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

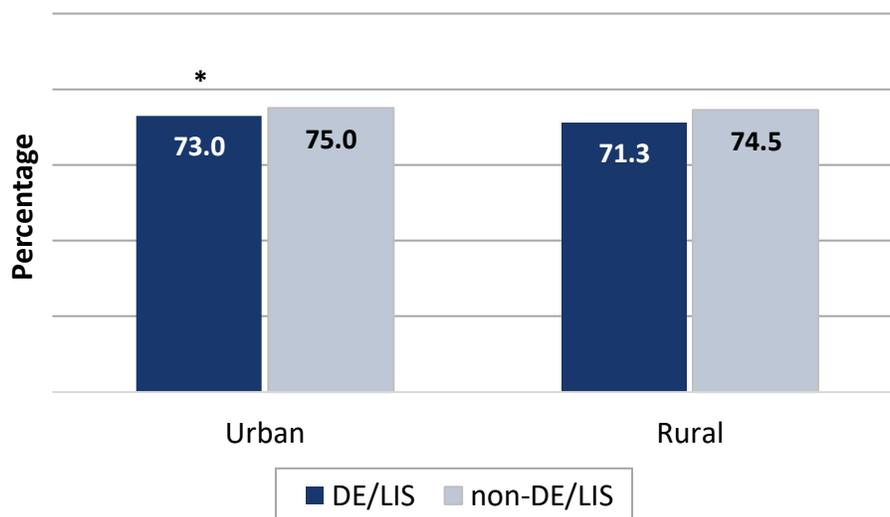
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Cardiovascular Conditions

### Controlling High Blood Pressure

Percentage of MA beneficiaries aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled<sup>†</sup> during the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, DE/LIS beneficiaries who had a diagnosis of hypertension were less likely than non-DE/LIS beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points.
- In rural areas, DE/LIS beneficiaries who had a diagnosis of hypertension were about as likely as non-DE/LIS beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

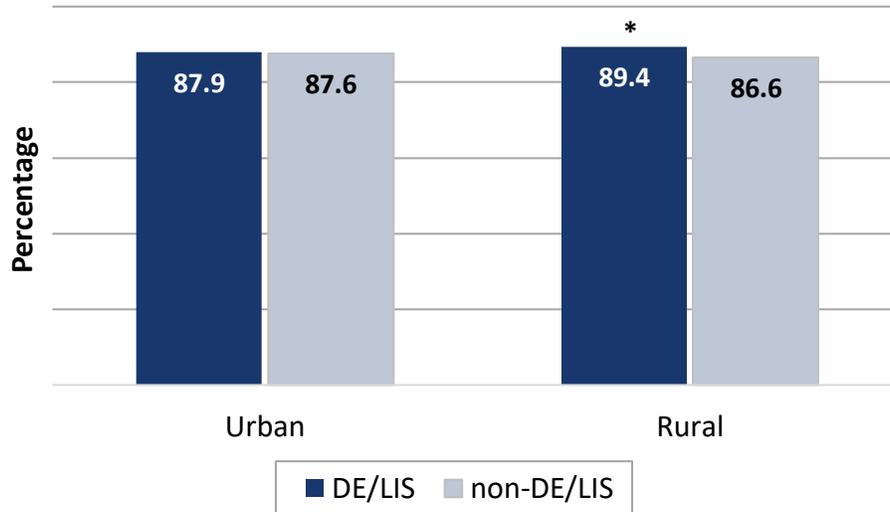
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Less than 140/90 for those 18 to 59 years of age and for those 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for those 60 to 85 years of age without a diagnosis of diabetes.

## Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA beneficiaries 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 DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries who were hospitalized for a heart attack were about as likely as non-DE/LIS beneficiaries who were hospitalized for a heart attack to have received continuous beta-blocker treatment.
- In rural areas, DE/LIS beneficiaries who were hospitalized for a heart attack were more likely than non-DE/LIS beneficiaries who were hospitalized for a heart attack to have received continuous beta-blocker treatment. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

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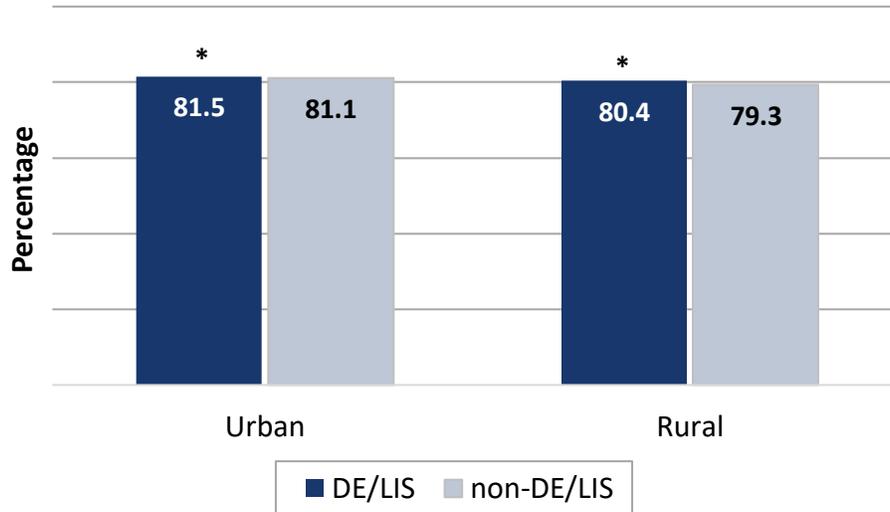
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Cardiovascular Disease

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical ASCVD who received statin therapy, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with ASCVD were more likely than non-DE/LIS beneficiaries with ASCVD to have received statin therapy. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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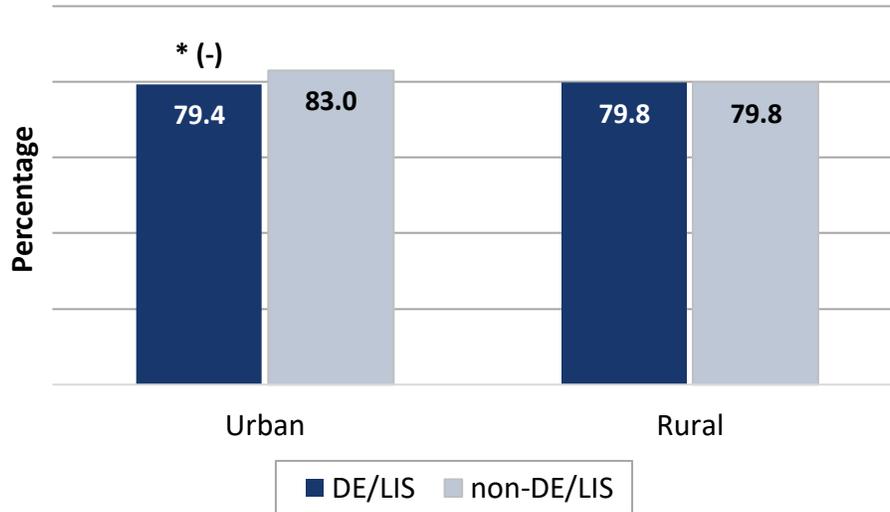
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA beneficiaries aged 21 to 75 years and female MA beneficiaries aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries with ASCVD were less likely than non-DE/LIS beneficiaries with ASCVD to have had proper statin medication adherence. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries with ASCVD were about as likely as non-DE/LIS beneficiaries with ASCVD to have had proper statin medication adherence.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

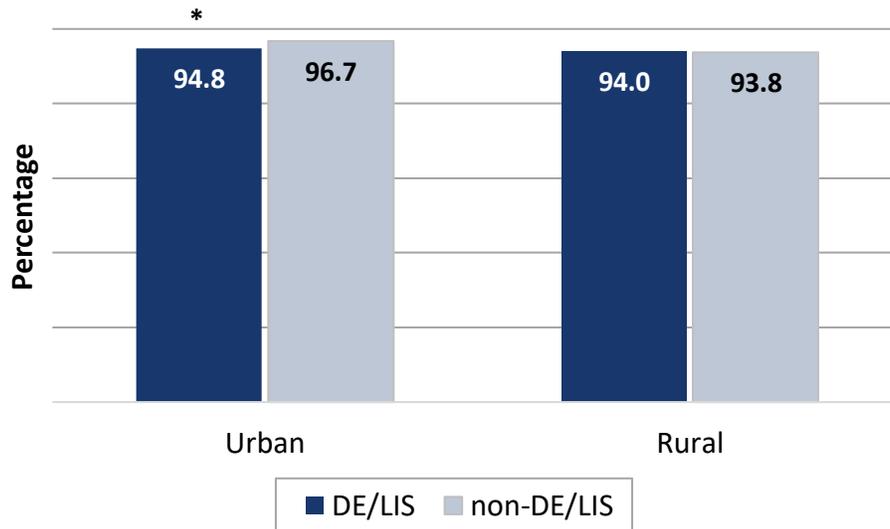
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

# Diabetes

## Diabetes Care—Blood Sugar Testing

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points.
- In rural areas, DE/LIS beneficiaries with diabetes were about as likely as non-DE/LIS beneficiaries with diabetes to have had their blood sugar tested at least once in the past year.

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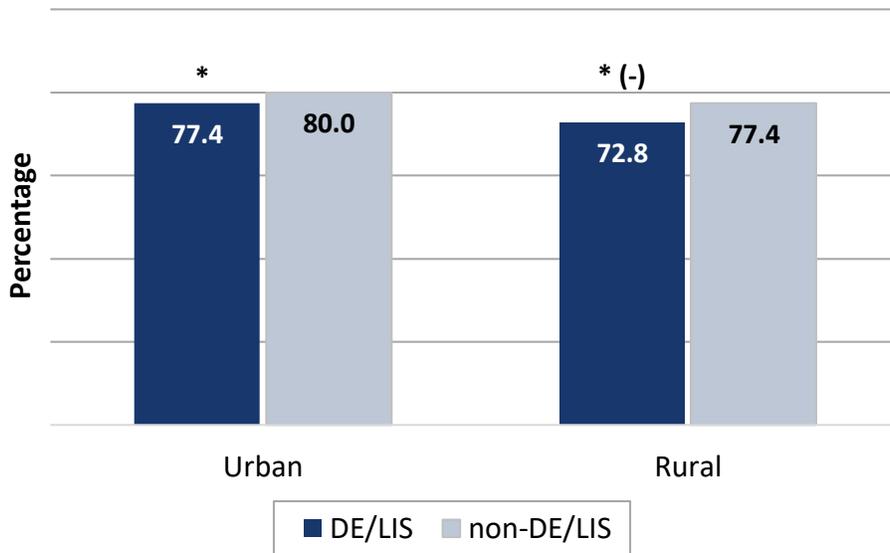
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Eye Exam

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had an eye exam in the past year. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was greater than 3 percentage points.

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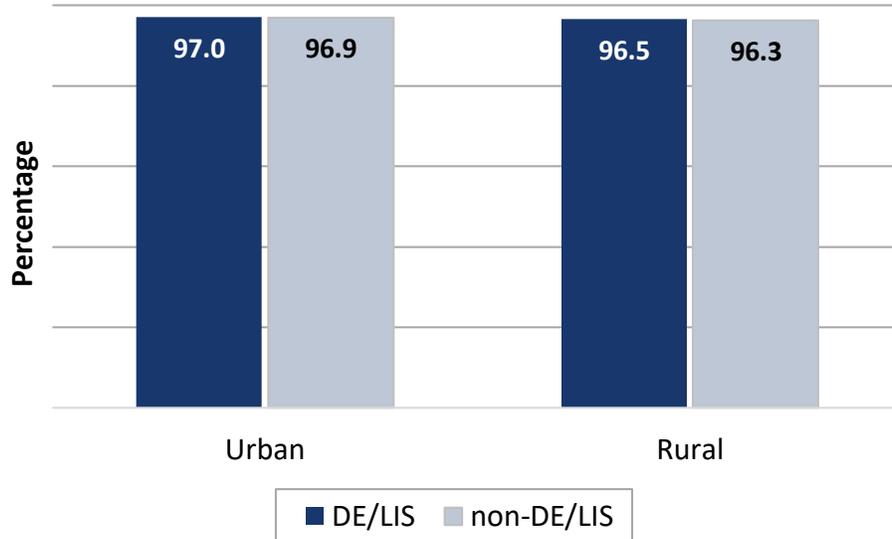
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Kidney Disease Monitoring

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

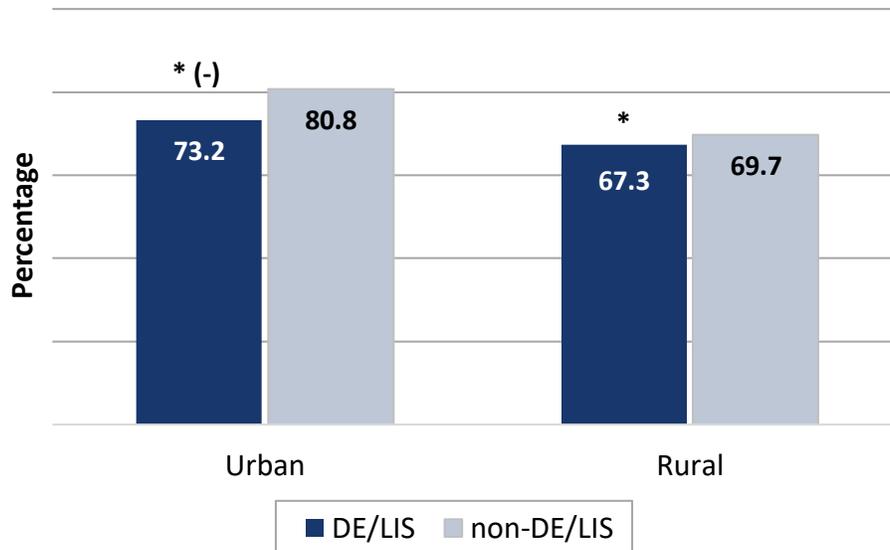
**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with diabetes were about as likely as non-DE/LIS beneficiaries with diabetes to have had medical attention for nephropathy in the past year.

## Diabetes Care—Blood Pressure Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have their blood pressure under control. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

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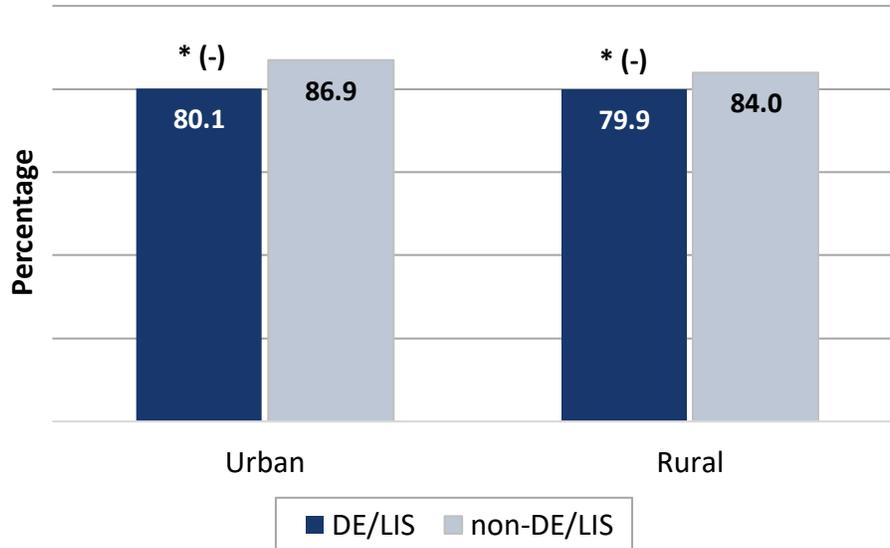
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Diabetes Care—Blood Sugar Controlled

Percentage of MA beneficiaries aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had their blood sugar level under control. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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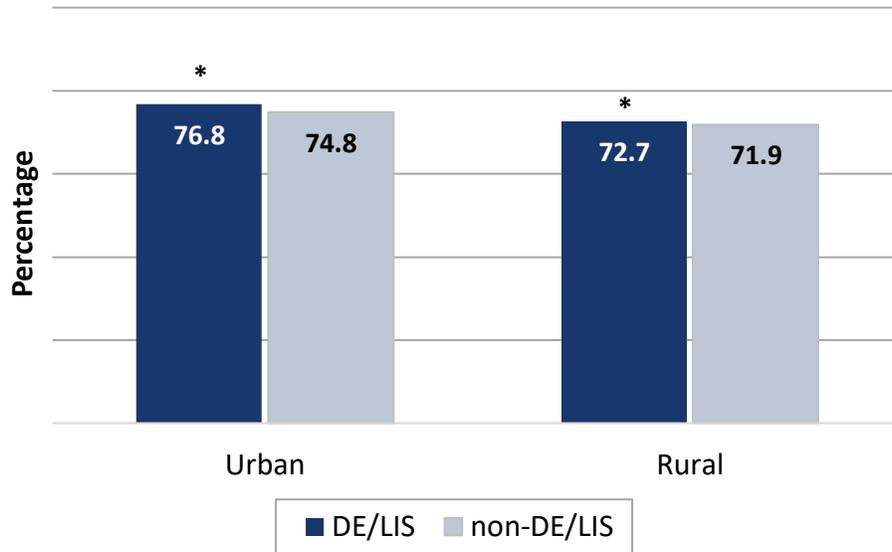
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Statin Use in Patients with Diabetes

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who received statin therapy, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with diabetes were more likely than non-DE/LIS beneficiaries with diabetes to have received statin therapy. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

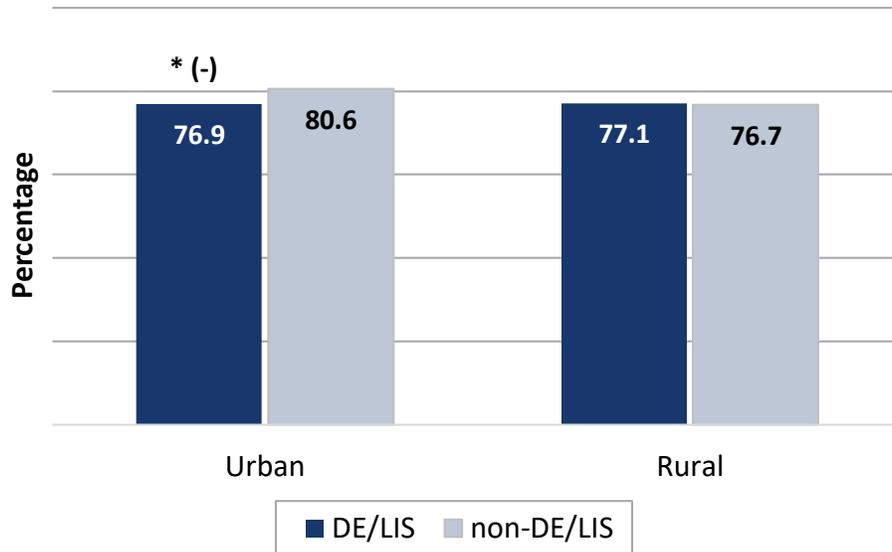
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

## Medication Adherence for Diabetes—Statins

Percentage of MA beneficiaries aged 40 to 75 years with diabetes (type 1 and type 2)<sup>†</sup> who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries with diabetes were less likely than non-DE/LIS beneficiaries with diabetes to have had proper statin medication adherence. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries with diabetes were about as likely as non-DE/LIS beneficiaries with diabetes to have had proper statin medication adherence.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

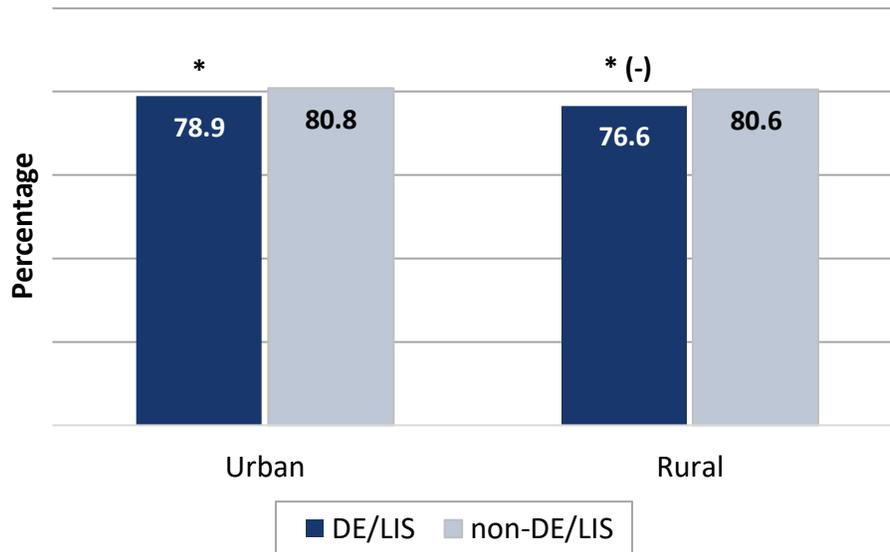
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Excludes those who also have clinical ASCVD.

# Musculoskeletal Conditions

## Rheumatoid Arthritis Management

Percentage of MA beneficiaries aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a DMARD, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who were diagnosed with rheumatoid arthritis were less likely than non-DE/LIS beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

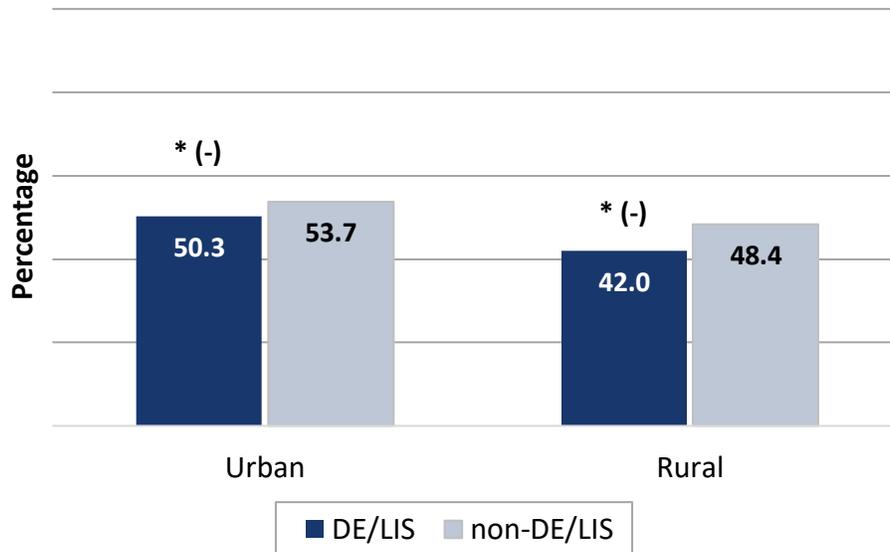
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA beneficiaries aged 65 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, female DE/LIS beneficiaries who suffered a fracture were less likely than female non-DE/LIS beneficiaries who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. In each case, the difference between female DE/LIS beneficiaries and female non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

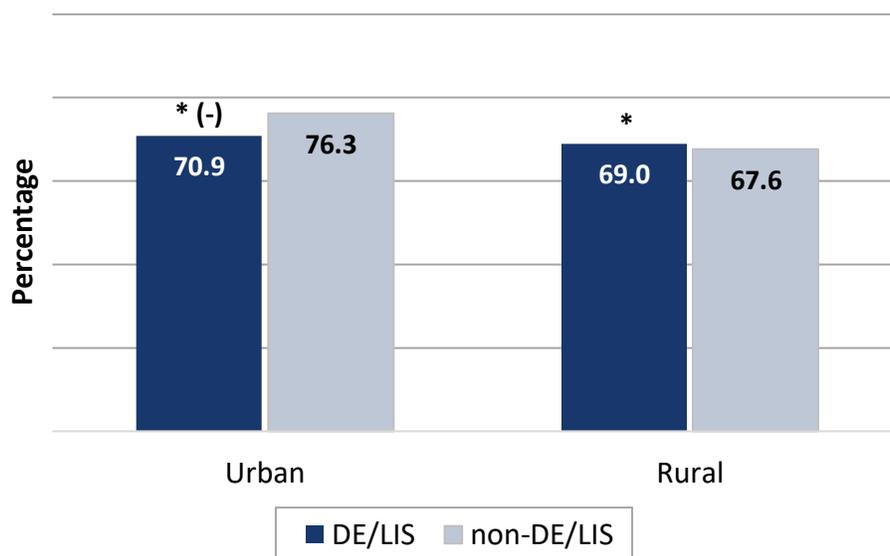
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Behavioral Health

### Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, DE/LIS beneficiaries diagnosed with a new episode of major depression were less likely than non-DE/LIS beneficiaries diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries diagnosed with a new episode of major depression were more likely than non-DE/LIS beneficiaries diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

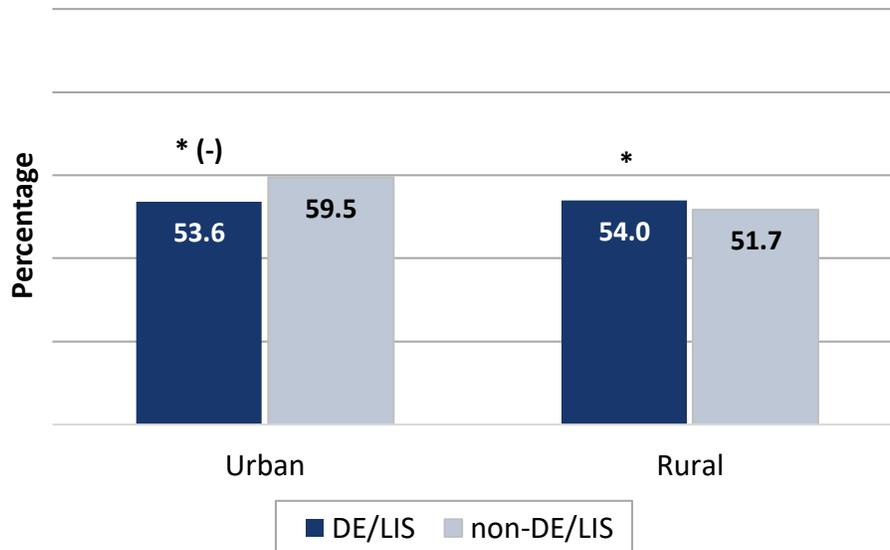
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA beneficiaries aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries who were diagnosed with a new episode of major depression were less likely than non-DE/LIS beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries who were diagnosed with a new episode of major depression were more likely than non-DE/LIS beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

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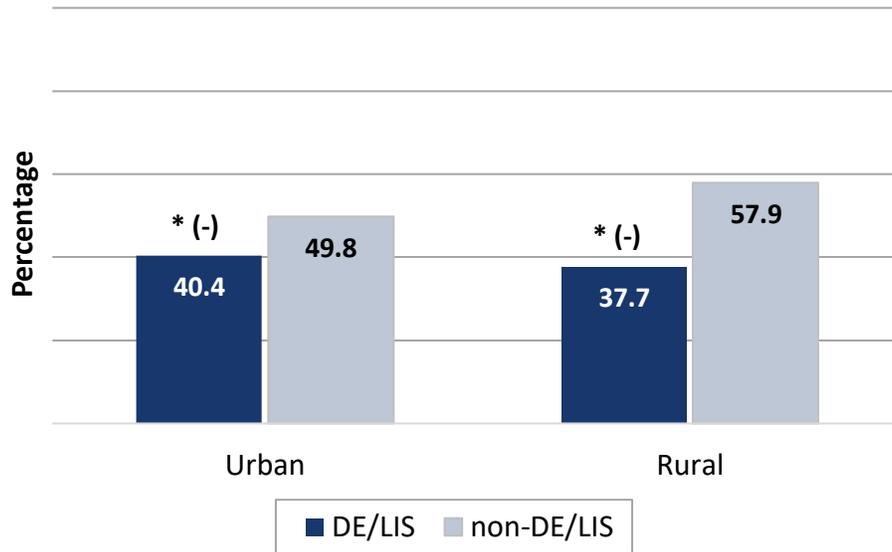
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who were hospitalized for a mental health disorder were less likely than non-DE/LIS beneficiaries who were hospitalized for a mental health disorder to have had appropriate follow-up care within 30 days of discharge. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

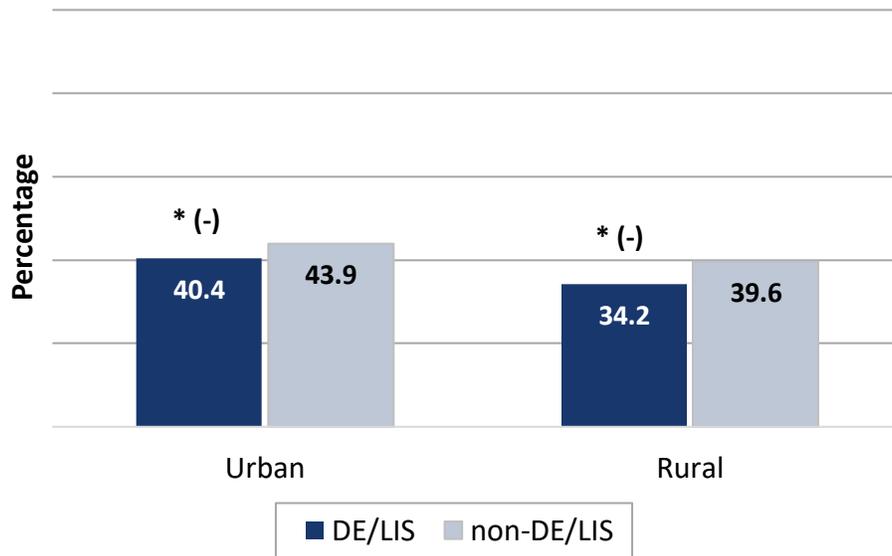
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Follow-Up After Emergency Department Visit for Mental Illness (within 30 days of discharge)

**Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit 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 the ED visit, by DE/LIS status within urban and rural areas, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who had an ED visit for a mental health disorder were less likely than non-DE/LIS beneficiaries who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

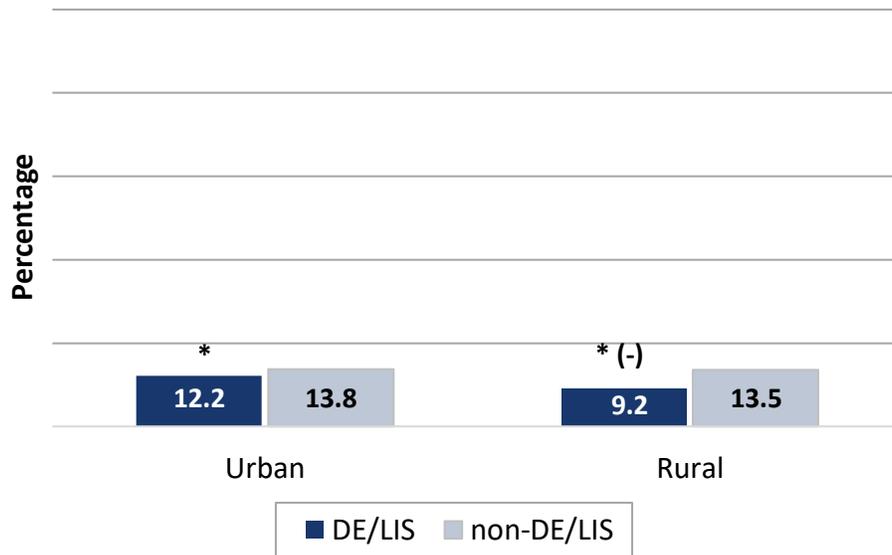
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

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

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who had an ED visit for AOD abuse or dependence were less likely than non-DE/LIS beneficiaries who had an ED visit for AOD abuse or dependence to have had a follow-up visit within 30 days of the ED visit. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was less than 3 percentage points. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was greater than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

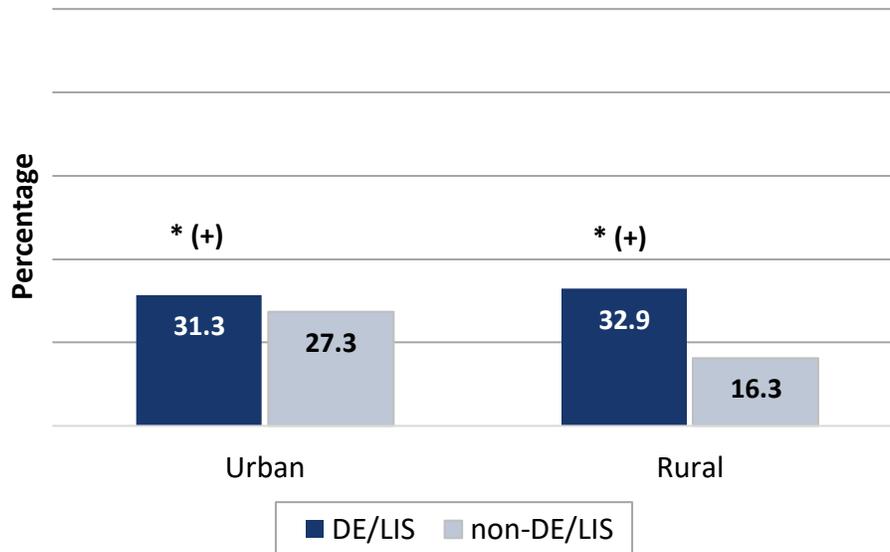
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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 Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated<sup>‡</sup> treatment within 14 days of the diagnosis, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with a new episode of AOD dependence were more likely than non-DE/LIS beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

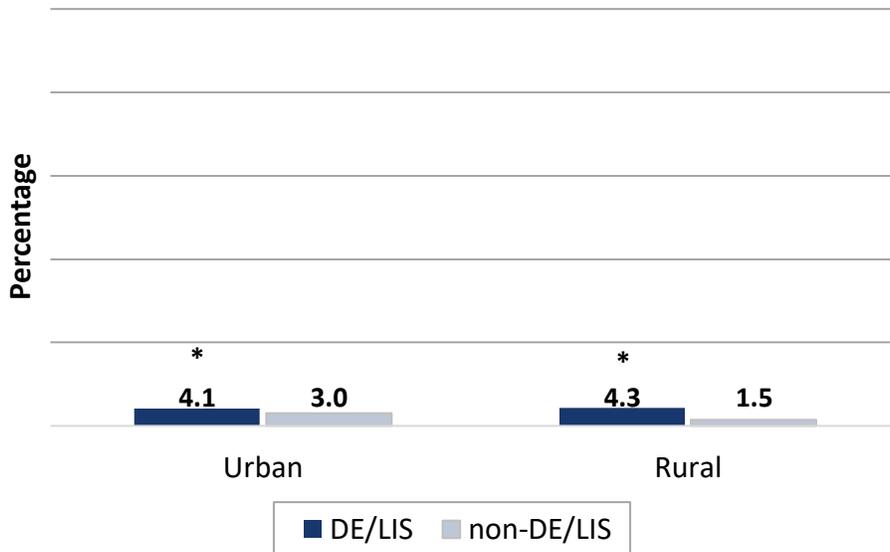
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

<sup>‡</sup> Initiation might occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

## Engagement of Alcohol or Other Drug Treatment

Percentage of MA beneficiaries aged 18 years and older<sup>†</sup> with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries with a new episode of AOD dependence who initiated treatment were more likely than non-DE/LIS beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

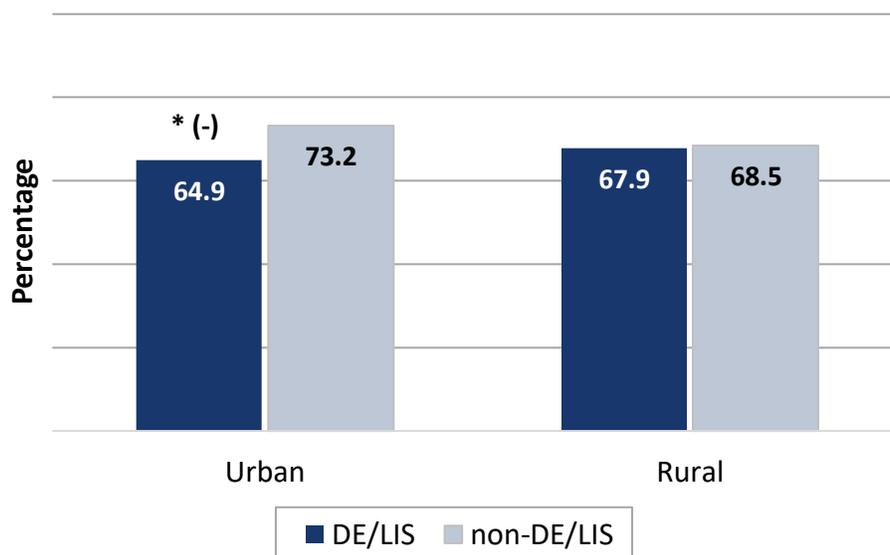
- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Medication Management and Care Coordination

### Medication Reconciliation After Hospital Discharge

Percentage of MA beneficiaries aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries who were discharged from an inpatient facility were about as likely as non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

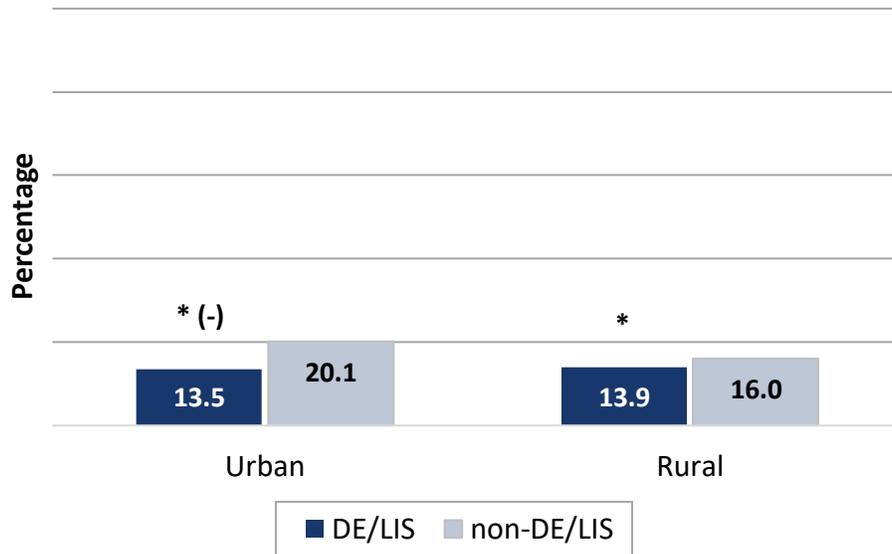
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Notification of Inpatient Admission

Percentage of MA beneficiaries 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 DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, the primary or ongoing care providers of DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than the primary or ongoing care providers of non-DE/LIS beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. In urban areas, the difference was greater than 3 percentage points. In rural areas, the difference was less than 3 percentage points.

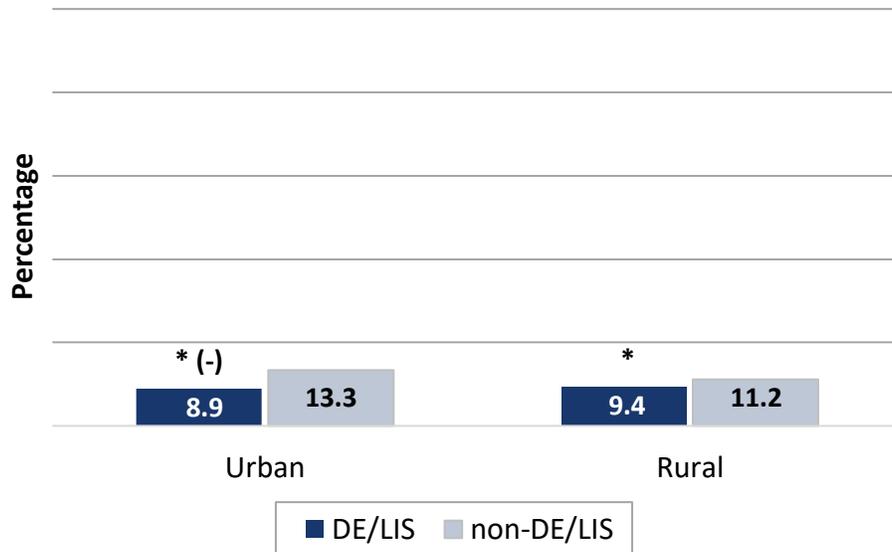
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Receipt of Discharge Information

Percentage of MA beneficiaries 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 DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

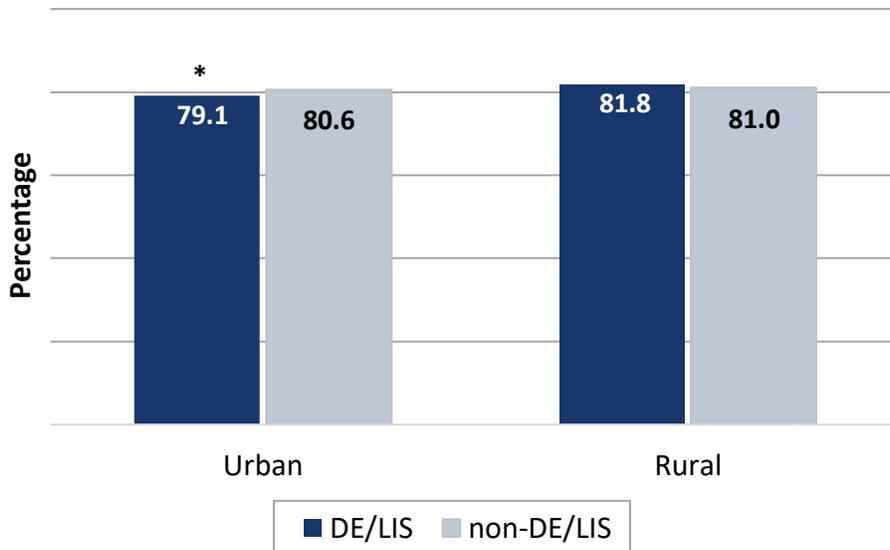
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA beneficiaries 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 DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries who were discharged from an inpatient facility were less likely than non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had an office visit, have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between urban DE/LIS and urban non-DE/LIS beneficiaries was less than 3 percentage points.
- In rural areas, DE/LIS beneficiaries who were discharged from an inpatient facility were about as likely as non-DE/LIS beneficiaries who were discharged from an inpatient facility to have had an office visit, have had a home visit, or to have received telehealth services within 30 days of discharge.

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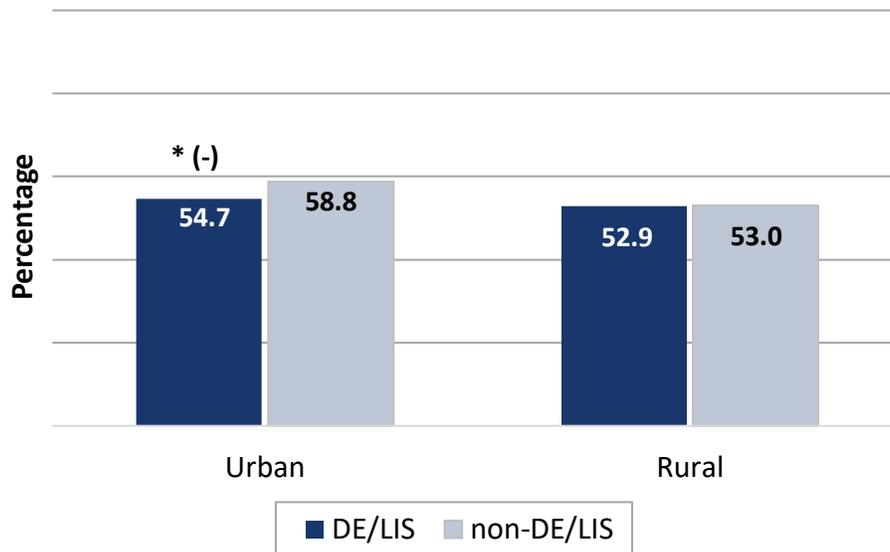
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA beneficiaries aged 18 years and older with multiple high-risk chronic conditions<sup>†</sup> who received follow-up care within 7 days of an ED visit, by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, DE/LIS beneficiaries with multiple high-risk chronic conditions were less likely than non-DE/LIS beneficiaries with multiple high-risk chronic conditions to have received follow-up care within 7 days of an ED visit. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, DE/LIS beneficiaries with multiple high-risk chronic conditions were about as likely as non-DE/LIS beneficiaries with multiple high-risk chronic conditions to have received follow-up care within 7 days of an ED visit.

\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

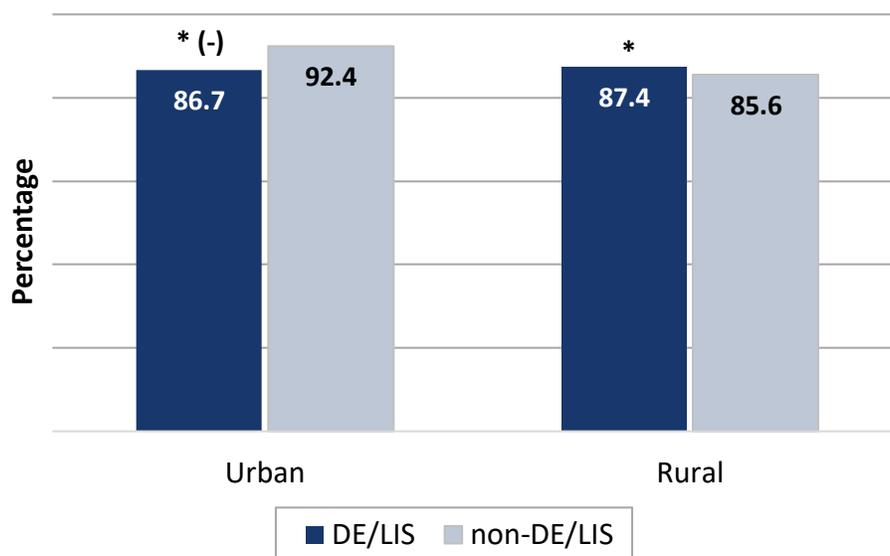
(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> 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.

## Overuse/Appropriateness

### Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of MA beneficiaries aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within race and ethnicity, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with chronic renal failure than for elderly non-DE/LIS beneficiaries with chronic renal failure. The difference between elderly urban DE/LIS beneficiaries and elderly urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, use of potentially harmful medication was avoided more often for elderly DE/LIS beneficiaries with chronic renal failure than for elderly non-DE/LIS beneficiaries with chronic renal failure. The difference between elderly rural DE/LIS beneficiaries and elderly rural non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

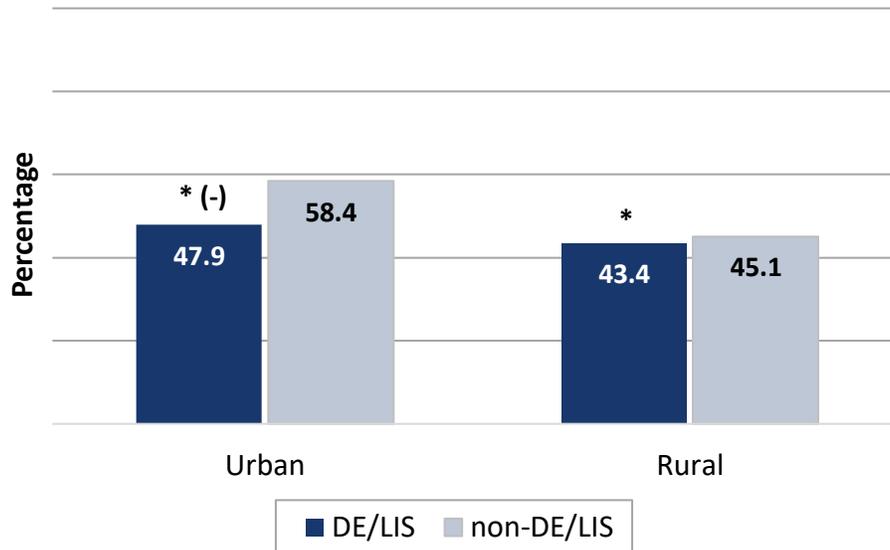
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> This includes cyclooxygenase-2 selective NSAIDs or nonaspirin NSAIDs.

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

**Percentage of MA beneficiaries aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within urban and rural areas, Reporting Year 2019**



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with dementia than for elderly non-DE/LIS beneficiaries with dementia. The difference between elderly urban DE/LIS beneficiaries and elderly urban non-DE/LIS beneficiaries was greater than 3 percentage points. The difference between elderly rural DE/LIS beneficiaries and elderly rural non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

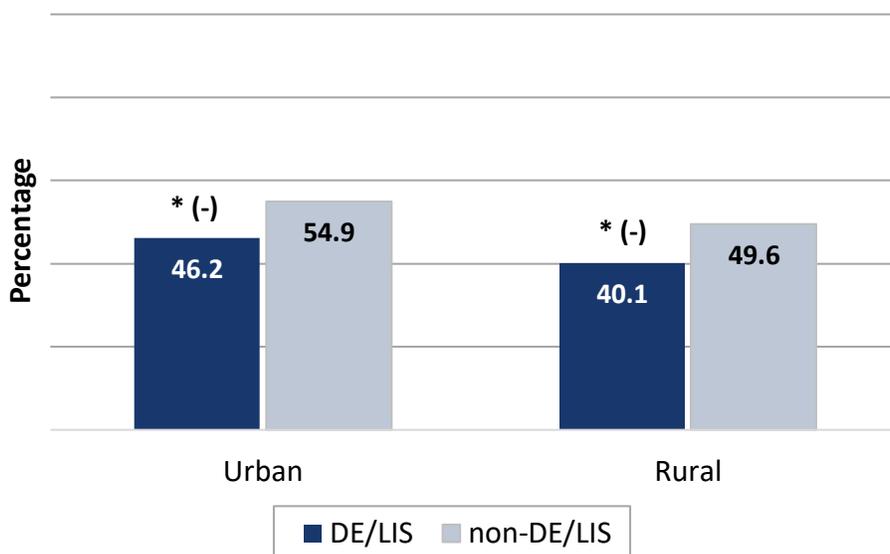
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

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

## Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of MA beneficiaries aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,<sup>†</sup> by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, use of potentially harmful medication was avoided less often for elderly DE/LIS beneficiaries with a history of falls than for elderly non-DE/LIS beneficiaries with a history of falls. In each case, the difference between elderly DE/LIS beneficiaries and elderly non-DE/LIS beneficiaries was greater than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

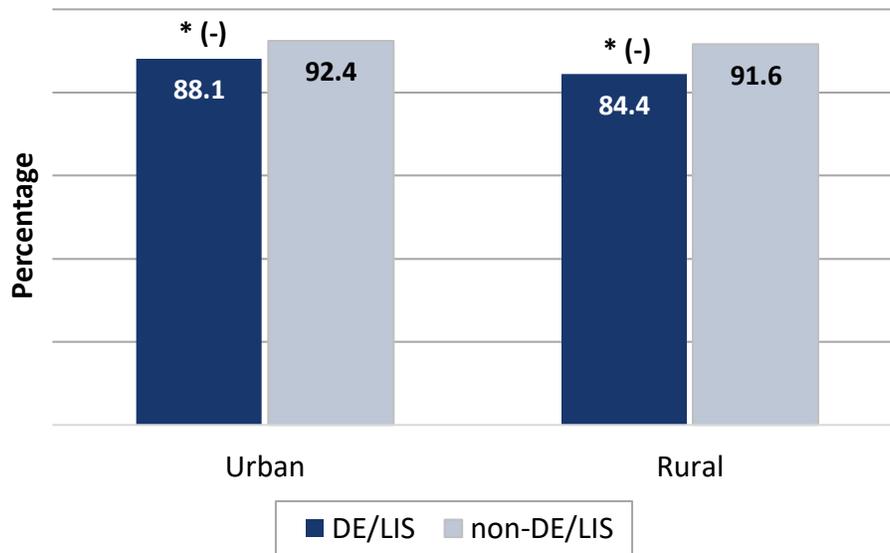
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

## Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA beneficiaries aged 65 years and older who were not prescribed a high-risk medication, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, use of high-risk medication was avoided less often for elderly DE/LIS beneficiaries than for elderly non-DE/LIS beneficiaries. In each case, the difference between elderly DE/LIS beneficiaries and elderly non-DE/LIS beneficiaries was greater than 3 percentage points.

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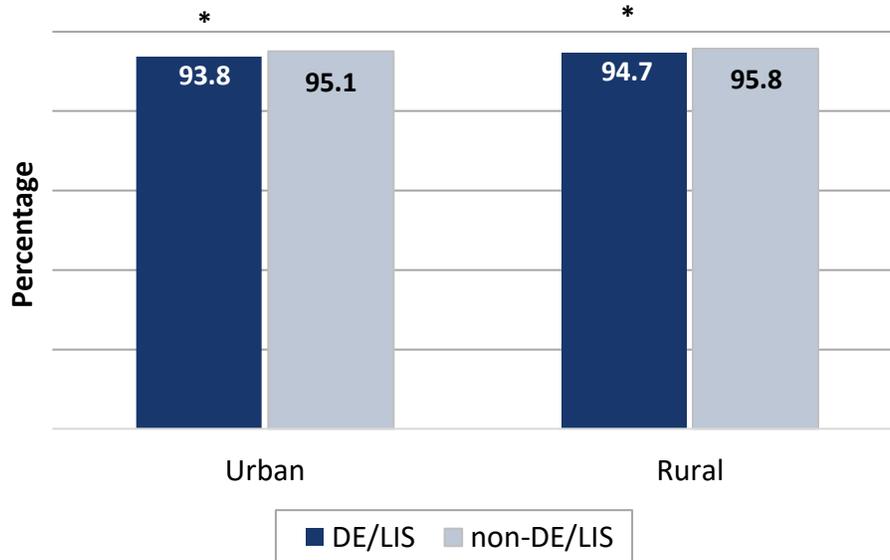
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids at High Dosage

Percentage of MA beneficiaries aged 18 years and older who were not prescribed opioids at a high dosage<sup>†</sup> for more than 14 days, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, use of opioids at a high dosage for more than 14 days was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

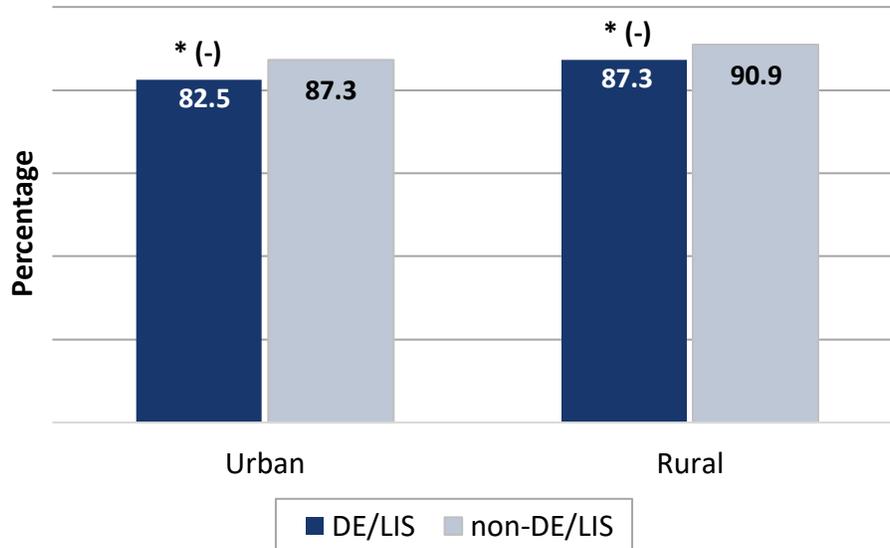
(+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.

(-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

<sup>†</sup> Average morphine equivalent dose > 120 mg.

## Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In both urban and rural areas, use of opioids from multiple prescribers was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. In each case, the difference between DE/LIS beneficiaries and non-DE/LIS beneficiaries was greater than 3 percentage points.

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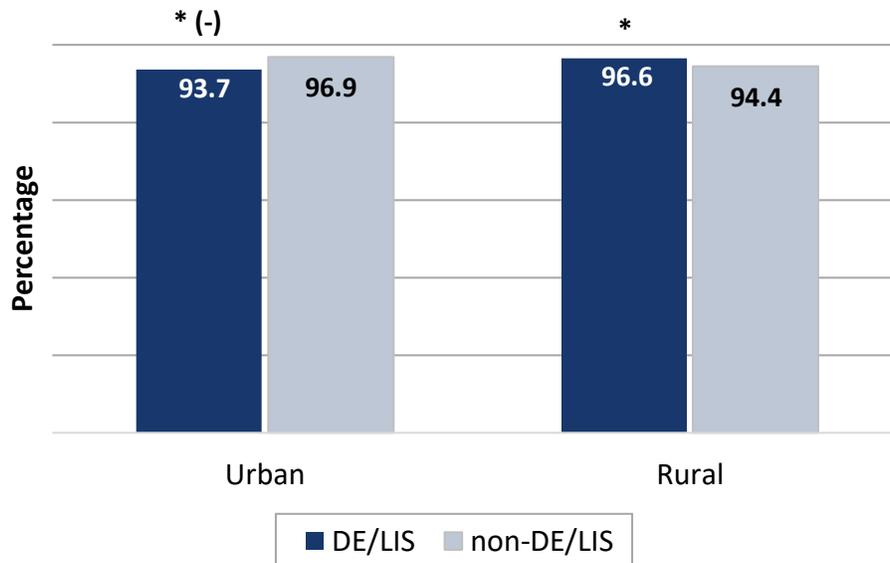
\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA beneficiaries aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

### Disparities

- In urban areas, use of opioids from multiple pharmacies was avoided less often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. The difference between urban DE/LIS beneficiaries and urban non-DE/LIS beneficiaries was greater than 3 percentage points.
- In rural areas, use of opioids from multiple pharmacies was avoided more often for DE/LIS beneficiaries than for non-DE/LIS beneficiaries. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

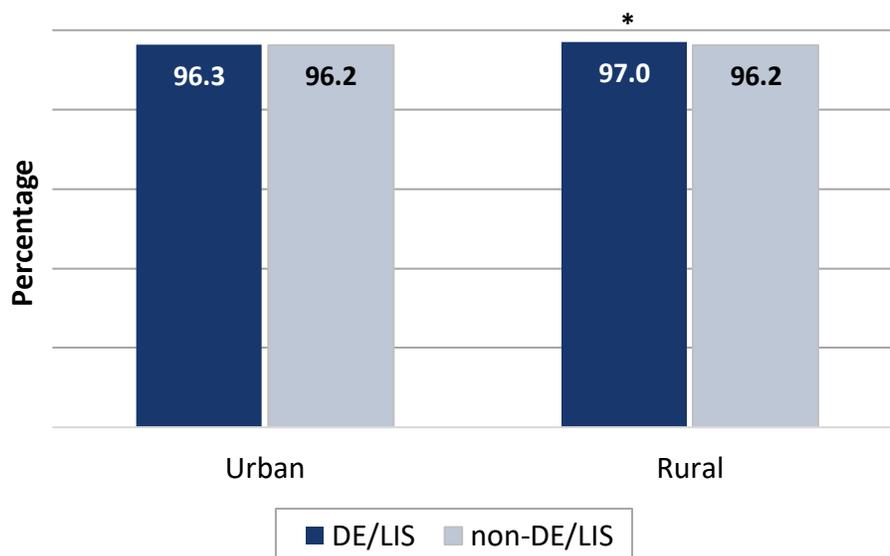
For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Access/Availability of Care

### Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA beneficiaries aged 65 years and older who had an ambulatory or preventive care visit in the past year, by DE/LIS status within urban and rural areas, Reporting Year 2019



**SOURCE:** Clinical quality data were collected in 2018 from MA plans nationwide.

**NOTES:** DE/LIS beneficiaries are beneficiaries who are dually eligible for Medicare and Medicaid or eligible for an LIS. Non-DE/LIS beneficiaries are neither DE nor eligible for an LIS.

#### Disparities

- In urban areas, DE/LIS beneficiaries were about as likely as non-DE/LIS beneficiaries to have had an ambulatory or preventive care visit.
- In rural areas, DE/LIS beneficiaries were more likely than non-DE/LIS beneficiaries to have had an ambulatory or preventive care visit. The difference between rural DE/LIS beneficiaries and rural non-DE/LIS beneficiaries was less than 3 percentage points.

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\* Significantly different from the score for non-DE/LIS beneficiaries ( $p < 0.05$ ).

For statistically significant differences between DE/LIS and non-DE/LIS beneficiaries of the same locality, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (before rounding) and favors DE/LIS beneficiaries.
- (-) Difference is equal to or larger than 3 points (before rounding) and favors non-DE/LIS beneficiaries.

## Appendix: Data Sources and Methods

### *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 [NCQA], undated). These domains are effectiveness of care, access/availability of care, experience of care, utilization and risk-adjusted utilization, relative resource use, and health plan descriptive information. HEDIS measures are developed, tested, and validated under the direction of NCQA. HEDIS data are gathered via both surveys and medical charts and insurance claims for hospitalizations, medical office visits, and procedures. To avoid pooling data across different versions of a measure, we excluded measures that underwent a recent change in specification. We also excluded measures that were similar to reported measures preferred by CMS or were deemed unsuitable for this application by CMS experts. HEDIS data are available only for MA beneficiaries. To be counted as an MA beneficiary, the general requirement for HEDIS measures is continuous MA enrollment for the measurement year (in this case, 2018), with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. In Measurement Year 2018, there were 529 MA contracts that supplied the 18,551,524 HEDIS measure records used.

### *Information on DE/LIS Status*

Information on beneficiaries' DE/LIS status came from CMS administrative data. DE/LIS information on the 2019 HEDIS data file (Measurement Year 2018) represents beneficiaries' DE/LIS status in March 2019. For this report, all dual eligible individuals (i.e., those who would be considered full benefit, partial benefit, and QMBs) are included in the DE group.

### *Information on Race and Ethnicity*

Beneficiary race and ethnicity was imputed using a methodology that combines information from administrative data, surname, and residential location (Haas et al., 2019). This methodology—which is called Medicare Bayesian Surname Geocoding (MBISG)—is recommended for estimating racial and ethnic disparities for API, Black, Hispanic, and White beneficiaries (Haas et al., 2019). MBISG 2.1 imputations, which are used for this report, are strongly predictive of self-reported race and ethnicity for these four racial and ethnic groups. MBISG 2.1 is the most accurate measure of race and ethnicity that is available for all Medicare beneficiaries. 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 ranges from 0.5 (no predictiveness) to 1.0 (perfect predictiveness). C-statistics for MBISG 2.1 imputations of API, Black, Hispanic, and White race or ethnicity are 0.99, 0.99, 0.96, and 0.96, respectively.

### *Information on Geography*

Beneficiaries were classified as living in a rural or urban area according to the ZIP code of their mailing address and the corresponding U.S. Census Bureau CBSA. CBSAs consist of the county or counties or equivalent entities associated with at least one core urban area plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties that make up the core. Metropolitan statistical areas contain a core urban area of 50,000 or more people. Micropolitan statistical areas contain a core urban area of at least 10,000 but less than 50,000 people. For this report, any beneficiary residing within a metropolitan statistical area was classified as an urban resident; any beneficiary living in a micropolitan statistical area or outside a CBSA was classified as a rural resident.

### *Analytic Approach*

HEDIS measure estimates for DE/LIS and non-DE/LIS beneficiaries are from beneficiary-level logistic regression models that predicted whether the care for a patient met the HEDIS criterion (1) or did not (0) from DE/LIS status. Predicted probabilities of racial and ethnic group membership were used as weights to develop HEDIS measure estimates for DE/LIS and non-DE/LIS beneficiaries of different racial and ethnic backgrounds (Elliott et al., 2009). Estimates for DE/LIS and non-DE/LIS beneficiaries residing in urban and rural areas are from logistic regression models that were stratified by urban or rural residence.

Cases with missing data on outcome measures were excluded from the analysis. There were no missing data on predictors (i.e., DE/LIS status, race and ethnicity, and urban or rural residence).

Statistical significance tests were used to compare the model-estimated scores for DE/LIS beneficiaries with the scores for non-DE/LIS beneficiaries. A difference in scores 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 percentage points are further denoted as practically significant. That is, in the charts that present national data on differences in clinical care by DE/LIS status, differences that are not statistically significant or are statistically significant but less than 3 points in magnitude are distinguished (using symbols and labeling) from differences that are both statistically significant and 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

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