Rural-Urban Disparities in Health Care in Medicare

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Preface

This report presents summary information on the quality of health care received by people with Medicare nationwide. The report highlights (1) rural-urban differences in health care experiences and clinical care, (2) how rural-urban differences in quality of care vary by race and ethnicity, and (3) how racial and ethnic differences in quality of care vary between rural and urban areas.

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Executive Summary

Introduction

This report presents summary information on the quality of health care received by people with Medicare nationwide. The report highlights (1) rural-urban differences in health care experiences and clinical care,[1] (2) how rural-urban differences in quality of care vary by race and ethnicity, and (3) how racial and ethnic differences in quality of care vary between rural and urban areas.

The report is based on an analysis of two sources of information. The first source is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which is conducted annually by the Centers for Medicare & Medicaid Services (CMS) and focuses on the health care experiences (e.g., ease of getting needed care, how well providers communicate, getting needed prescription drugs) of people with Medicare across the country. The survey also contains a patient-reported measure of having received a flu immunization in the past year. The second source of information is the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is composed of information collected from medical records and administrative data on the clinical quality of care that people with Medicare receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. A comprehensive list of the seven patient experience and 36 clinical care measures is provided in the section titled "Patient Experience and Clinical Care Measures Included in This Report." Scores on CAHPS measures are case mix–adjusted, as described in the appendix. HEDIS measures are not case mix–adjusted.

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

The report uses data reported in 2021. The CAHPS data pertain to care experiences reported on the 2021 Medicare CAHPS survey, which was fielded from March to May 2021. Respondents were asked about care received in the six months prior to the survey. HEDIS data reported in 2021 (hereafter referred to as "Reporting Year 2021") correspond to care received from January to December 2020.

Previous versions of this report presented information on the quality of care received by people with Medicare nationwide based on data reported in 2017, 2018, and 2019. Because of the coronavirus disease 2019 (COVID-19) pandemic, the MA CAHPS survey was not fielded in 2020; likewise, HEDIS data were not gathered from (i.e., reported by) MA plans in that year. Thus, this report resumes this series of reports with a focus on data reported in 2021.

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

Rural-Urban Disparities in Health Care in Medicare

With just one exception, MA enrollees living in rural and urban areas had CAHPS survey scores that were similar to the national average for all MA enrollees (see Figure 1).[2] The exception pertained to the flu vaccination rate for rural MA enrollees, which was below the national average for all MA enrollees. This same pattern was evident among people with Medicare FFS coverage.

Across all 36 measures of clinical care, MA enrollees living in urban areas had results that were similar to the national average for all MA enrollees (see Figure 2). In contrast, MA enrollees living in rural areas had results that were below the national average for a quarter of all clinical care measures.[3] The largest differences were for (1) antidepressant medication management (a 4-percentage-point deficit for MA enrollees living in rural areas), (2) osteoporosis management in women who had a fracture (a 4-percentage-point deficit), and (3) a set of three measures pertaining to the avoidance of potential drug-disease interactions in elderly patients (4- to 6-percentage-point deficits).

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

Among those with FFS coverage, the overall pattern of rural and urban residents having CAHPS scores that were similar to the national average generally held across racial and ethnic groups (American Indian and Alaska Native [AI/AN], Asian American and Native Hawaiian or other Pacific Islander [AA and NHPI], Black, Hispanic, Multiracial, and White); however, this was less often the case in MA (see Figures 3 and 4). AA and NHPI MA enrollees living in rural areas had CAHPS scores that were above the national average for all AA and NHPI MA enrollees on 3 of 7 measures, while Hispanic MA enrollees living in rural areas had scores that were below the national average for all Hispanic MA enrollees for 2 of 7 measures; in each case, their counterparts living in urban areas had scores that were consistently similar to the national average for their group.

The overall pattern of urban residents having results on clinical care measures that were similar to the national average and rural residents often having results that were below the national average was evident among AA and NHPI, Black, and White MA enrollees (see Figure 5). A different pattern emerged among AI/AN and Hispanic MA enrollees.[4]

AI/AN MA enrollees living in urban areas had results that were either similar to the national average for all AI/AN MA enrollees (86 percent of the time) or below that national average (14 percent of the time). In contrast, AI/AN MA enrollees living in rural areas had results that were above the national average for all AI/AN MA enrollees 43 percent of the time; otherwise, their results were similar to that national average. The measures on which AI/AN MA enrollees living in rural areas had results that were above

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

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

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

the national average are breast cancer screening, statin therapy for patients with atherosclerotic cardiovascular disease (ASCVD), adherence to statin therapy for patients with ASCVD and diabetes, follow-up care for people with high-risk multiple chronic conditions after an emergency department (ED) visit, and avoidance of overuse of opioids.[5]

The most complex pattern of rural-urban differences in clinical care was evident among Hispanic MA enrollees. In urban areas, there was a small set of measures on which Hispanic MA enrollees had results that were below the national average for all Hispanic MA enrollees and a small set of measures on which they had results that were above the national average. This divergent pattern was magnified in rural areas. In rural areas, Hispanic MA enrollees had results that were below the national average on more than 30 percent of all clinical care measures, and they had results that were above the national average on more than 30 percent of all measures. The measures on which Hispanic MA enrollees living in rural areas had results that were below the national average pertained to care for patients with ASCVD, chronic obstructive pulmonary disease (COPD), depression, alcohol or other drug (AOD) abuse or dependence, kidney disease, dementia, a history of falls, and multiple chronic conditions. The measures on which Hispanic MA enrollees living in rural areas had results that were above the national average pertained to care for patients with high blood pressure, diabetes, rheumatoid arthritis, osteoporosis (female enrollees), and behavioral health; they also included measures of preventive care, care coordination, avoidance of overuse of opioids, and access to care.

Racial and Ethnic Disparities in Health Care in Medicare Within Urban and Rural Areas

AI/AN, Black, Multiracial, and White MA enrollees frequently had CAHPS scores that were similar to the national average for all MA enrollees, regardless of whether they lived in urban or rural areas (see Figure 6). This was also the case among people with FFS coverage (see Figure 7). Findings for AA and NHPI and Hispanic people were more complex.

Although there are scale use issues that need to be considered when comparing AA and NHPI respondents to other respondents,[6] CAHPS scores for AA and NHPI MA enrollees were much more often below the national average for all MA enrollees living in urban areas than they were below the national average for all MA enrollees living in rural areas. This divergence in findings between urban and rural areas was not as evident among AA and NHPI people with FFS coverage. In urban areas, AA and NHPI people with FFS coverage had CAHPS scores that were below the national average for all people with

[5] There were enough data from AI/AN MA enrollees to compare scores for those living in urban and rural areas to the national average for all AI/AN MA enrollees on only 14 of the 36 clinical care measures.
Although avoiding overuse of services is generally considered a positive quality outcome, some authors have suggested that, in the AI/AN population, it may instead be yet another signal of the substantial access barriers that this population is known to face (Martino et al., 2022).

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

FFS coverage on 3 of 7 measures; in rural areas, AA and NHPI people with FFS coverage had CAHPS scores that were below the national average for all people with FFS coverage on 3 of 5 measures.[7]

Regardless of coverage type, CAHPS scores for Hispanic people living in urban areas were often similar to the national average for all people living in urban areas, whereas CAHPS scores for Hispanic people living in rural areas were often below the national average for all people living in rural areas.

AI/AN MA enrollees had clinical care results that were below the national average much less often in rural areas than in urban areas (see Figure 8). For AA and NHPI MA enrollees, the opposite pattern emerged: AA and NHPI MA enrollees had clinical care results that were above the national average 3.5 times as often in urban areas as in rural areas. For Black MA enrollees, place of residence mattered less often as a possible driver of the quality of clinical care; regardless of place of residence, Black MA enrollees had results that were below the national average on more than a third of all clinical care measures and above the national average on just a few measures. Whereas in urban areas White MA enrollees had clinical care results that were similar to the national average for all urban residents on almost every measure, in rural areas, clinical care results for White MA enrollees were more mixed. Clinical care results for Hispanic MA enrollees were both more often above the national average and more often below the national average in rural than in urban areas.

Conclusion

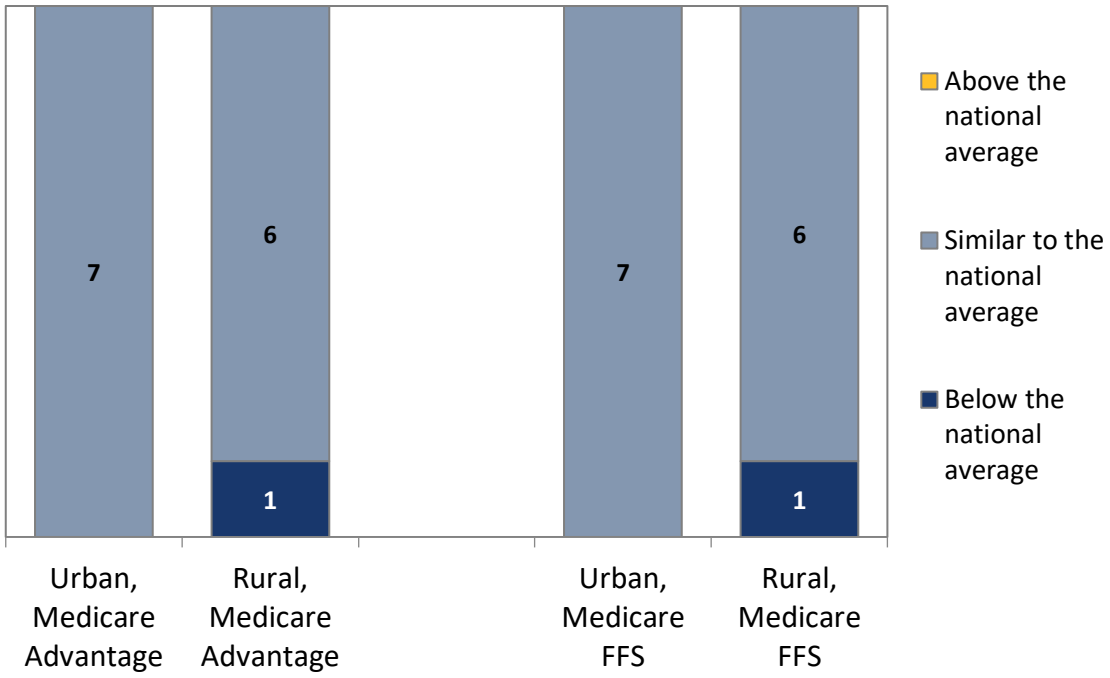
Overall, this analysis found that people with Medicare living in rural and urban areas had experiences with care that were similar to the national average. In the area of clinical care, MA enrollees living in rural areas were found to have results that were below the national average for a quarter of all measures examined. This analysis also identified noteworthy variation in patterns of rural-urban differences by race and ethnicity. For example, AA and NHPI MA enrollees living in rural areas had CAHPS scores that were above the national average for all AA and NHPI MA enrollees on 3 of 7 measures, whereas AA and NHPI MA enrollees living in urban areas had CAHPS scores that were consistently similar to the national average for all AA and NHPI MA enrollees. These patterns were not evident in FFS data, suggesting that there may be a plan role in generating these positive findings. In the area of clinical care, this analysis found that AI/AN MA enrollees living in rural areas had results that were above the national average for all AI/AN MA enrollees on nearly half of the measures for which this group met sample size requirements. This may suggest fundamental differences in quality and access to care in the places where rural and urban AI/AN people receive care. Finally, this analysis uncovered noteworthy variation in racial and ethnic differences when looking separately within rural and urban areas. For example, CAHPS scores for AA and NHPI MA enrollees were much more often below the national average for all MA enrollees living in urban areas than they were below the national average for all MA enrollees living in rural areas. This divergence in findings between urban and rural areas was not as evident among AA and NHPI people with FFS coverage, again suggesting a positive role for plans in the experiences of AA and NHPI people with Medicare living in rural areas. In contrast, CAHPS scores for Hispanic people with Medicare living in rural areas were generally below the national average for all people with Medicare living in rural areas, while scores for Hispanic people with Medicare living in urban areas were generally similar to the national average for all people with Medicare living in urban areas. These patterns applied to people with both MA and FFS coverage, suggesting that there

[7] There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare their scores on two measures with scores for all AA and NHPI people with FFS coverage living in rural areas.

may be some barriers to positive patient experience (e.g., a lack of language services) that affect many Hispanic people with Medicare in rural areas.

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

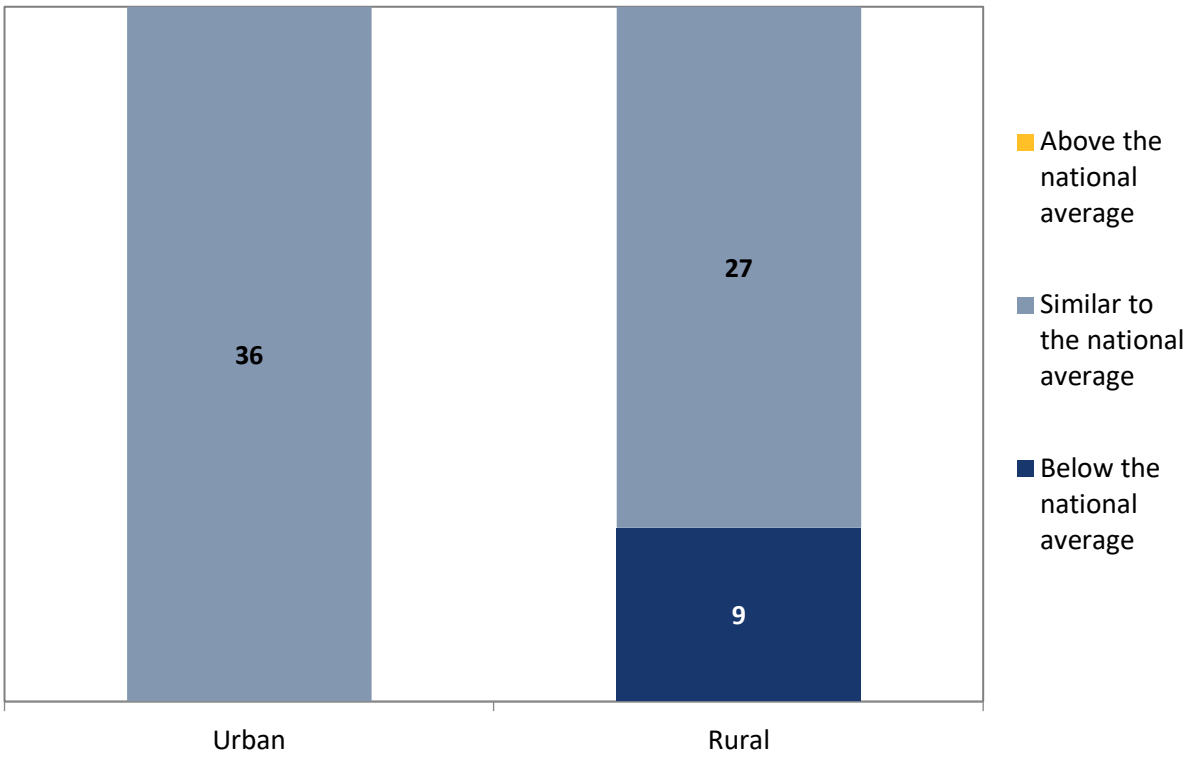
Number of patient experience measures (out of 7) for which rural and urban residents reported experiences that were above, similar to, or below the national average in 2021



SOURCE: This chart summarizes data from all MA enrollees and people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

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

Number of clinical care measures (out of 36) for which rural and urban residents had results that were above, similar to, or below the national average in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide. Clinical quality data are not available for people with Medicare FFS coverage.

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

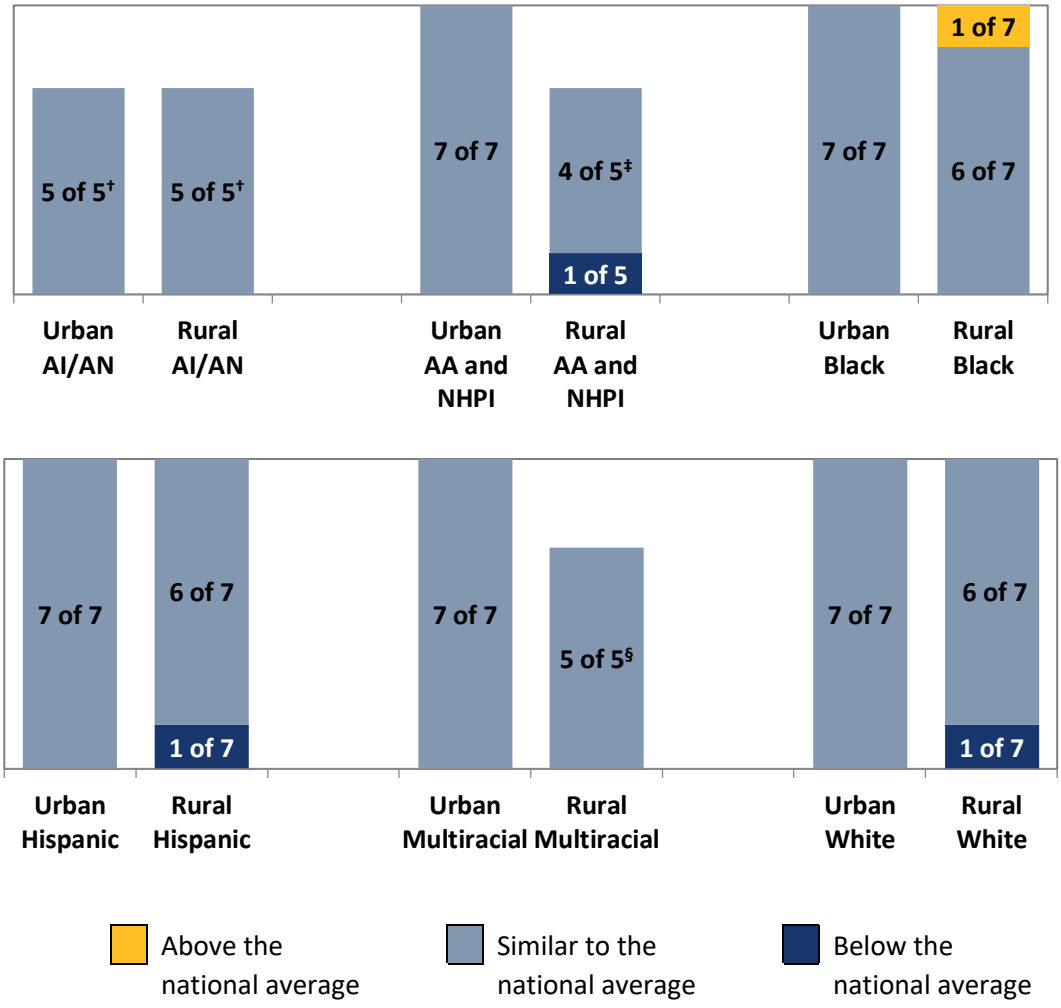
Figure 3. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures, Medicare Advantage

Number of patient experience measures (out of 7) for which urban or rural MA enrollees reported experiences that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity in 2021

SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2021 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

Number of patient experience measures for which urban or rural residents with Medicare FFS coverage reported experiences that were above, similar to, or below the national average for all people with Medicare FFS coverage of the same race or ethnicity in 2021



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

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

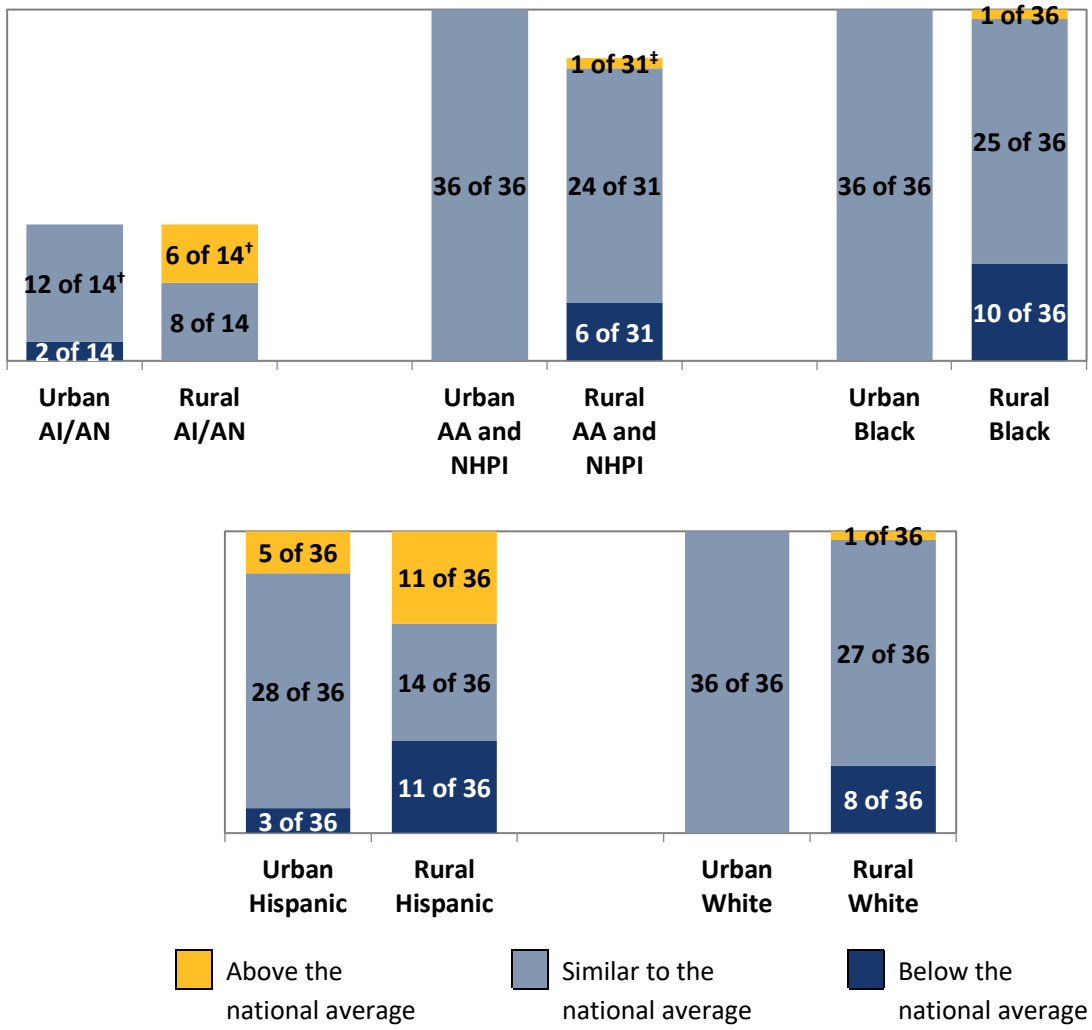
† There were not enough data from AI/AN people with FFS coverage living in urban areas to compare this group to the national average for all AI/AN people with FFS coverage on two patient experience measures. There were also not enough data from AI/AN people with FFS coverage living in rural areas to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

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

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

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

Number of clinical care measures for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care data stratified by race and ethnicity, racial and ethnic group membership is estimated using a method that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when their accuracy does not meet standards described on pp. 4–5. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

† There were not enough data from AI/AN MA enrollees living in urban areas to compare this group to the national average for all AI/AN MA enrollees on 22 clinical care measures. There were also not enough data from AI/AN MA enrollees living in rural areas to compare this group to the national average for all AI/AN MA enrollees on the same 22 measures.

‡ There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group to the national average for all AA and NHPI MA enrollees on five clinical care measures.

Figure 6. Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Medicare Advantage

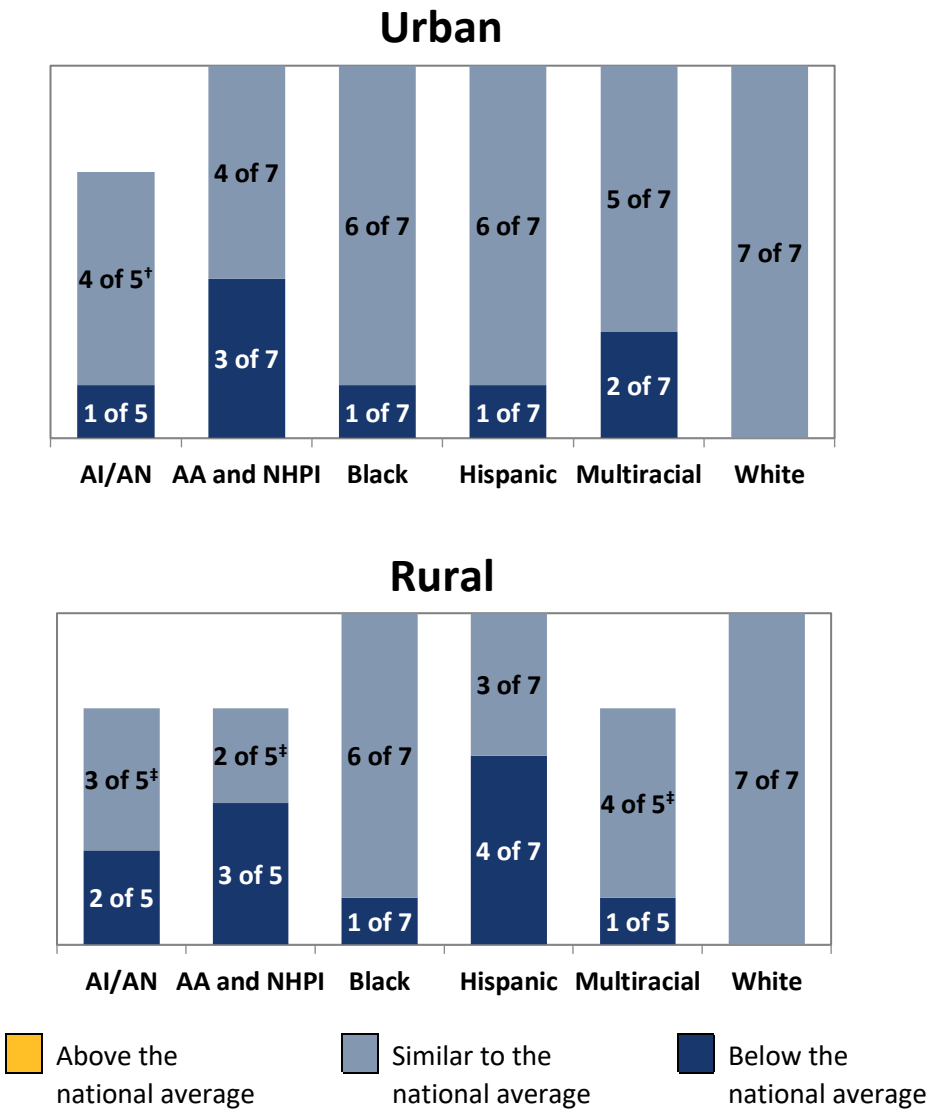
Number of patient experience measures (out of 7) for which MA enrollees of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all MA enrollees living in the same type of area (urban or rural) in 2021

SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2021 Medicare CAHPS survey.

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

Figure 7. Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Medicare FFS

Number of patient experience measures for which people with Medicare FFS coverage from selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all people with Medicare FFS coverage living in the same type of area (urban or rural) in 2021



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

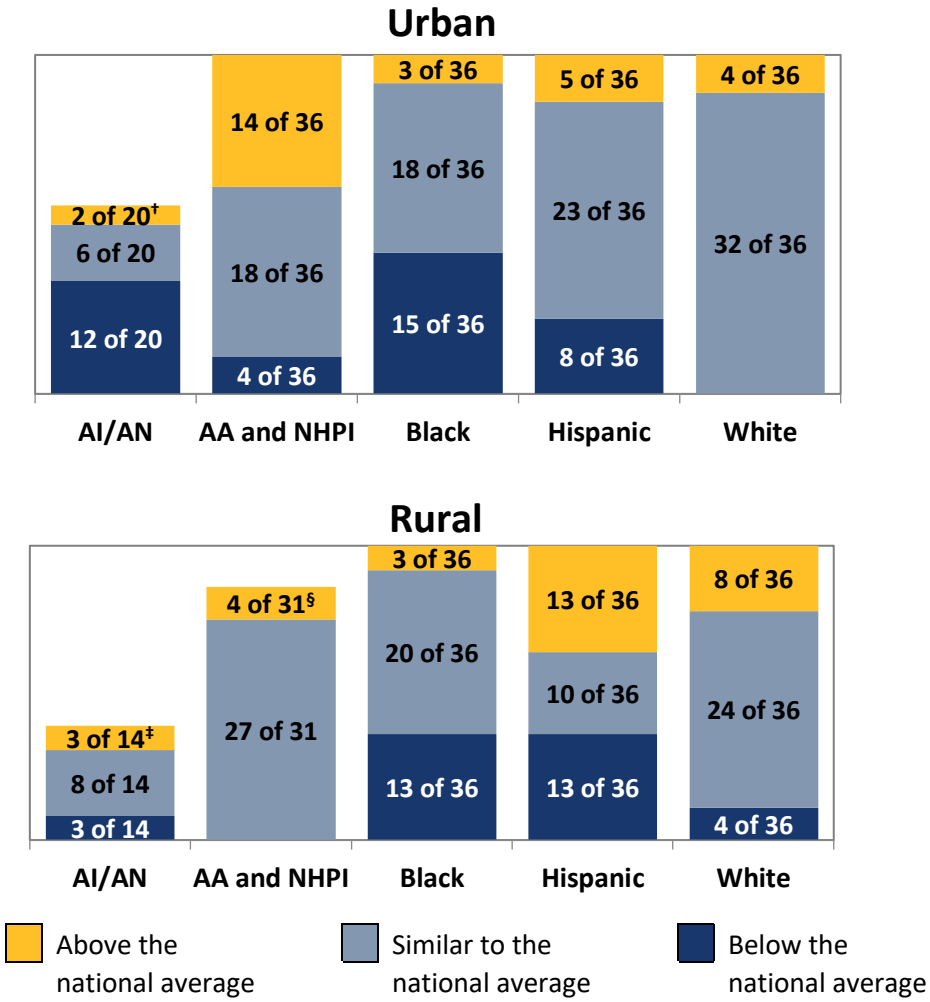
NOTES: AI/AN = American Indian or Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

† There were not enough data from AI/AN people with FFS coverage living in urban areas to compare their scores on two measures to scores for all people with FFS coverage living in urban areas.

‡ There were not enough data from AI/AN, AA and NHPI, or Multiracial people with FFS coverage living in rural areas to compare their scores on two measures to scores for all people with FFS coverage living in rural areas.

Figure 8. Rural-Urban Disparities in Care in Medicare Advantage by Racial and Ethnic Group: All Clinical Care Measures

Number of clinical care measures for which MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all MA enrollees living in the same type of area (urban or rural) in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian or Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet standards described on pp. 4–5. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

† There were not enough data from AI/AN MA enrollees living in urban areas to compare their scores on 16 measures to scores for all people living in urban areas.
‡ There were not enough data from AI/AN MA enrollees living in rural areas to compare their scores on 22 measures to scores for all people living in rural areas.
§ There were not enough data from AA and NHPI people living in rural areas to compare their scores on five measures to scores for all people living in rural areas.

Patient Experience and Clinical Care Measures Included in This Report[1]

Patient Experience (CAHPS) Measures

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Doctors Who Communicate Well
- Care Coordination
- Getting Needed Prescription Drugs
- Annual Flu Vaccine[2]

Clinical Care (HEDIS) Measures

Prevention and Screening

- Breast Cancer Screening
- Colorectal Cancer Screening

Respiratory Conditions

- Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Cardiovascular Conditions

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

[1] This report considers all HEDIS measures that meet the measurement criteria and are not limited to the measures used in the CMS Part C and D Star Ratings program.

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

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 and Other Drug Dependence Treatment
- Engagement of Alcohol and Other Drug Dependence Treatment

Medication Management and Care Coordination

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

Overuse and Appropriate Use of Medications

- 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 Opioids from Multiple Prescribers
- Avoiding Use of Opioids from Multiple Pharmacies

Access to and Availability of Care

- Older Adults' Access to Preventive and Ambulatory Services

Abbreviations Used in This Report

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

Overview, Methods, and Summary of Results

Overview

This report presents summary information on the quality of health care received by people with Medicare nationwide, as reported in 2021. Two types of quality-of-care data are presented: (1) measures of patient experience, which describe how well the care that patients receive meets their needs for such things as timely appointments, respectful care, clear communication, and access to information; and (2) measures of clinical care, which describe the extent to which patients receive appropriate screening and treatment for specific health conditions.

Previous versions of this report, which are available on the Stratified Reporting page at CMS.gov (Centers for Medicare & Medicaid Services [CMS], 2022), presented information on the quality of care received by people with Medicare nationwide based on data reported in 2017, 2018, and 2019.

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

Given these prior findings, three sets of comparisons are presented in this report. In the first set, quality of care for rural and urban residents is compared with quality of care for all people with the same type of Medicare coverage (i.e., the national average for people with that coverage type), either Medicare Advantage (MA) or Medicare Fee-for-Service (FFS). In the second set of comparisons, quality of care for rural and urban residents is compared with the national average for people of the same racial or ethnic group. In the third set, quality of care for racial and ethnic groups is compared with quality of care for all MA enrollees or people with FFS coverage living in the same type of area (i.e., either rural or urban).

Use of the national average as a reference point is a departure from past reports in this series. Prior reports used urban residents (the larger and historically advantaged group) as the reference point for comparisons by rurality, and White people (the largest and historically advantaged group) as the reference point for comparisons by race and ethnicity. There are potential advantages of using the national average as a reference point rather than using the score for the largest or historically advantaged group. First, using the largest or historically advantaged group as a reference point might inappropriately suggest that care for that group is normative or typical of care for all. Second, using the national average as a reference point allows for the investigation of all groups, including the largest or historically advantaged group. As in the 2018–2020 reports, the three sets of comparisons just described—which might be of interest to people with Medicare, MA organizations, Medicare Part D sponsors, and federal policymakers—are being presented in a single report to provide a comprehensive understanding of the ways in which care differs by rurality, race/ethnicity, and the intersection of these characteristics. The focus of this report is on differences at the national level. Interested readers can find information about health care quality for specific Medicare plans (more specifically, contracts) at

Medicare.gov (Medicare.gov, undated) and information about racial and ethnic differences in health care quality within Medicare plans on the Stratified Reporting page at CMS.gov (CMS, 2022).

Data Sources

In all, this report provides data regarding seven patient experience measures and 36 clinical care measures. The set of patient experience measures presented in this report is the same as the set reported on in the 2018–2020 reports (reporting 2017–2019 data). Three clinical care measures that were included in the 2020 report were excluded from this report because they were retired from the Healthcare Effectiveness Data and Information Set (HEDIS) beginning with Measurement Year 2021. The excluded measures are Adult Body Mass Index, Avoiding Use of High-Risk Medications in the Elderly, and Avoiding Use of Opioids at High Dosage.

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

Clinical care data were gathered through medical records and insurance claims or encounter data for hospitalizations, medical office visits, and procedures. These data, which are collected each year from MA plans nationwide, are part of HEDIS; detailed information about these data can be found on the National Committee for Quality Assurance's HEDIS webpage (National Committee for Quality Assurance, undated). In this report, clinical care measures are grouped into nine categories: prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse and appropriate use of medications, and access to and availability of care. The 2021 HEDIS data reported here pertain to care received from January to December 2020. Whereas all patient experience measures are applicable to people with Medicare aged 18 years and older, certain HEDIS measures apply to people in a more limited age range, as noted throughout the report.

Whereas CAHPS surveys are administered to both MA plan enrollees and people with Medicare FFS, most of the HEDIS measures presented in this report are available only for those enrolled in MA plans. Thus, in this report, comparisons on CAHPS measures are presented for both MA enrollees and people with FFS coverage, while comparisons on HEDIS measures are presented only for MA enrollees.

People were classified as living in a rural or urban area based on the ZIP code of their mailing address and the corresponding U.S. Census Bureau core-based statistical area (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 with a population of 50,000 or more. Micropolitan statistical areas contain a core urban area with a population of at least 10,000 but less than 50,000. For this report, anyone living within a

metropolitan division or metropolitan statistical area was classified as an urban resident; anyone residing in a micropolitan statistical area or outside a CBSA was classified as a rural resident. By this definition, 15.7 percent (approximately 3.3 million) of MA enrollees and 20.6 percent (approximately 6.5 million) of people with FFS coverage were rural residents in 2021. Of all people with Medicare residing in rural areas in 2021, 34.0 percent were enrolled in MA; of those residing in urban areas, 41.8 percent were enrolled in MA.

The 2021 CAHPS survey asked respondents to report their race and ethnicity. This information was used to classify respondents into one of seven mutually exclusive categories: American Indian and Alaska Native (AI/AN), Asian American and Native Hawaiian or other Pacific Islander (AA and NHPI), Black, Hispanic, Multiracial, White, or unknown. The appendix provides detail on the survey questions and classification scheme. Unknown cases were dropped from the analysis. HEDIS data, unlike CAHPS data, do not contain the patient's self-reported race and ethnicity. Therefore, we imputed race and ethnicity for the HEDIS data using a methodology that combines information from administrative data, first and last name, and residential location (Haas et al., 2019). Scores on patient experience measures are reported for each of the six racial and ethnic groups named above whenever the reporting criteria specified below are met. This is the first time in this series of reports that patient experience data are being reported for Multiracial people. Scores on clinical care measures are reported for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees whenever the reporting criteria specified below are met. This is the first time in this series of reports that clinical care data are being reported for AI/AN people. Recent improvements to the algorithm used to predict racial and ethnic group membership for the clinical care data have made this possible.[10] Estimates of membership in the Multiracial group are still not accurate enough to permit reporting of clinical care scores for this group. In 2021, AA and NHPI, Black, Hispanic, and Multiracial people with Medicare were more likely to be enrolled in MA than were AI/AN and White people with Medicare. In particular, whereas about half of AA and NHPI (44.3 percent), Black (48.3 percent), Hispanic (56.2 percent), and Multiracial (45.0 percent) people with Medicare were enrolled in MA, only about a quarter of AI/AN people with Medicare (25.8 percent) and a third of White people with Medicare (36.9 percent) were enrolled in MA.

Reportability of Information

Scores based on 400 or more observations were considered sufficiently precise for reporting patient experience and clinical care scores for rural and urban residents; they are also considered sufficiently precise for reporting patient experience scores for all racial and ethnic groups and for reporting clinical care scores for AA and NHPI, Black, Hispanic, and White MA enrollees. Scores based on more than 99 but fewer than 400 observations were considered low in precision and were flagged as such.[11] Flagged scores—which should be regarded as tentative information—are shown unbolded with a superscript symbol appended; the symbol links to a note at the bottom of the chart that cautions about the precision of the score. Scores based on 99 or fewer observations are suppressed (i.e., not reported). When a score is suppressed for a particular group, a note at the bottom of the relevant chart states that there were not enough data from that group to make a racial and ethnic comparison on the measure. The algorithm used to predict AI/AN group membership for the clinical care data—although adequate in many cases—is not as good as it is for predicting membership in other racial or ethnic groups.

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

[11] A sample size of 400 ensures that the margin of error for a dichotomous measure is no greater than 5 percent. With a sample size of 100, the maximum margin of error is 10 percent.

Accordingly, stricter criteria are required for reporting clinical care scores for AI/AN MA enrollees. Here, we required both a minimum sample size of 400 observations and that the standard error of the log-odds coefficient in a logistic regression model comparing AI/AN scores with the national mean be 0.25 or smaller (indicating adequate precision). Clinical care scores for AI/AN MA enrollees not meeting these stricter criteria are suppressed (i.e., not reported).

Rural-Urban Disparities in Health Care in Medicare

Section I of this report begins with a pair of stacked bar charts showing the number of patient experience measures for which rural and urban residents reported experiences of care that were above, similar to, or below the national average, separately for MA enrollees and people with FFS coverage. In these stacked bar charts, as in all stacked bar charts in this report, the focus is on practically significant differences (that is, differences that are statistically significant and exceed a magnitude threshold of 3 points). The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013). Following the pair of stacked bar charts are pairs of unstacked bar charts for each patient experience measure. These charts show the average scores (and associated 95-percent confidence intervals) for rural and urban residents on a 0–100 scale and indicate how each group's average score compares with the national average for people with the same Medicare coverage type (MA or FFS).[12] Scores on patient experience measures represent the percentage of the best possible score for a measure. For example, consider a measure for which the best possible score is 4 and the worst possible score is 1. If a given group's score on that measure is 3.5, then that group's score on a 0–100 scale is ([3.5−1] / [4−1]) × 100 = 83.3. In the unstacked bar charts, all differences from the national average that are statistically significant (regardless of magnitude) are indicated through the use of symbols.[13] In the bullet-point summaries that appear below these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically significant differences that are 3 points in magnitude or larger. After the patient experience measures, Section I presents a stacked bar chart showing the number of clinical care measures for which rural and urban MA enrollees scored above, similar to, or below the national average for all MA enrollees (again, focusing on practically significant differences). Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure that show the percentages (and associated 95-percent confidence intervals) of rural and urban MA enrollees whose care met the standard called for by the specific measure (e.g., a test or treatment). In these unstacked bar charts, all differences from the national average that are statistically significant (regardless of magnitude) are indicated through the use of symbols; statistically significant differences that are less than 3 points in magnitude are distinguished—via bullet-point commentary—from statistically significant differences that are 3 points in magnitude or larger.

[12] In Section I, the charts for individual patient experience measures show data for urban and rural MA enrollees alongside data for urban and rural people with FFS coverage. Bars for urban and rural MA enrollees are colored a darker blue and darker gray, whereas bars for urban and rural people with FFS coverage are colored a lighter blue and lighter gray. That same coloring scheme is carried forward to Sections II and III, even though in those sections, MA and FFS CAHPS data are displayed in separate charts.

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

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

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

Racial and Ethnic Disparities in Health Care in Medicare Within Urban and Rural Areas

Section III of the report begins with a pair of stacked bar charts that show, separately for rural and urban MA enrollees, the number of patient experience measures for which members of each racial and ethnic group reported experiences of care that were above, similar to, or below the national average for all MA enrollees who live in the same type of area (rural or urban). Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for rural and urban MA enrollees, the average score for each racial and ethnic group on a 0–100 scale and indicate how each group's average score compares with the national average for all MA enrollees who live in the same type of area. Comparable information on the patient experiences of different racial and ethnic groups living in rural and urban areas is then presented for people with FFS coverage. After the patient experience measures, Section III presents a pair of stacked bar charts that show, separately for rural and urban MA enrollees, the number of clinical care measures for which members of each racial and ethnic group scored above, similar to, or below the national average for all MA enrollees who live in the same type of area. Following these stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for rural and MA enrollees, the percentage of enrollees in each racial and ethnic group whose care met the standard called for by the specific measure.

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

Summary of Results and Conclusions

Overall, this analysis found that people with Medicare living in rural and urban areas had experiences with care that were similar to the national average. In the area of clinical care, MA enrollees living in rural areas were found to have results that were below the national average for a quarter of all measures examined. In contrast, MA enrollees living in urban areas were found to have results that were similar to the national average for all clinical care measures. This analysis also identified

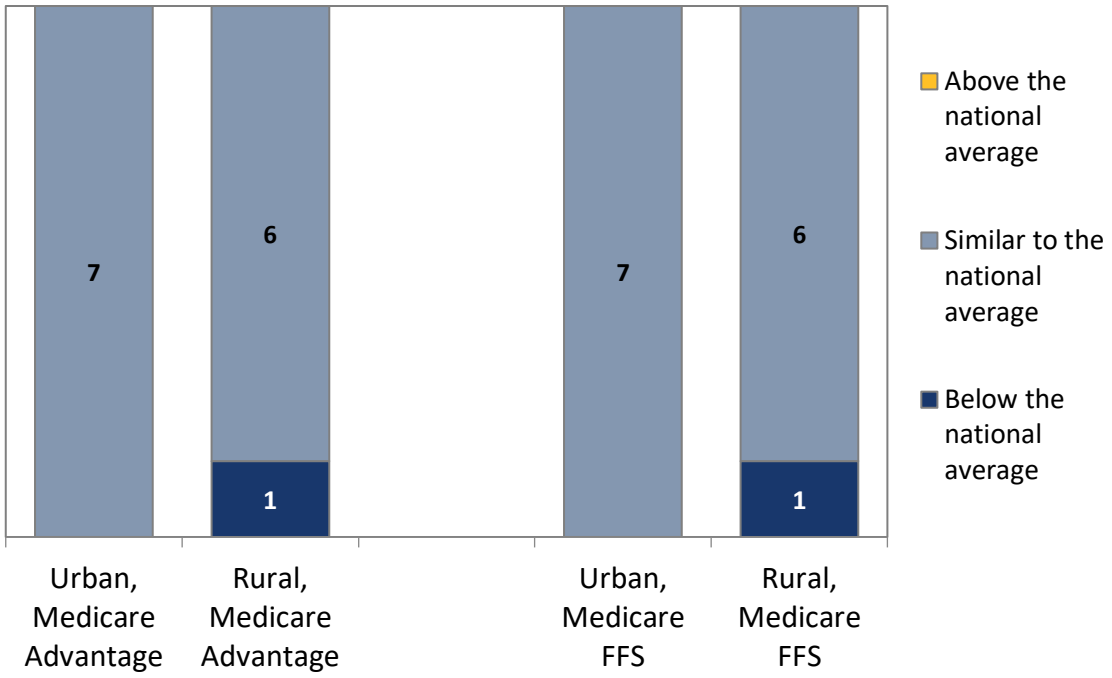
noteworthy variation in patterns of rural-urban differences by race and ethnicity. For example, AA and NHPI MA enrollees living in rural areas had CAHPS scores that were above the national average for all AA and NHPI MA enrollees on 3 of 7 measures, whereas AA and NHPI MA enrollees living in urban areas had CAHPS scores that were consistently similar to the national average for all AA and NHPI MA enrollees. These patterns were not evident in FFS data, suggesting that there may be a plan role in generating these positive findings. In the area of clinical care, this analysis found that AI/AN MA enrollees living in rural areas had results that were above the national average for all AI/AN MA enrollees on nearly half of the measures for which this group was reportable. This may suggest fundamental differences in quality and access to care in the places where rural and urban AI/AN people receive care. Finally, this analysis uncovered noteworthy variation in racial and ethnic differences when looking separately within rural and urban areas. For example, CAHPS scores for AA and NHPI MA enrollees were much more often below the national average for all MA enrollees living in urban areas than they were below the national average for all MA enrollees living in rural areas. This divergence in findings between urban and rural areas was not as evident among AA and NHPI people with FFS coverage, again suggesting a positive role for plans in the experiences of AA and NHPI people with Medicare living in rural areas. In contrast, CAHPS scores for Hispanic people with Medicare living in rural areas were generally below the national average for all people with Medicare living in rural areas, while scores for Hispanic people with Medicare living in urban areas were generally similar to the national average for all people with Medicare living in urban areas. These patterns applied to people with both MA and FFS coverage, suggesting that there may be some barriers to positive patient experience (e.g., a lack of language services) that affect many Hispanic people with Medicare in rural areas. In the cases where we have suggested that there may be a plan role in generating more positive patient experiences for historically disadvantaged groups, it may be the case that enrollees have benefitted from management and oversight functions provided by MA plans. It is also the case that quality bonus payments are made to MA plans by CMS to incentivize high-quality care to all members. This bonus payment system may also play a role in generating these findings. In any case, the different patterns of disparities in patient experience that exist in MA versus FFS warrant further investigation.

Section I:

Rural-Urban Disparities in Health Care in Medicare

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

Number of patient experience measures (out of 7) for which rural and urban residents reported experiences that were above, similar to, or below the national average in 2021



SOURCE: This chart summarizes data from all MA enrollees and people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

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

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

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

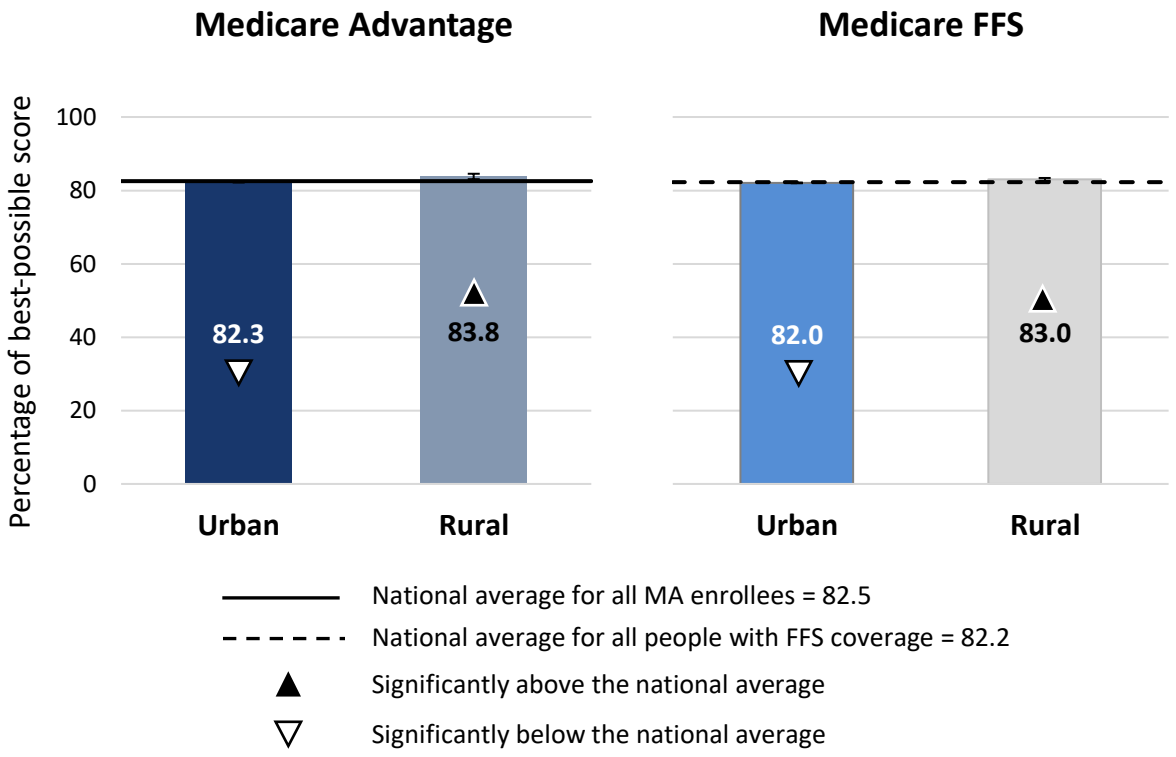
MA enrollees living in rural areas had results that were below the national average
• Annual Flu Vaccine

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

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

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

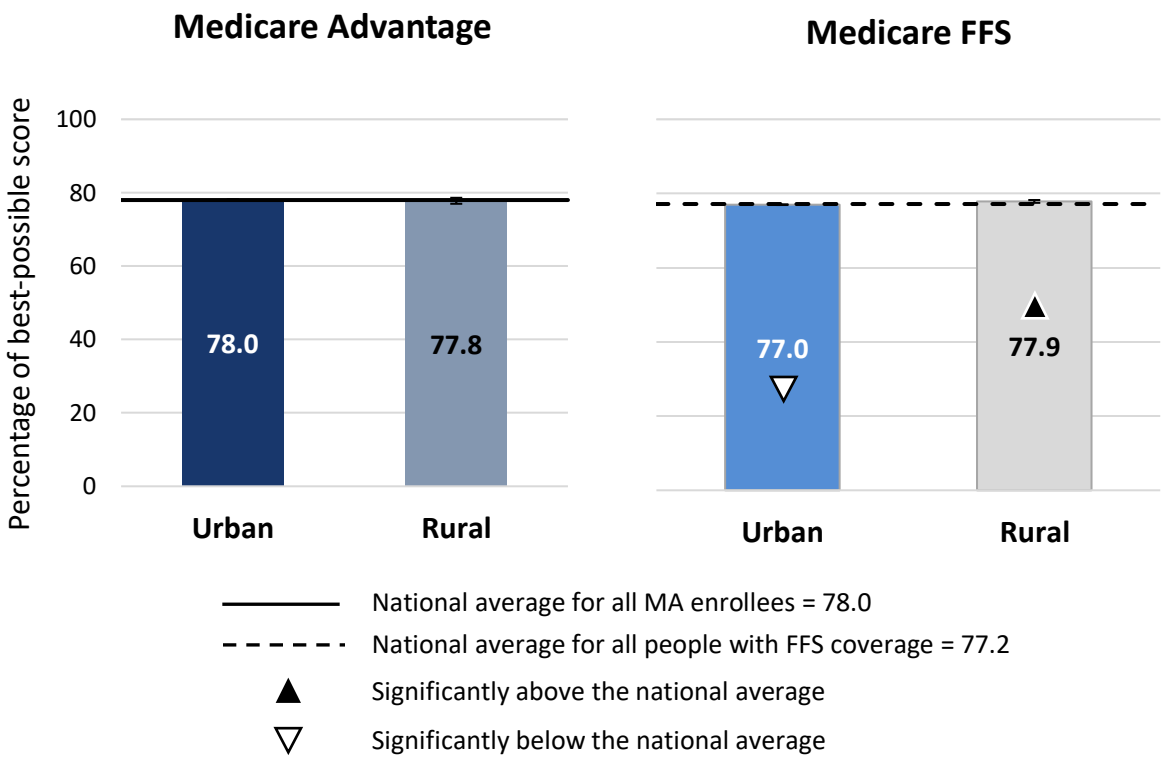
- People with FFS coverage living in urban areas reported experiences with getting needed care that were **below** the national average for all people with FFS coverage by less than 3 points on a 0–100 scale. People with FFS coverage living in rural areas reported experiences with getting needed care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

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

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

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

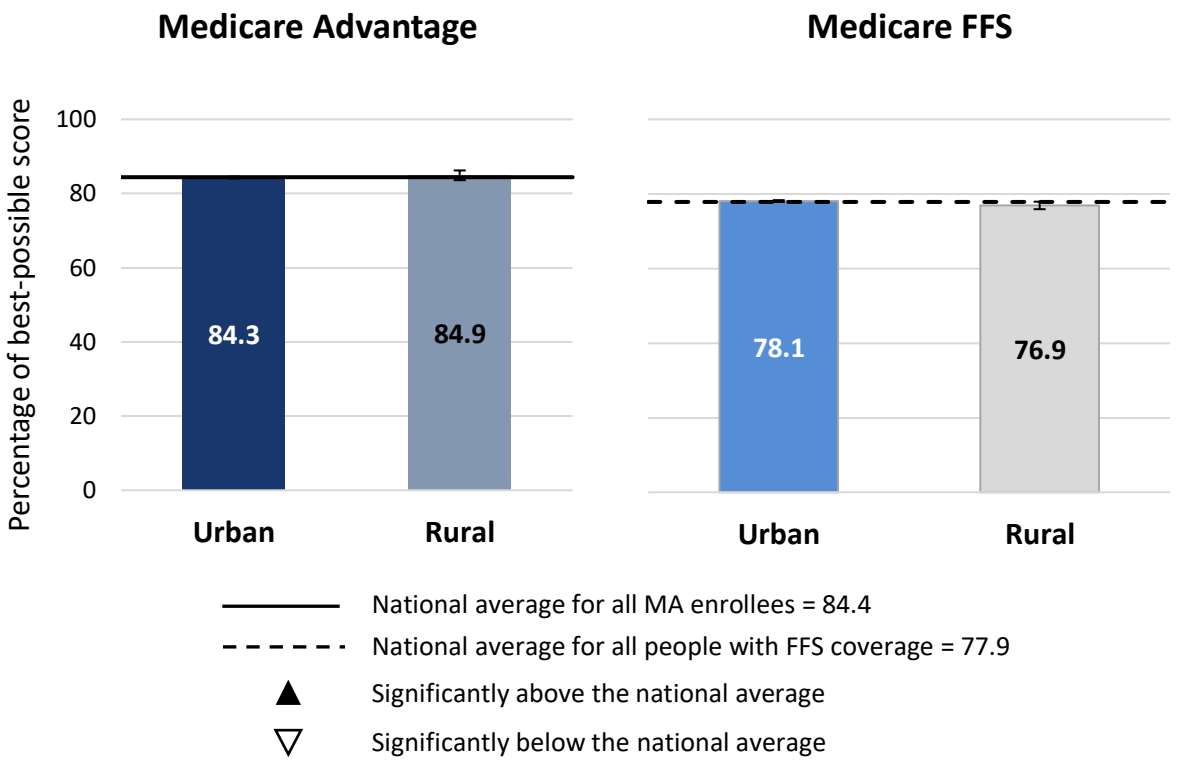
- MA enrollees living in urban areas reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with getting appointments and care quickly that were **similar to** the national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

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

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

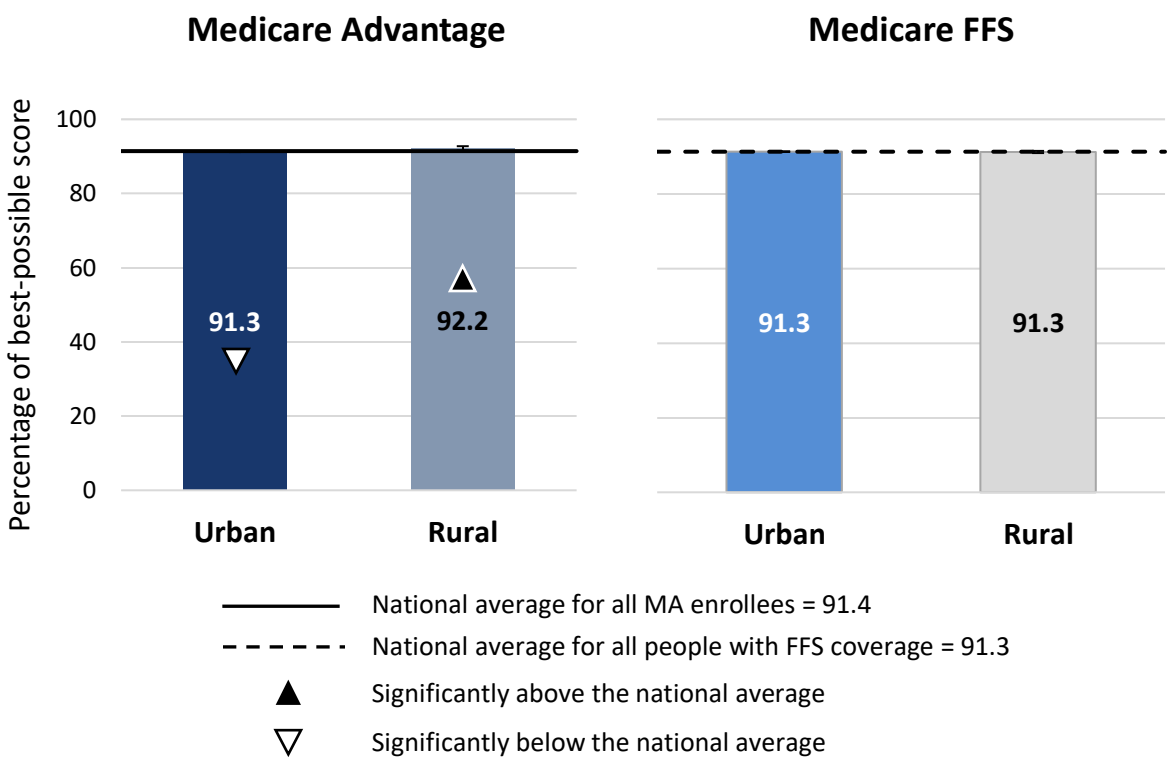
- MA enrollees living in urban areas reported experiences with customer service that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with customer service that were **similar to** the national average for all MA enrollees.

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

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

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

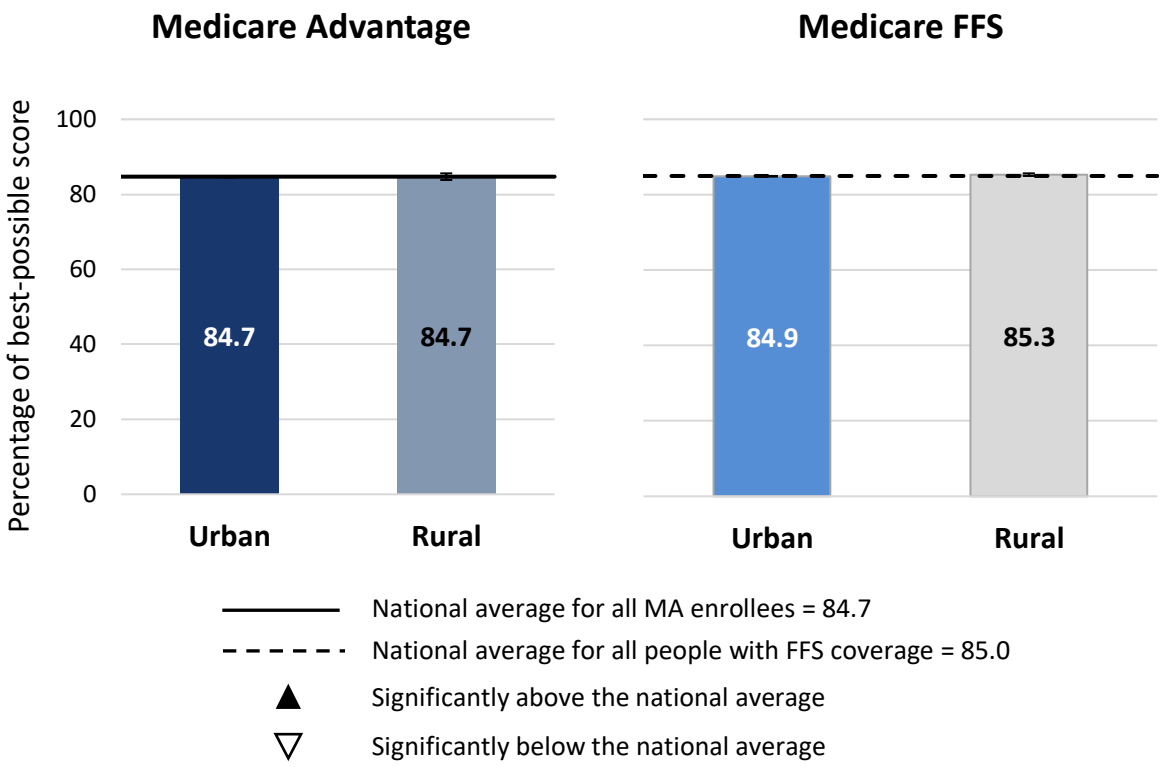
- MA enrollees living in urban areas reported experiences with doctor communication that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale. MA enrollees living in rural areas reported experiences with doctor communication that were **above** the national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

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

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

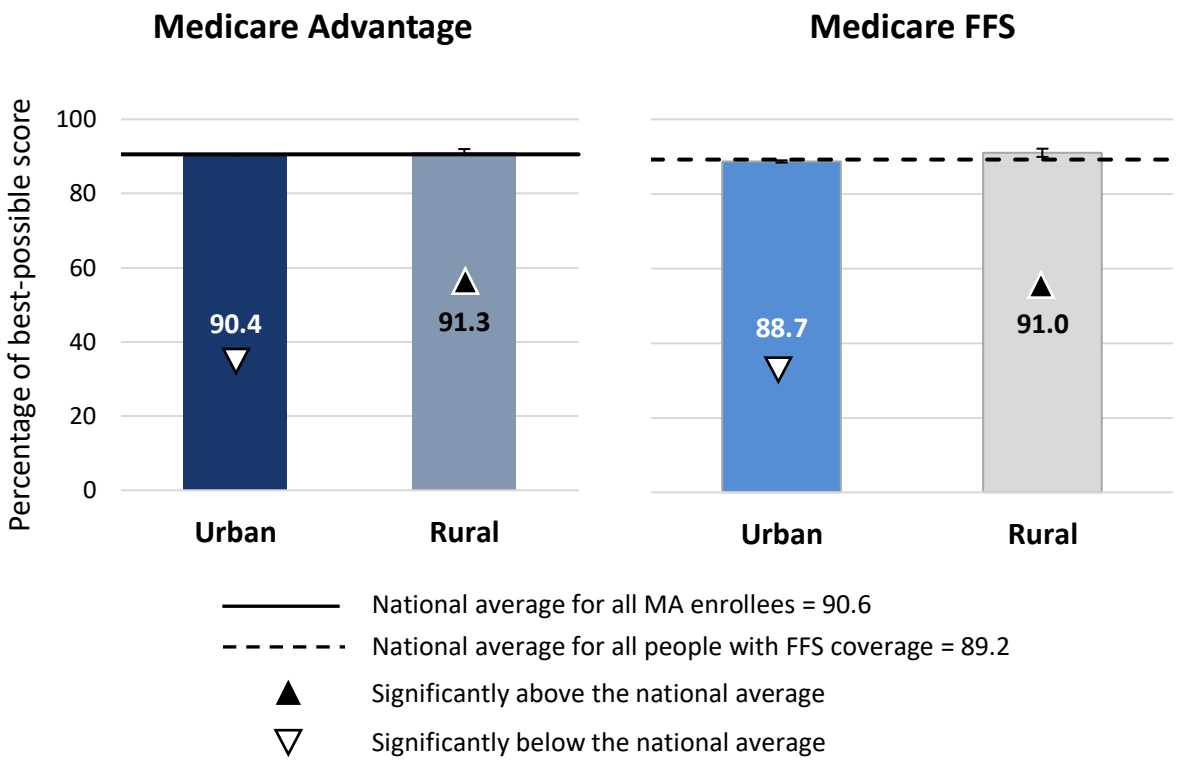
- MA enrollees living in urban areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees. MA enrollees living in rural areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees.

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

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,† by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

Disparities

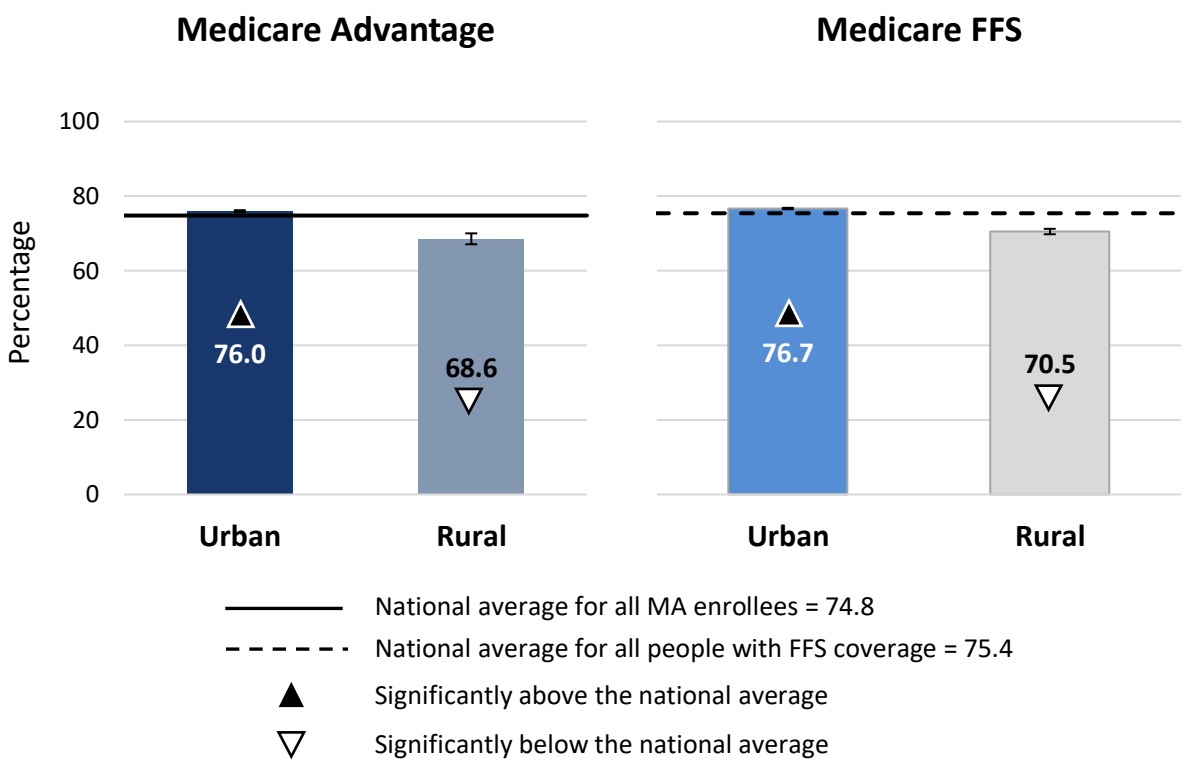
- MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale. MA enrollees living in rural areas reported experiences with getting needed prescription drugs that were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

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

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

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by geography within coverage type, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

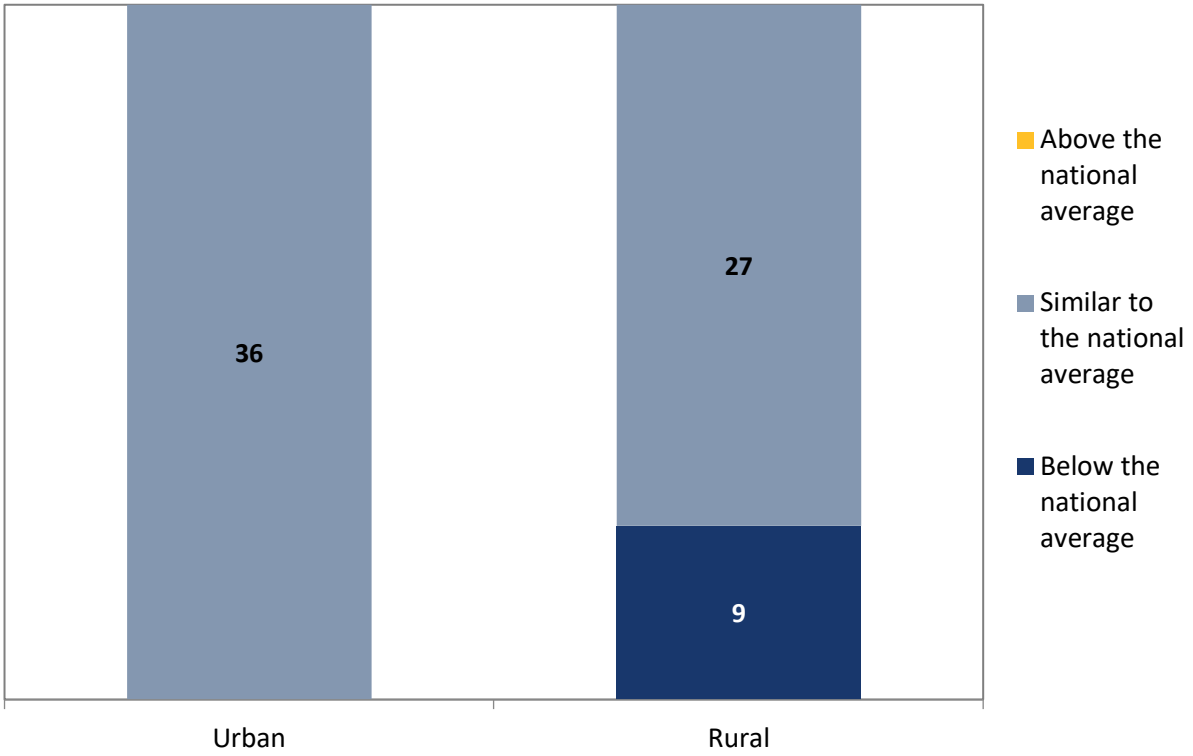
Disparities

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

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

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

Number of clinical care measures (out of 36) for which rural and urban residents had results that were above, similar to, or below the national average in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide. Clinical quality data are not available for people with Medicare FFS coverage.
NOTES: When only two groups are compared, scores for the larger group—in this case, MA enrollees living in urban areas—will always be closer to the overall (national) average than scores for the smaller group.

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

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

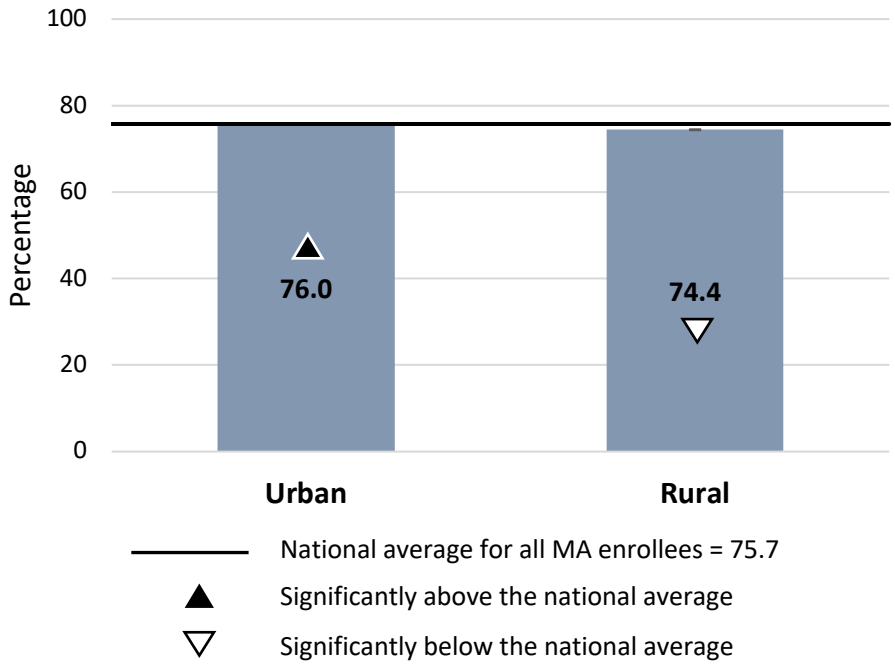
† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

MA enrollees living in rural areas had results that were below the national average
• Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD) • Osteoporosis Management in Women Who Had a Fracture • Antidepressant Medication Management—Acute Phase Treatment • Follow-Up After Emergency Department (ED) Visit for Mental Illness (within 30 days of discharge) • Initiation of Alcohol and Other Drug (AOD) Dependence Treatment • 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

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

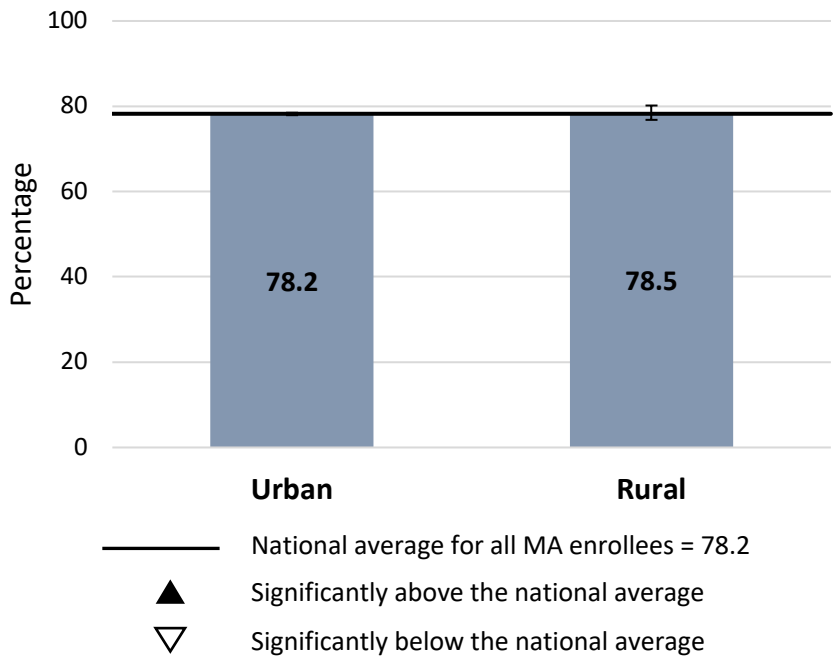
- The percentage of eligible female MA enrollees living in rural areas who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.

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

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

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

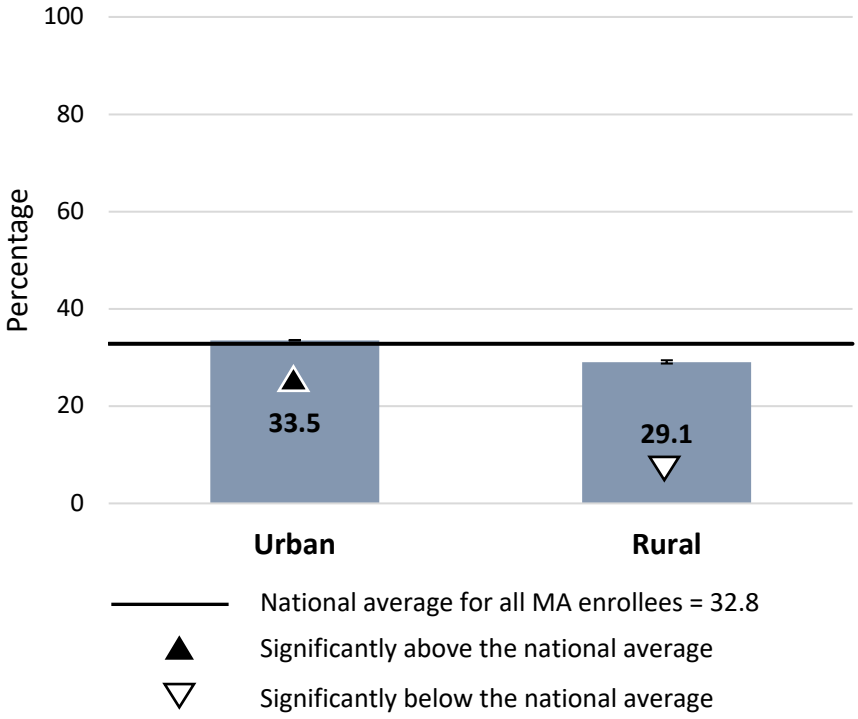
- The percentage of eligible MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **similar to** the national average for all eligible MA enrollees.

- The percentage of eligible MA enrollees living in rural areas who were appropriately screened for colorectal cancer was **similar to** the national average for all eligible MA enrollees.

Clinical Care: Respiratory Conditions

Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

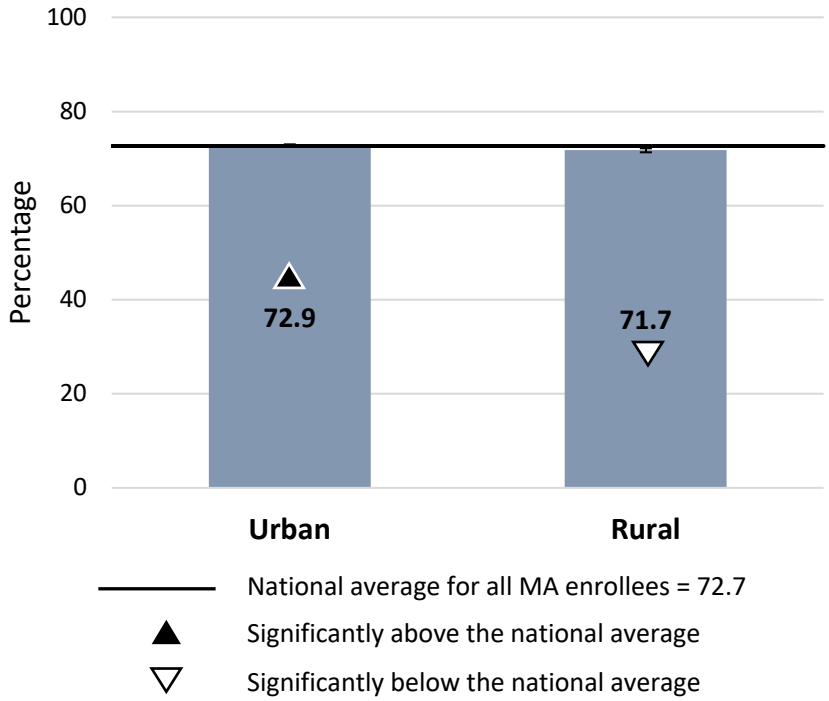
Disparities

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

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

Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department (ED) encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

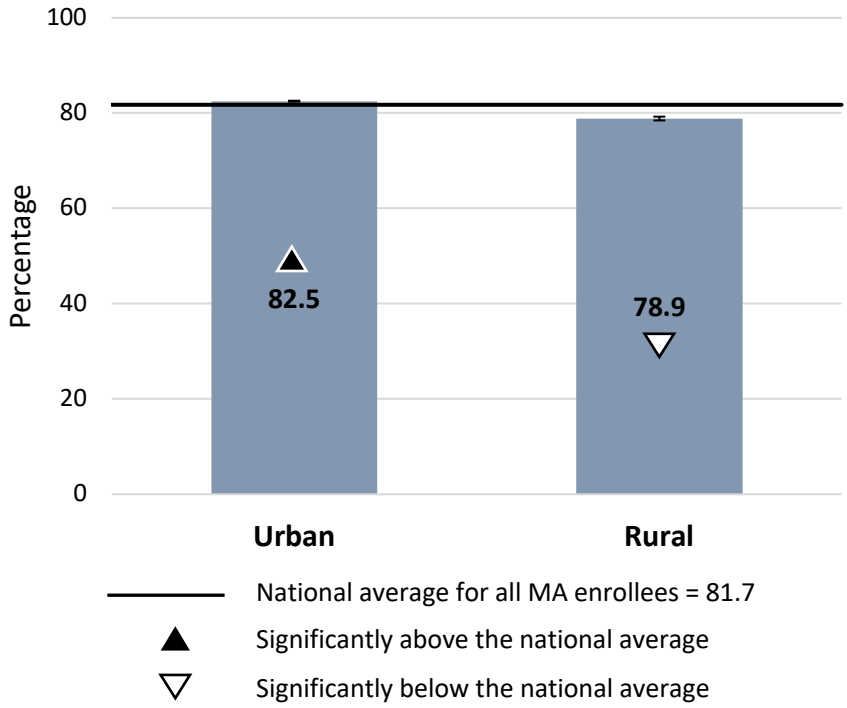
Disparities

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

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

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

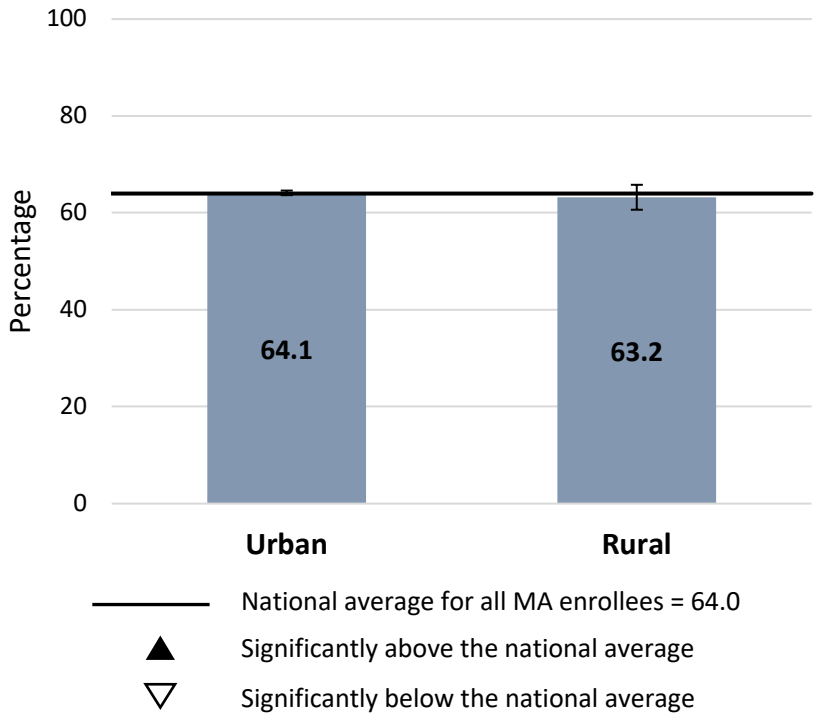
- The percentage of eligible MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

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

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

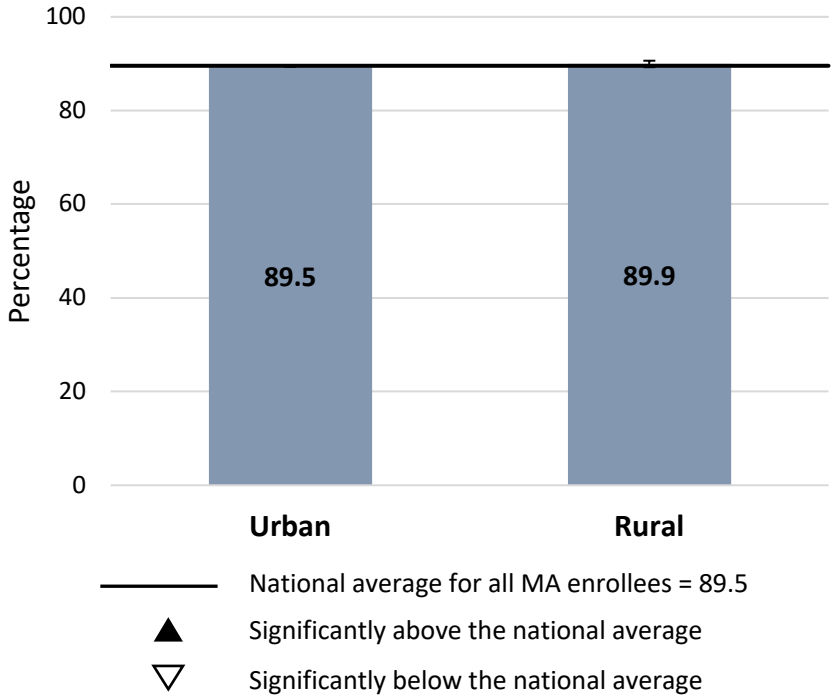
Disparities

- The percentage of eligible MA enrollees living in urban areas who had their blood pressure adequately controlled was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible MA enrollees living in rural areas who had their blood pressure adequately controlled was **similar to** the national average for all eligible MA enrollees.

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

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by geography, Reporting Year 2021



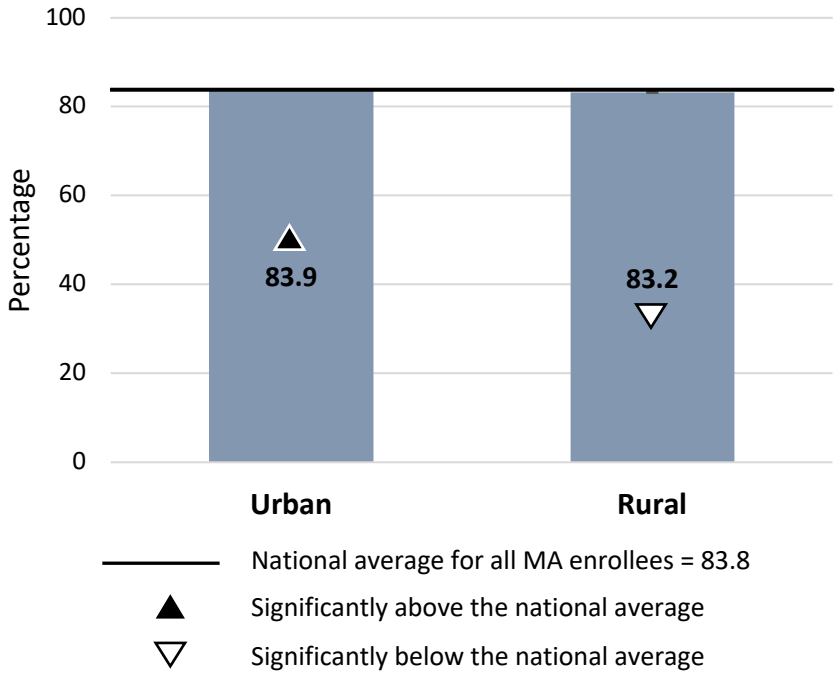
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by geography, Reporting Year 2021



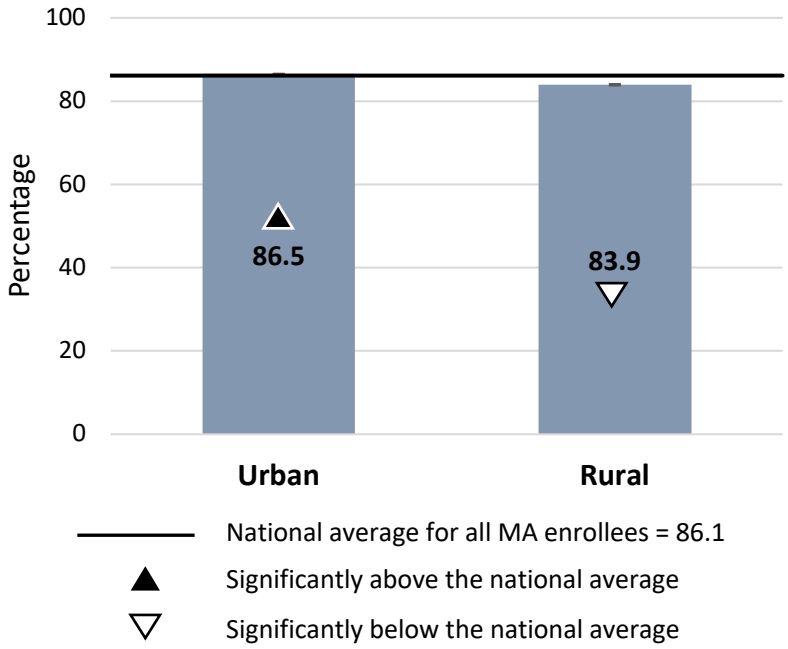
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication who remained on the medication for at least 80 percent of the treatment period, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

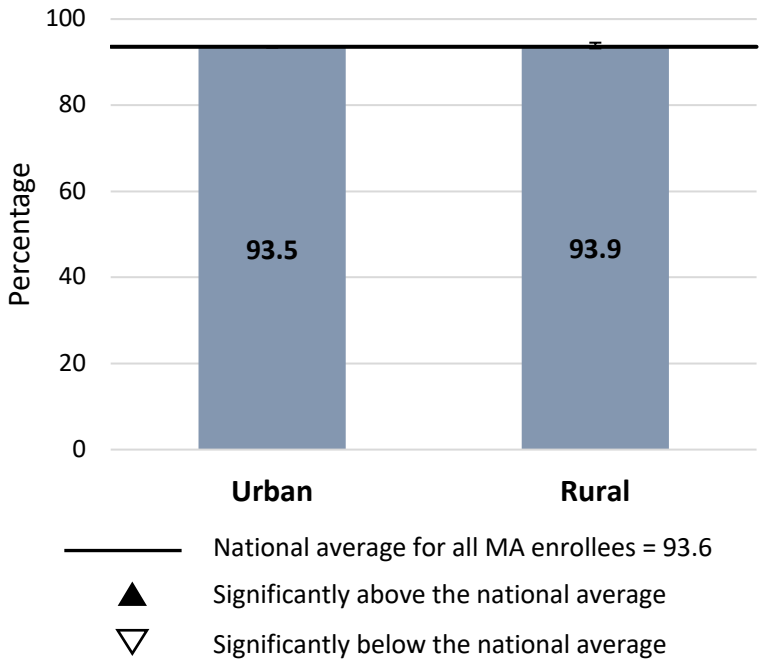
- The percentage of MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

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

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

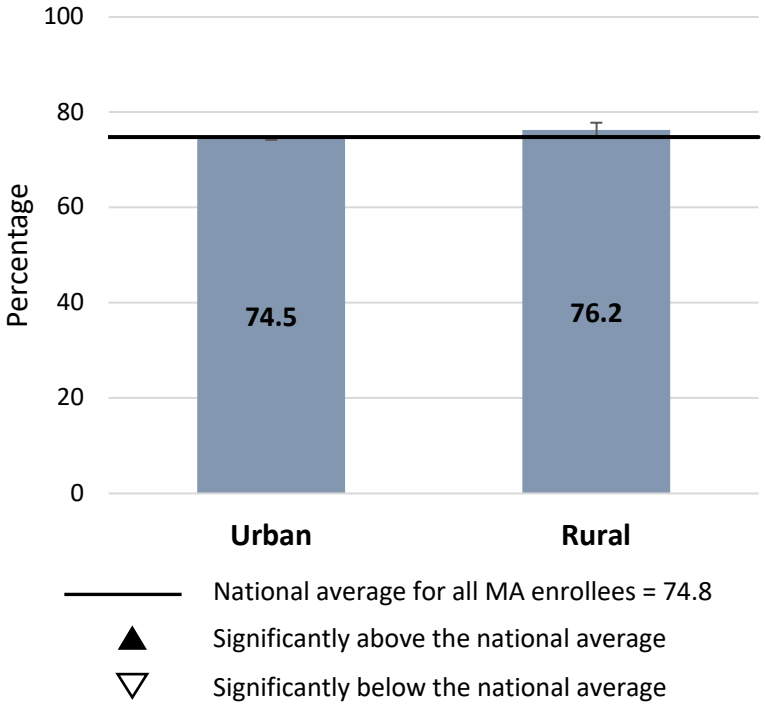
Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes.

- The percentage of MA enrollees with diabetes living in rural areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes.

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by geography, Reporting Year 2021



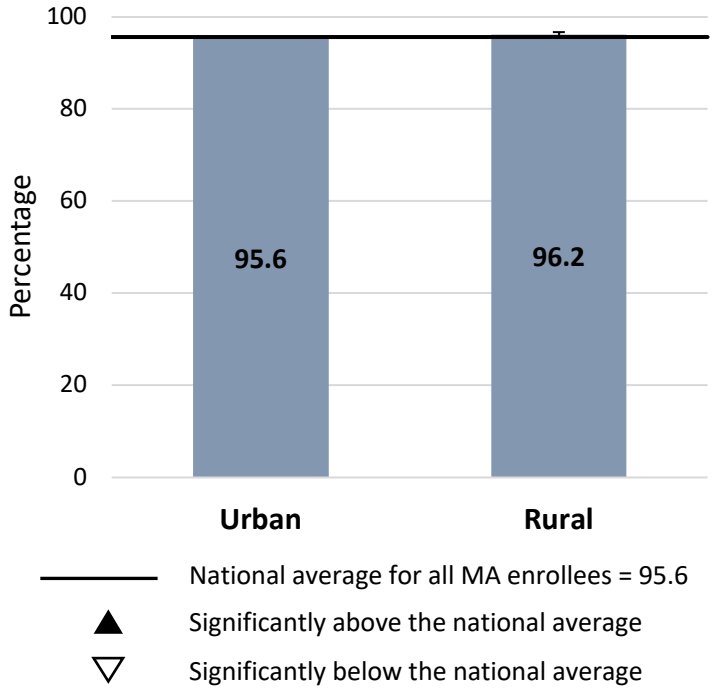
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **similar to** the national average for all MA enrollees with diabetes.

Diabetes Care—Kidney Disease Monitoring

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

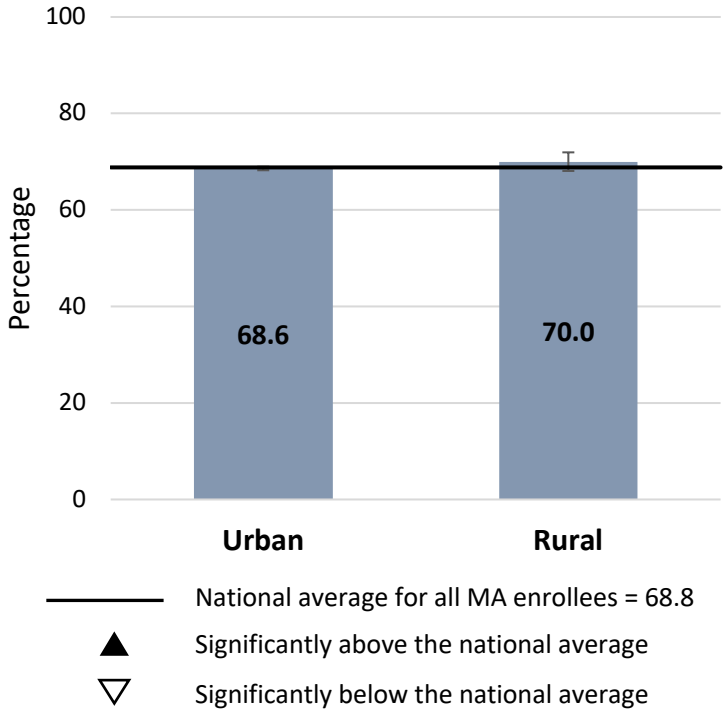
Disparities

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

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

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by geography, Reporting Year 2021



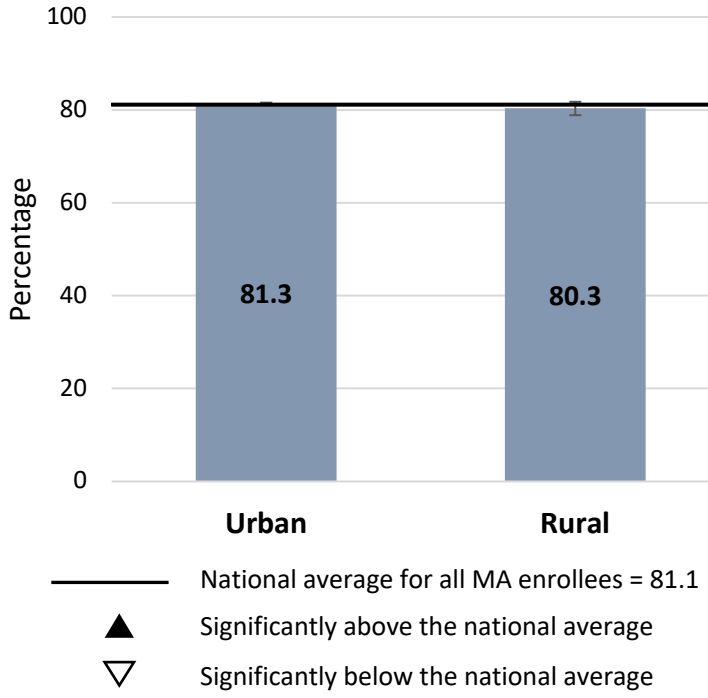
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

- The percentage of MA enrollees with diabetes living in urban areas who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of MA enrollees with diabetes living in rural areas who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by geography, Reporting Year 2021



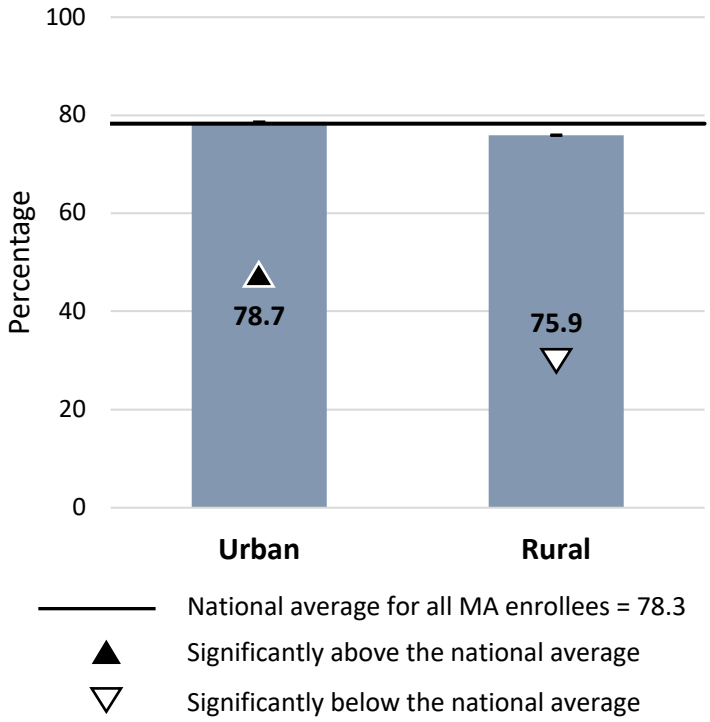
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who received statin therapy, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

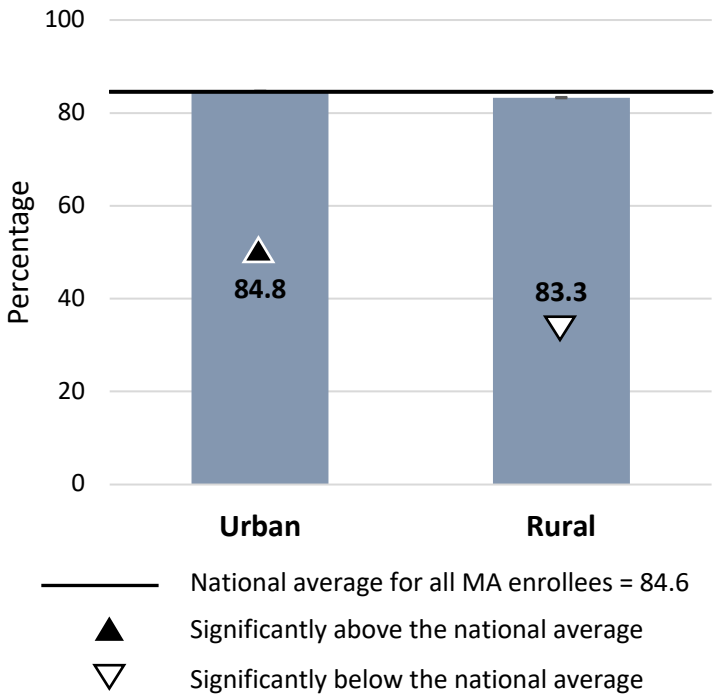
Disparities

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

[†] Excludes those who also have clinical ASCVD.

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

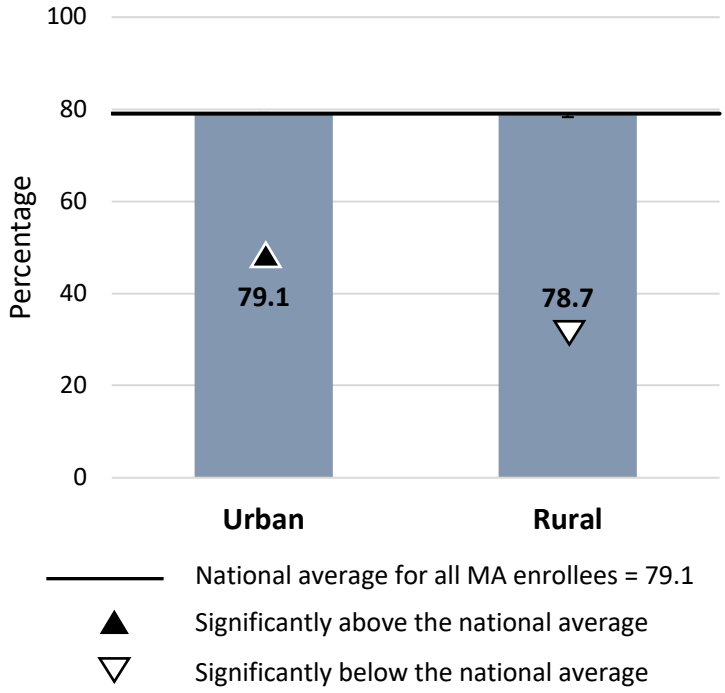
- The percentage of MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of MA enrollees living in rural areas with diabetes who had proper statin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

[†] Excludes those who also have clinical ASCVD.

Clinical Care: Musculoskeletal Conditions

Rheumatoid Arthritis Management

Percentage of MA enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD), by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

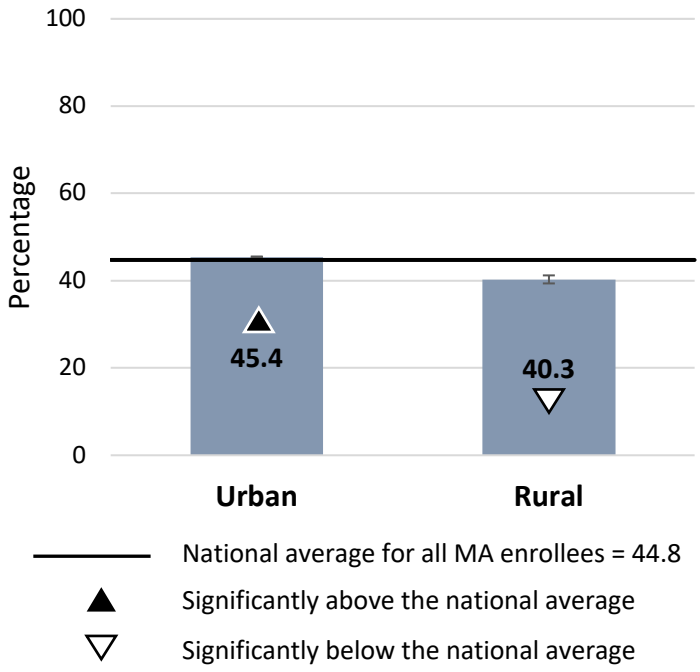
- The percentage of eligible MA enrollees living in urban areas who were dispensed at least one DMARD was **above** the national average for all eligible MA enrollees by less than 3 percentage points.[†]

- The percentage of eligible MA enrollees living in rural areas who were dispensed at least one DMARD was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] Prior to rounding.

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

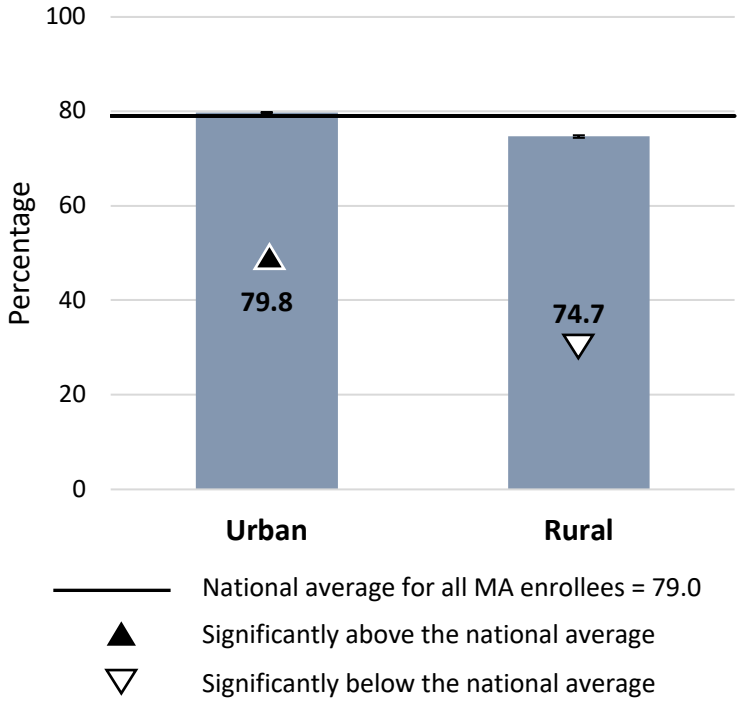
- The percentage of eligible female MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.

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

Clinical Care: Behavioral Health

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

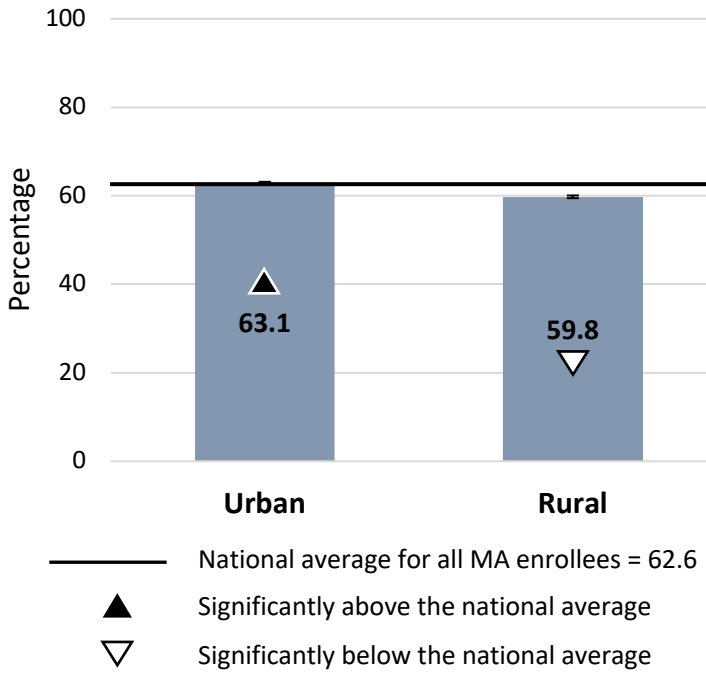
Disparities

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

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

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

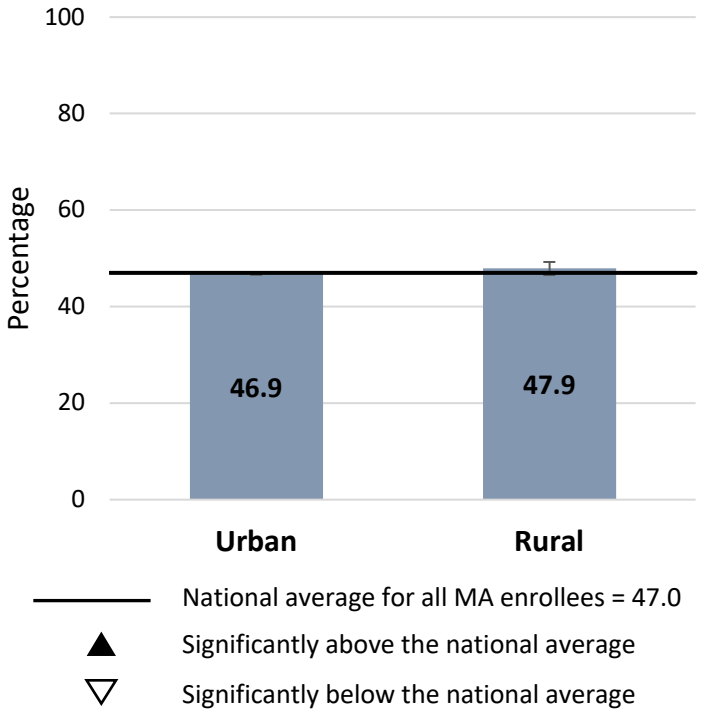
Disparities

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

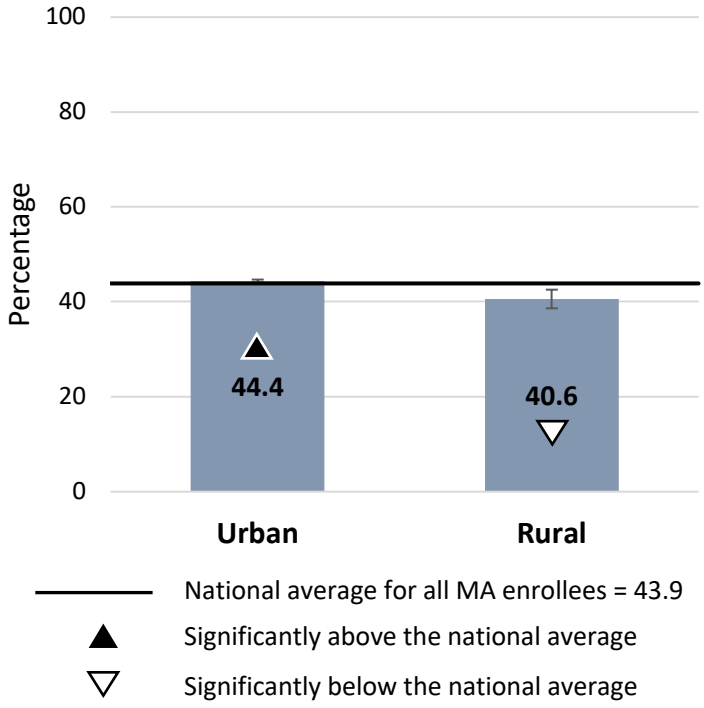
Disparities

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

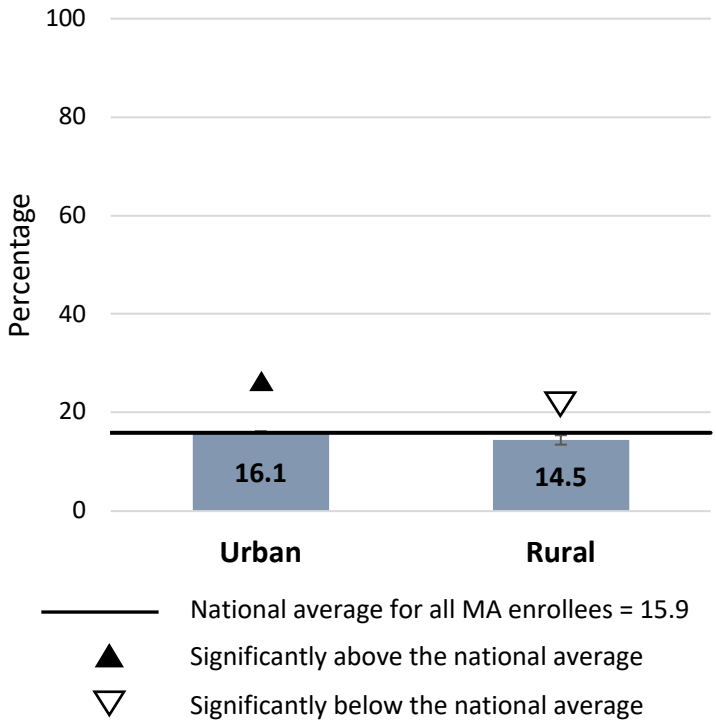
- The percentage of MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

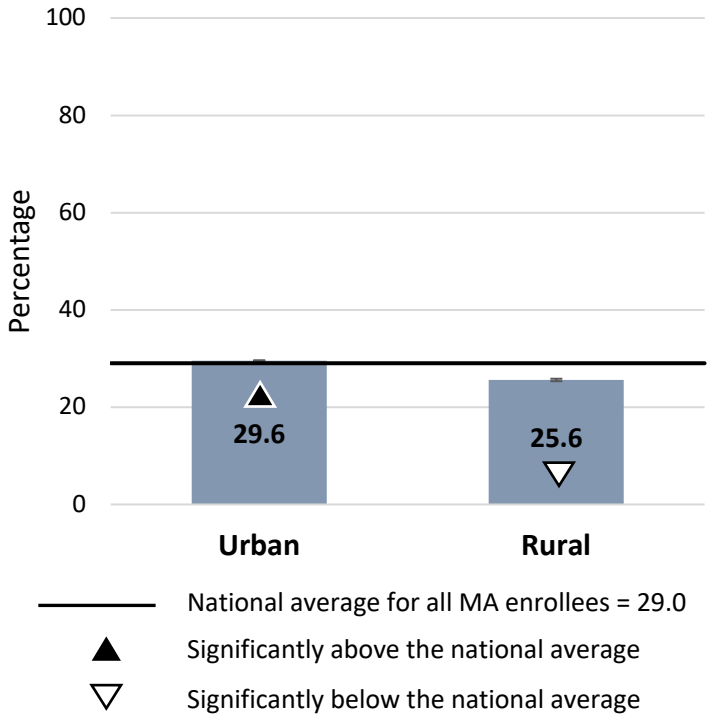
- The percentage of MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

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

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

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated[‡] treatment within 14 days of the diagnosis, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

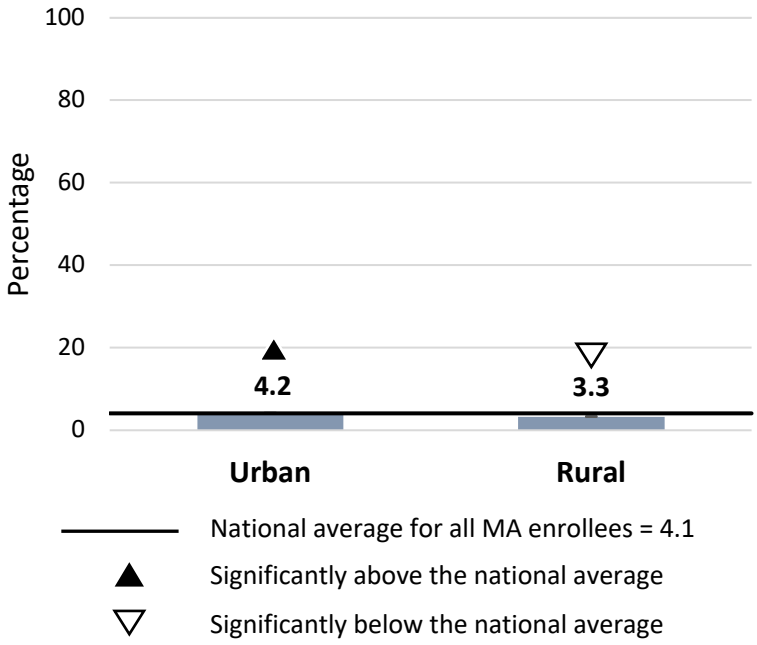
- The percentage of MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of MA enrollees living in rural areas who initiated treatment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

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

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

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

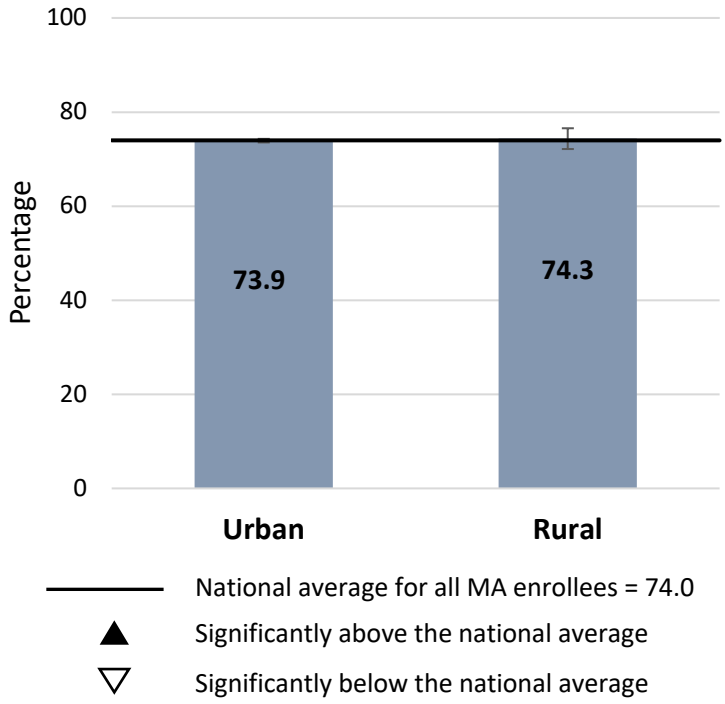
- The percentage of MA enrollees with a new episode of AOD dependence living in rural areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

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

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

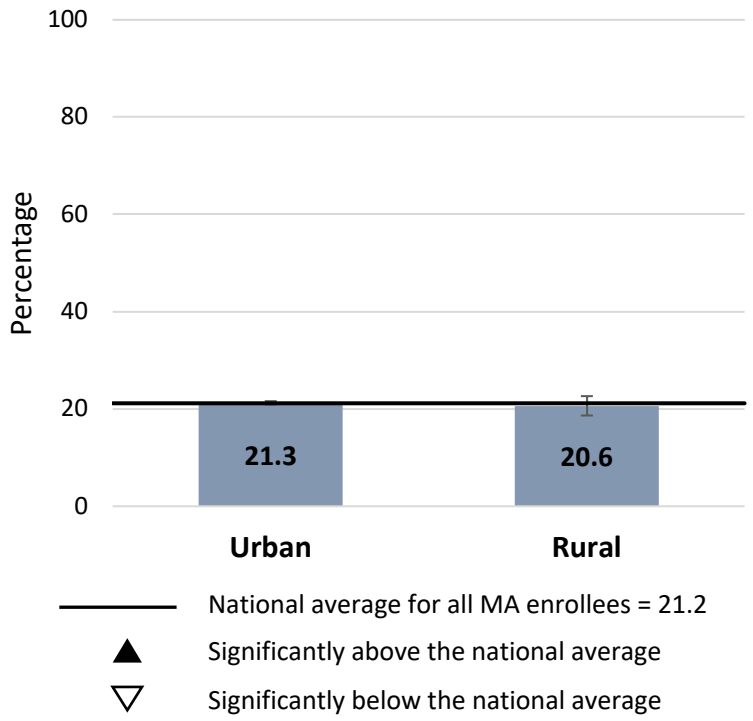
Disparities

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

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

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

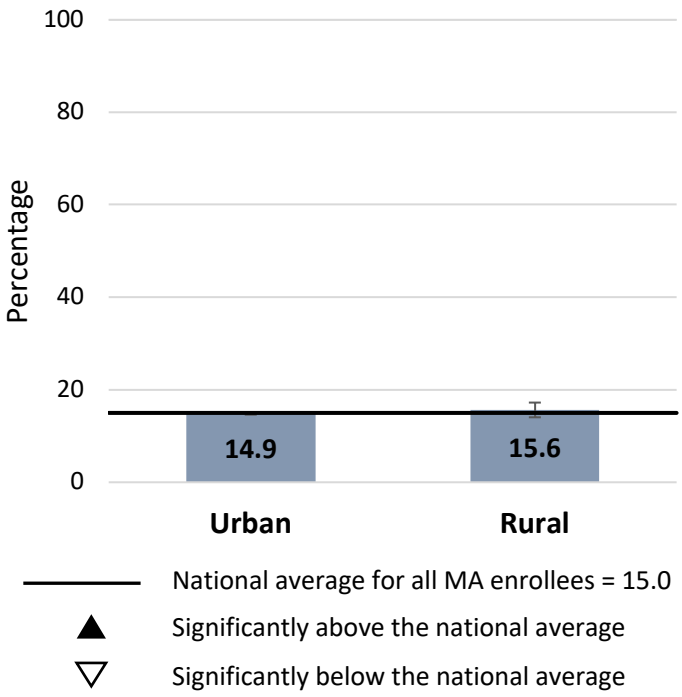
Disparities

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

- The percentage of MA enrollees living in rural areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all eligible MA enrollees.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

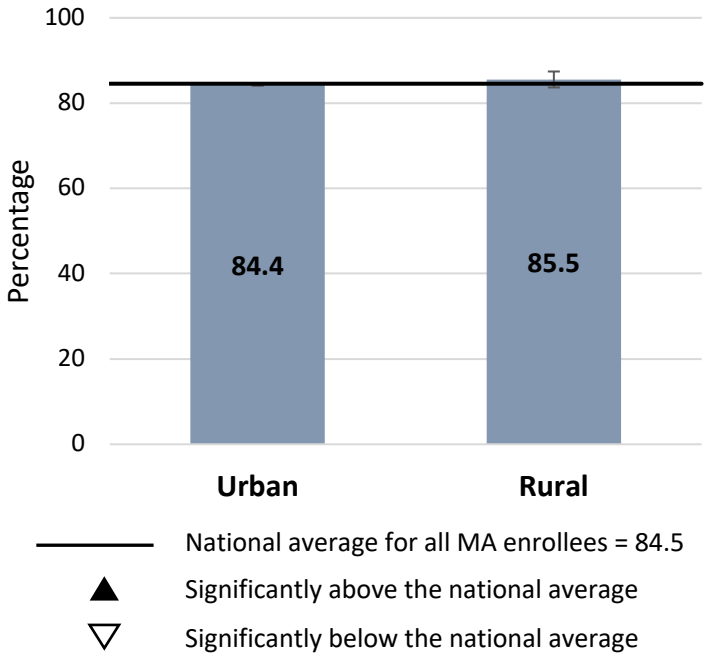
Disparities

- The percentage of MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees.

- The percentage of MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth) was provided within 30 days of discharge, by geography, Reporting Year 2021



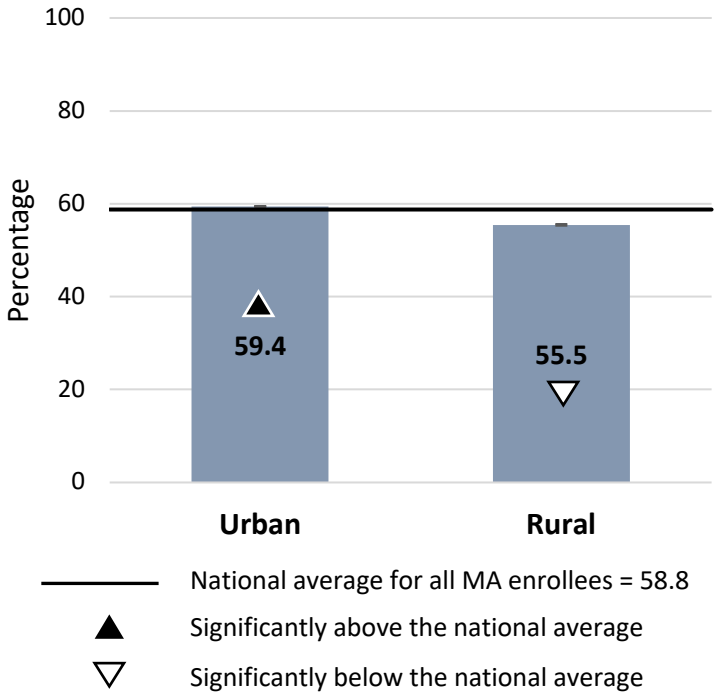
SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

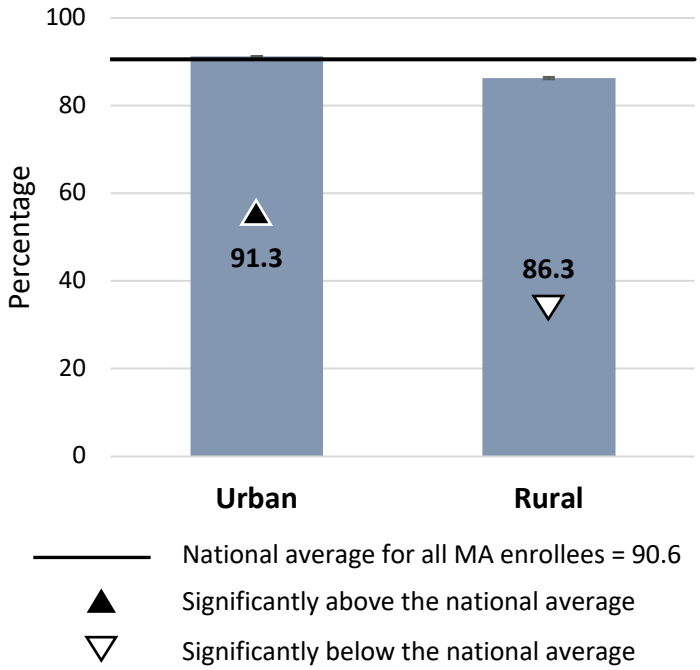
- The percentage of MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of MA enrollees with multiple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

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

Clinical Care: Overuse and Appropriate Use of Medications

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

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,[†] by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

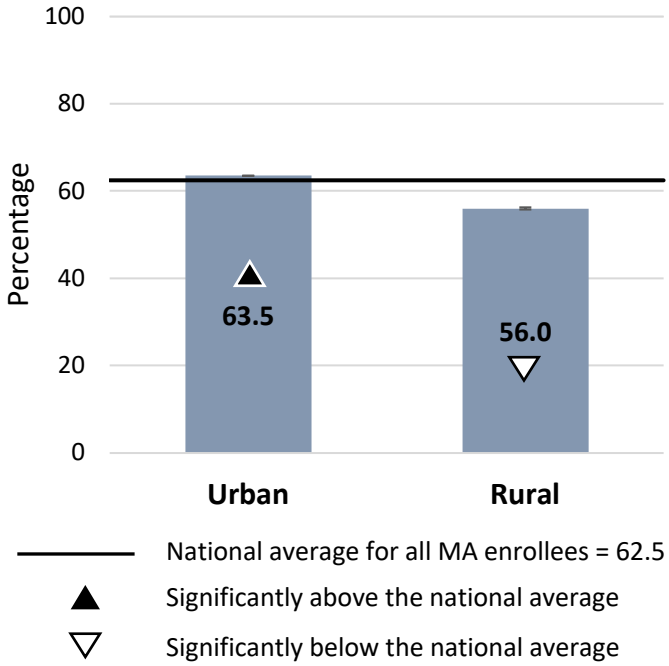
- The percentage of elderly MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly MA enrollees by less than 3 percentage points.

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

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

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

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

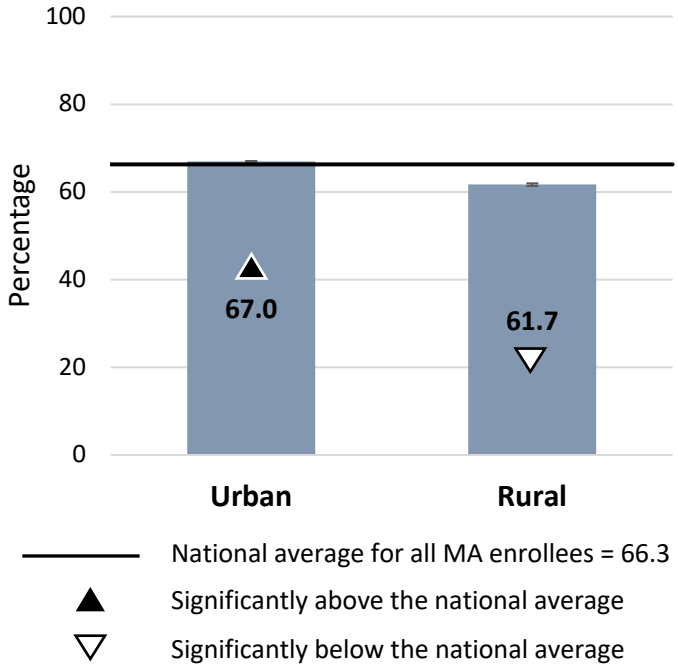
- The percentage of elderly MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly MA enrollees by less than 3 percentage points.

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

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

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

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,[†] by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

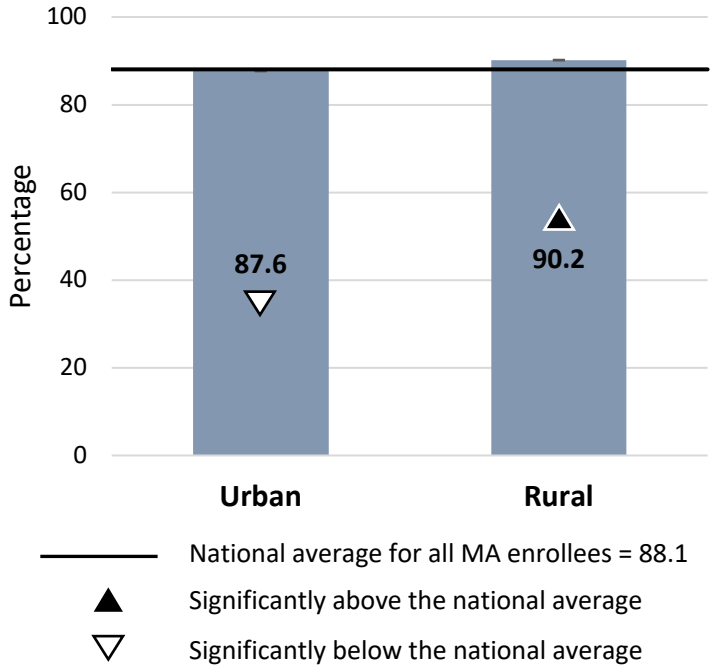
- The percentage of elderly MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly MA enrollees by less than 3 percentage points.

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

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

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

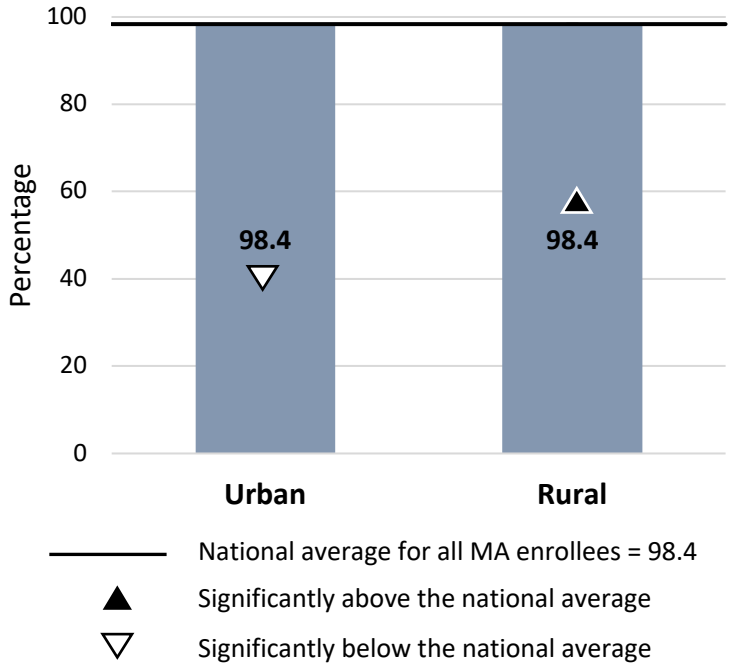
Disparities

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

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

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

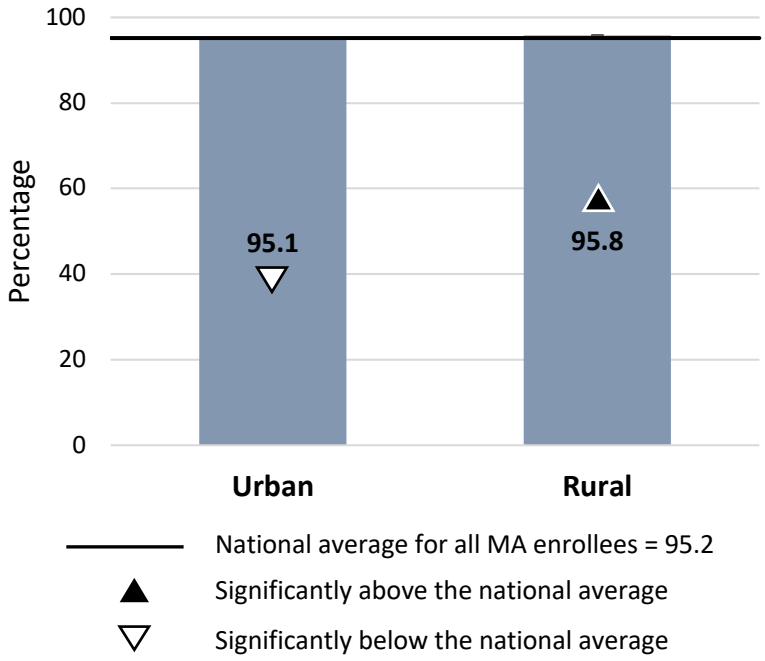
- The percentage of MA enrollees living in rural areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average[†] for all MA enrollees by less than 3 percentage points.

[†] Prior to rounding.

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by geography, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.

Disparities

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

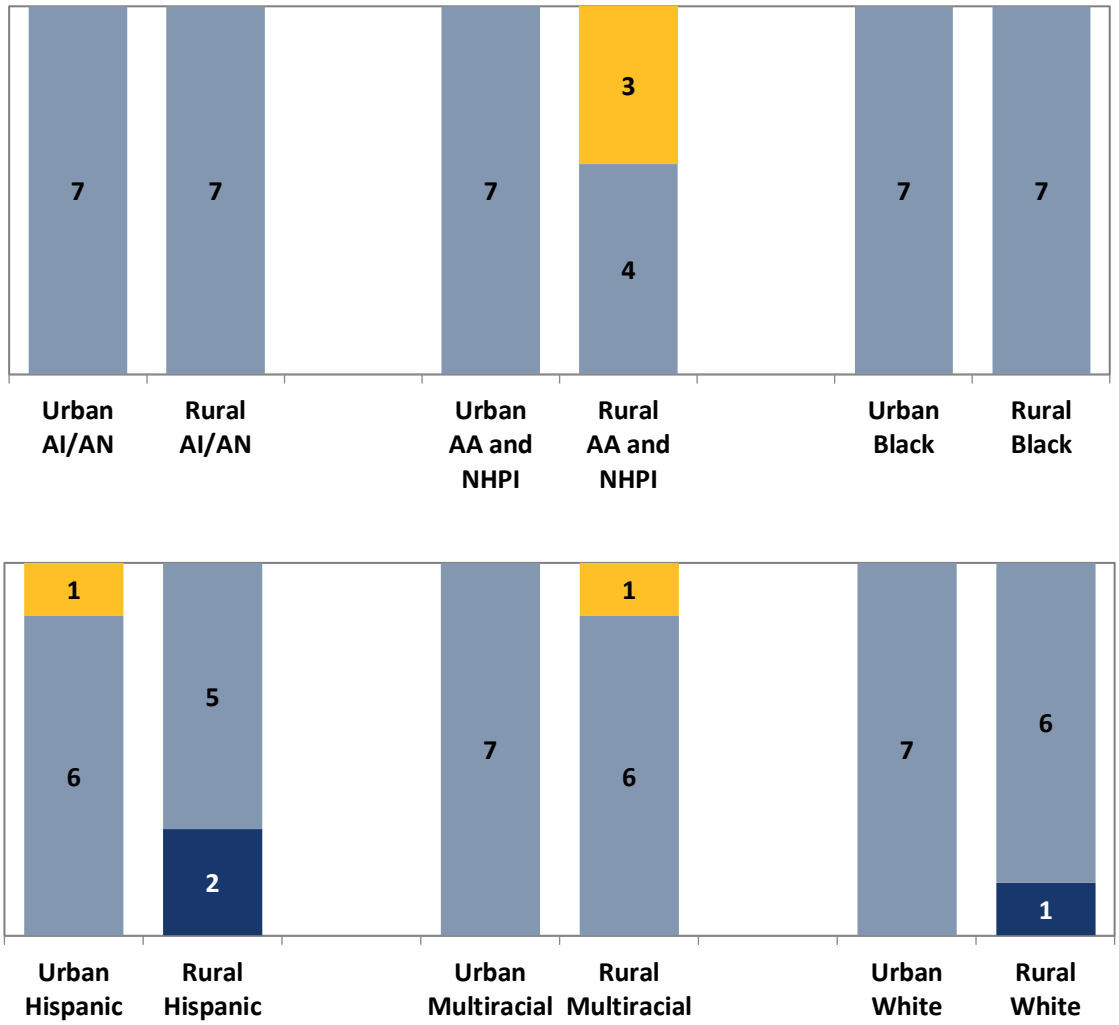
- The percentage of MA enrollees living in rural areas who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.

Section II:

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

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

Number of patient experience measures (out of 7) for which urban or rural MA enrollees reported experiences that were above, similar to, or below the national average for all MA enrollees <u>of the same race or ethnicity</u> in 2021



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2021 Medicare CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

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

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

AA and NHPI MA enrollees living in rural areas had results that were above the national average for all AA and NHPI MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Getting Needed Prescription Drugs

Hispanic MA enrollees living in urban areas had results that were above the national average for all Hispanic MA enrollees
• Annual Flu Vaccine

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

Multiracial MA enrollees living in rural areas had results that were above the national average for all Multiracial MA enrollees
• Getting Appointments and Care Quickly

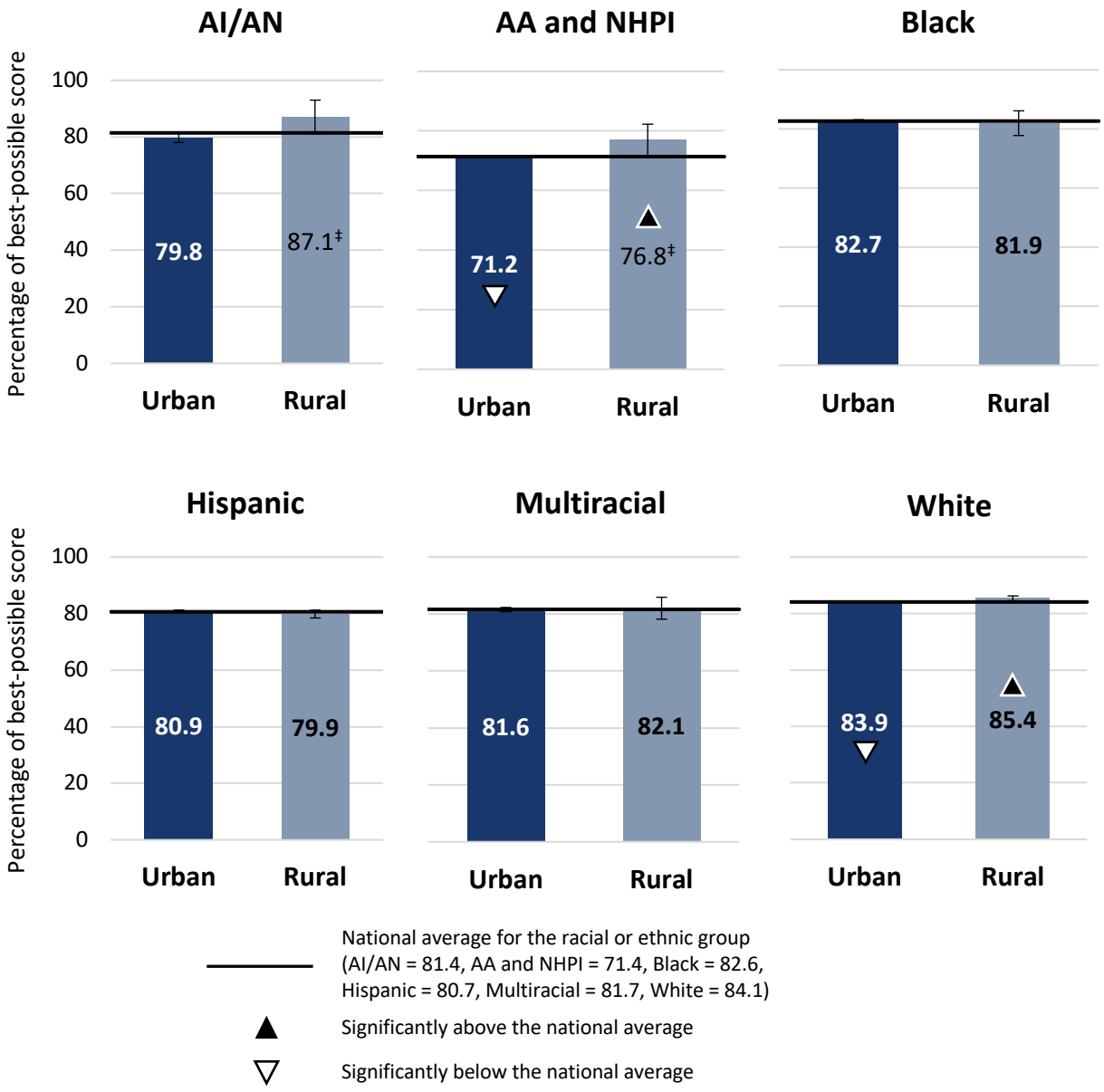
White MA enrollees living in rural areas had results that were below the national average for all White MA enrollees
• Annual Flu Vaccine

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

Patient Experience: Medicare Advantage

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

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

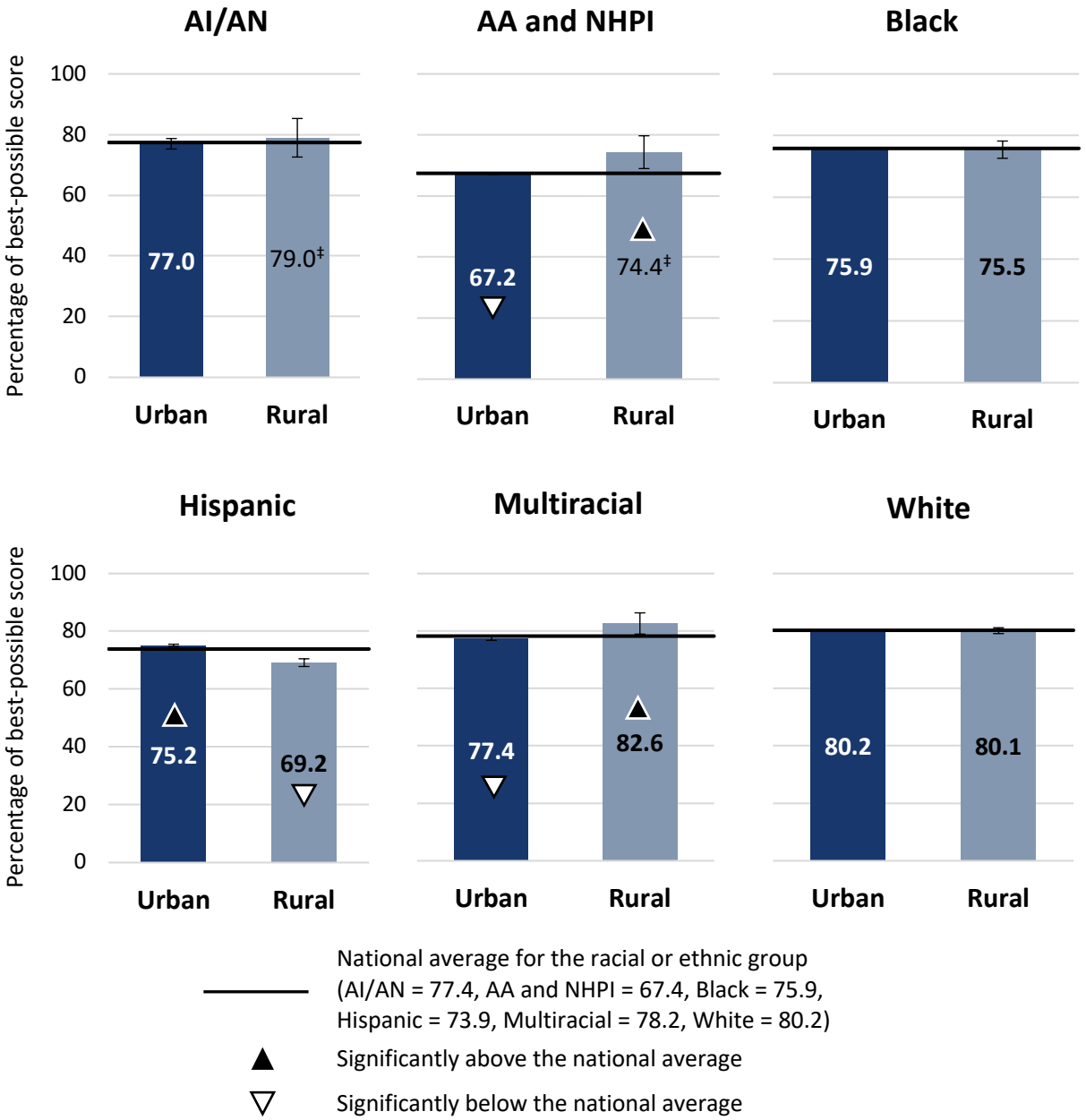
- Multiracial MA enrollees living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Multiracial MA enrollees.

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

[§] Unlike on pages 57–58, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

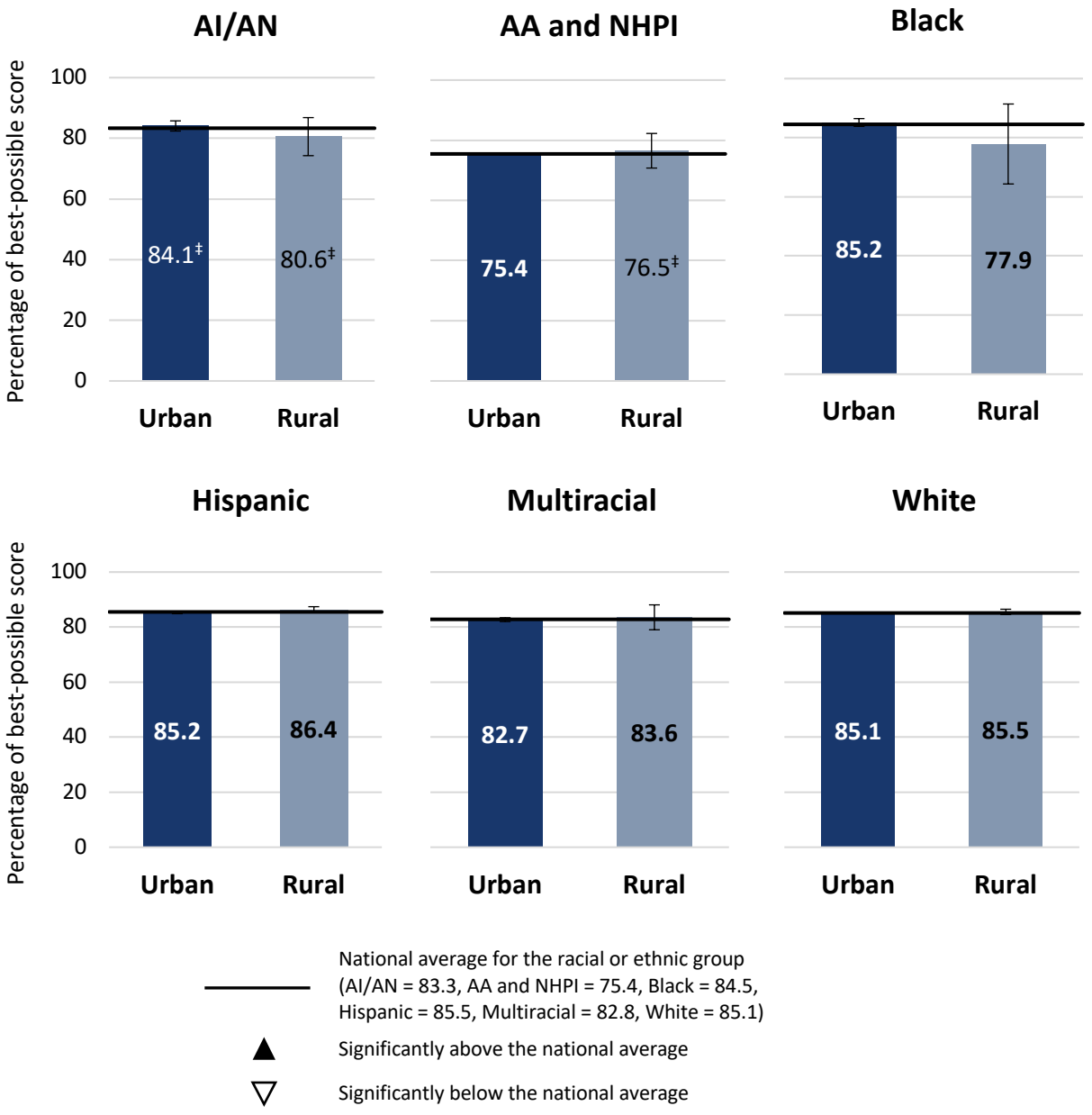
- Hispanic MA enrollees living in urban areas reported experiences with getting appointments and care quickly that were **above** the national average for all Hispanic MA enrollees by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with getting appointments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

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

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

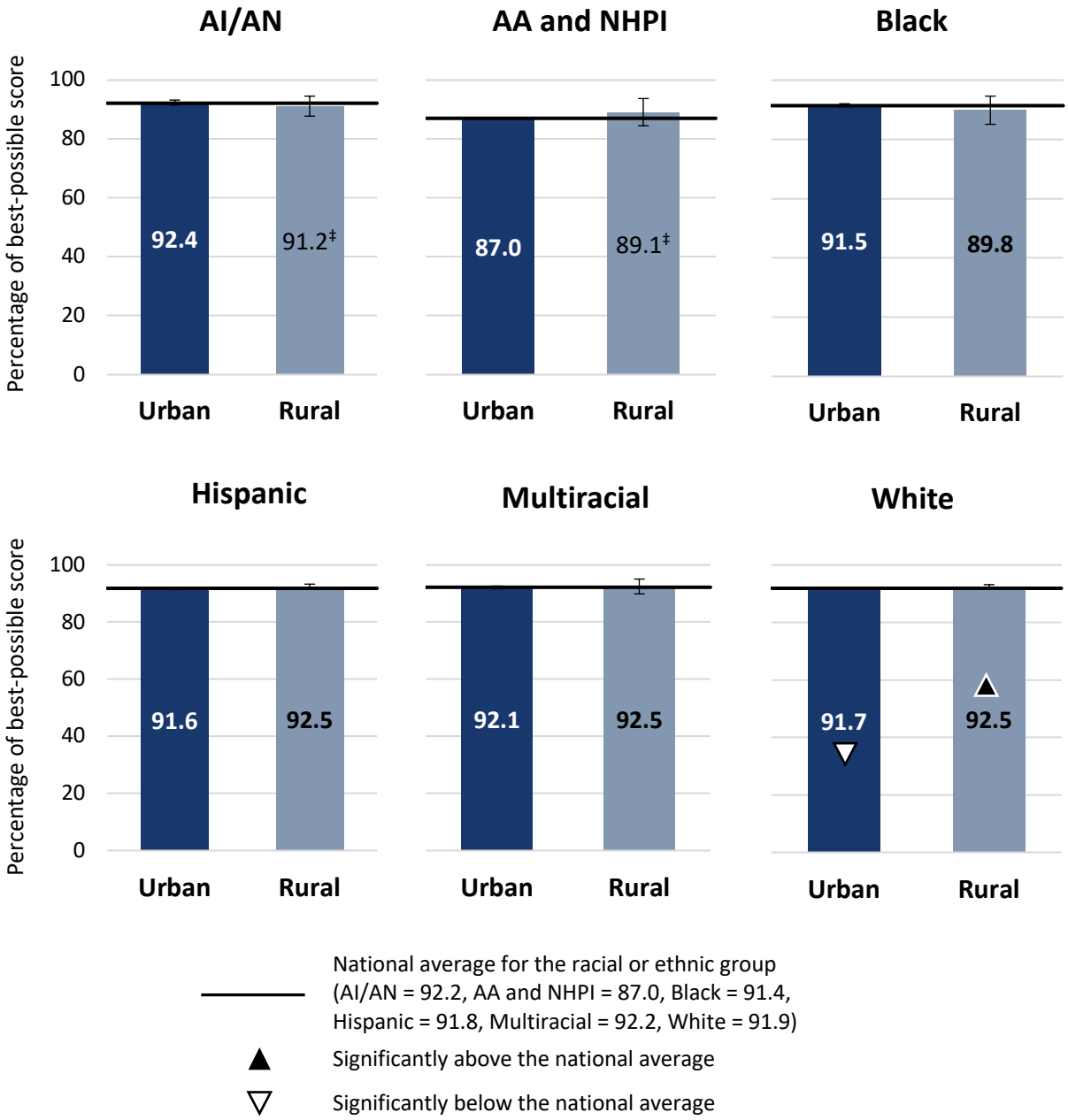
- Hispanic MA enrollees living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Hispanic MA enrollees.

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

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

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

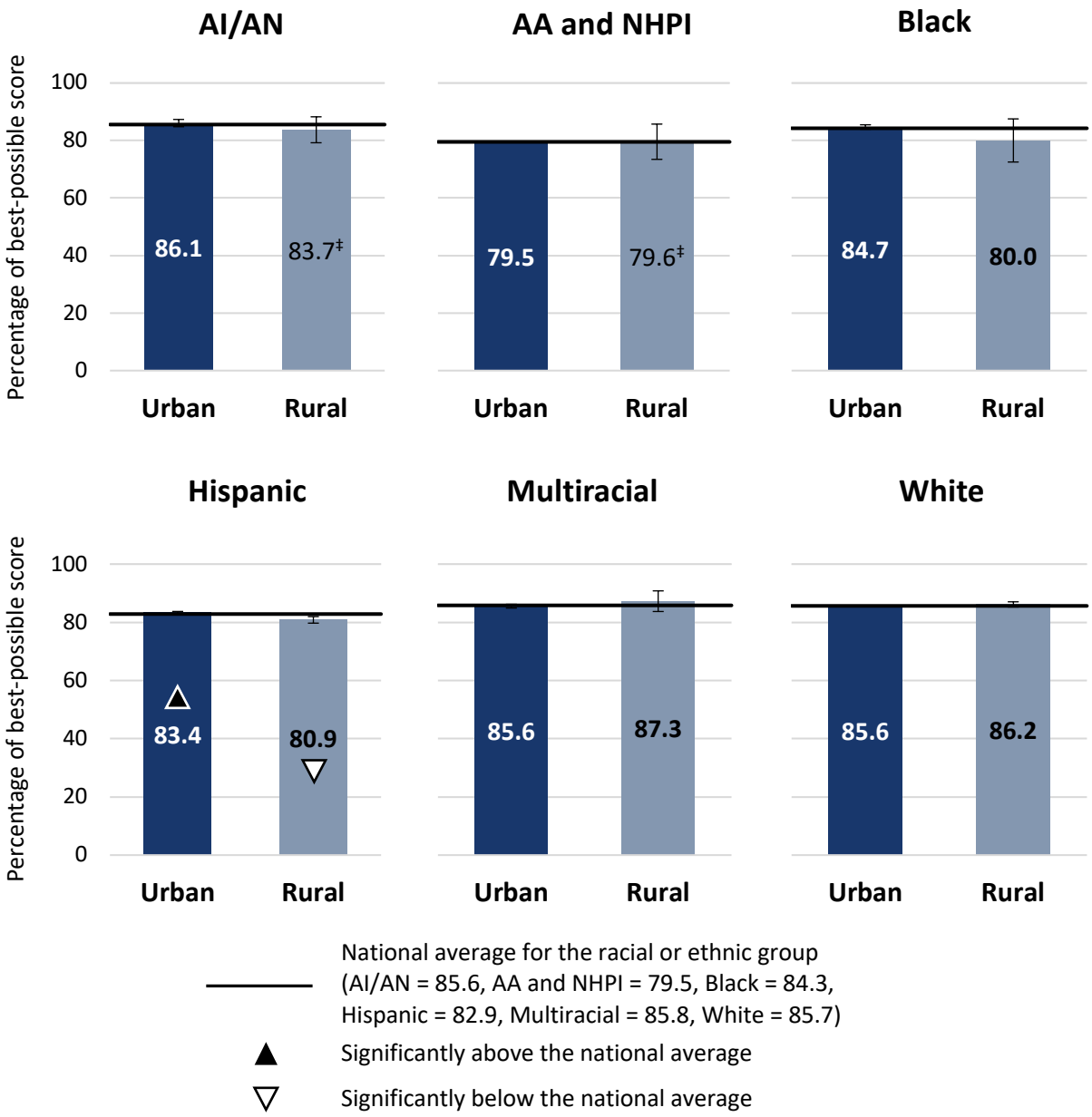
- Hispanic MA enrollees living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Hispanic MA enrollees.

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

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

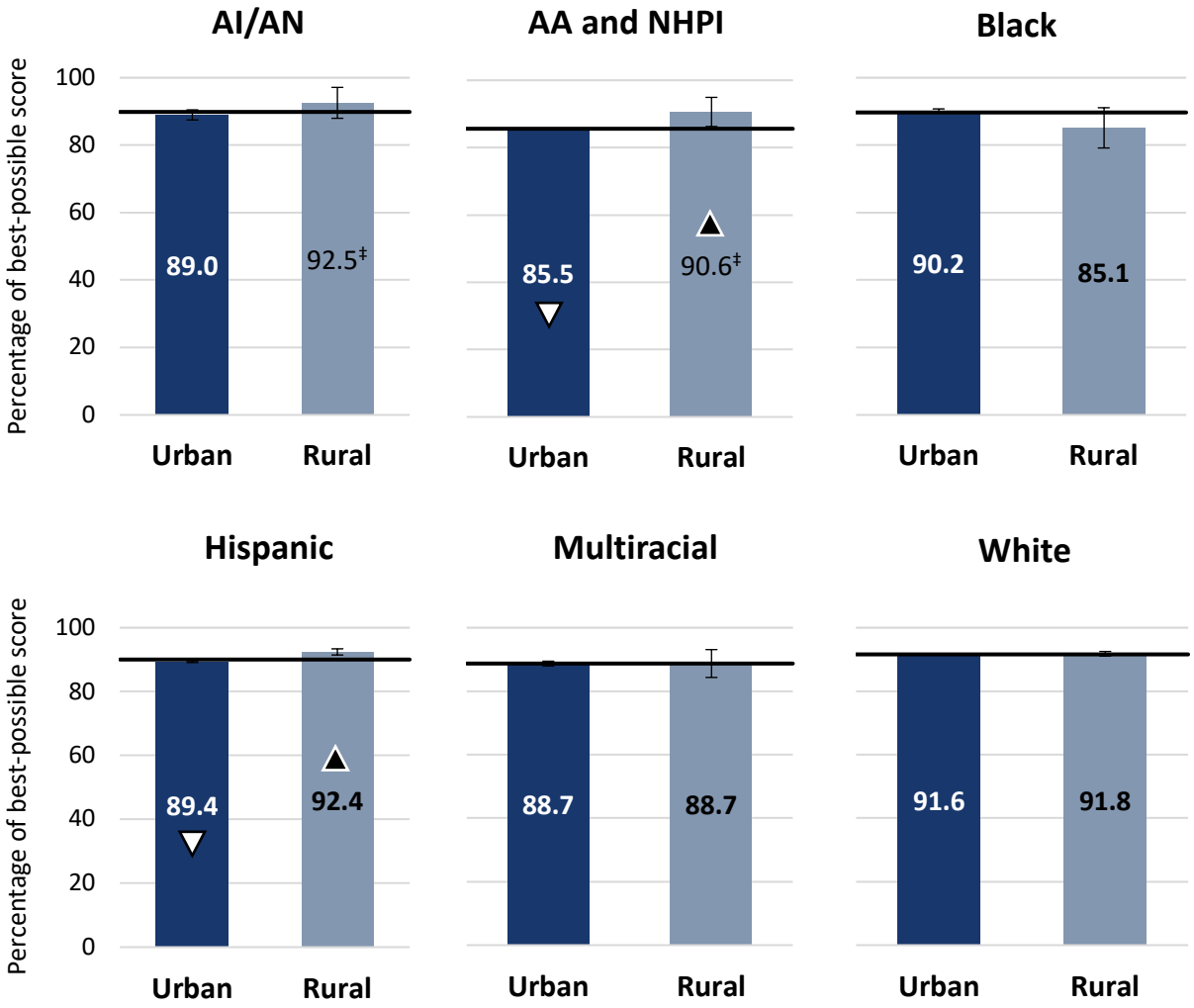
- Hispanic MA enrollees living in urban areas reported experiences with care coordination that were **above** the national average for all Hispanic MA enrollees by less than 3 percentage points. Hispanic MA enrollees living in rural areas reported experiences with care coordination that were **below** the national average for all Hispanic MA enrollees by less than 3 percentage points.

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

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

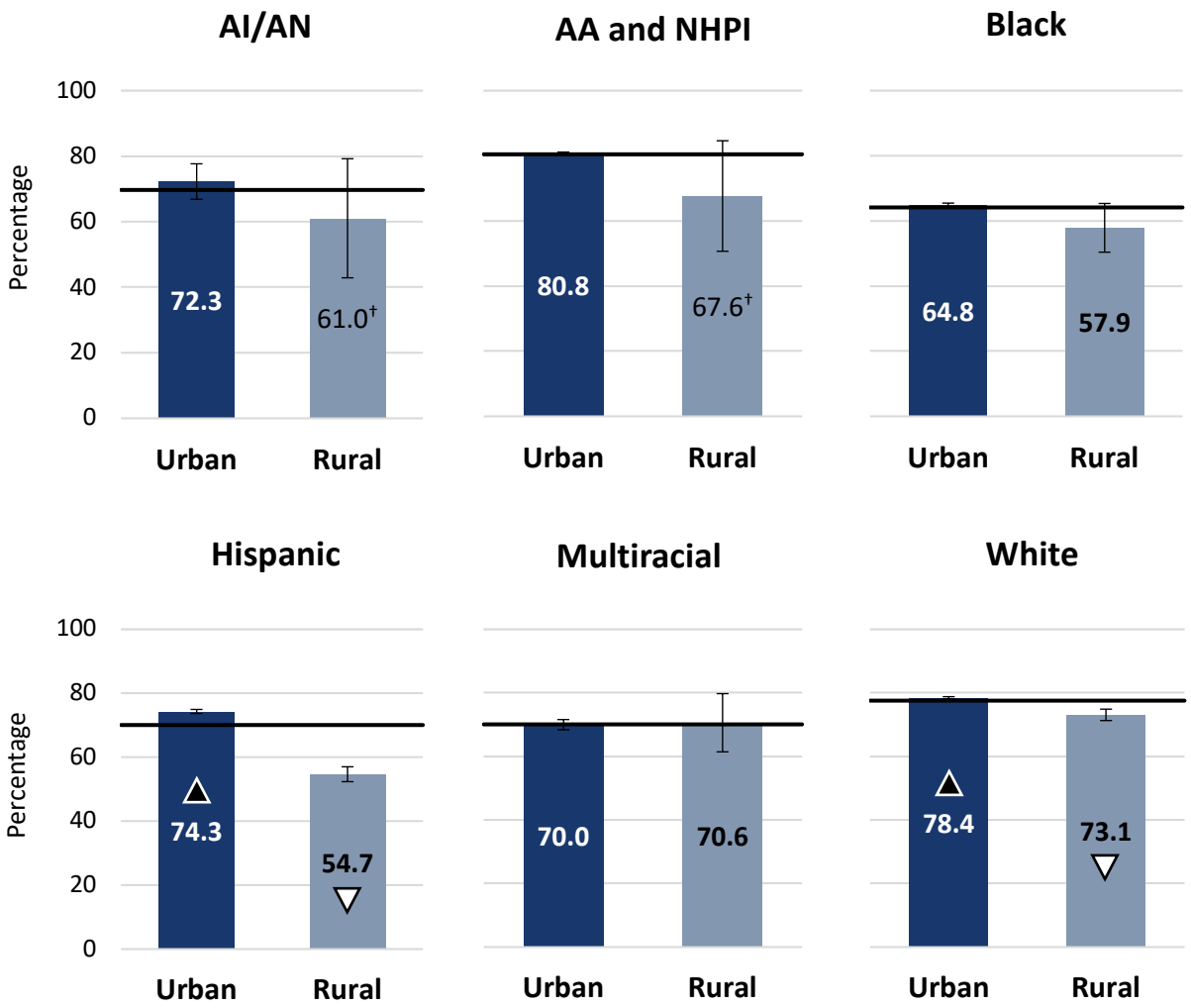
- Hispanic MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all Hispanic MA enrollees by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with getting needed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

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

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

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

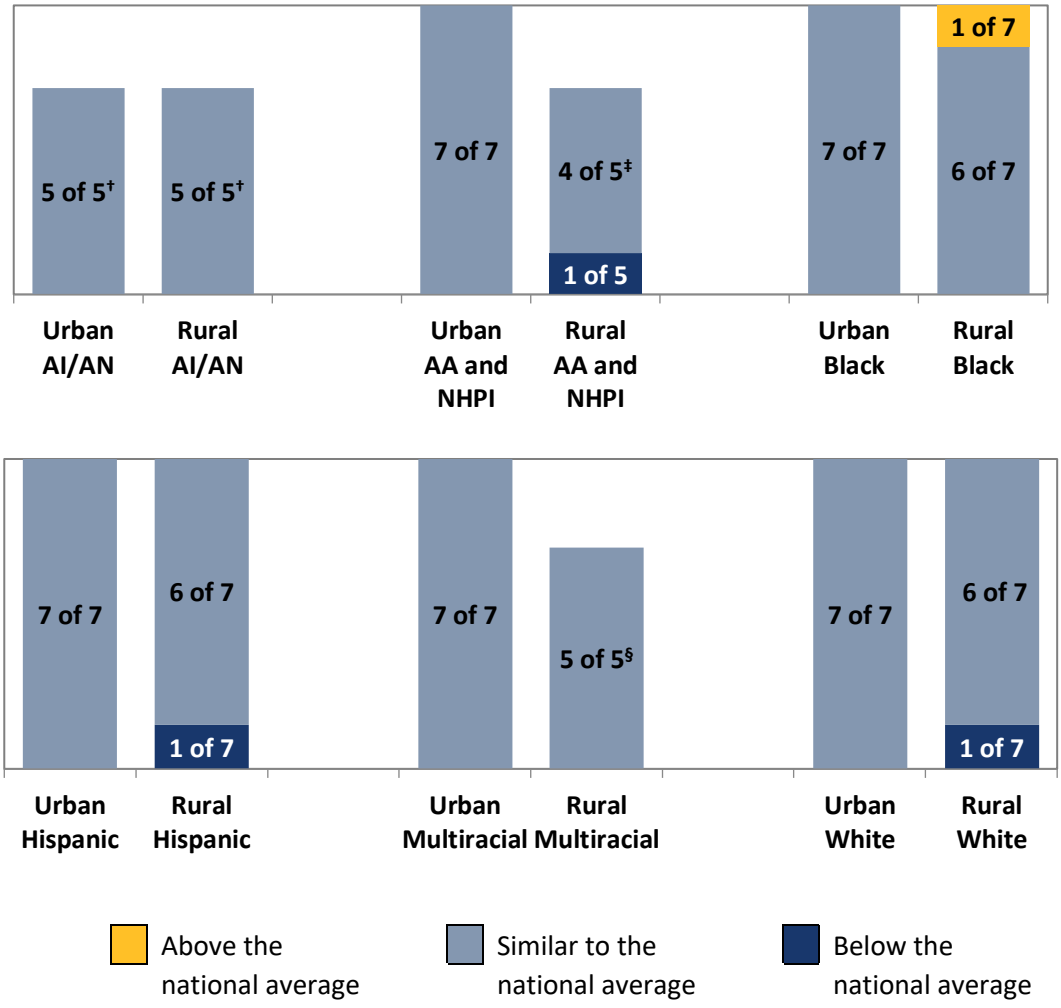
- The percentage of Hispanic MA enrollees living in urban areas who received the flu vaccine was **above** the national average for all Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who received the flu vaccine was **below** the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

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

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

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

Number of patient experience measures for which urban or rural residents with Medicare FFS coverage reported experiences that were above, similar to, or below the national average for all people with Medicare FFS coverage of the same race or ethnicity in 2021



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

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

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

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

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

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

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

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

Black people with FFS coverage living in rural areas had results that were above the national average for all Black people with FFS coverage
• Getting Needed Prescription Drugs

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

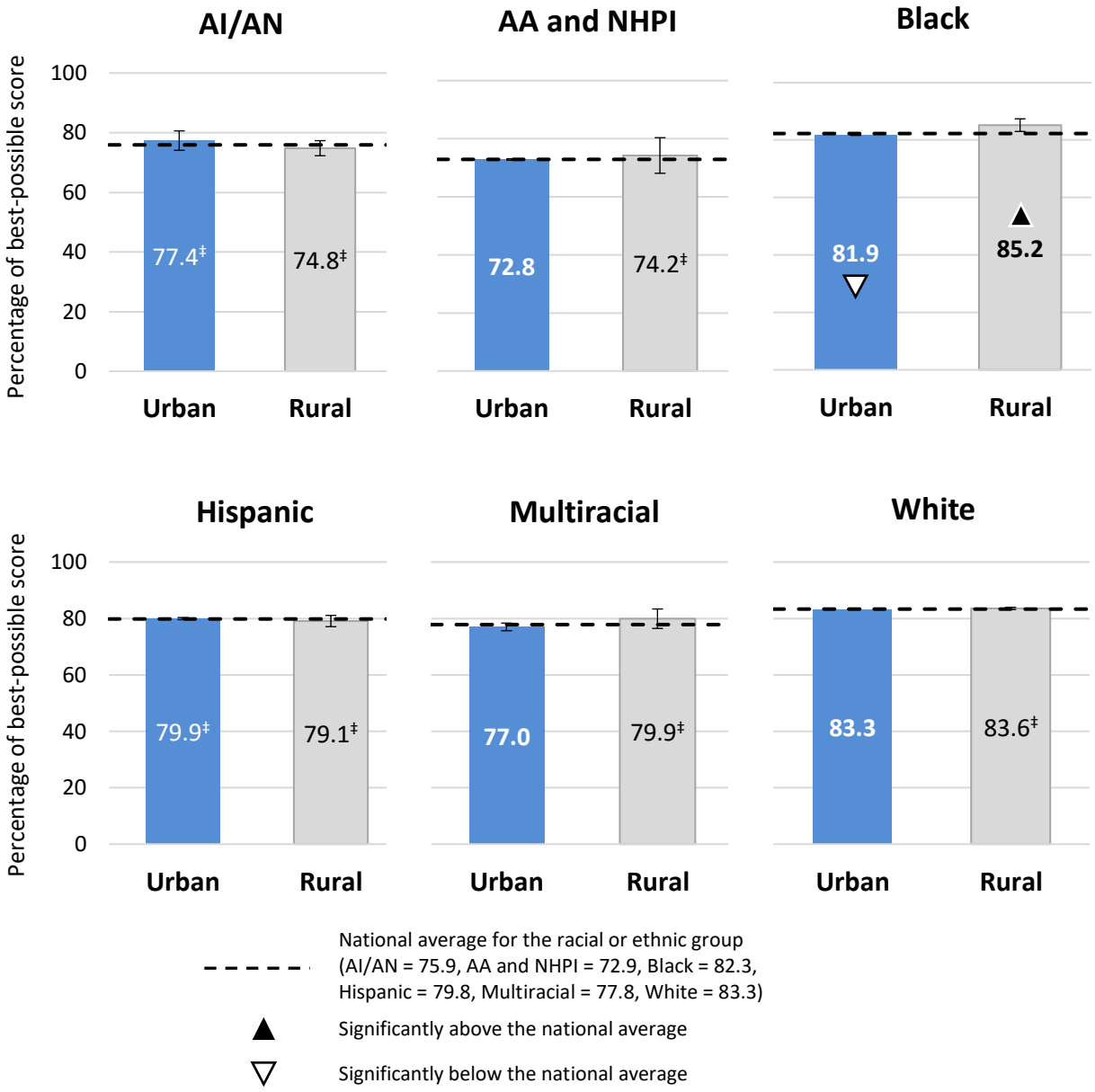
White people with FFS coverage living in rural areas had results that were below the national average for all White people with FFS coverage
• Annual Flu Vaccine

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

Patient Experience: Medicare FFS

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

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

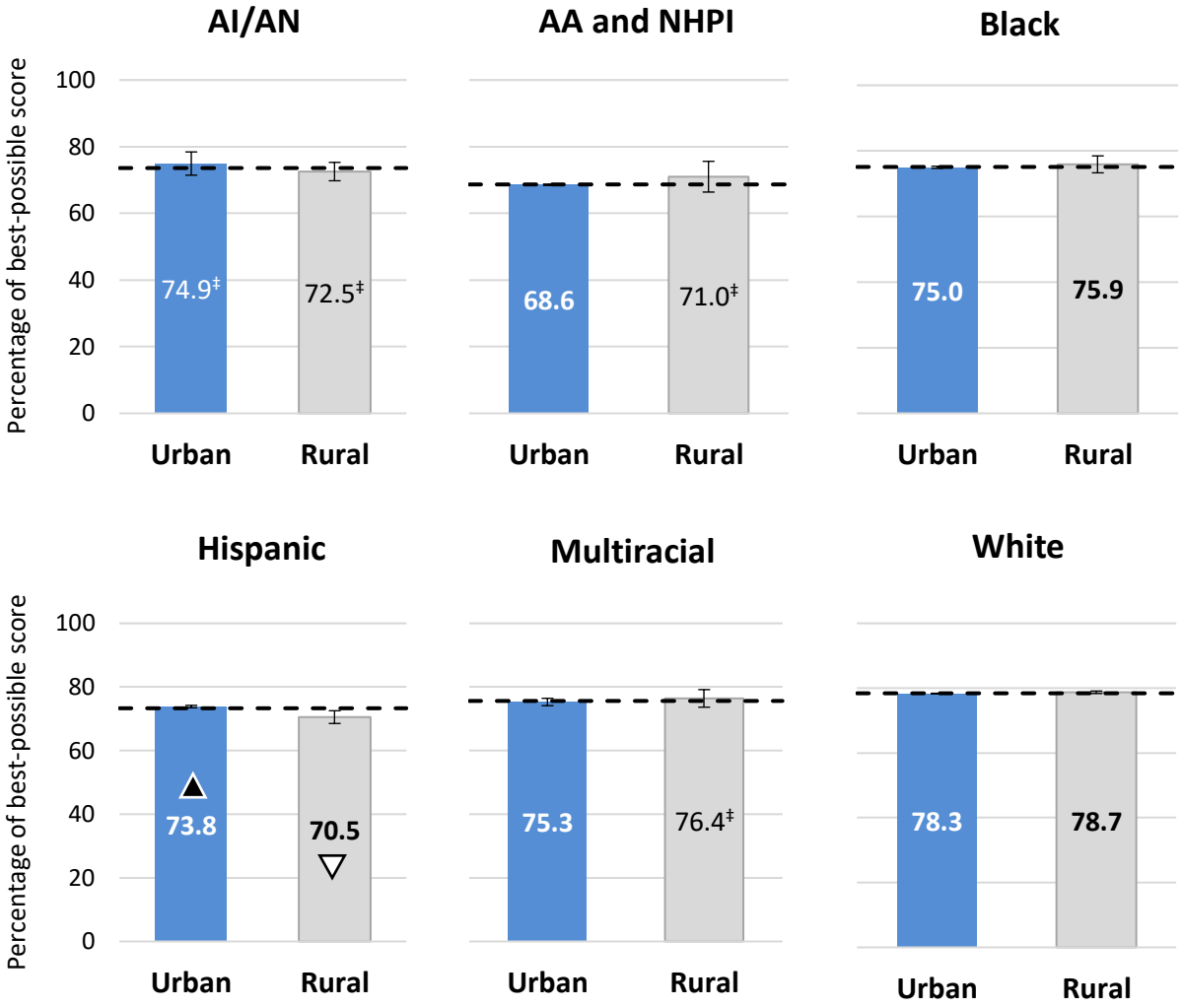
- Multiracial people with FFS coverage living in urban and rural areas reported experiences with getting needed care that were **similar to** the national average for all Multiracial people with FFS coverage.

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

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

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

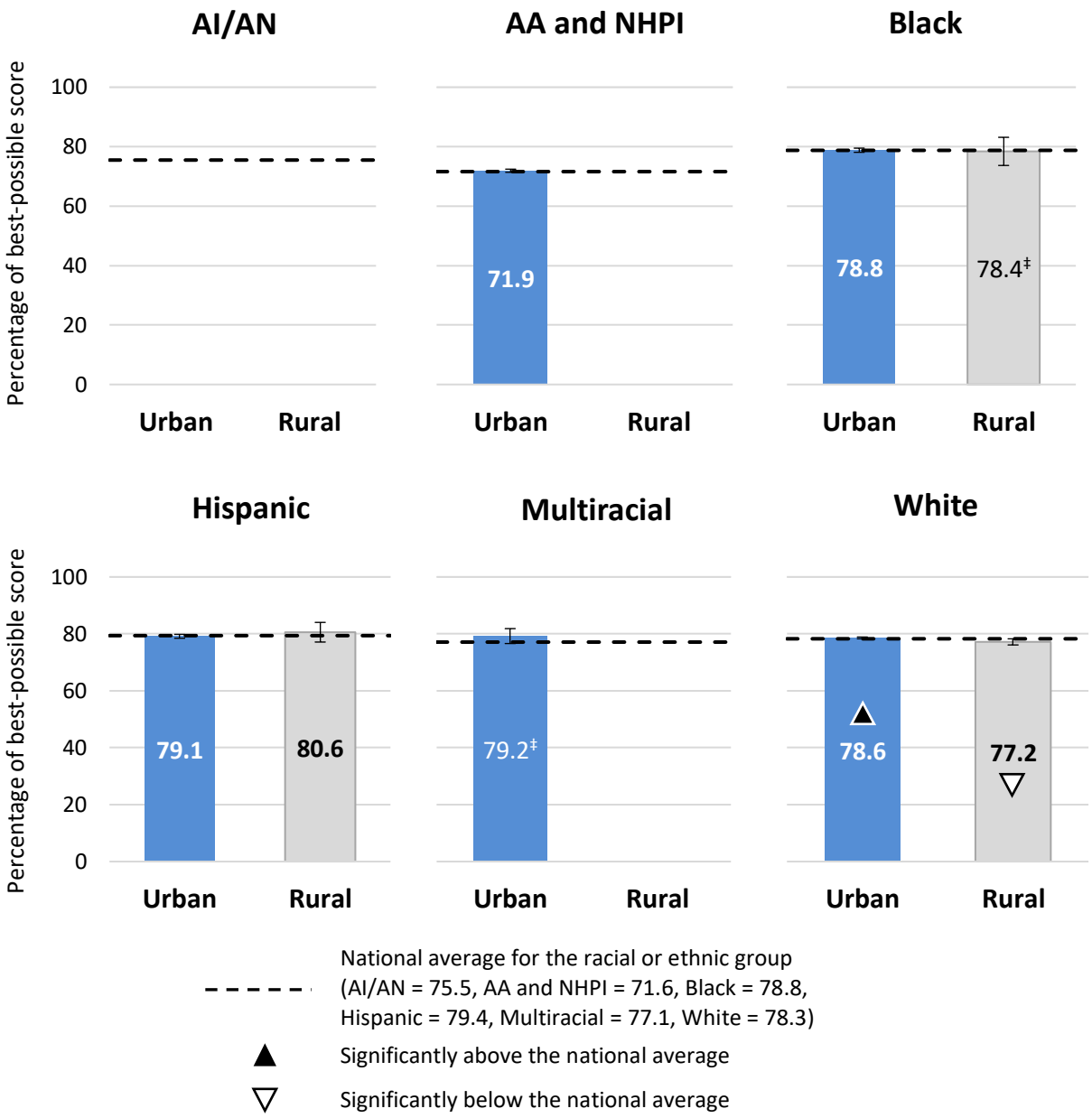
- Hispanic people with FFS coverage living in urban areas reported experiences with getting appointments and care quickly that were **above** the national average for all Hispanic people with FFS coverage by less than 3 points on a 0–100 scale. Hispanic people with FFS coverage living in rural areas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

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

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

- There were not enough data from AI/AN people with FFS coverage living in urban areas to compare the score for this group to the national average for all AI/AN people with FFS coverage on experiences with customer service. There were also not enough data from AI/AN people with FFS coverage living in rural areas to compare the score for this group to the national average for all AI/AN people with FFS coverage on experiences with customer service.

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

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

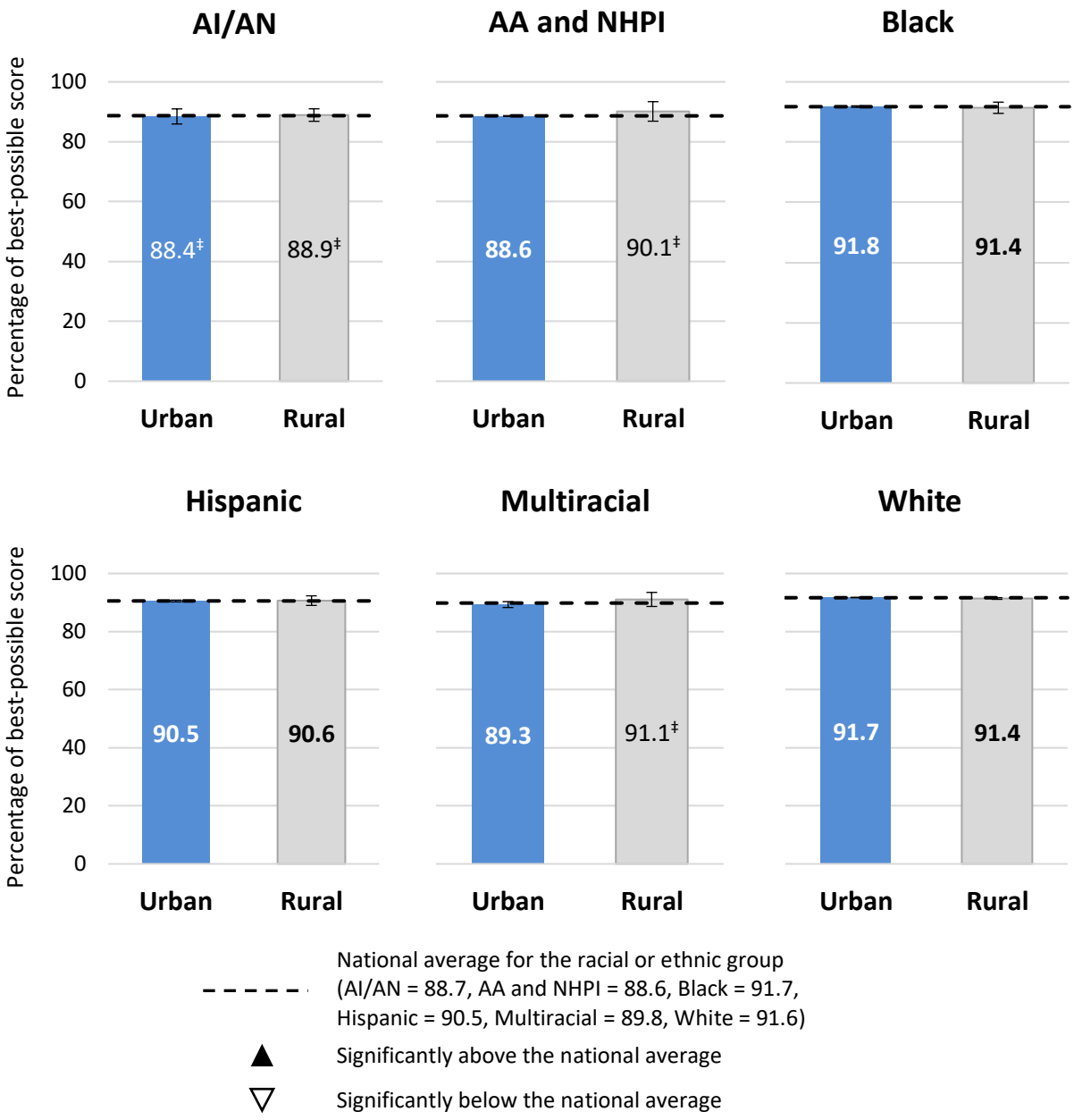
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with customer service that were **similar to** the national average for all Hispanic people with FFS coverage.

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

- White people with FFS coverage living in urban areas reported experiences with customer service that were **above** the national average for all White people with FFS coverage by less than 3 percentage points. White people with FFS coverage living in rural areas reported experiences with customer service that were **below** the national average for all White people with FFS coverage by less than 3 percentage points.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

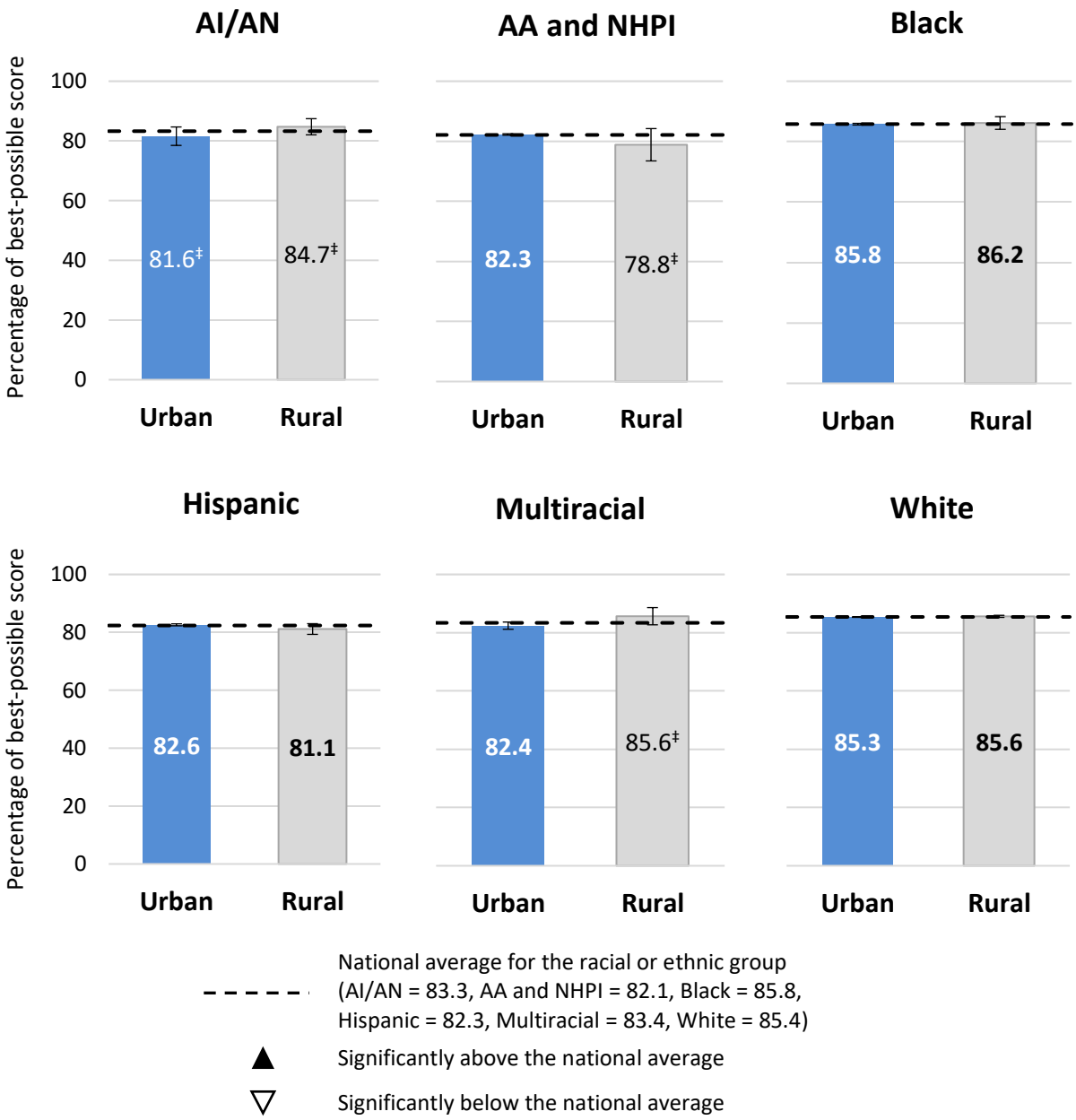
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with doctor communication that were **similar to** the national average for all Hispanic people with FFS coverage.

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

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

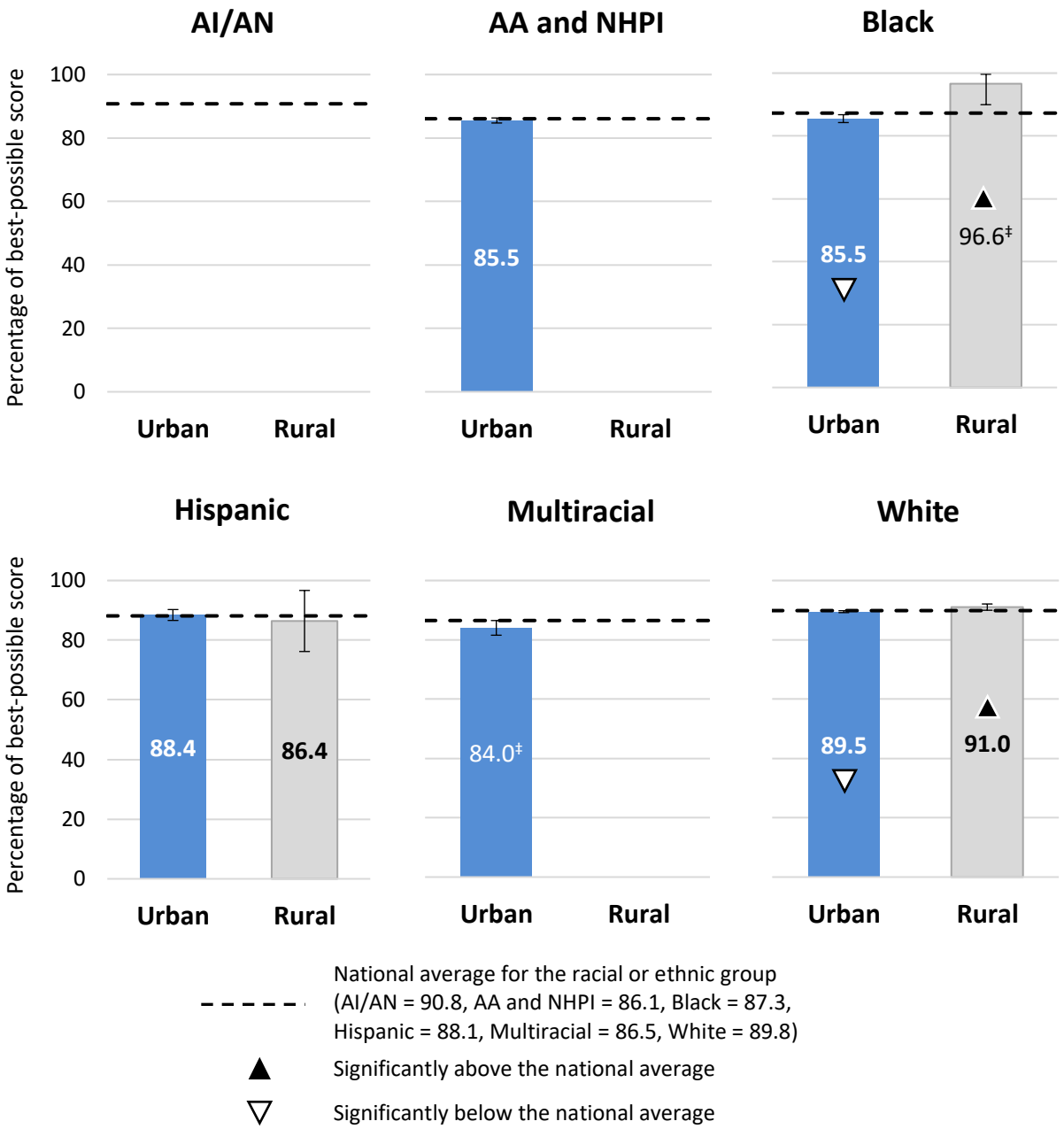
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with care coordination that were **similar to** the national average for all Hispanic people with FFS coverage.

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

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,† by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

- Black people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all Black people with FFS coverage by less than 3 percentage points. Black people with FFS coverage living in rural areas reported experiences with getting needed prescription drugs that were **above** the national average for all Black people with FFS coverage by more than 3 percentage points.

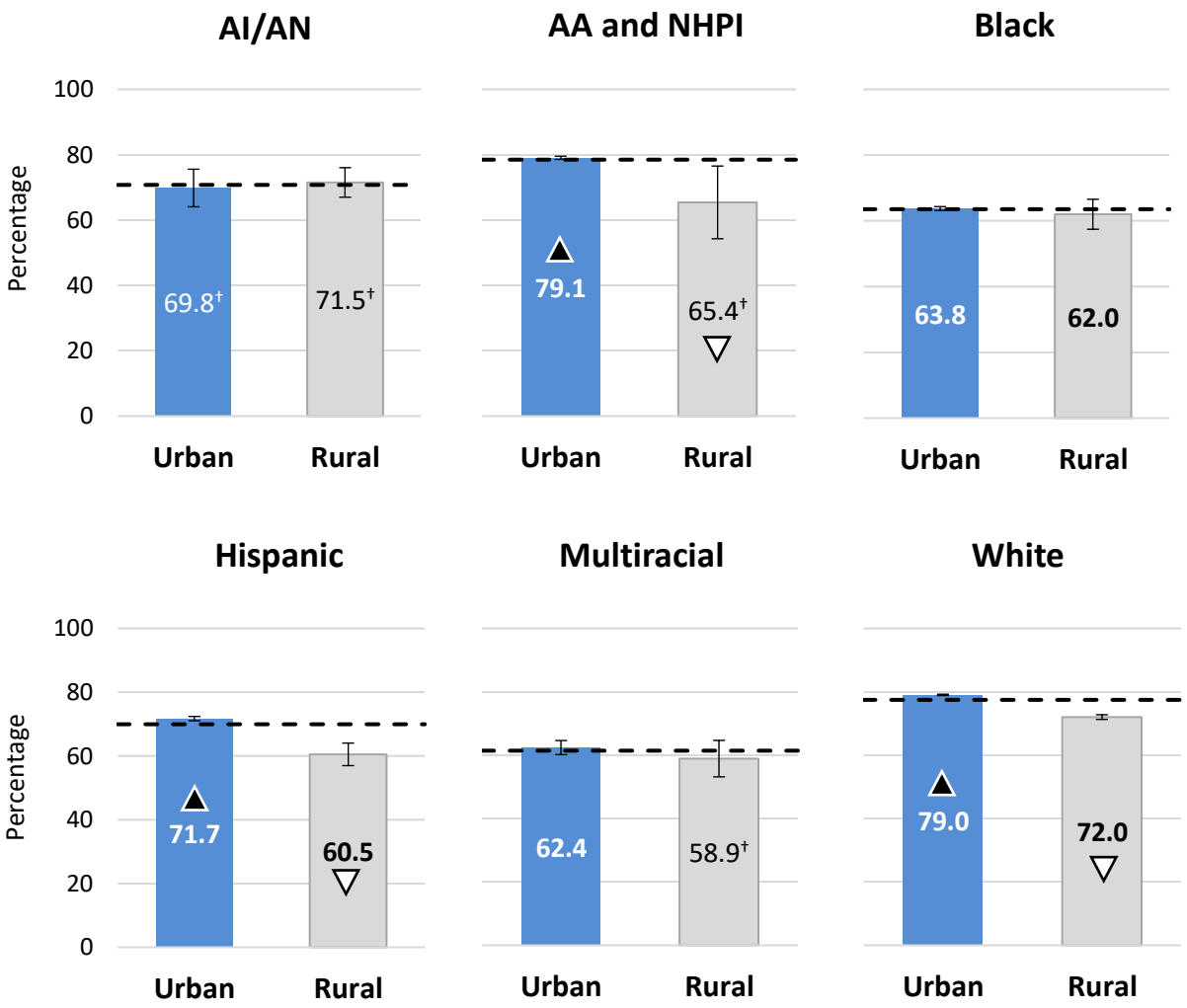
- Hispanic people with FFS coverage living in urban and rural areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all Hispanic people with FFS coverage.

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

- White people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all White people with FFS coverage by less than 3 percentage points. White people with FFS coverage living in rural areas reported experiences with getting needed prescription drugs that were **above** the national average for all White people with FFS coverage by less than 3 percentage points.

Annual Flu Vaccine

Percentage of people with FFS coverage who got a vaccine (flu shot), by geography within racial and ethnic group, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

Disparities

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

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

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

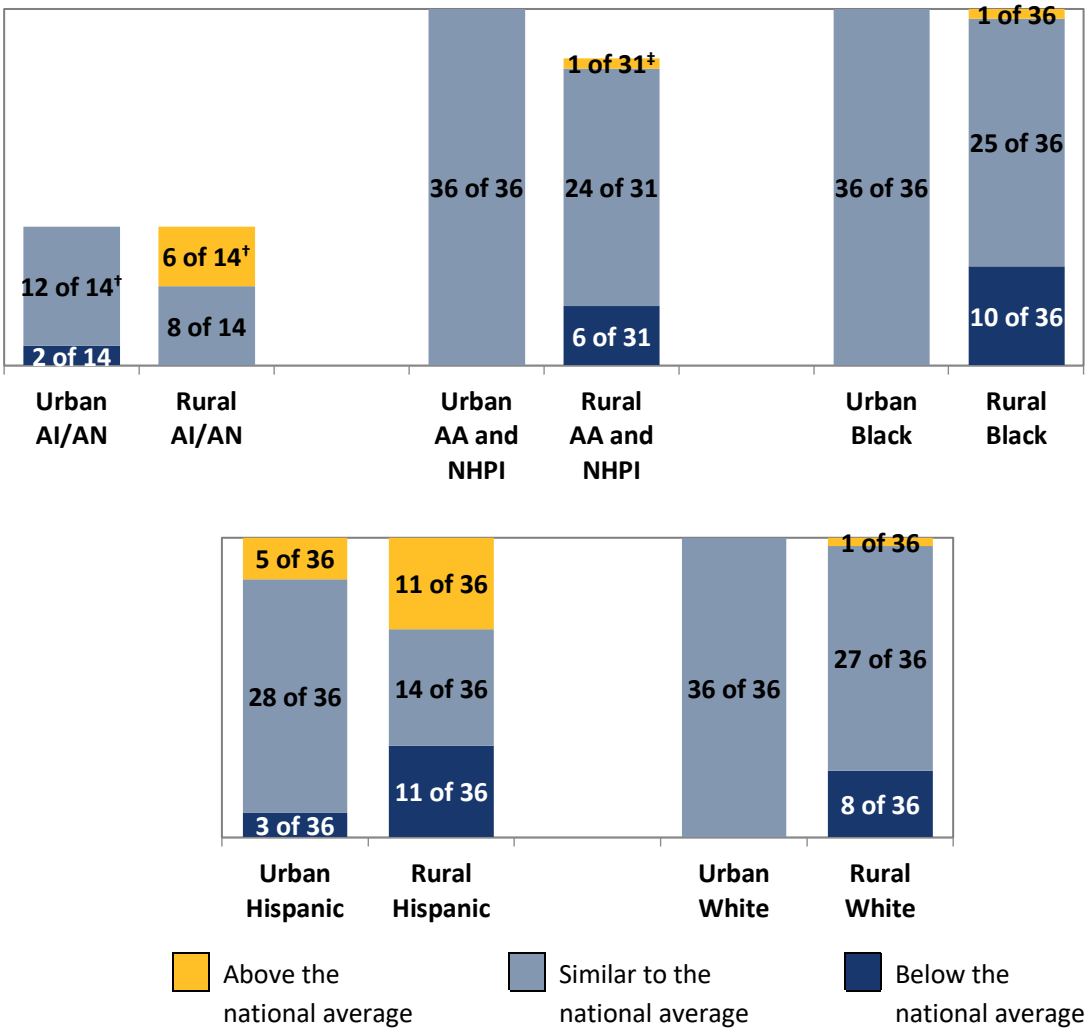
- The percentage of Hispanic people with FFS coverage living in urban areas who received the flu vaccine was **above** the national average for all Hispanic people with FFS coverage by less than 3 percentage points. The percentage of Hispanic people with FFS coverage living in rural areas who received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

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

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

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

Number of clinical care measures for which urban or rural MA enrollees had results that were above, similar to, or below the national average for all MA enrollees of the same race or ethnicity in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care data stratified by race and ethnicity, racial and ethnic group membership is estimated using a method that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when their accuracy does not meet standards described on pp. 4–5. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

† There were not enough data from AI/AN MA enrollees living in urban areas to compare this group to the national average for all AI/AN MA enrollees on 22 clinical care measures. There were also not enough data from AI/AN MA enrollees living in rural areas to compare this group to the national average for all AI/AN MA enrollees on the same 22 measures.

[‡] There were not enough data from AA and NHPI MA enrollees living in rural areas to compare this group to the national average for all AA and NHPI MA enrollees on five clinical care measures.

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

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

AI/AN MA enrollees living in urban areas had results that were below the national average for all AI/AN MA enrollees
• Medication Adherence for Cardiovascular Disease—Statins
• Avoiding Use of Opioids from Multiple Prescribers

AI/AN MA enrollees living in rural areas had results that were above the national average for all AI/AN MA enrollees
• Breast Cancer Screening
• Stain Use in Patients with Cardiovascular Disease
• Medication Adherence for Cardiovascular Disease—Statins
• Medication Adherence for Diabetes—Statins
• Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
• Avoiding Use of Opioids from Multiple Prescribers

AA and NHPI MA enrollees living in rural areas had results that were below the national average for all AA and NHPI MA enrollees
• Testing to Confirm COPD
• Stain Use in Patients with Cardiovascular Disease
• Medication Adherence for Cardiovascular Disease—Statins
• Statin Use in Patients with Diabetes
• Medication Adherence for Diabetes—Statins
• Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

AA and NHPI MA enrollees living in rural areas had results that were above the national average for all AA and NHPI MA enrollees
• Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

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

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

- Colorectal Cancer Screening
- Testing to Confirm COPD
- Rheumatoid Arthritis Management
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management—Acute Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- 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

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

- Avoiding Use of Opioids from Multiple Prescribers

Hispanic MA enrollees living in urban areas had results that were below the national average for all Hispanic MA enrollees

- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information

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

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Antidepressant Medication Management—Acute Phase Treatment
- 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

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

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Medication Adherence for Cardiovascular Disease—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Potentially Harmful Drug-Disease Interactions in 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

Hispanic MA enrollees living in rural areas had results that were above the national average for all Hispanic MA enrollees
• Colorectal Cancer Screening • Controlling High Blood Pressure • Diabetes Care—Eye Exam • Diabetes Care—Blood Pressure 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) • Transitions of Care—Notification of Inpatient Admission • Transitions of Care—Receipt of Discharge Information • Avoiding Use of Opioids from Multiple Prescribers • Older Adults' Access to Preventive/Ambulatory Services

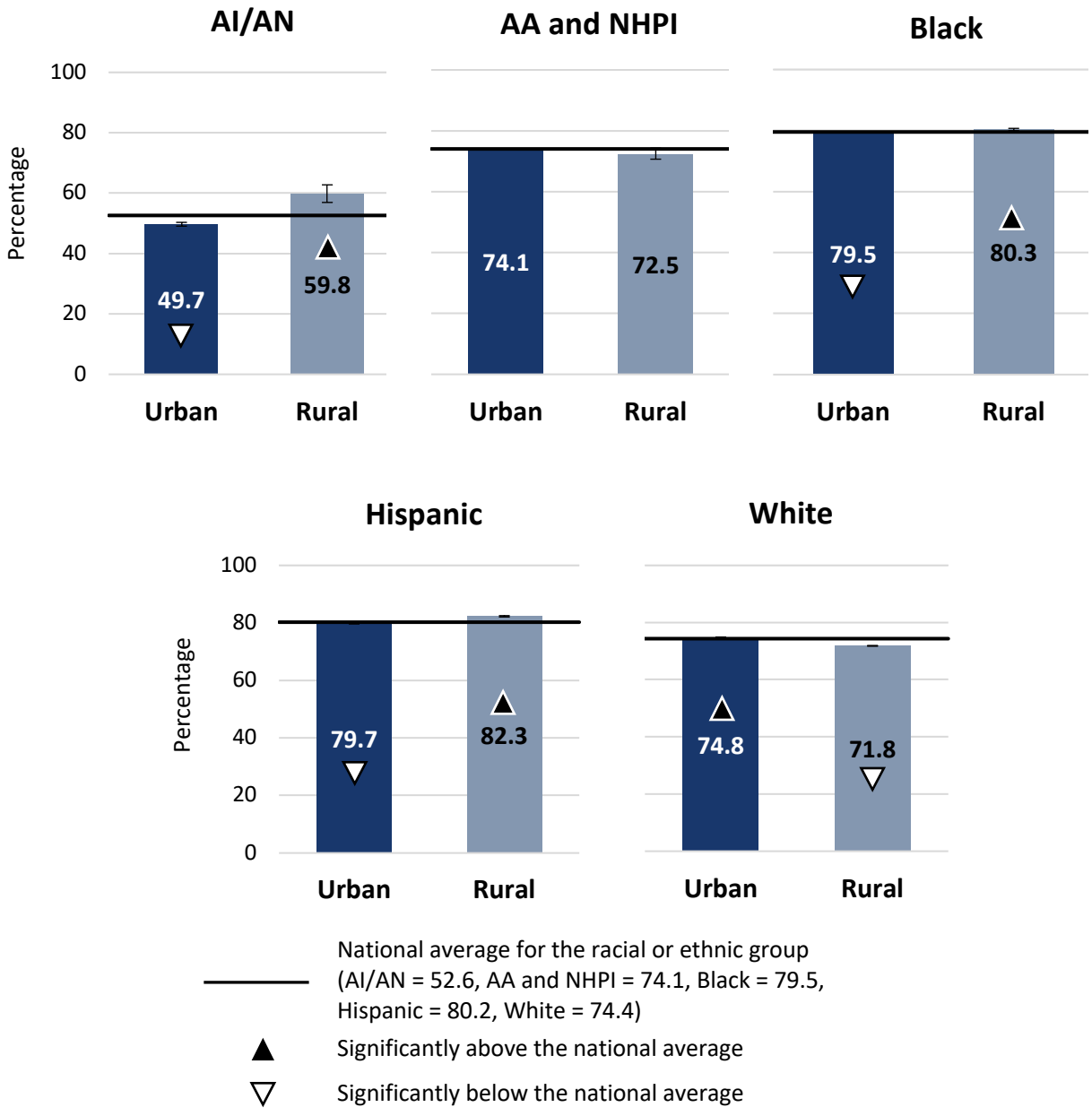
White MA enrollees living in rural areas had results that were below the national average for all White MA enrollees
• Testing to Confirm COPD • Controlling High Blood Pressure • Statin Use in Patients with Diabetes • Osteoporosis Management in Women Who Had a Fracture • Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge) • Follow-Up After ED Visit for Mental Illness (within 30 days of discharge) • Transitions of Care—Notification of Inpatient Admission • Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

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

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

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

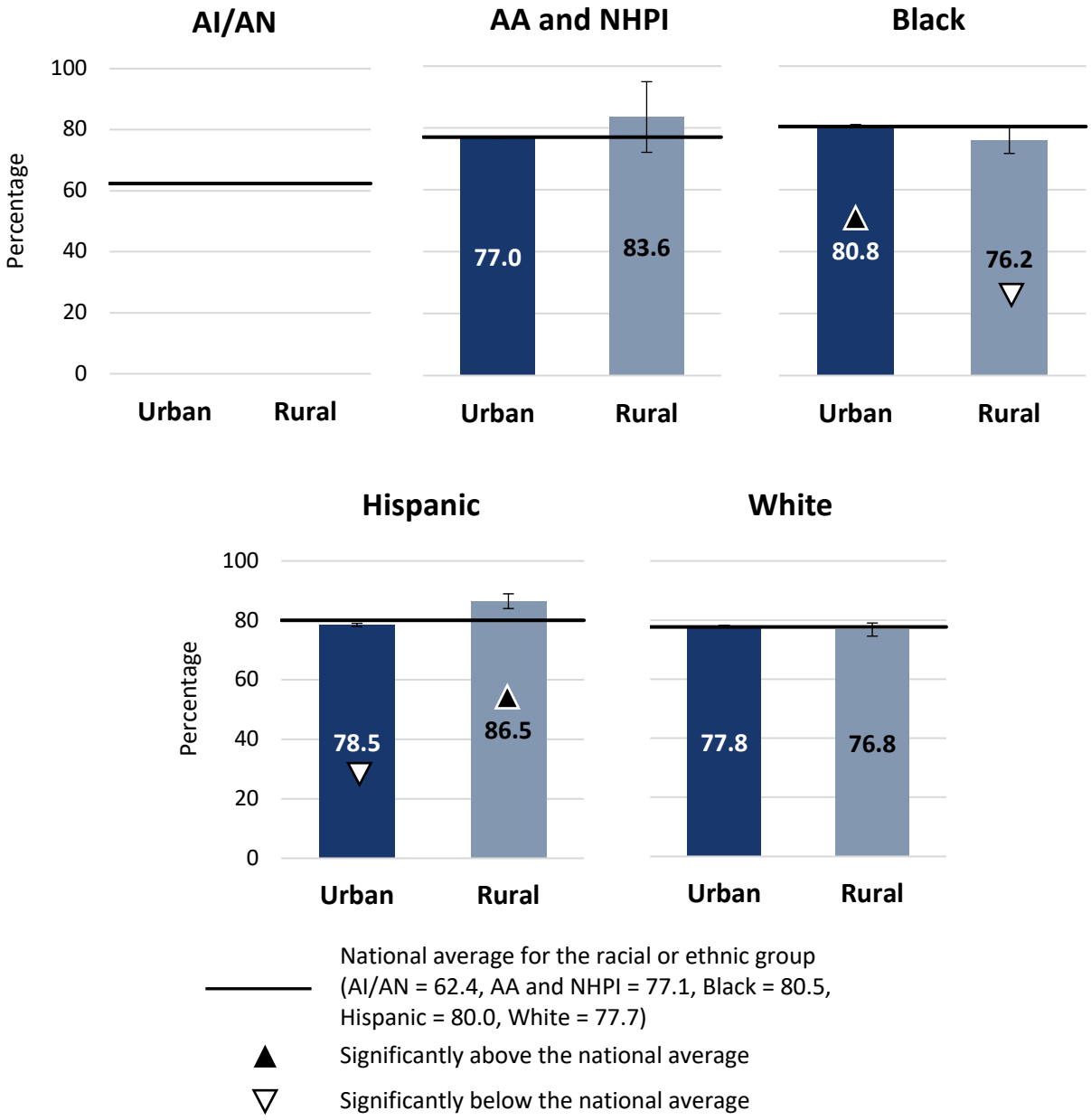
[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (specified at the top of the corresponding page).

[‡] Unlike on pages 89–92, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

[§] Prior to rounding.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

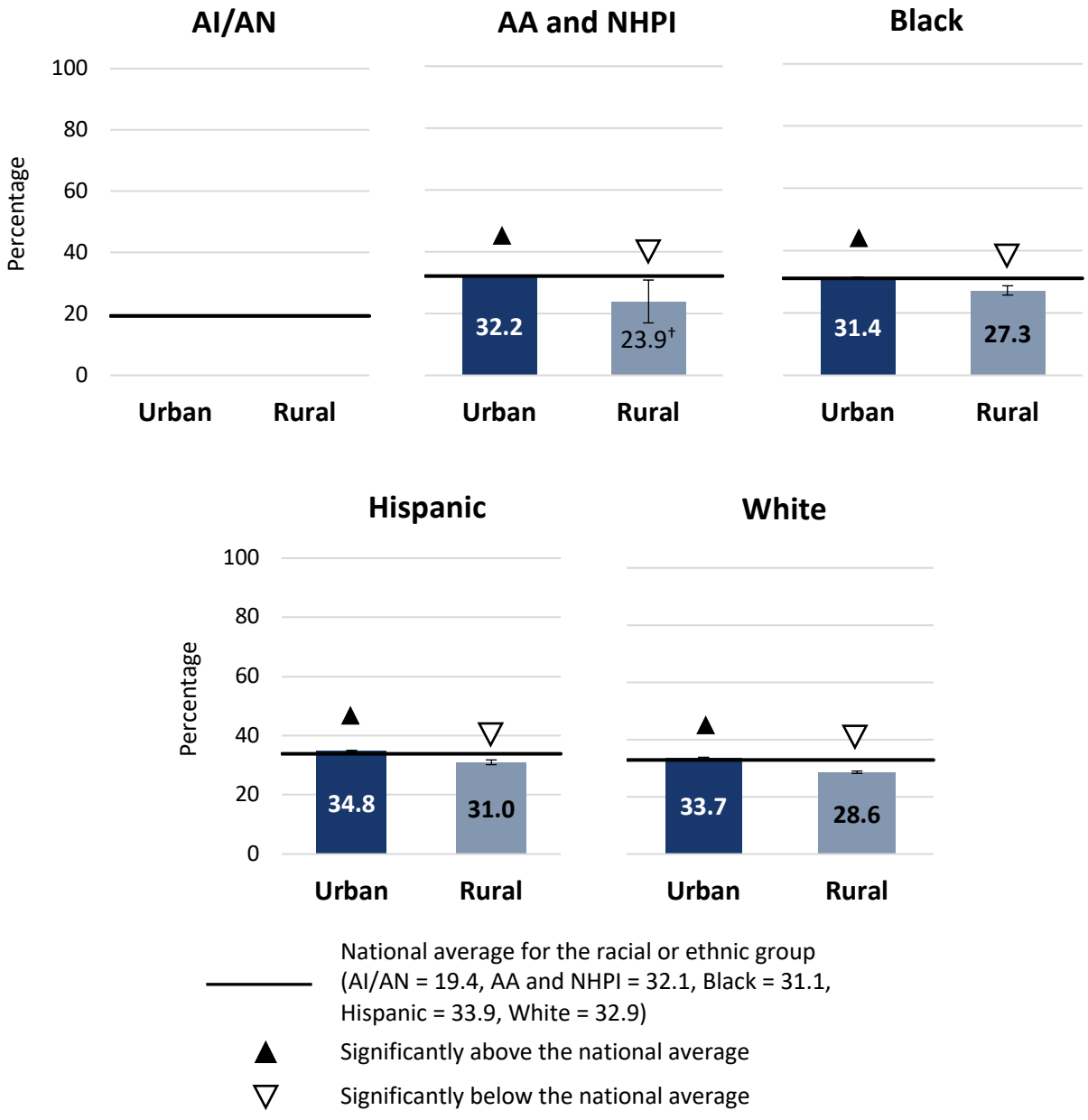
- The percentage of eligible Hispanic MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas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

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

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

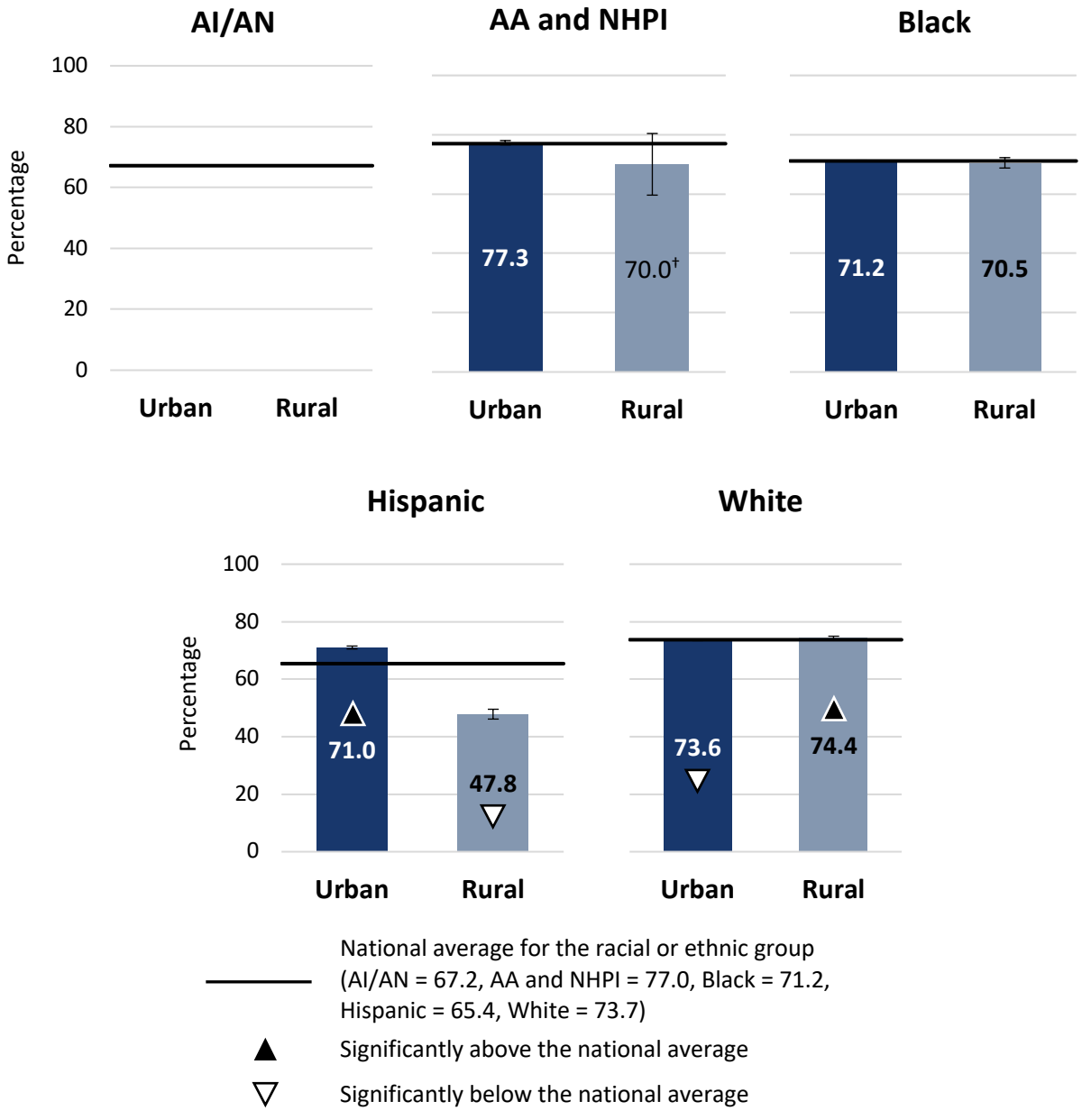
- The percentage of eligible Black MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas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

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

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

Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

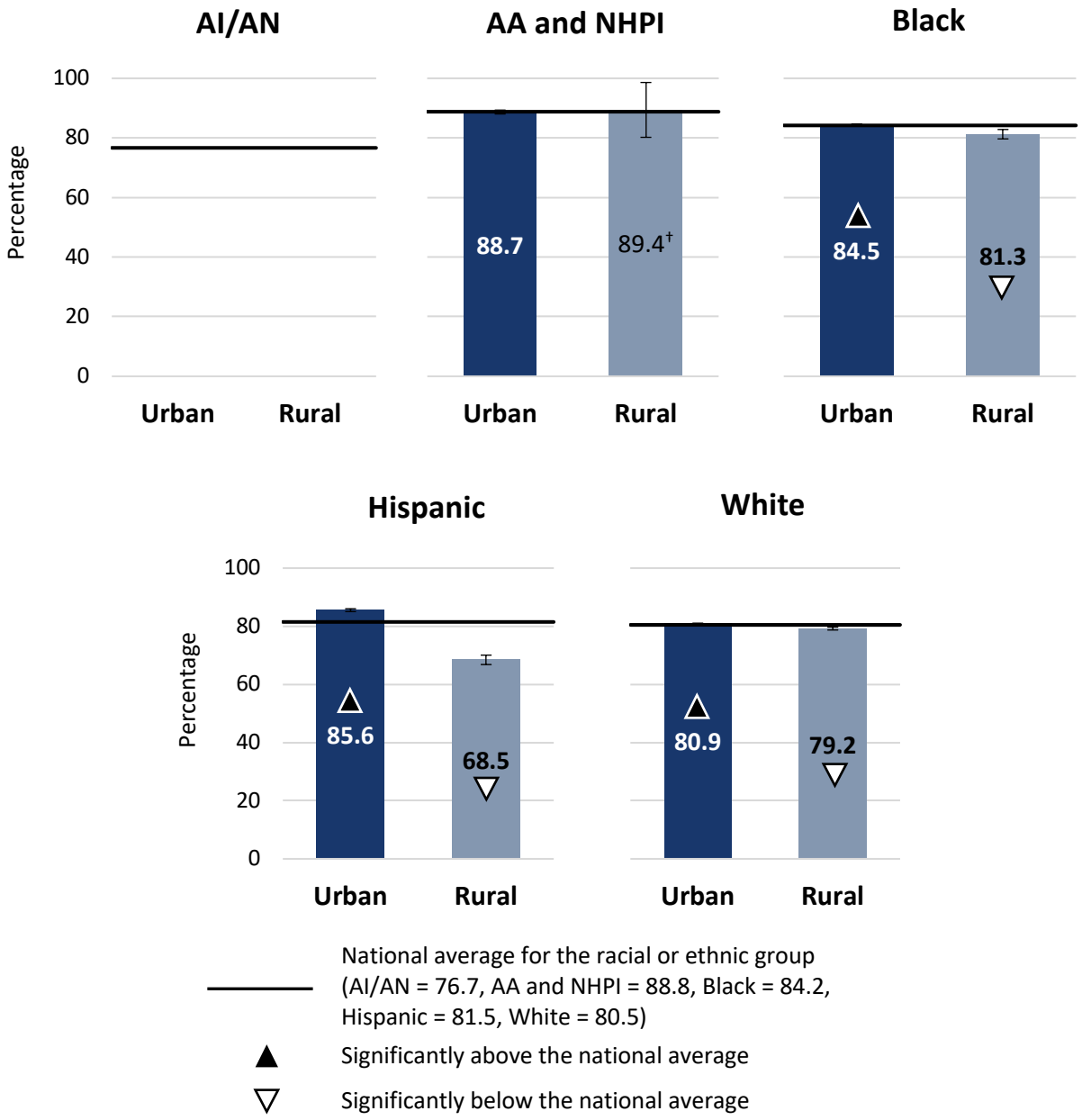
- The percentages of eligible Black MA enrollees living in urban and rural areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **similar to** the national average for all eligible Black MA enrollees.

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

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

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

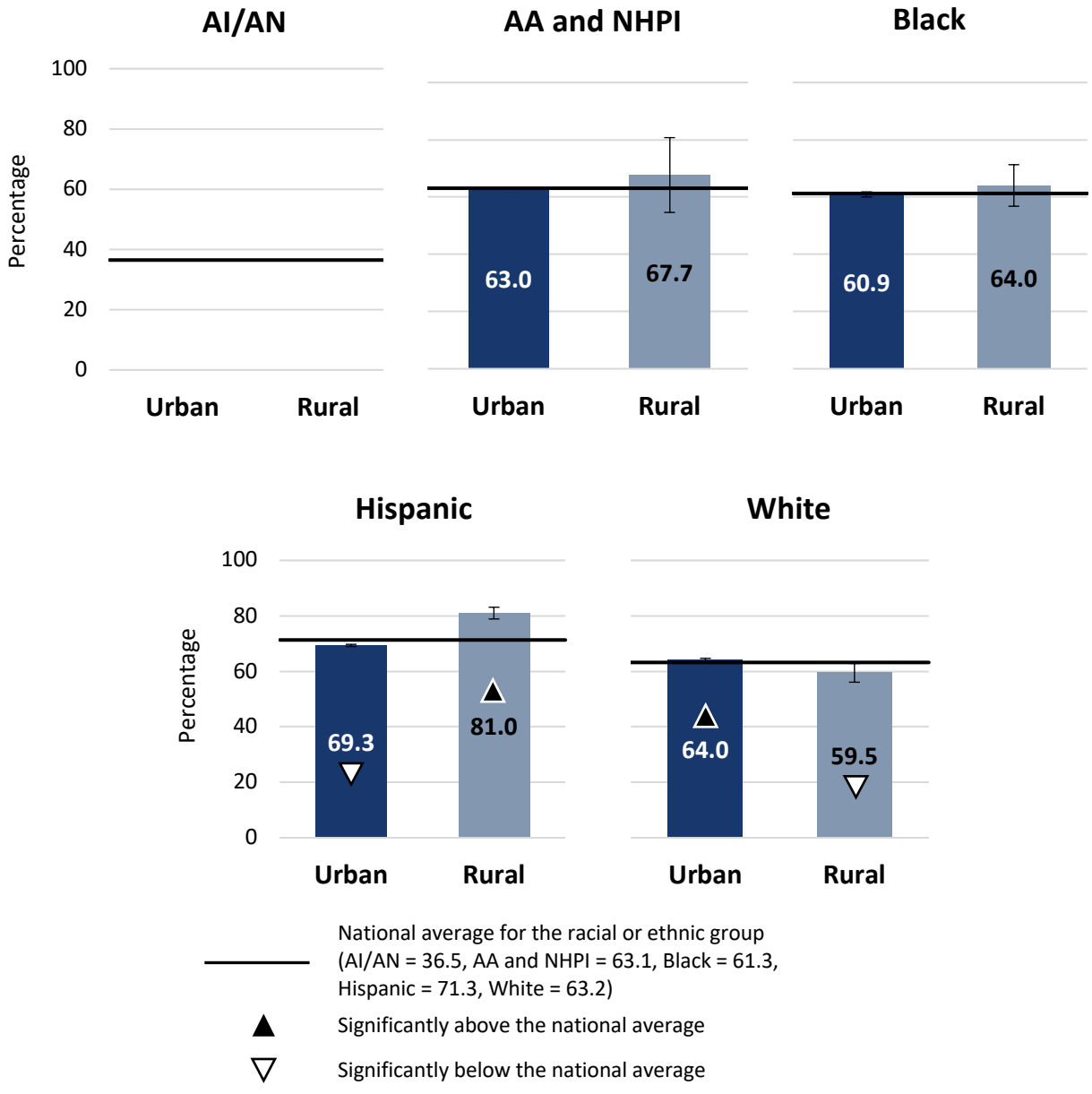
- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of eligible Hispanic MA enrollees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

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

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

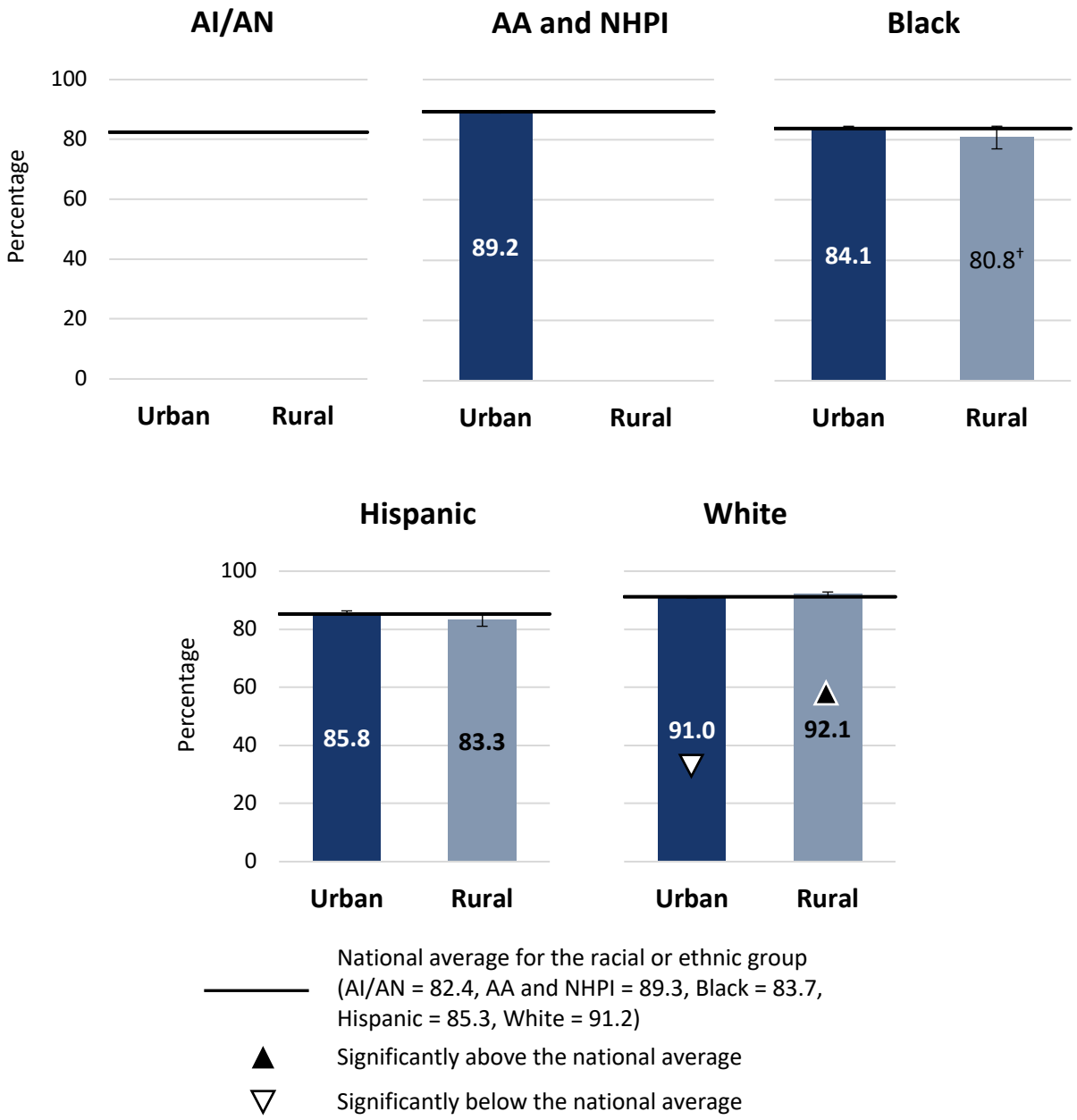
- The percentages of eligible Black MA enrollees living in urban and rural areas who had their blood pressure adequately controlled were each **similar to** the national average for all eligible Black MA enrollees.

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

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

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of AMI who received continuous beta-blocker treatment for six months after discharge, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

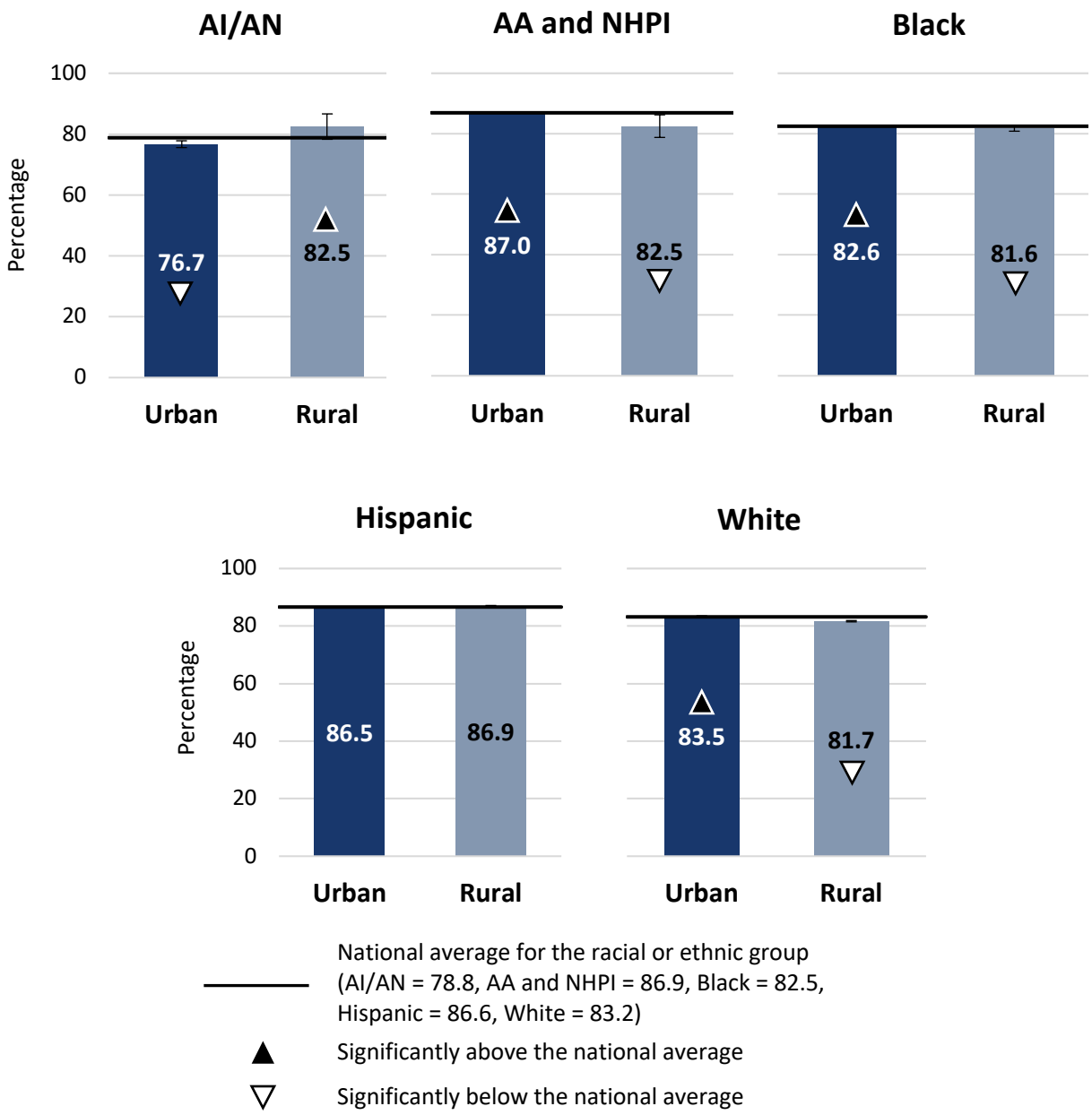
- The percentages of eligible Black MA enrollees living in urban and rural areas who received continuous beta-blocker treatment were each **similar to** the national average for all eligible Black MA enrollees.

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

- The percentage of eligible White MA enrollees living in urban areas who received continuous beta-blocker treatment was **below** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who received continuous beta-blocker treatment was **above** the national average for all eligible White MA enrollees by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who received statin therapy, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

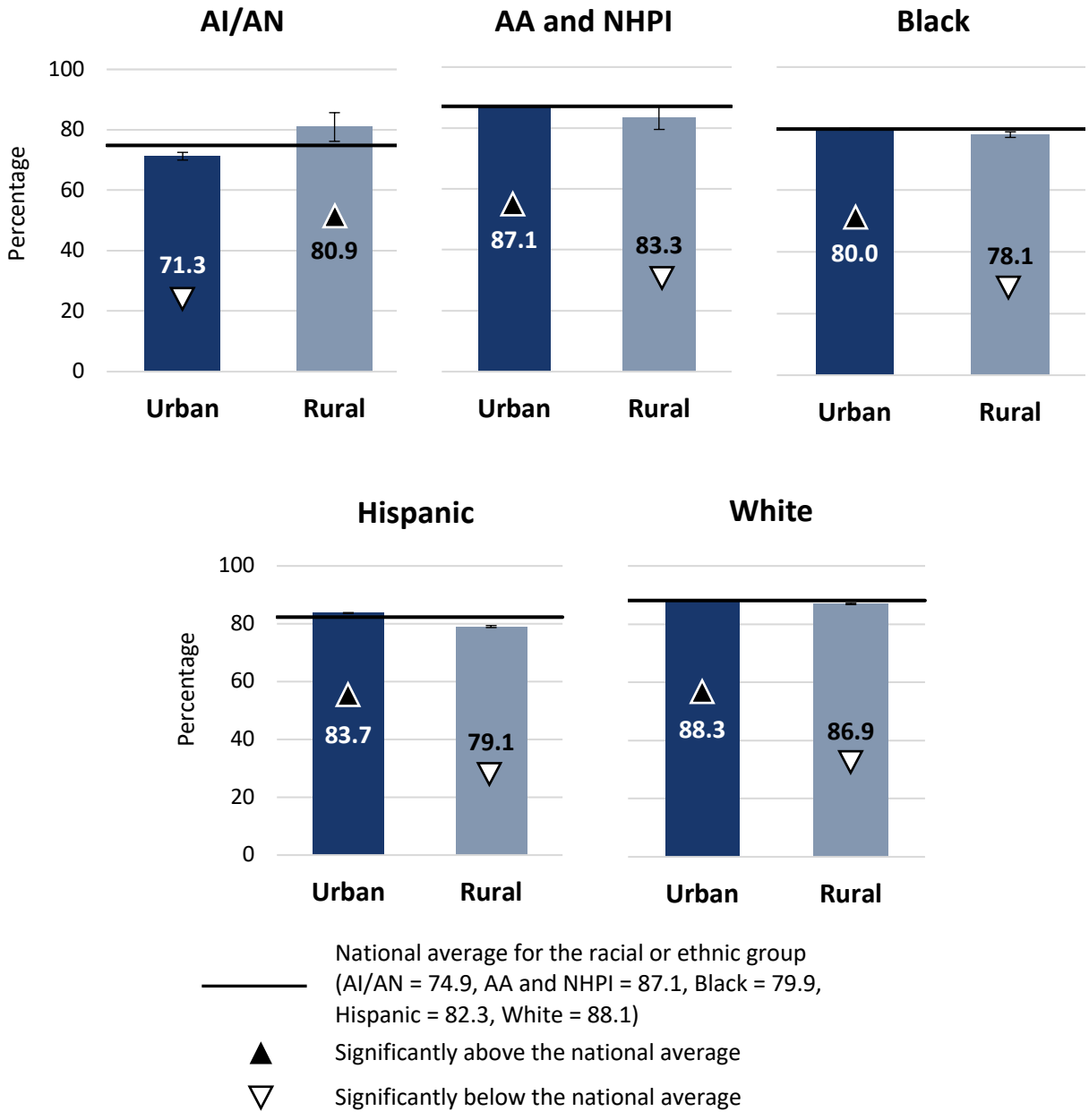
- The percentage of Black MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **above** the national average for all Black MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Black MA enrollees with clinical ASCVD living in rural areas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

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

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

Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication who remained on the medication for at least 80 percent of the treatment period, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

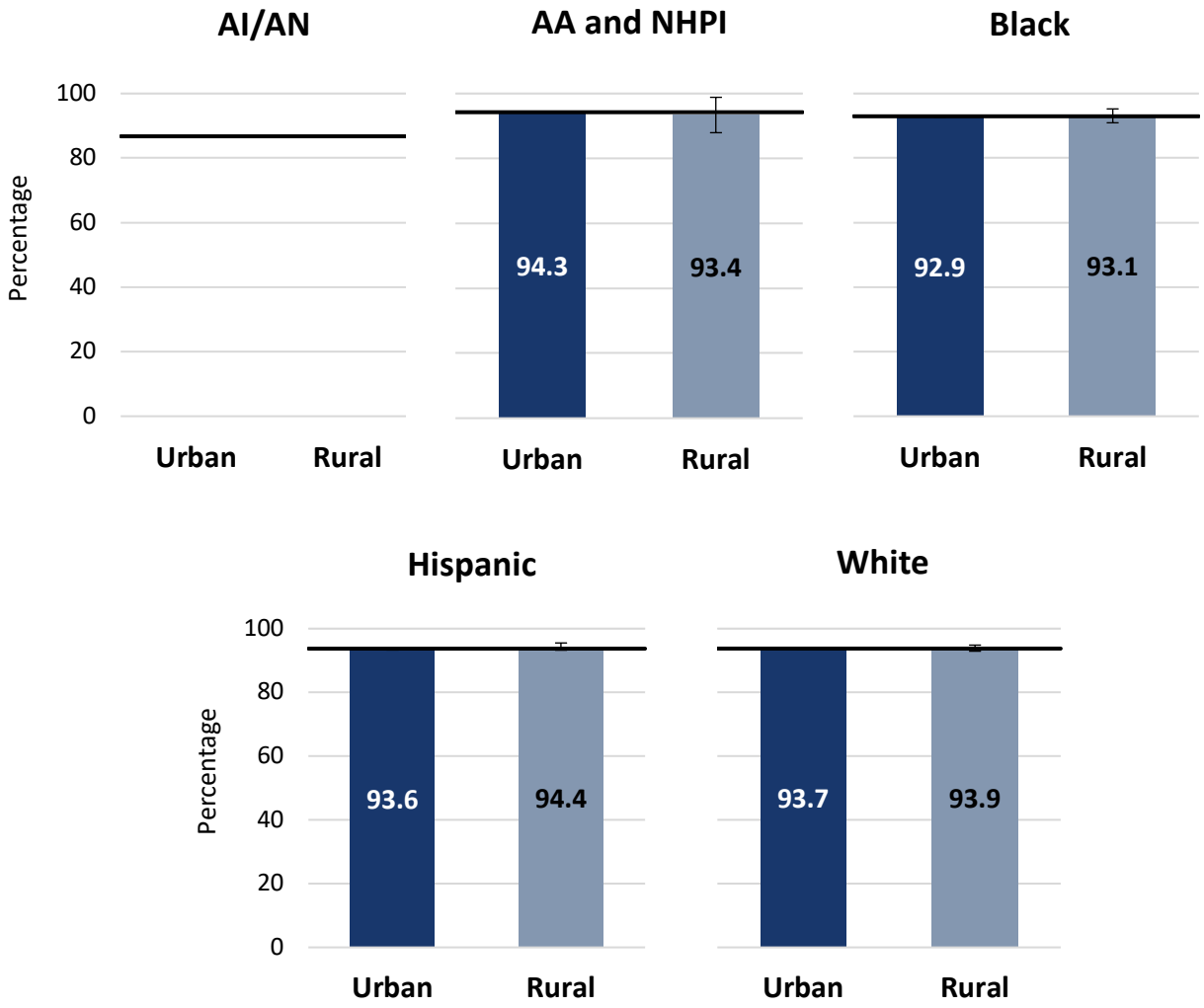
- The percentage of Hispanic MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all Hispanic MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of Hispanic MA enrollees with clinical ASCVD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

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

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

- The percentages of AA and NHPI MA enrollees with diabetes living in urban and rural areas who had their blood sugar tested at least once in the past year were each **similar to** the national average for all AA and NHPI MA enrollees with diabetes.

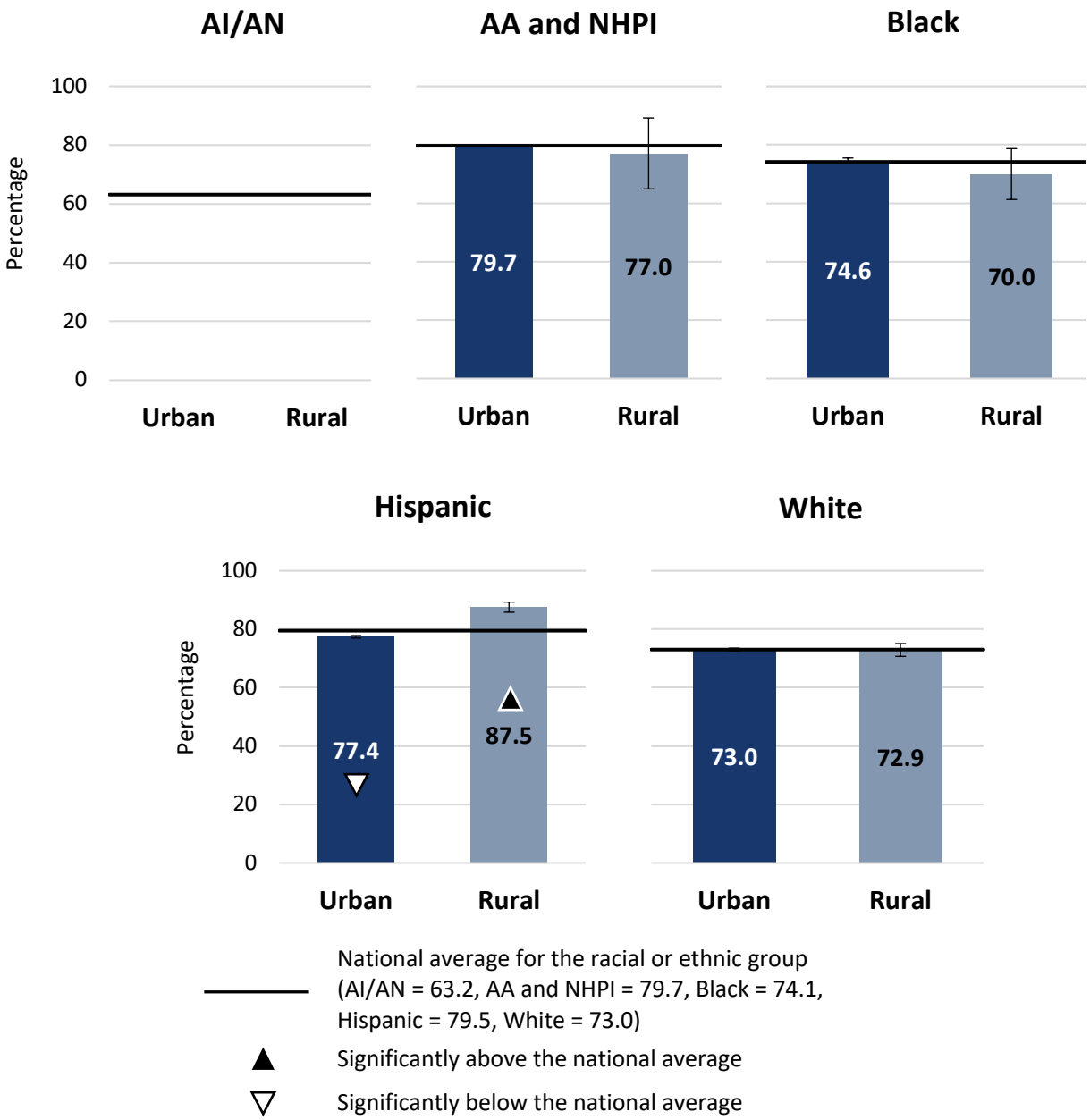
- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had their blood sugar tested at least once in the past year were each **similar to** the national average for all Black MA enrollees with diabetes.

- The percentages of Hispanic MA enrollees with diabetes living in urban and rural areas who had their blood sugar tested at least once in the past year were each **similar to** the national average for all Hispanic MA enrollees with diabetes.

- The percentages of White MA enrollees with diabetes living in urban and rural areas who had their blood sugar tested at least once in the past year were each **similar to** the national average for all White MA enrollees with diabetes.

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

- The percentages of AA and NHPI MA enrollees with diabetes living in urban and rural areas who had an eye exam in the past year were each **similar to** the national average for all AA and NHPI MA enrollees with diabetes.

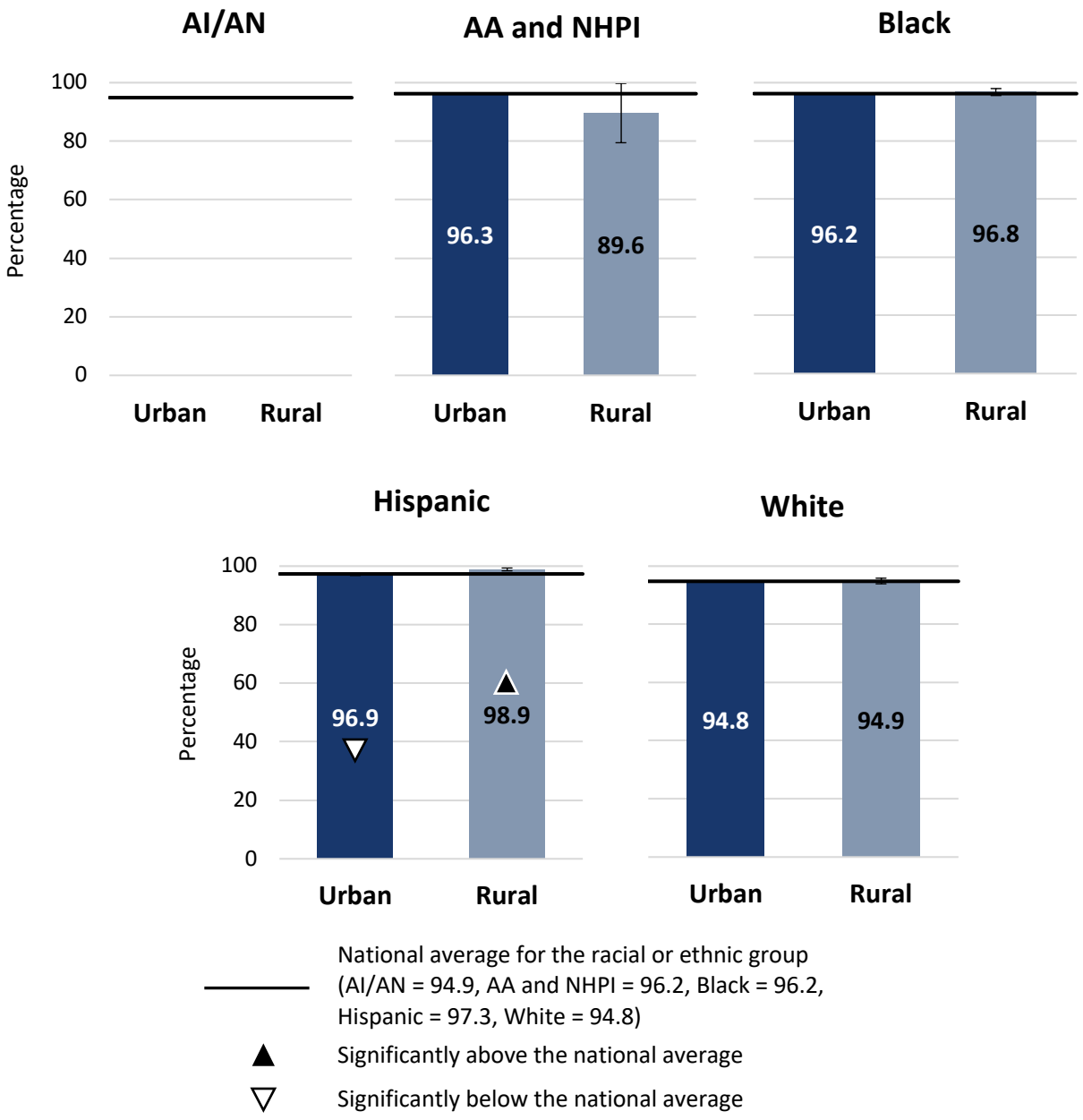
- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had an eye exam in the past year were each **similar to** the national average for all Black MA enrollees with diabetes.

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

- The percentages of White MA enrollees with diabetes living in urban and rural areas who had an eye exam in the past year were each **similar to** the national average for all White MA enrollees with diabetes.

Diabetes Care—Kidney Disease Monitoring

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

- The percentages of AA and NHPI MA enrollees with diabetes living in urban and rural areas who had medical attention for nephropathy in the past year were each **similar to** the national average for all AA and NHPI MA enrollees with diabetes.

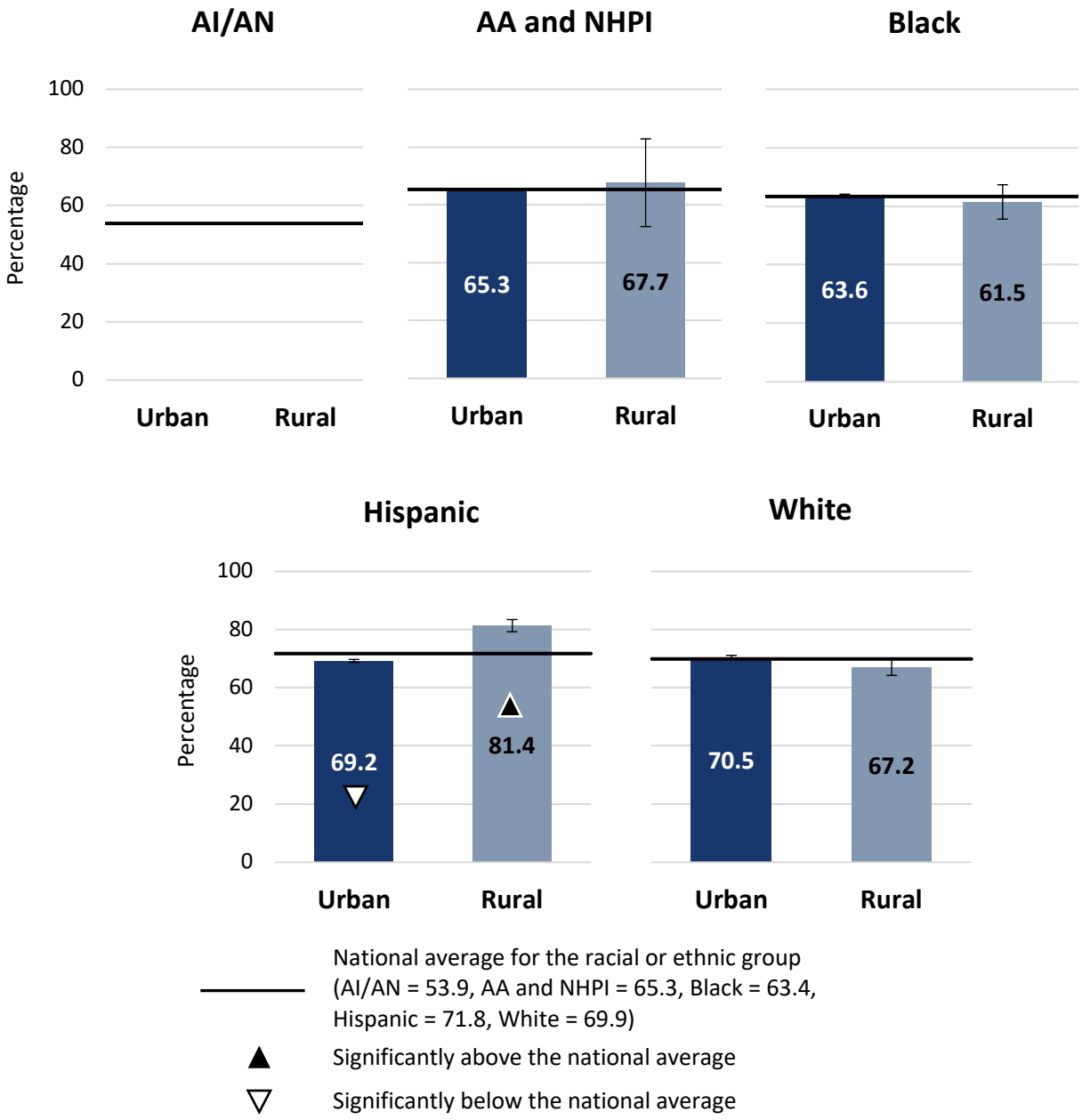
- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had medical attention for nephropathy in the past year were each **similar to** the national average for all Black MA enrollees with diabetes.

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

- The percentages of White MA enrollees with diabetes living in urban and rural areas who had medical attention for nephropathy in the past year were each **similar to** the national average for all White MA enrollees with diabetes.

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

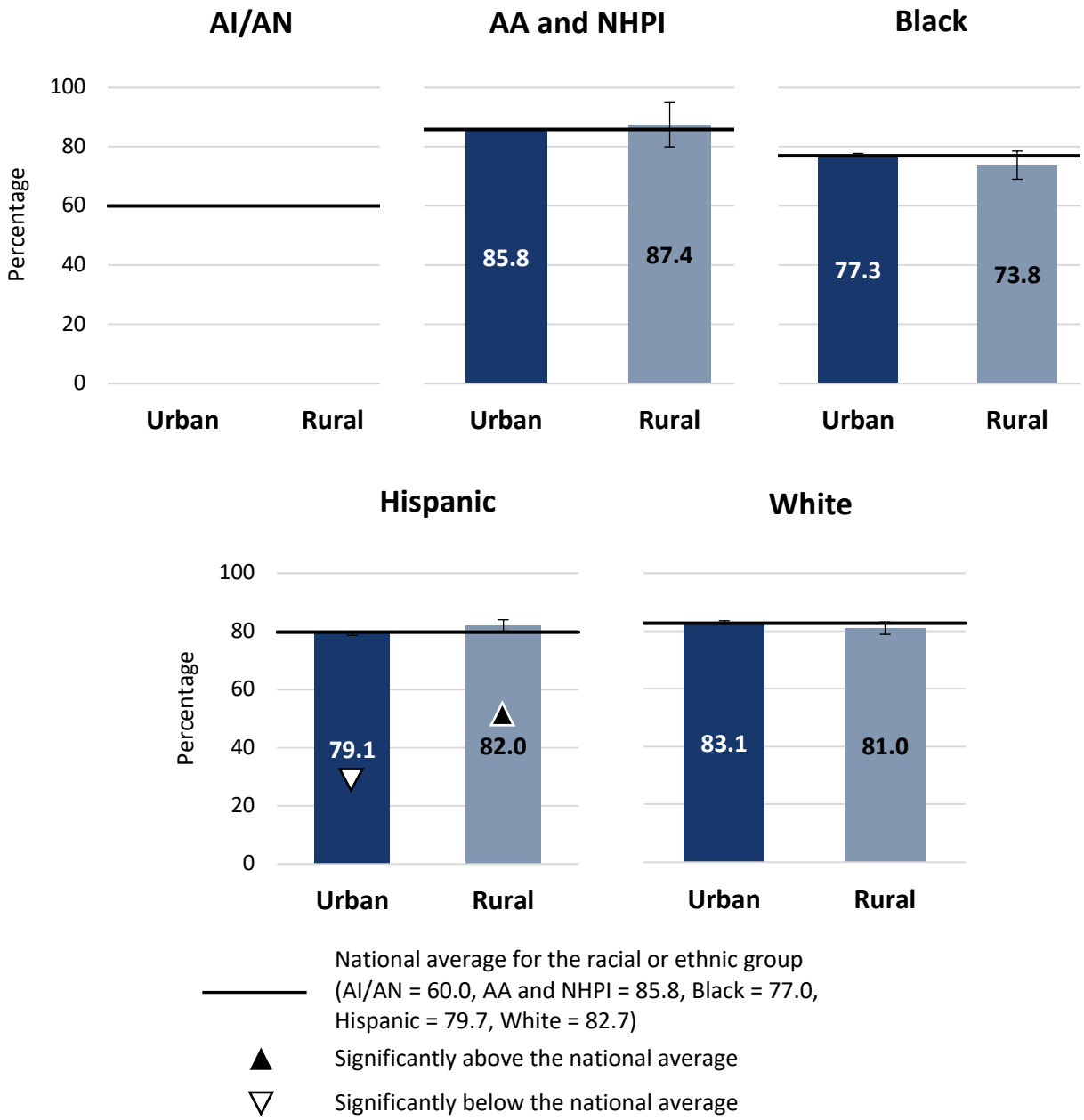
- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had their blood pressure under control were each **similar to** the national average for all Black MA enrollees with diabetes.

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

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

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

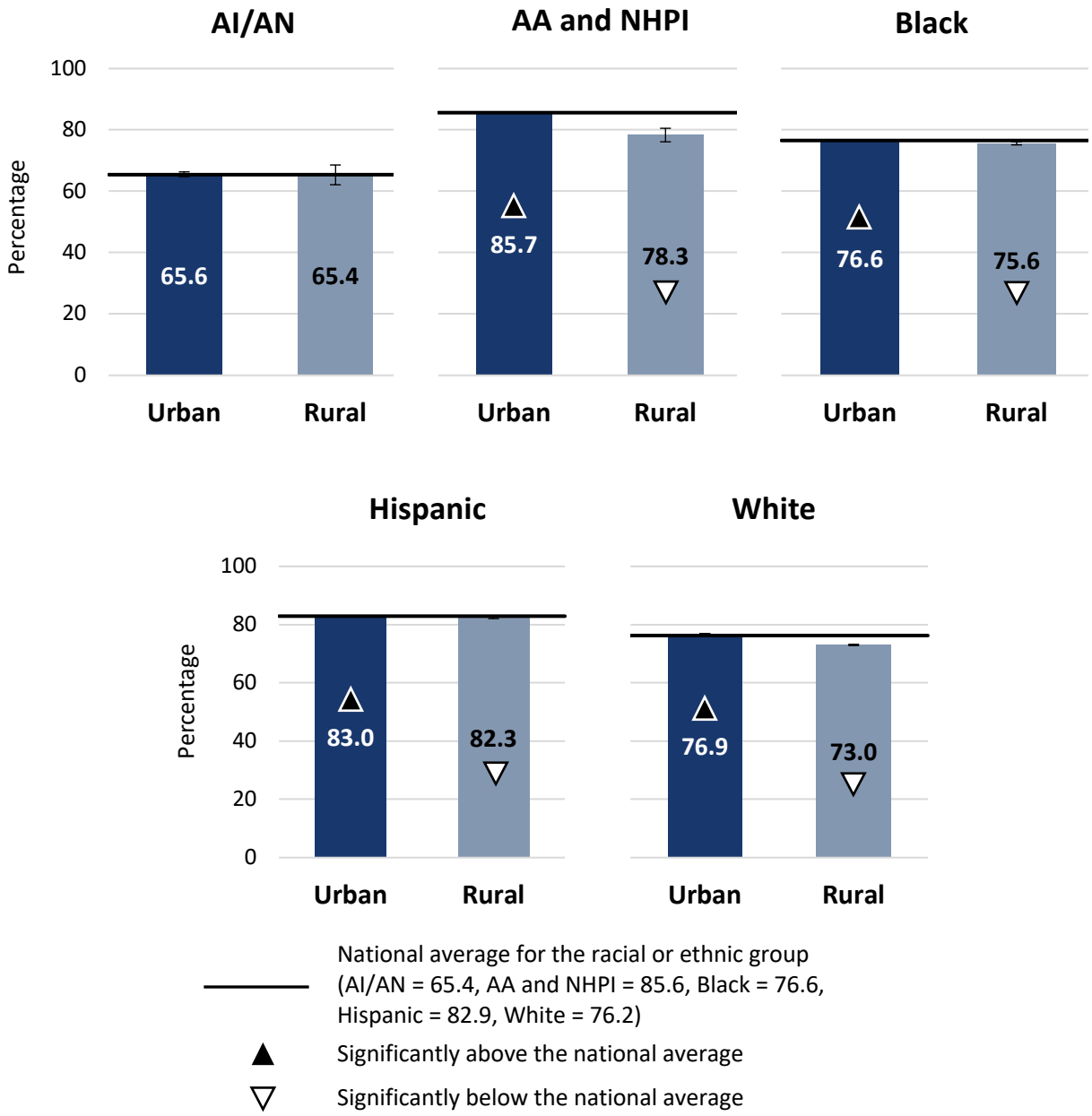
- The percentages of Black MA enrollees with diabetes living in urban and rural areas who had their blood sugar level under control were each **similar to** the national average for all Black MA enrollees with diabetes.

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

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

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who received statin therapy, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Excludes those who also have clinical ASCVD.

Disparities

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

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

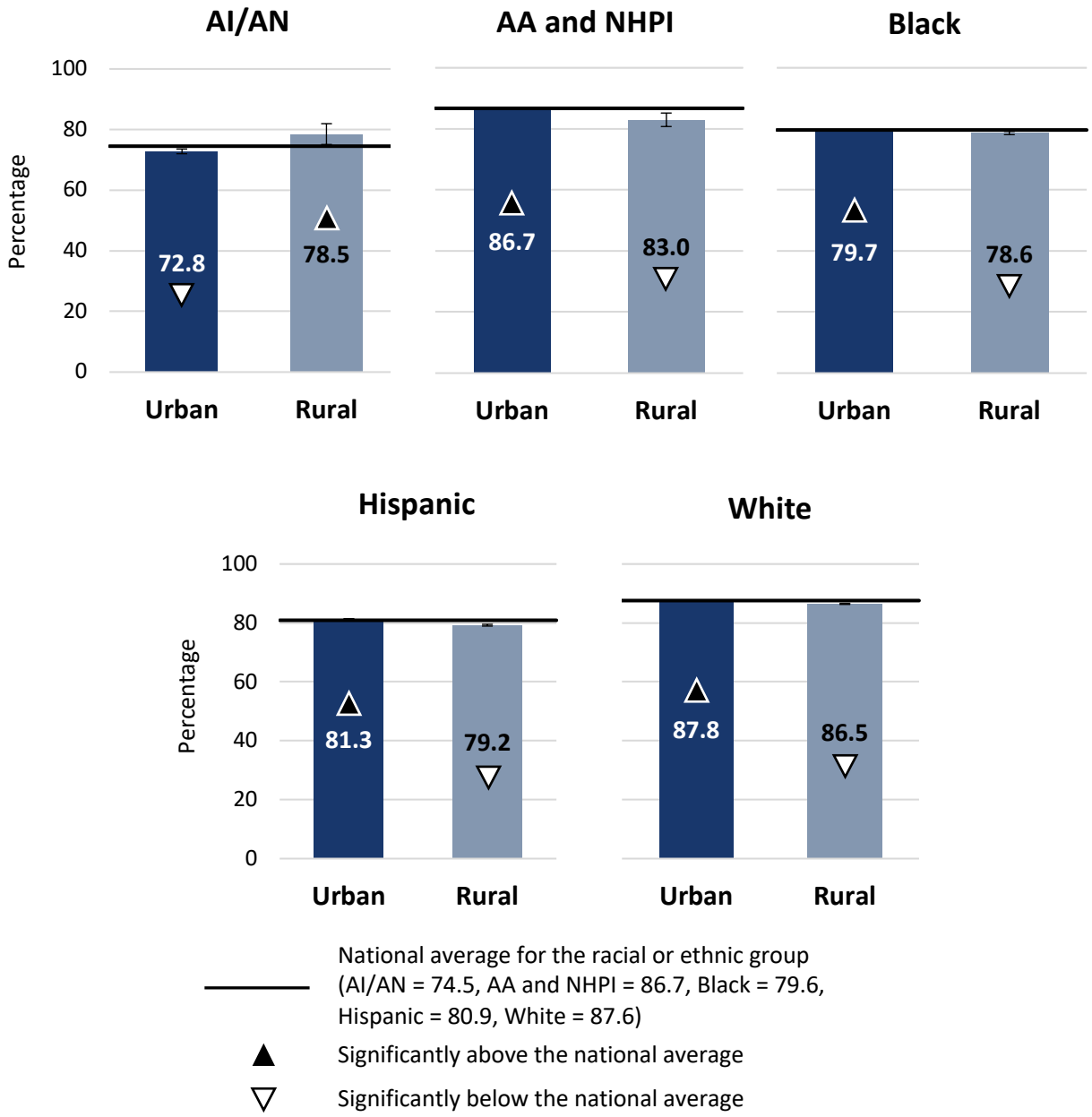
- The percentage of Black MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all Black MA enrollees with diabetes by less than 3 percentage points. The percentage of Black MA enrollees with diabetes living in rural areas who received statin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

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

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

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Excludes those who also have clinical ASCVD.

Disparities

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

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

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

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

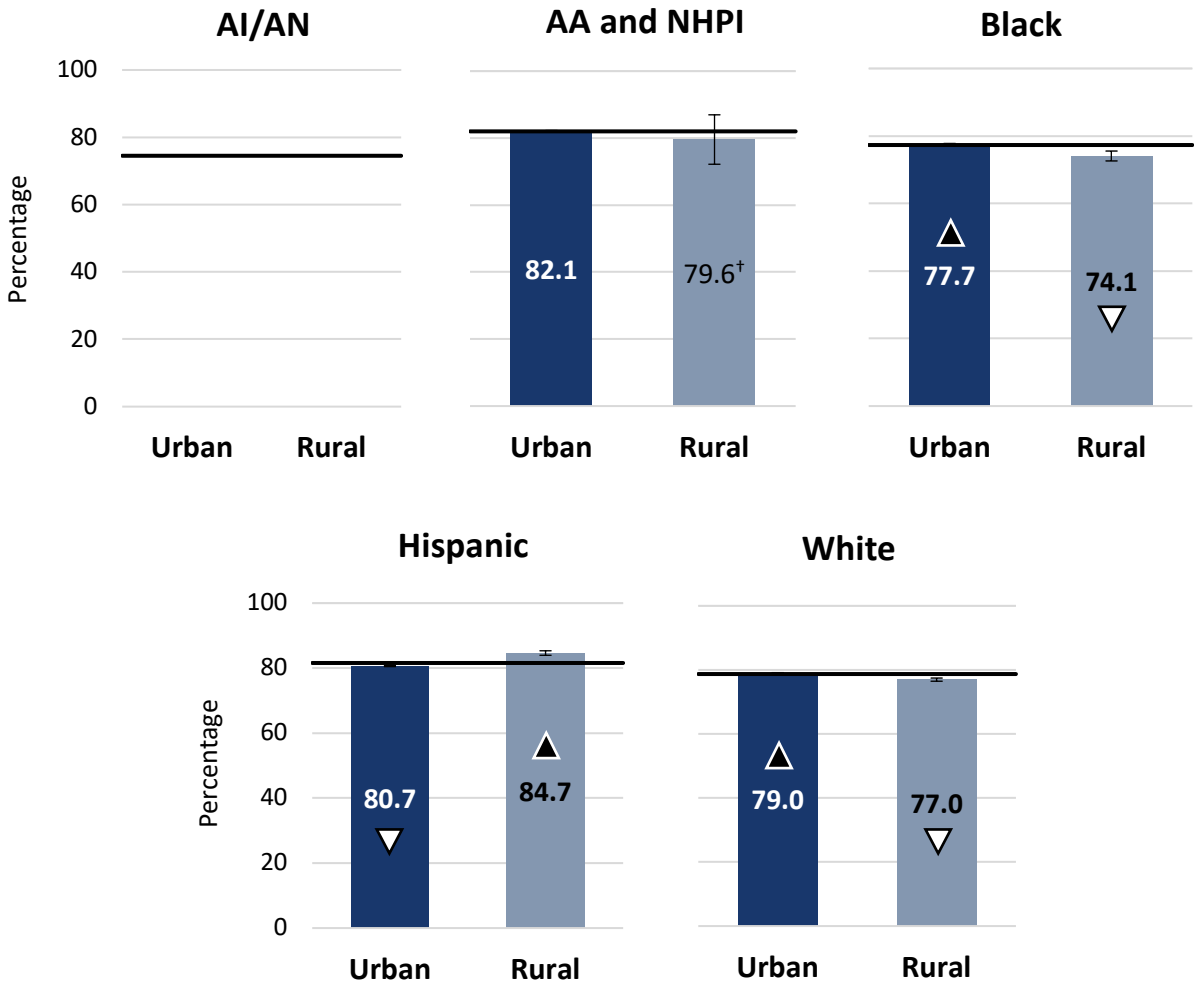
- The percentage of White MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all White MA enrollees with diabetes by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas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

[‡] Prior to rounding.

Clinical Care: Musculoskeletal Conditions

Rheumatoid Arthritis Management

Percentage of MA enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a DMARD, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentages of eligible AA and NHPI MA enrollees living in urban and rural areas who were dispensed at least one DMARD were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

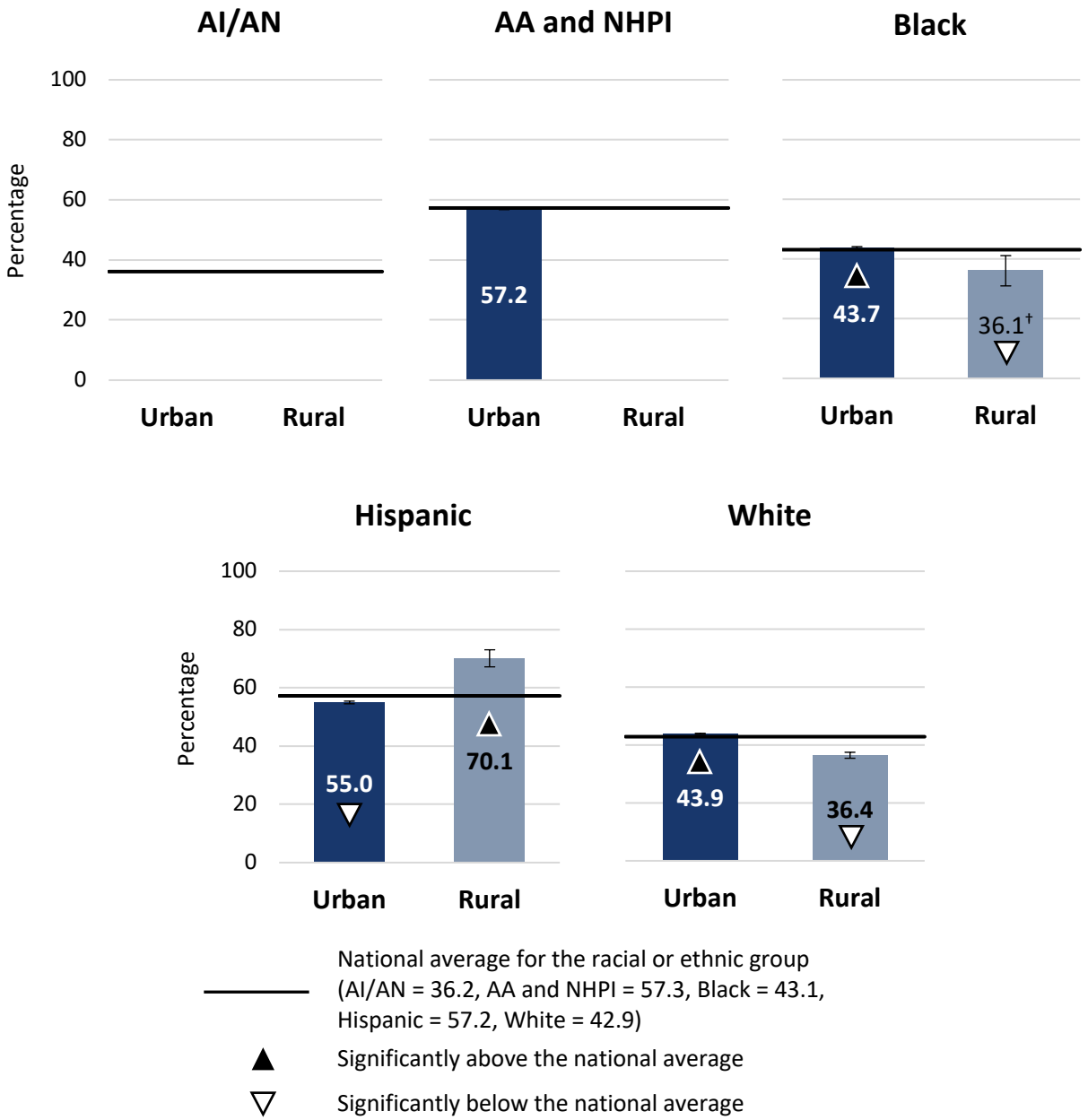
- The percentage of eligible Black MA enrollees living in urban areas who were dispensed at least one DMARD was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who were dispensed at least one DMARD was **below** the national average for all eligible Black MA enrollees by more than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed at least one DMARD was **below** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who were dispensed at least one DMARD was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were dispensed at least one DMARD was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who were dispensed at least one DMARD was **below** the national average for all eligible White MA enrollees by less than 3 percentage points.

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of eligible female AA and NHPI MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **similar to** the national average for all eligible female AA and NHPI MA enrollees. There were not enough data from female AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible female AA and NHPI MA enrollees on this measure.

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

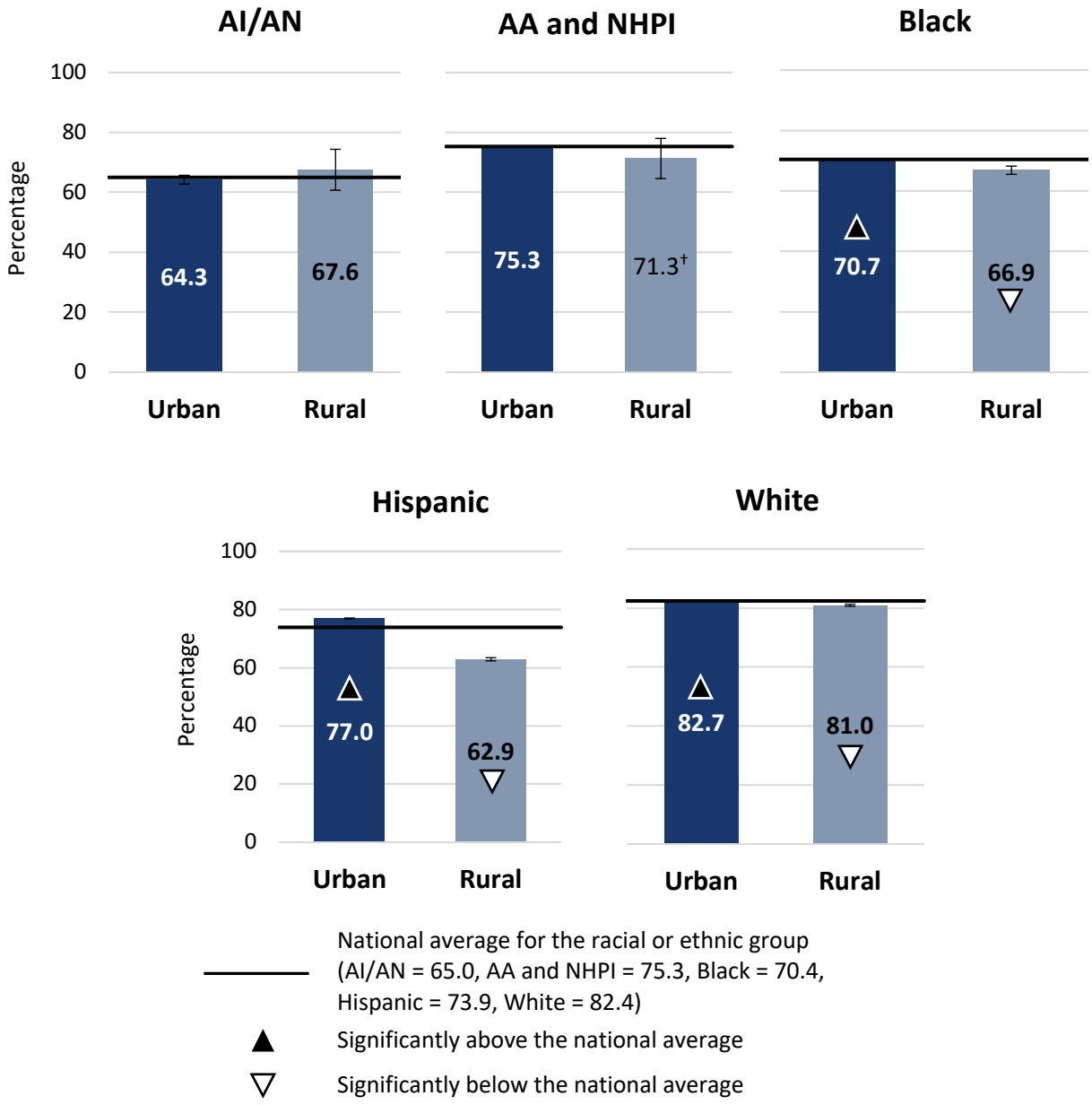
- The percentage of eligible female Hispanic MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female Hispanic MA enrollees by less than 3 percentage points. The percentage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

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

Clinical Care: Behavioral Health

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

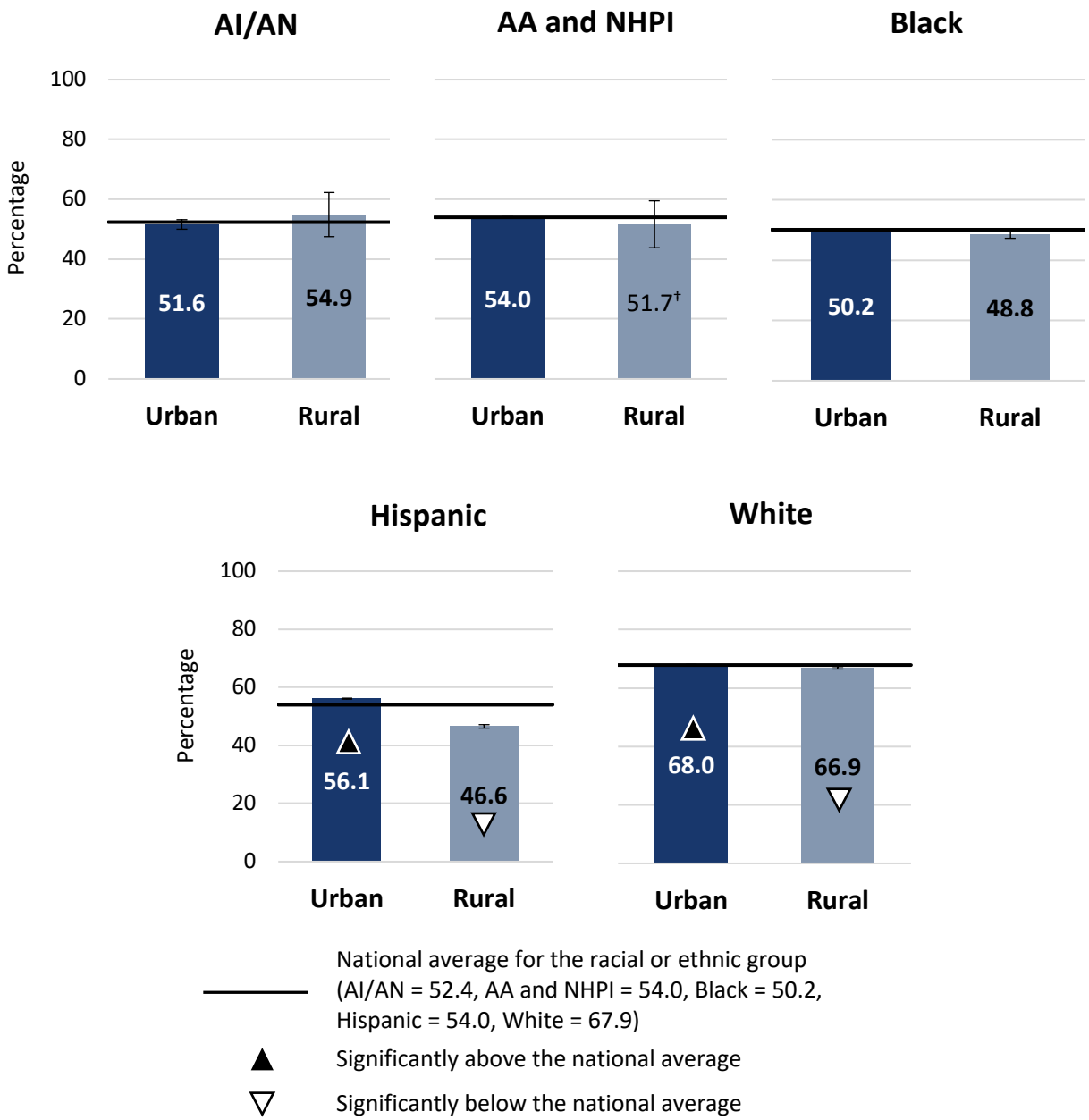
- The percentage of eligible Black MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of eligible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

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

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

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

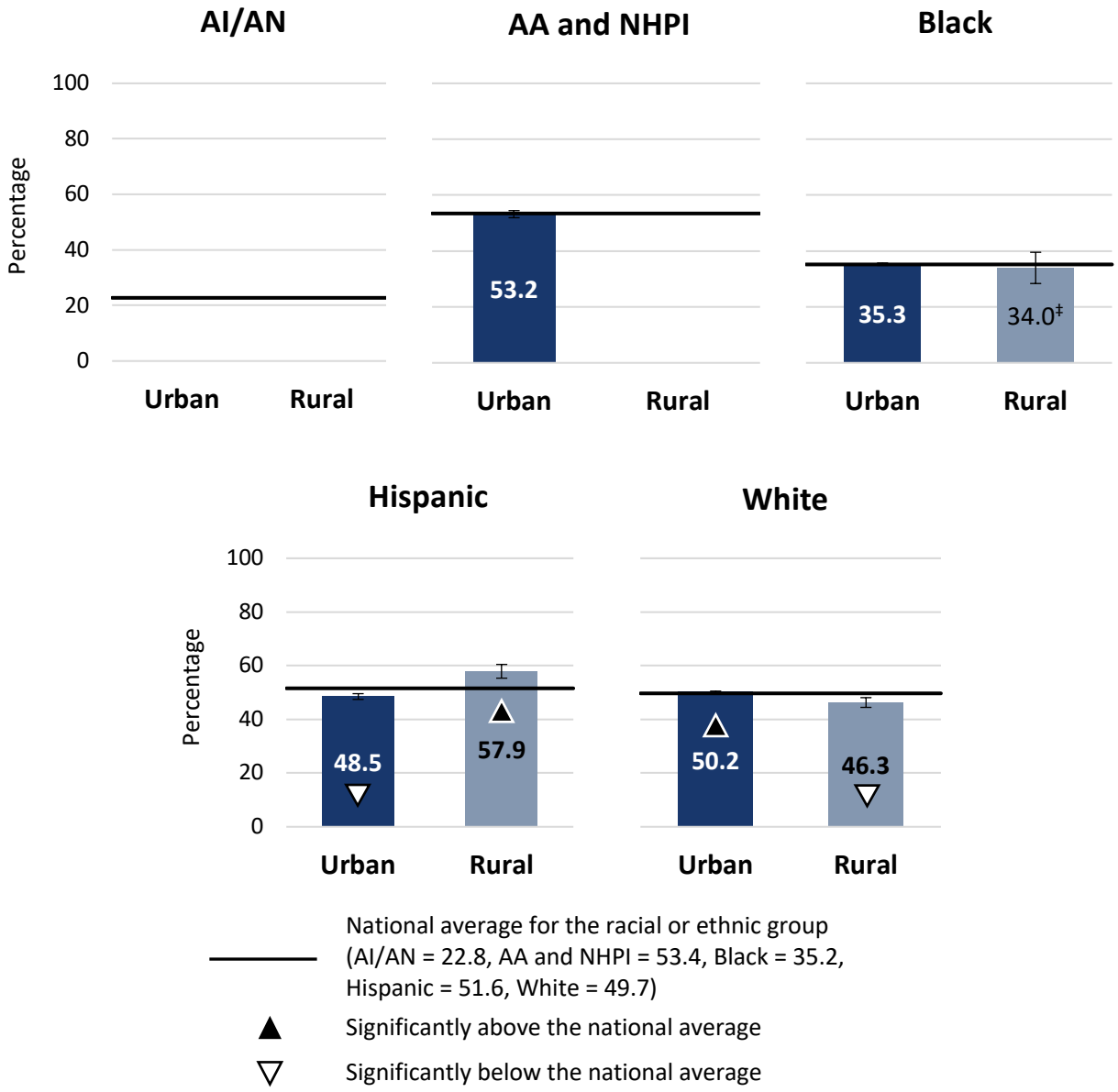
- The percentages of eligible Black MA enrollees living in urban and rural areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **similar to** the national average for all eligible Black MA enrollees.

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

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

Disparities

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

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

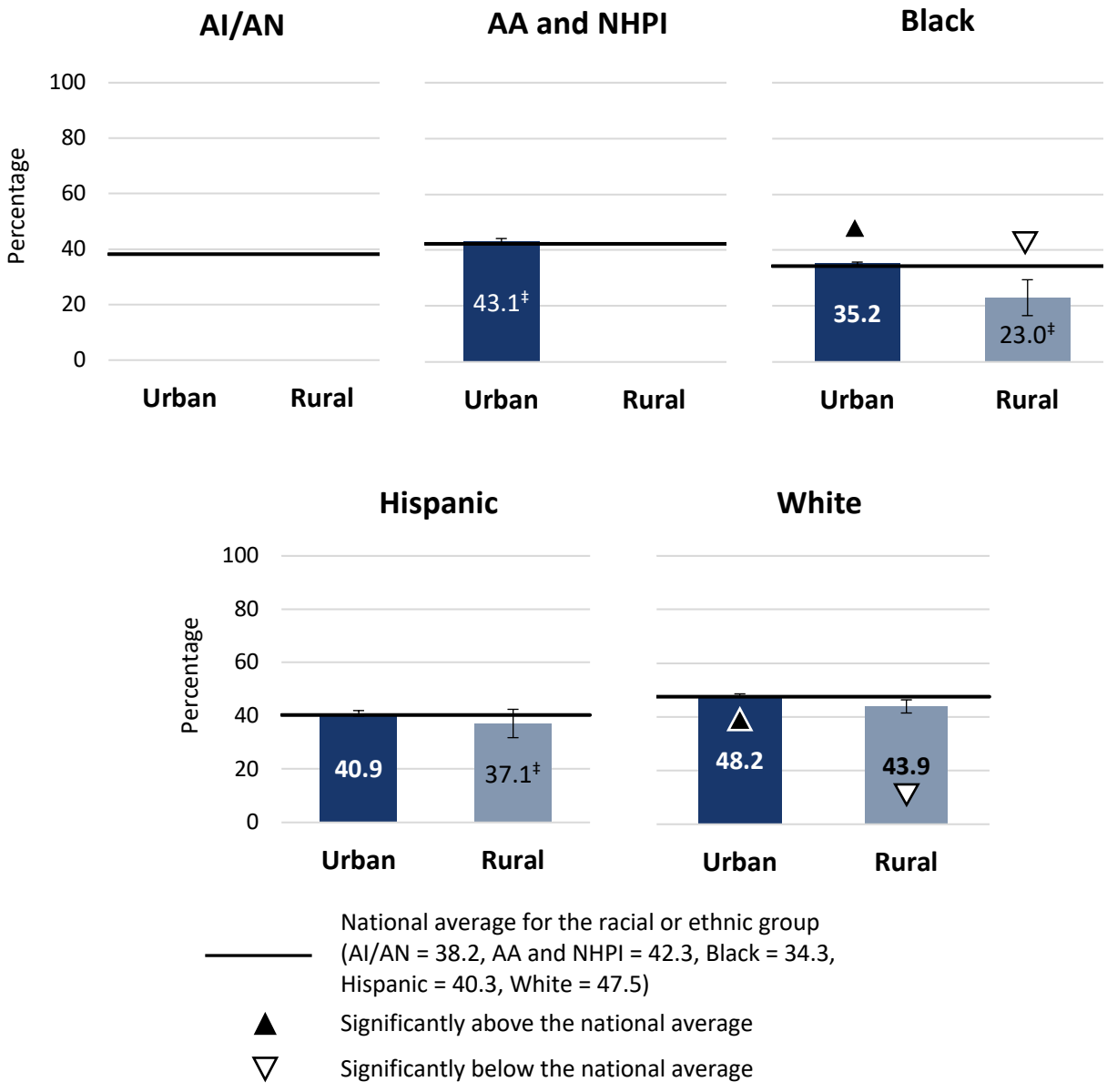
- The percentages of Black MA enrollees living in urban and rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible White MA enrollees by more than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

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

Disparities

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

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

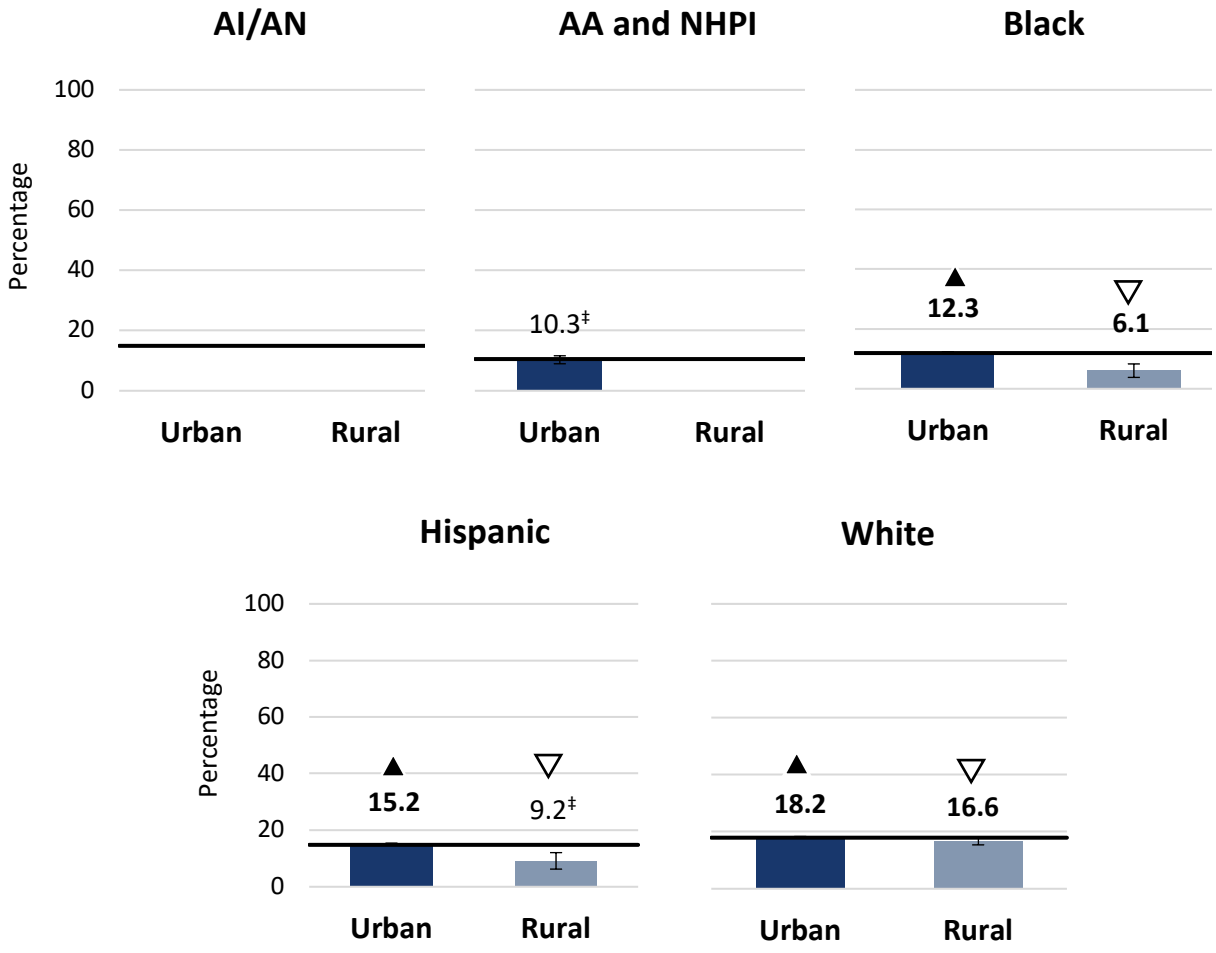
- The percentage of Black MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points.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

- The percentages of Hispanic MA enrollees living in urban and rural areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit were each **similar to** the national average for all eligible Hispanic MA enrollees.

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

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

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

Disparities

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

- The percentage of AA and NHPI MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all eligible AA and NHPI MA enrollees. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare this group's score to the national average for all eligible AA and NHPI MA enrollees on this measure.

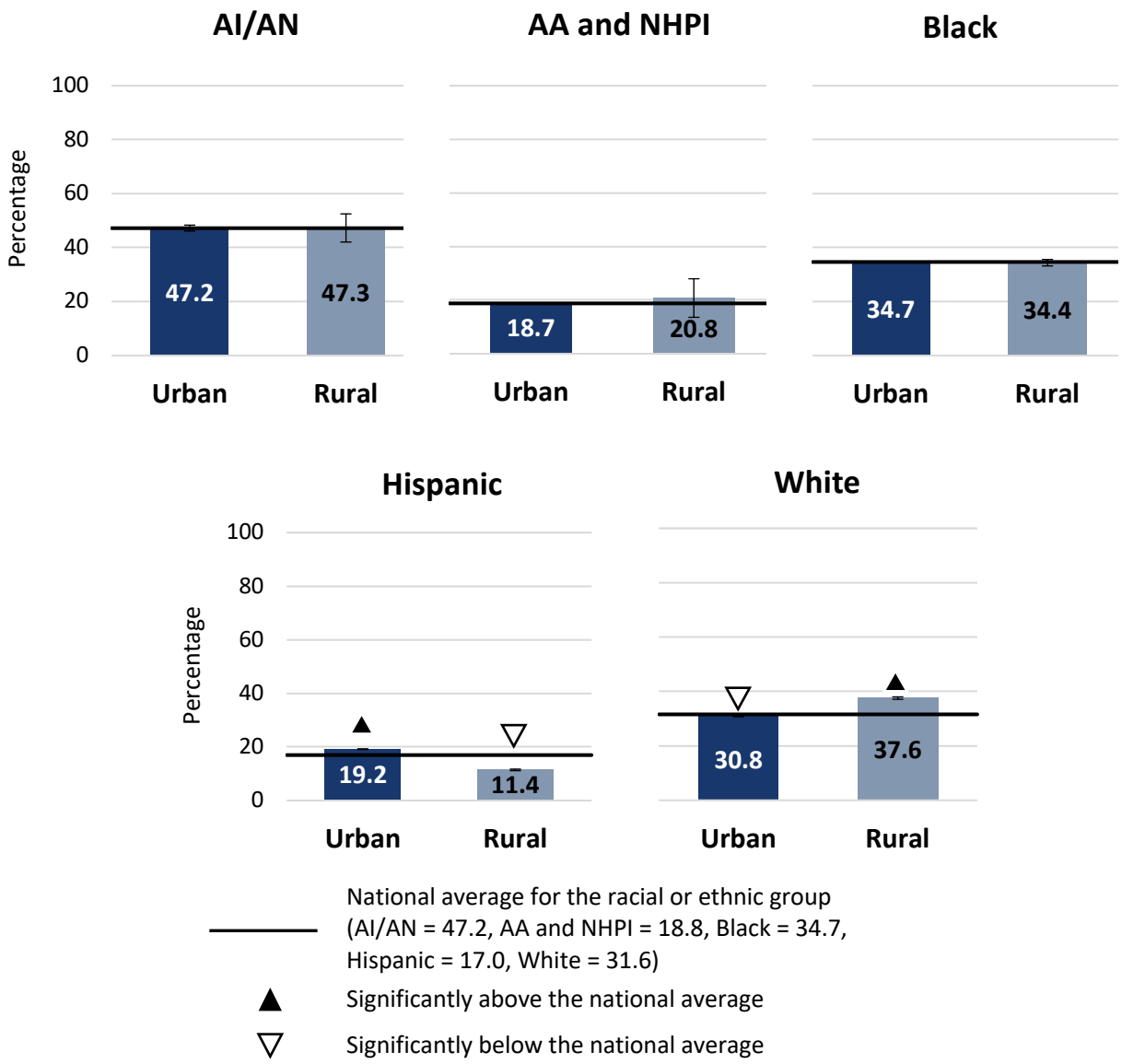
- The percentage of Black MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible Black MA enrollees by less than 3 percentage points. The percentage of Black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

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

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

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated[‡] treatment within 14 days of the diagnosis, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentages of AA and NHPI MA enrollees living in urban and rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

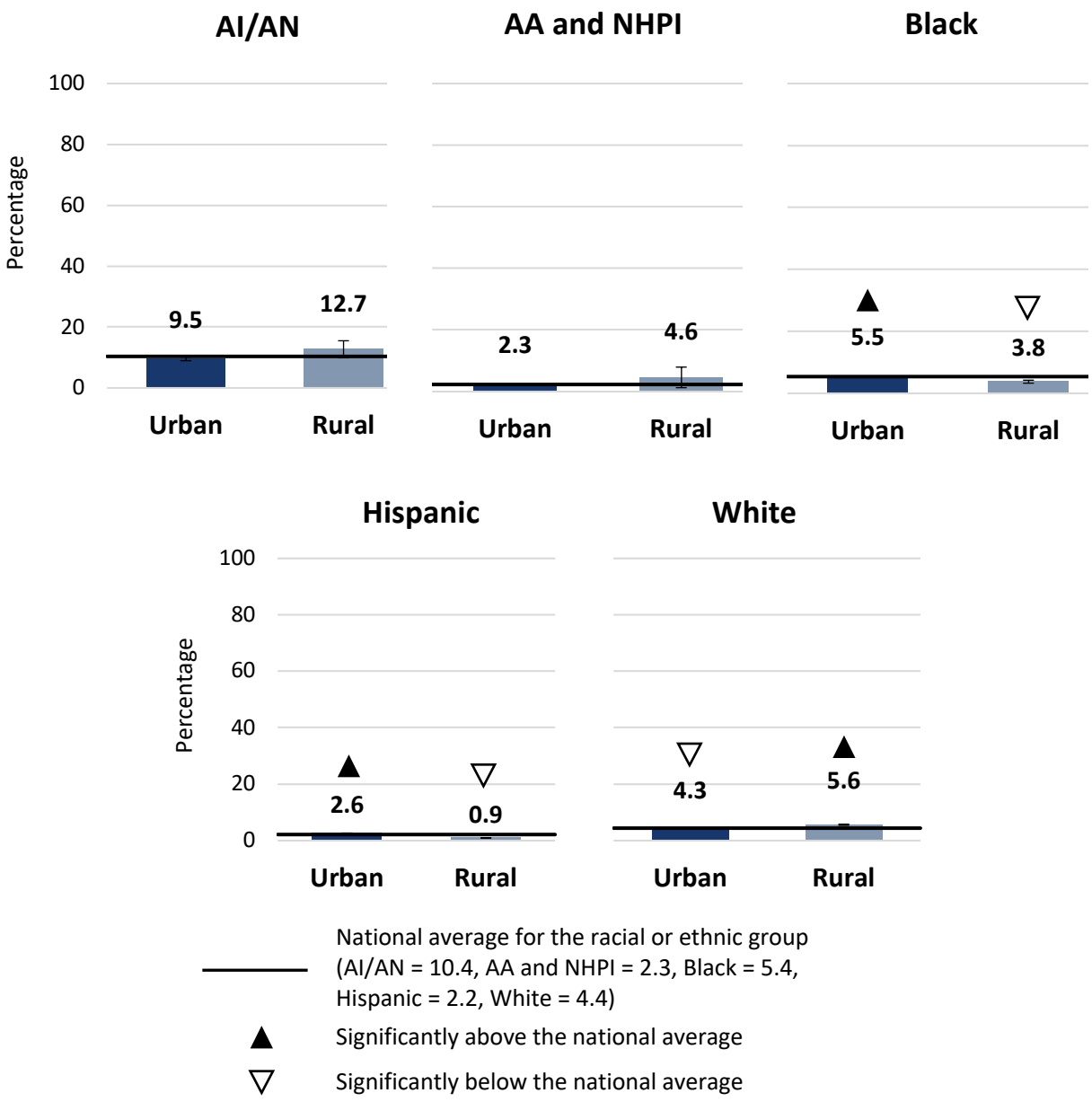
- The percentages of Black MA enrollees living in urban and rural areas who initiated treatment within 14 days of a diagnosis of AOD dependence were each **similar to** the national average for all eligible Black MA enrollees.

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

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

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

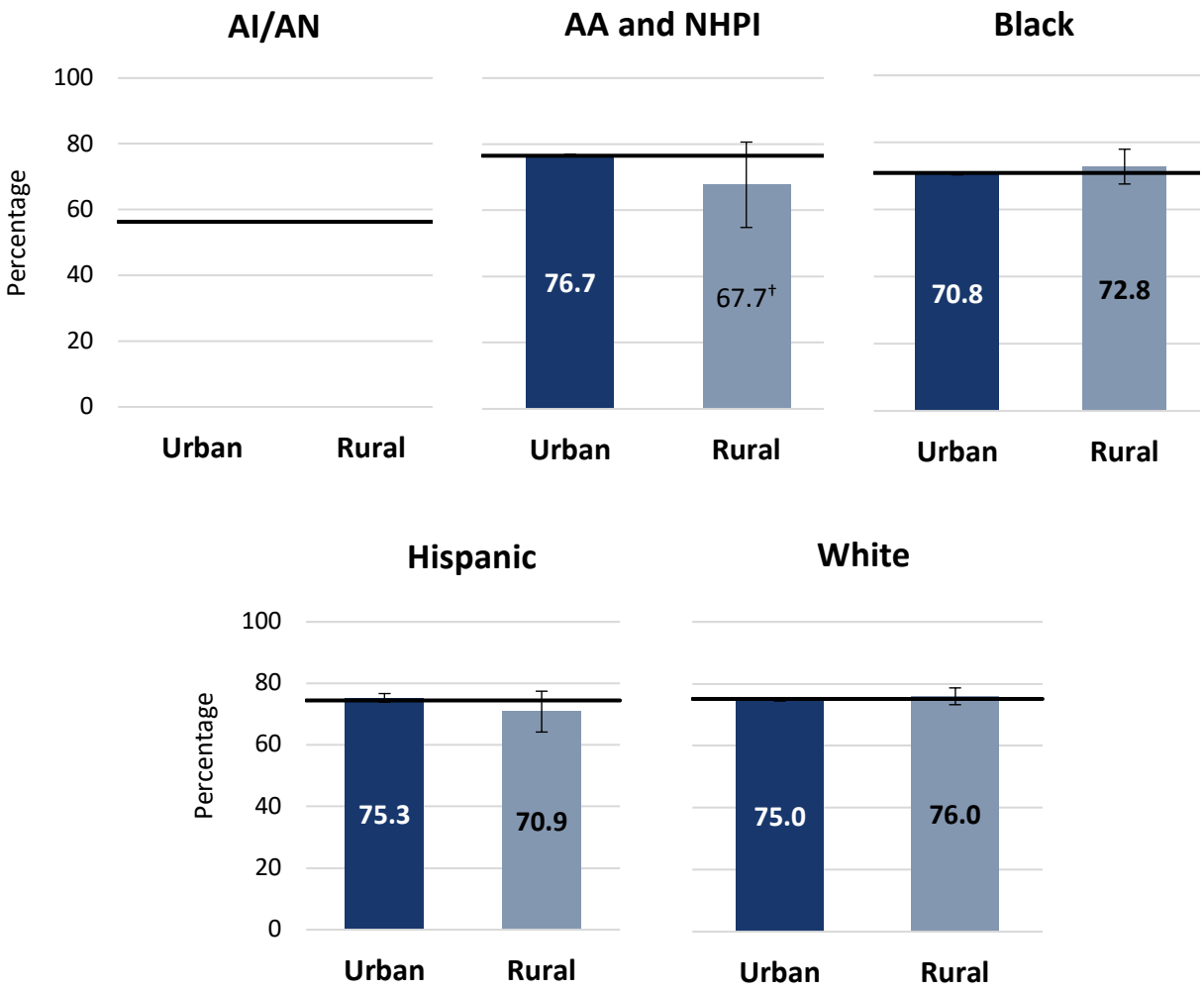
- The percentage of Hispanic MA enrollees with a new episode of AOD dependence living in urban areas who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible Hispanic MA enrollees by less than 3 percentage points.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

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

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

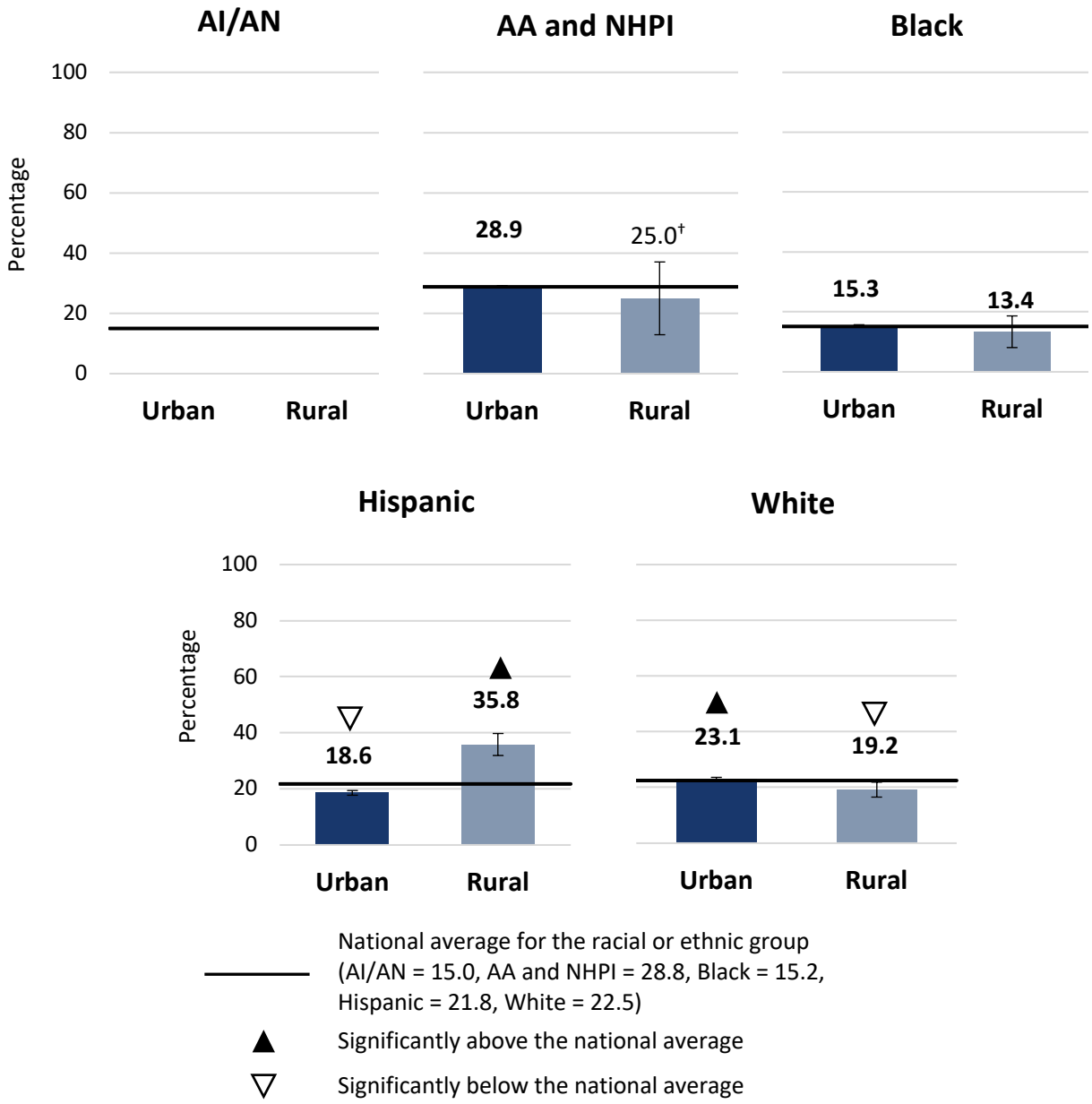
- The percentages of Black MA enrollees living in urban and rural areas who had their medications reconciled within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

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

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

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentages of AA and NHPI MA enrollees living in urban and rural areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission were each **similar to** the national average for all eligible AA and NHPI MA enrollees.

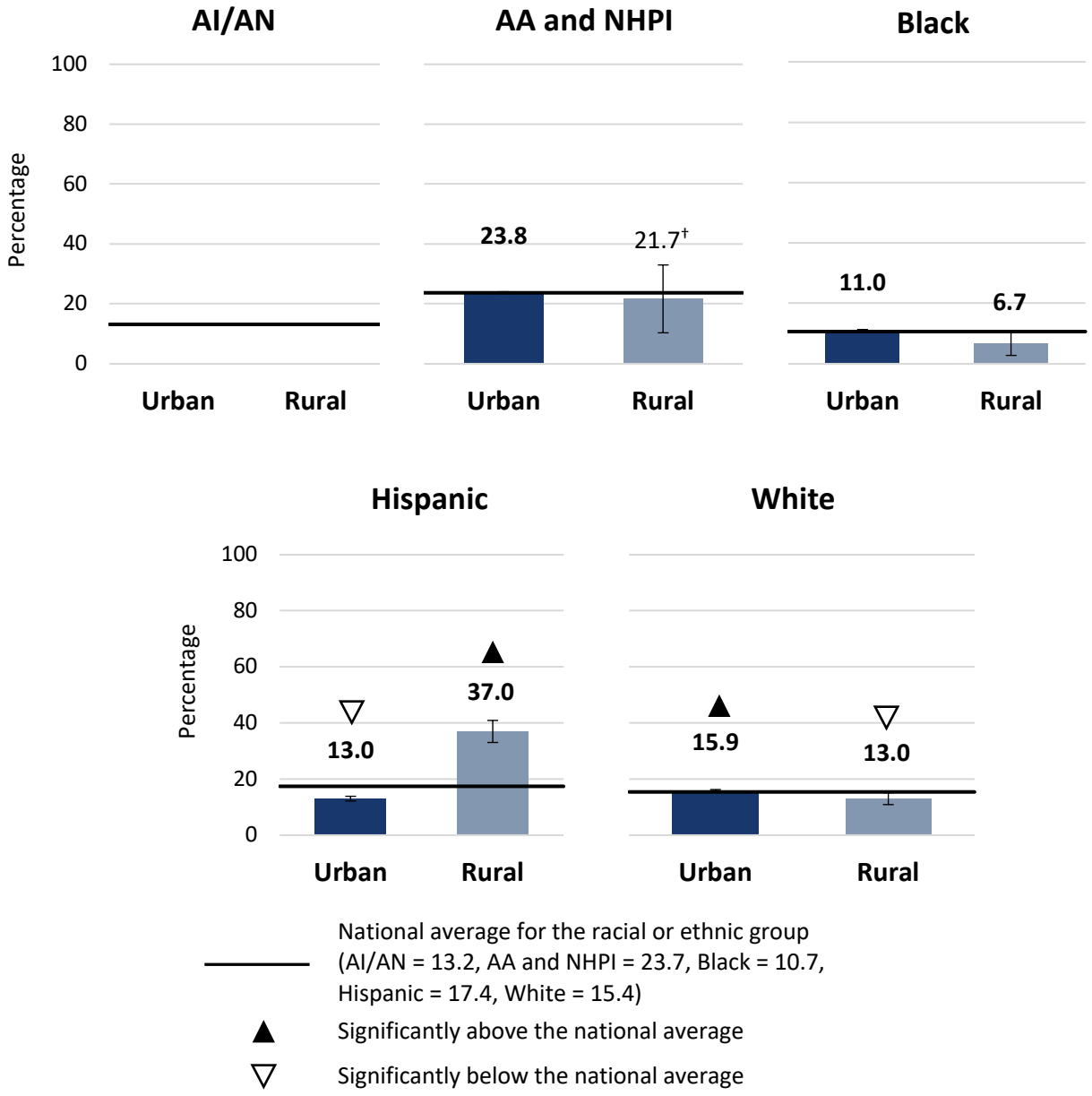
- The percentages of Black MA enrollees living in urban and rural areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission were each **similar to** the national average for all eligible Black MA enrollees.

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

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

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 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 geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

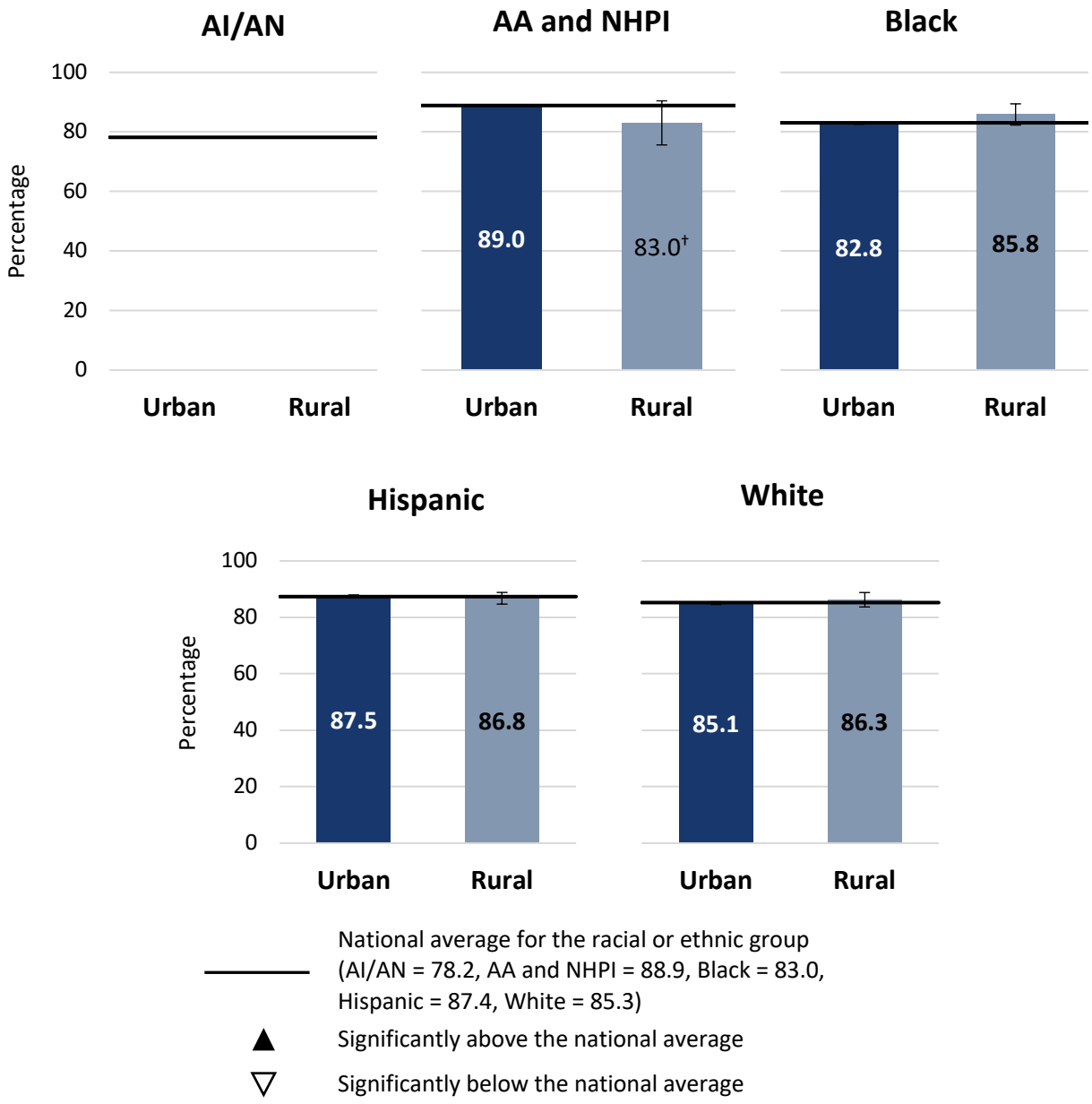
- The percentages of Black MA enrollees living in urban and rural areas who received discharge information on the day of or the day following discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

- The percentage of Hispanic MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible White MA enrollees by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible White MA enrollees by less than 3 percentage points.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth) was provided within 30 days of discharge, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

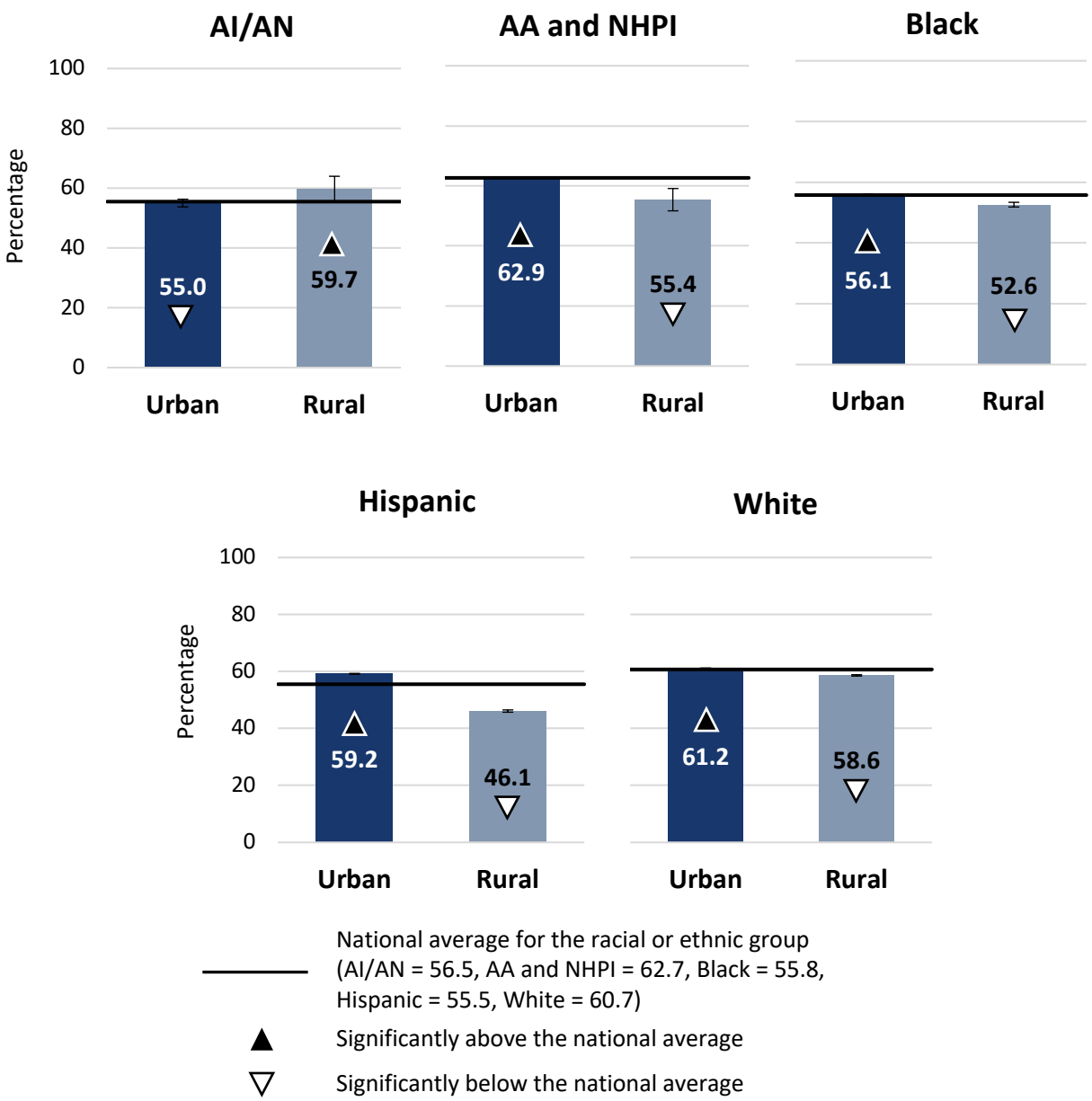
- The percentages of Black MA enrollees living in urban and rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible Black MA enrollees.

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

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

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

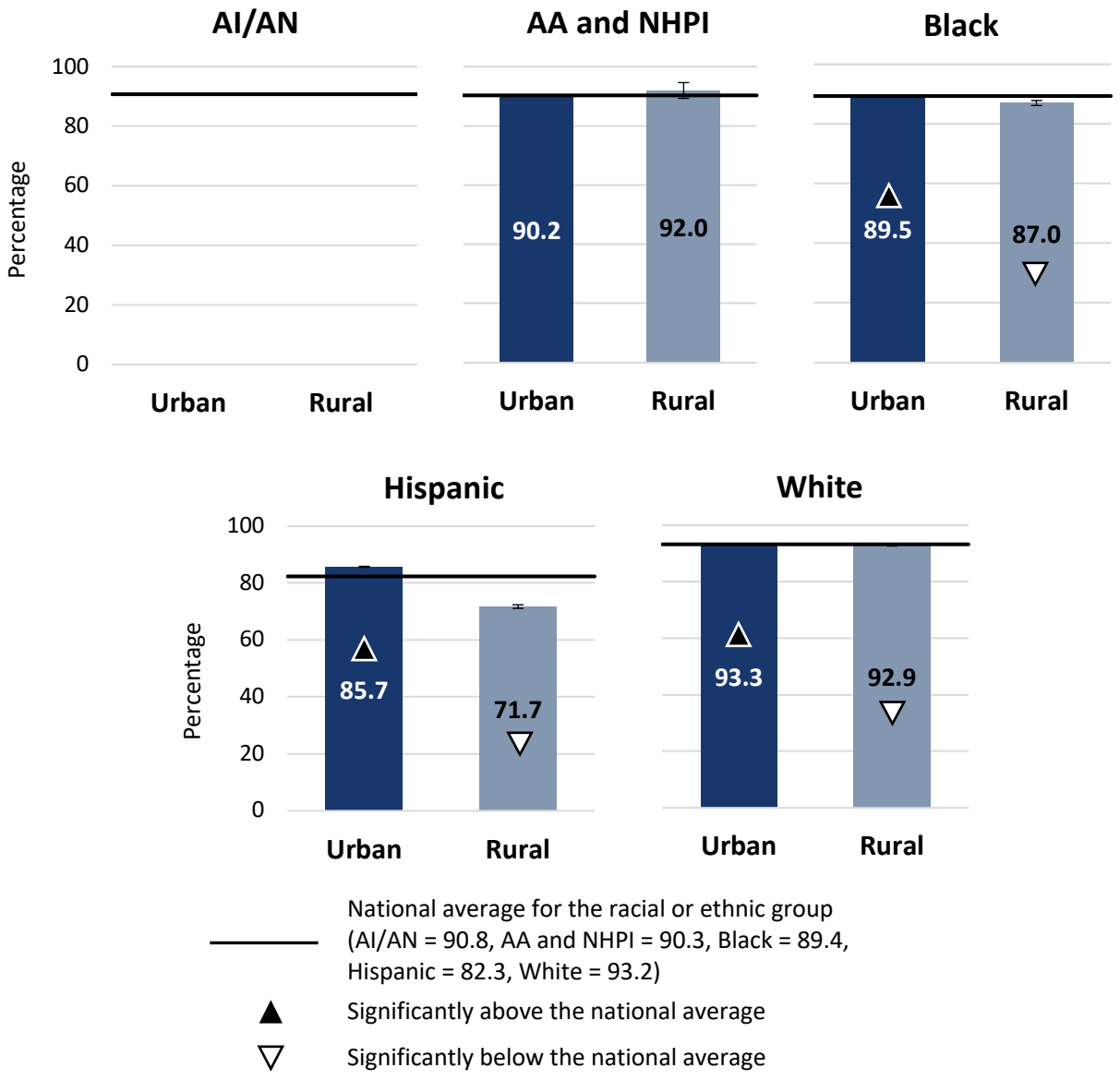
- The percentage of Hispanic MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **above** the national average for all eligible Hispanic MA enrollees by more than 3 percentage points. The percentage of Hispanic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

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

Clinical Care: Overuse and Appropriate Use of Medications

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

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,[†] by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

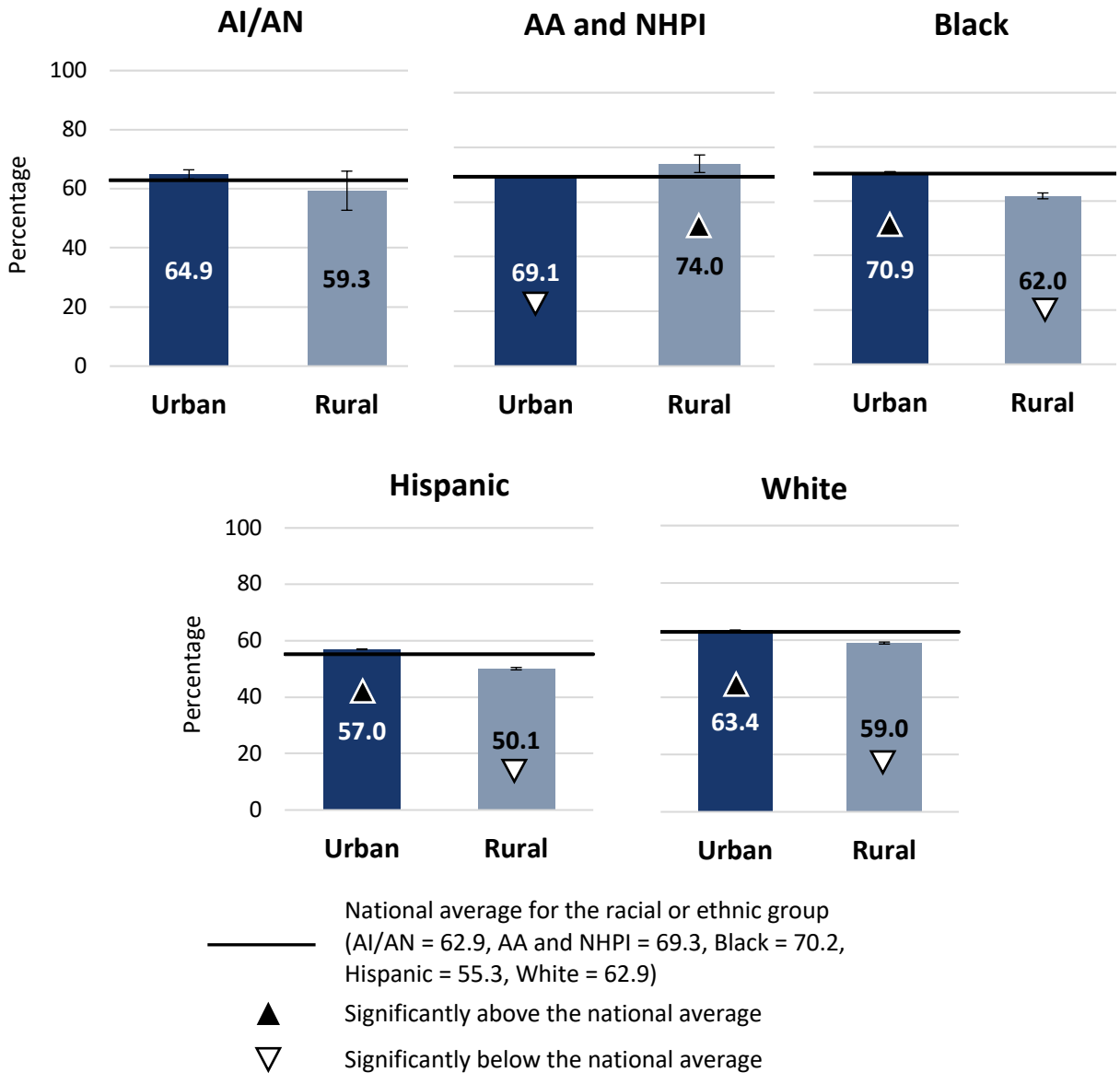
- The percentage of elderly Black MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly Black MA enrollees by less than 3 percentage points. The percentage of elderly Black MA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

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

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

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

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

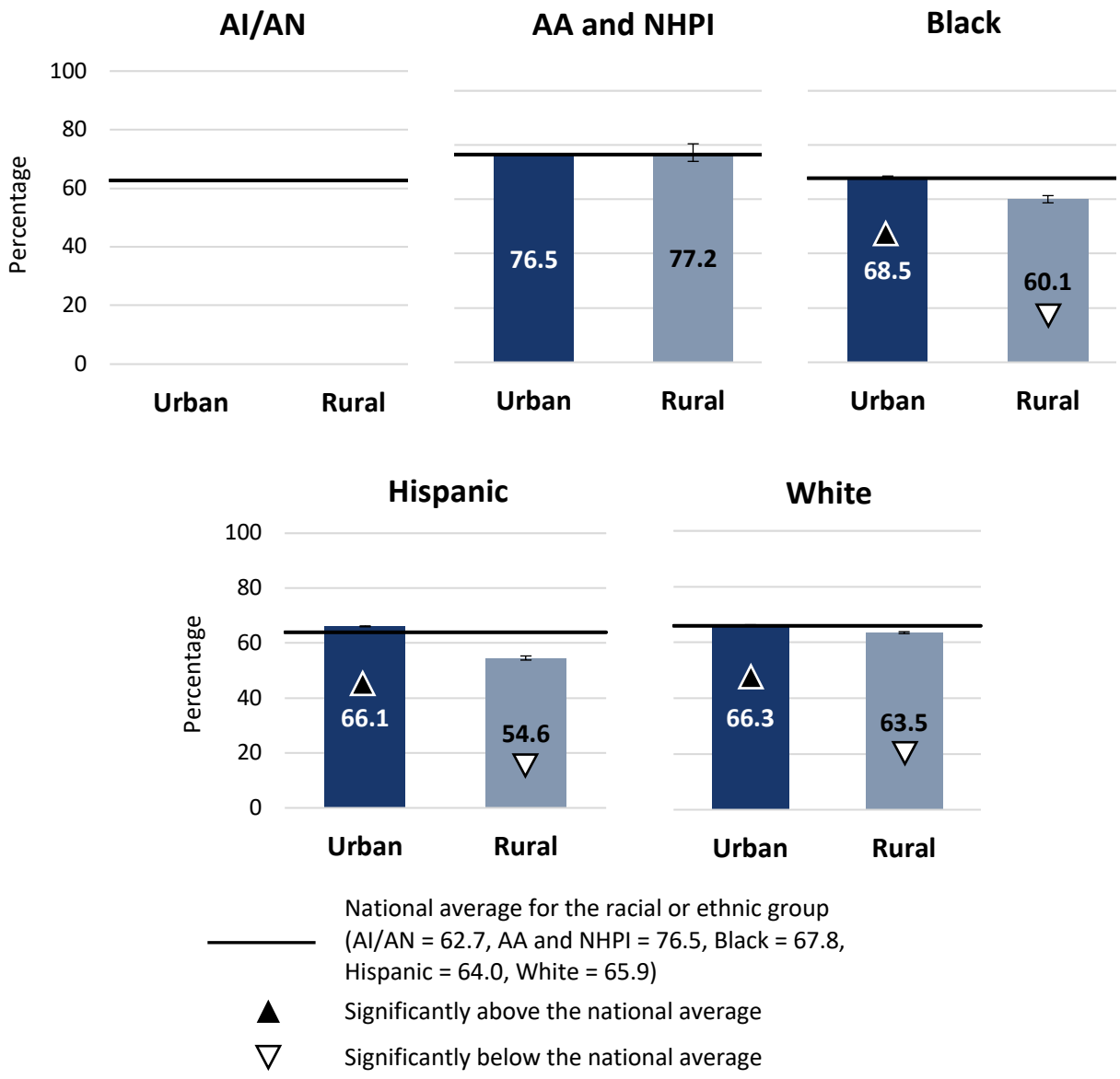
- The percentage of elderly Black MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly Black MA enrollees by less than 3 percentage points. The percentage of elderly Black MA enrollees with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

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

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

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

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,[†] by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

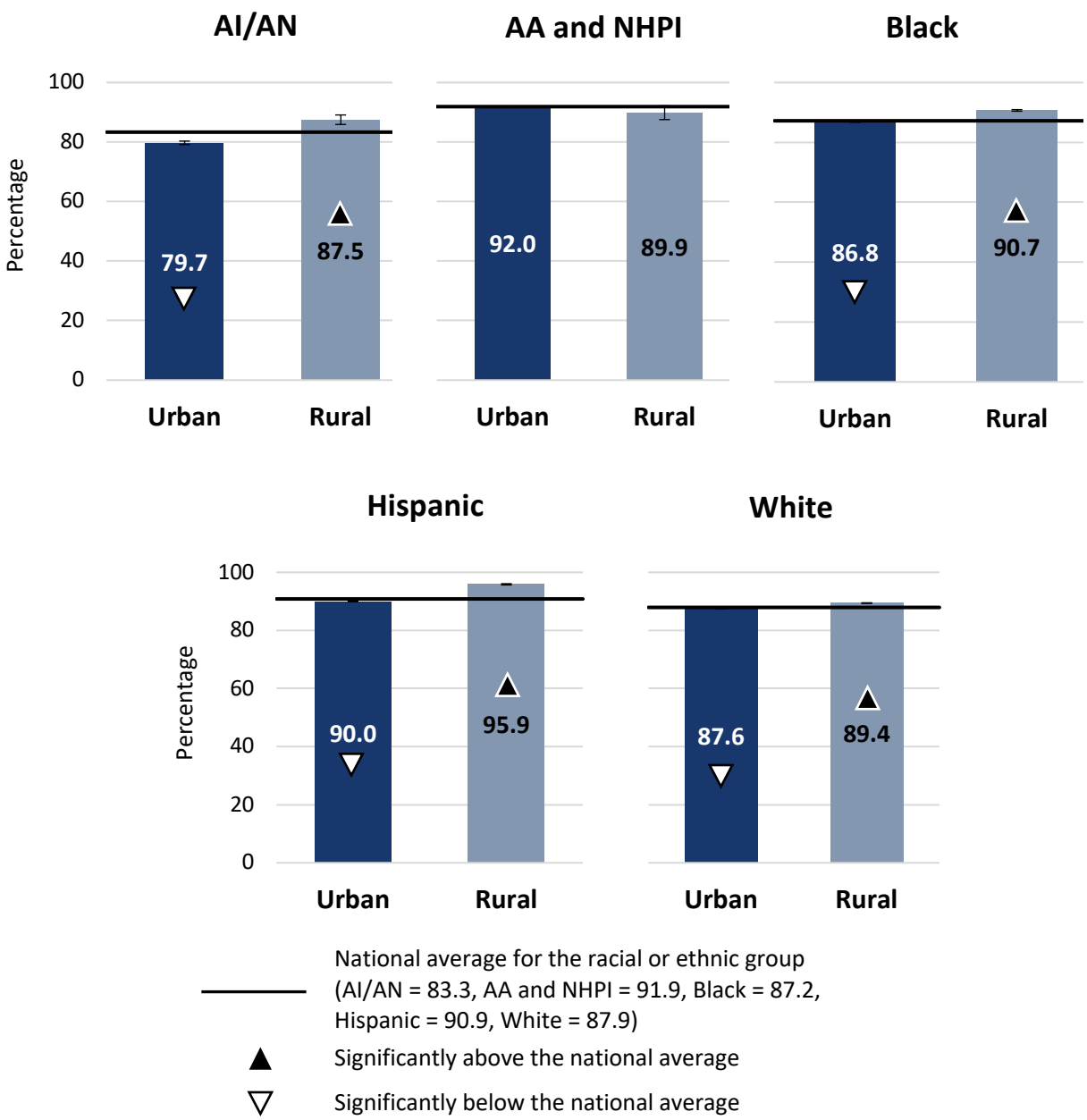
- The percentage of elderly Black MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly Black MA enrollees by less than 3 percentage points. The percentage of elderly Black MA enrollees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

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

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

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

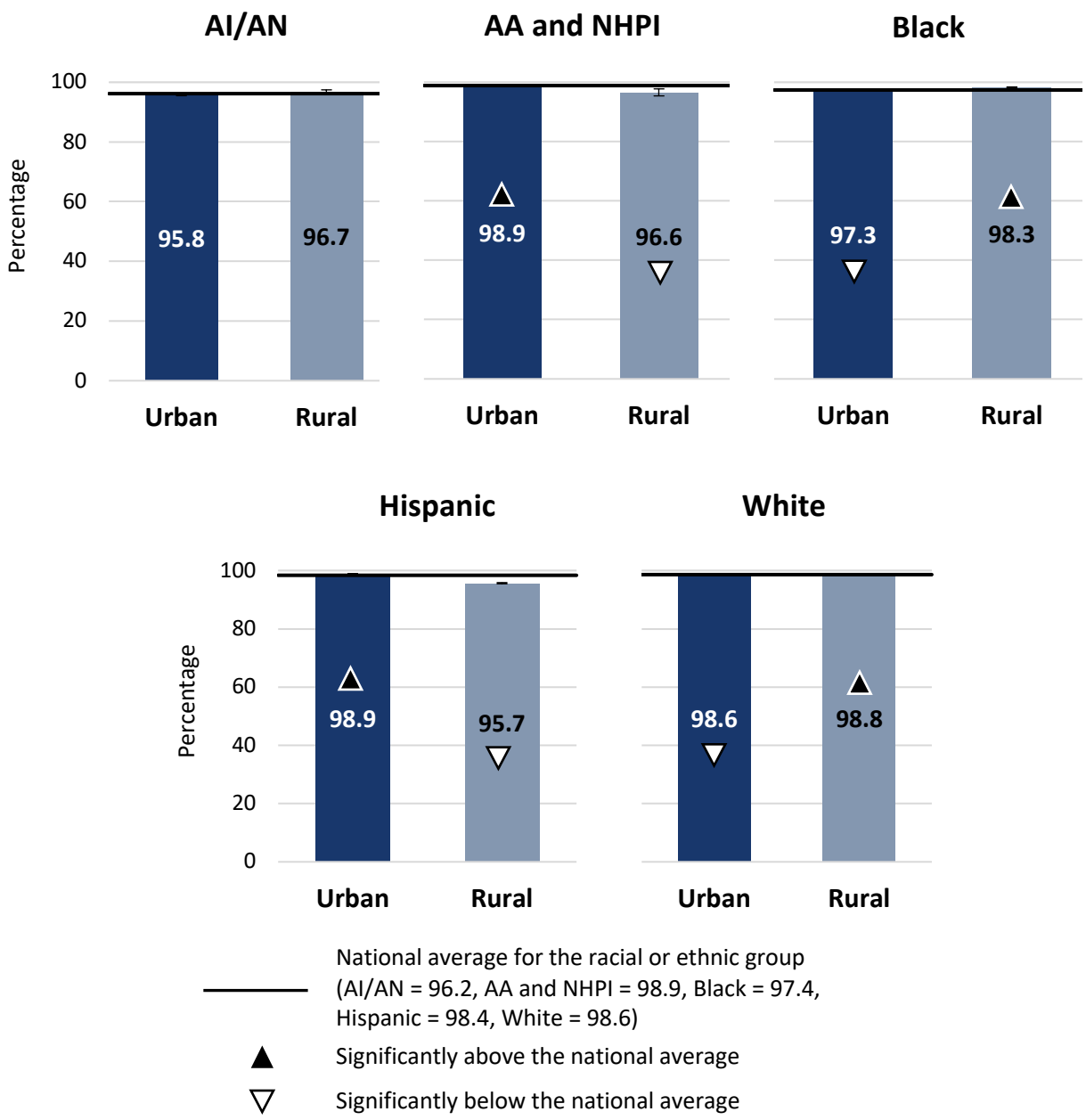
- The percentage of Black MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all Black MA enrollees by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas for whom use of opioids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

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

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

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

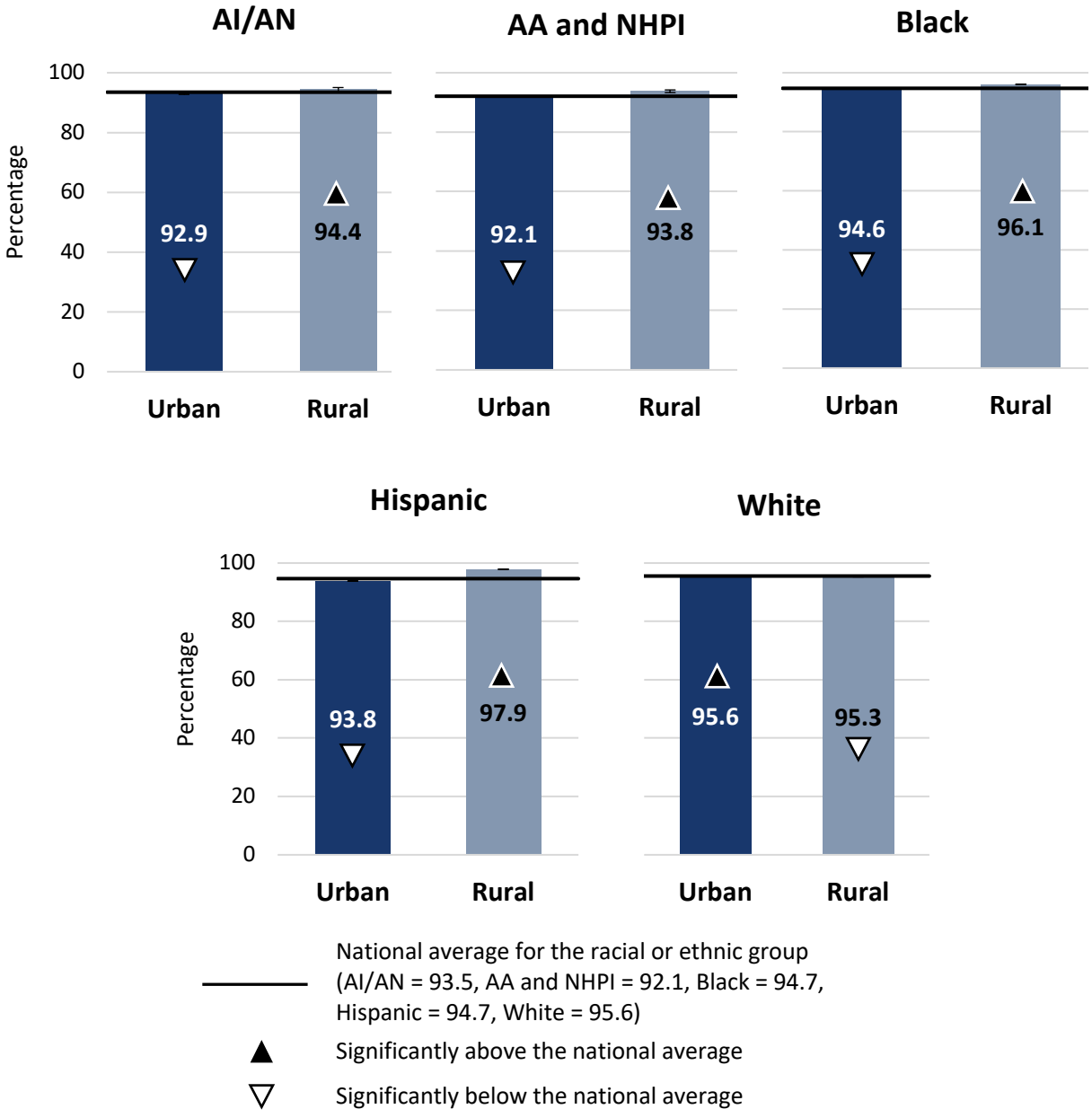
- The percentage of White MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all White MA enrollees by less than 3 percentage points.[†] The percentage of White MA enrollees living in rural areas for whom use of opioids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

[†] Prior to rounding.

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by geography within racial and ethnic group, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

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

[†] Prior to rounding.

Section III:

Racial and Ethnic Disparities in Health Care in Medicare Within Urban and Rural Areas

Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Medicare Advantage

Number of patient experience measures (out of 7) for which MA enrollees of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all MA enrollees living in the same type of area (urban or rural) in 2021

SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2021 Medicare CAHPS survey.

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

MA enrollees in each racial and ethnic group were compared with the national average for all MA enrollees separately for rural and urban areas.

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

AA and NHPI MA enrollees living in urban areas had results that were above the national average for all MA enrollees living in urban areas
• Annual Flu Vaccine

AA and NHPI MA enrollees living in urban areas had results that were below the national average for all MA enrollees living in urban areas
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Doctor Communication • Care Coordination • Getting Needed Prescription Drugs

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

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

AA and NHPI MA enrollees living in rural areas had results that were below the national average for all MA enrollees living in rural areas
• Getting Needed Care • Customer Service

Black MA enrollees living in rural areas had results that were below the national average for all MA enrollees living in rural areas
• Getting Needed Prescription Drugs • Annual Flu Vaccine

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

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

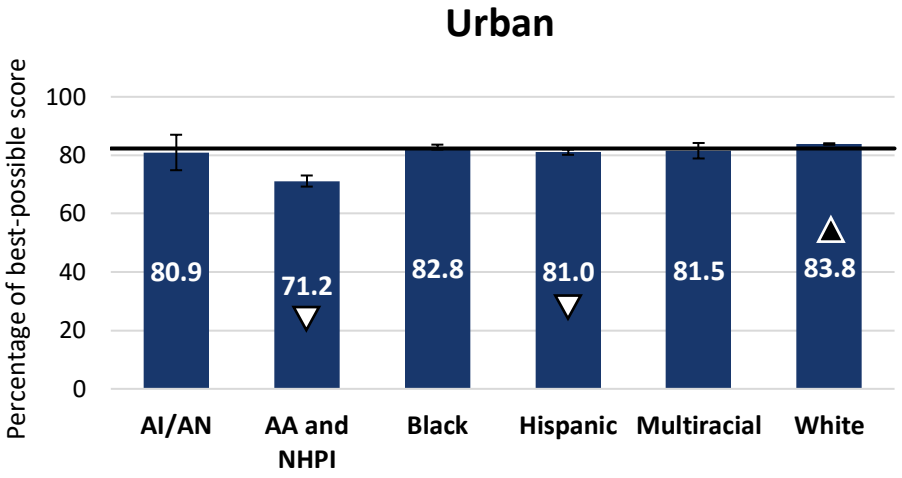
Multiracial MA enrollees living in rural areas had results that were above the national average for all MA enrollees living in rural areas
• Getting Appointments and Care Quickly

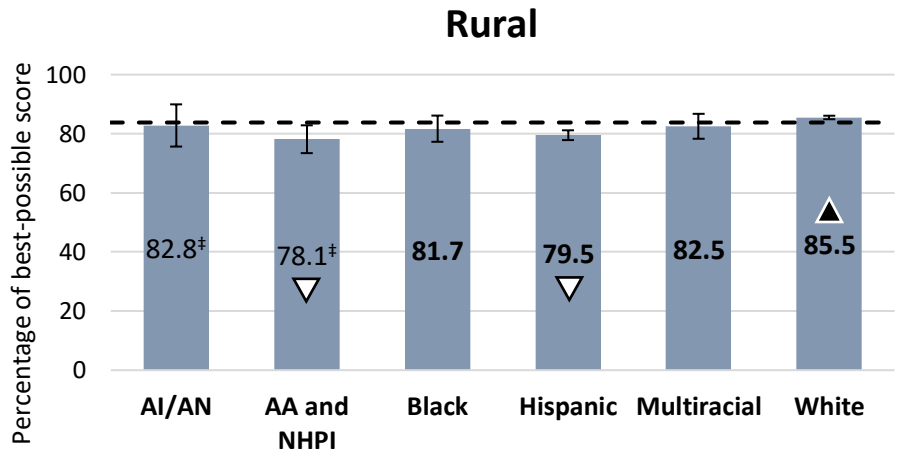
White MA enrollees living in rural areas had results that were above the national average for all MA enrollees living in rural areas
• Annual Flu Vaccine

Patient Experience: Medicare Advantage

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity within urban and rural areas, 2021





National average for all MA enrollees living in urban areas = 82.3

National average for all MA enrollees living in rural areas = 83.8

▲ Significantly above the national average

▽ Significantly below the national average

SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

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

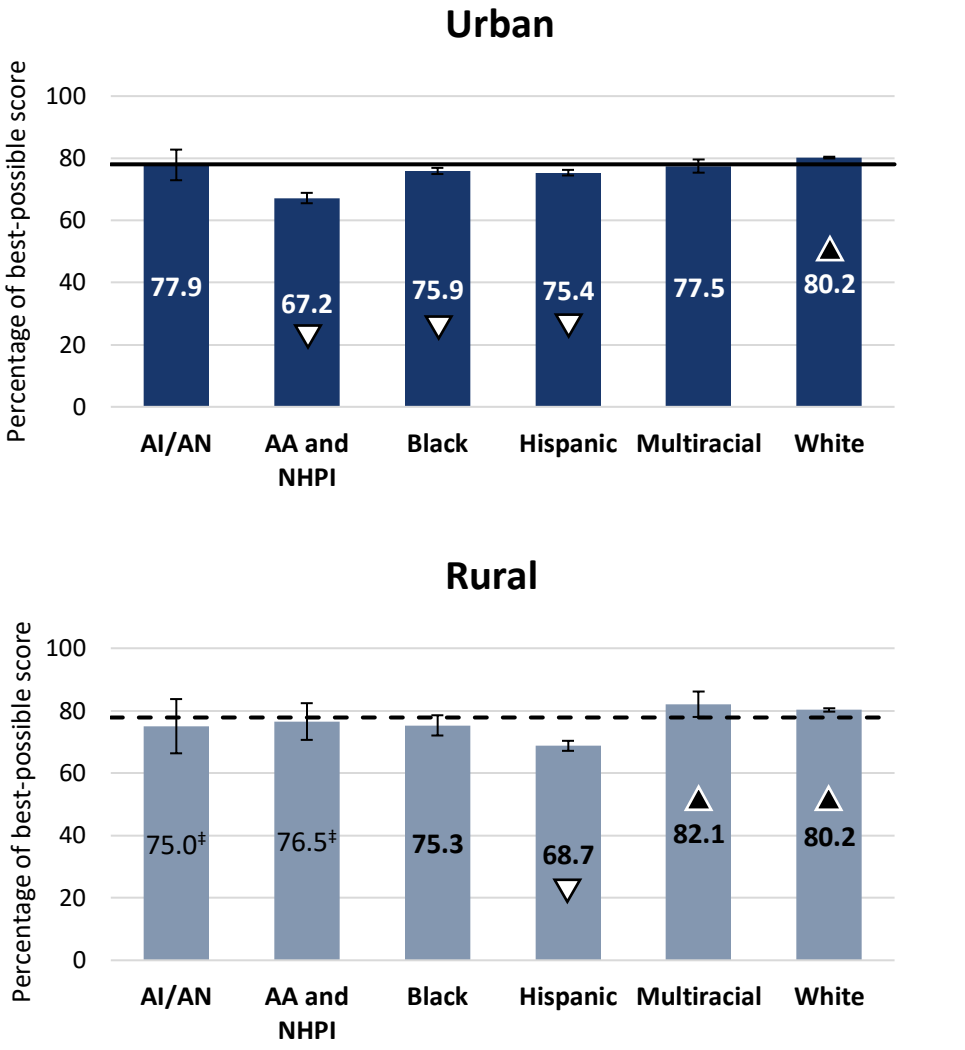
- Multiracial MA enrollees living in urban areas reported experiences with getting needed care that were **similar to** the national average for all MA enrollees living in urban areas. Multiracial MA enrollees living in rural areas reported experiences with getting needed care that were **similar to**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

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

[§] Unlike on pages 166–168, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

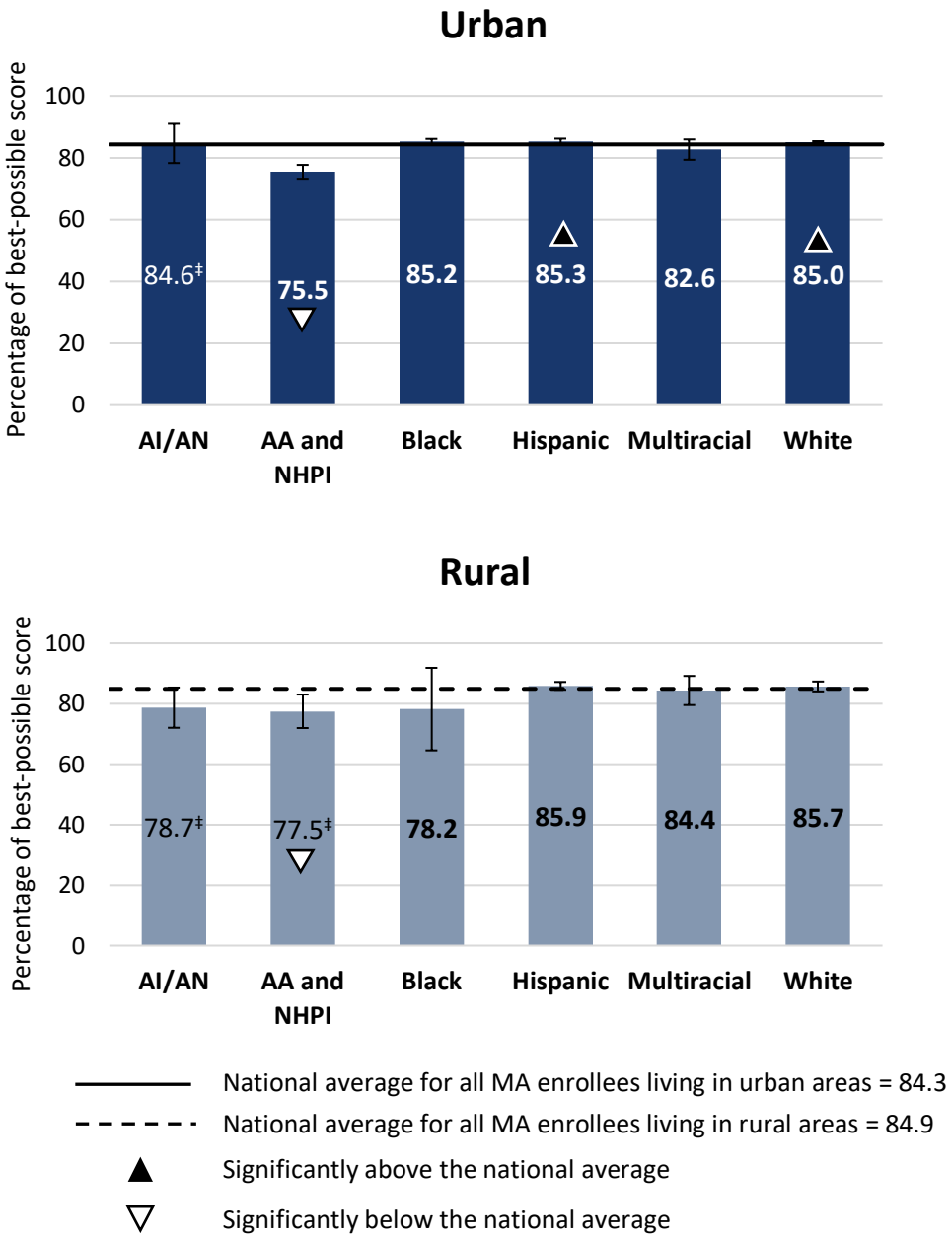
- Hispanic MA enrollees living in urban areas reported experiences with getting appointments and care quickly that were **below** the national average for all MA enrollees living in urban areas by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with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

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

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

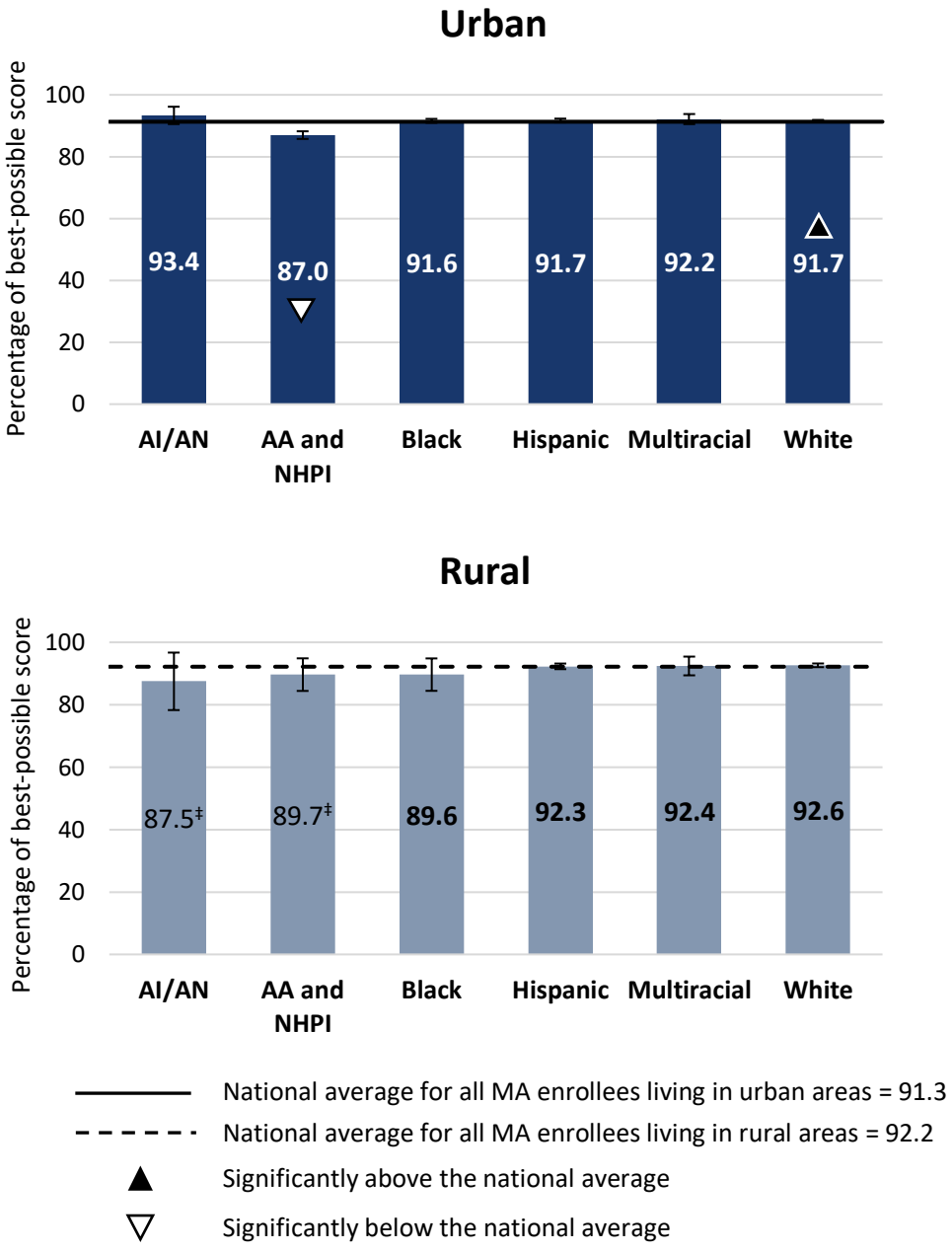
- Hispanic MA enrollees living in urban areas reported experiences with customer service that were **above** the national average for all MA enrollees living in urban areas by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with customer service that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

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

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

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

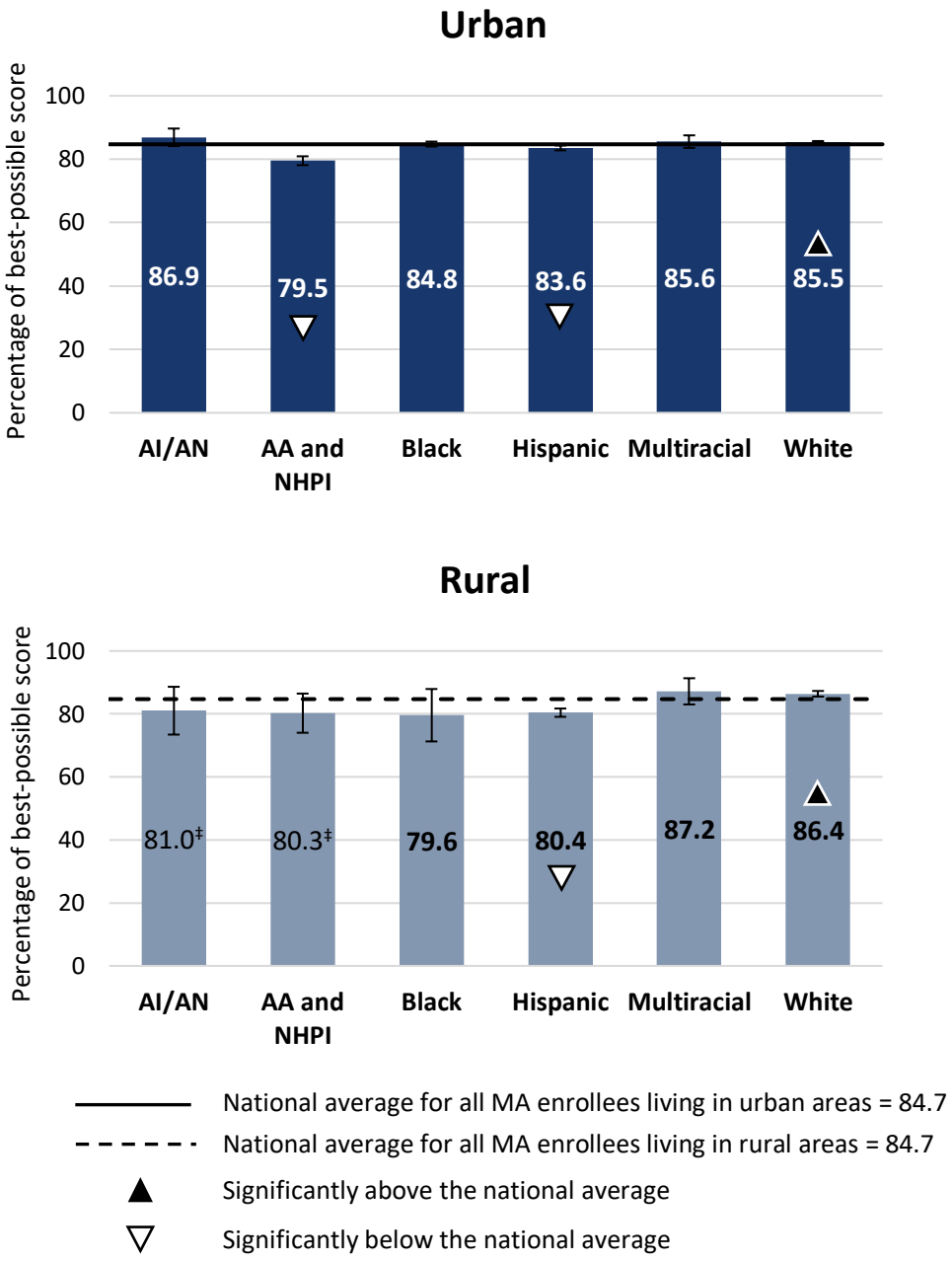
- Hispanic MA enrollees living in urban areas reported experiences with doctor communication that were **similar to** the national average for all MA enrollees living in urban areas. Hispanic MA enrollees living in rural areas reported experiences with doctor communication that were **similar to** the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

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

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well care was coordinated,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

- AA and NHPI MA enrollees living in urban areas reported experiences with care coordination that were **below** the national average for all MA enrollees living in urban areas by more than 3 points on a 0–100 scale. AA and NHPI MA enrollees living in rural areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees living in rural areas.

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

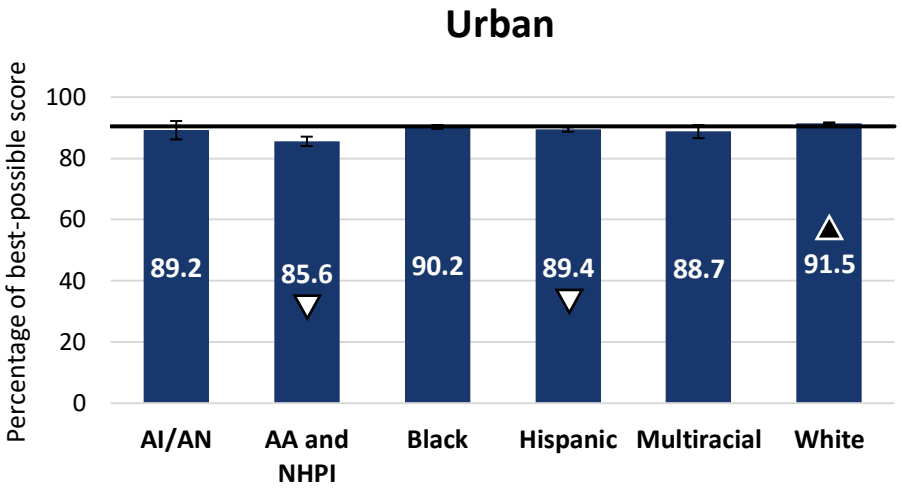
- Hispanic MA enrollees living in urban areas reported experiences with care coordination that were **below** the national average for all MA enrollees living in urban areas by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with care coordination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

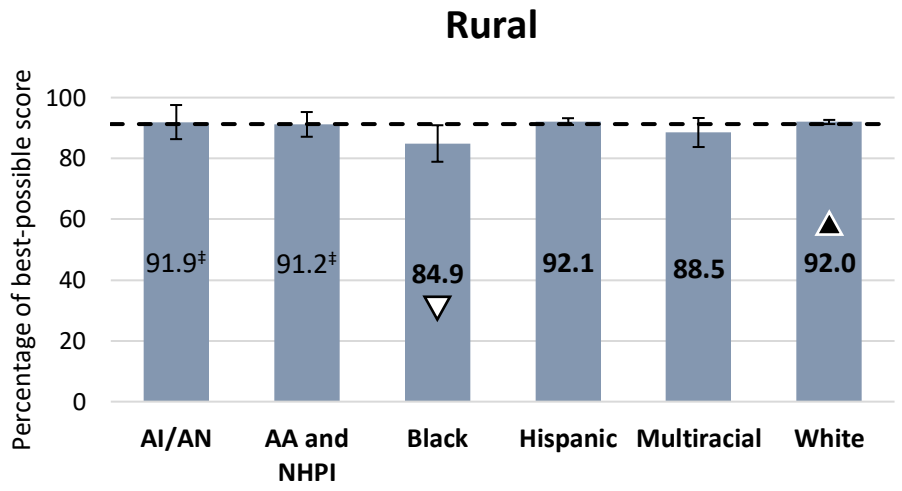
- Multiracial MA enrollees living in urban areas reported experiences with care coordination that were **similar to** the national average for all MA enrollees living in urban areas. Multiracial MA enrollees living in rural areas reported experiences with care coordination that were **similar to** the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

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plans,† by race and ethnicity within urban and rural areas, 2021





National average for all MA enrollees living in urban areas = 90.4

National average for all MA enrollees living in rural areas = 91.3

▲ Significantly above the national average

▽ Significantly below the national average

SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

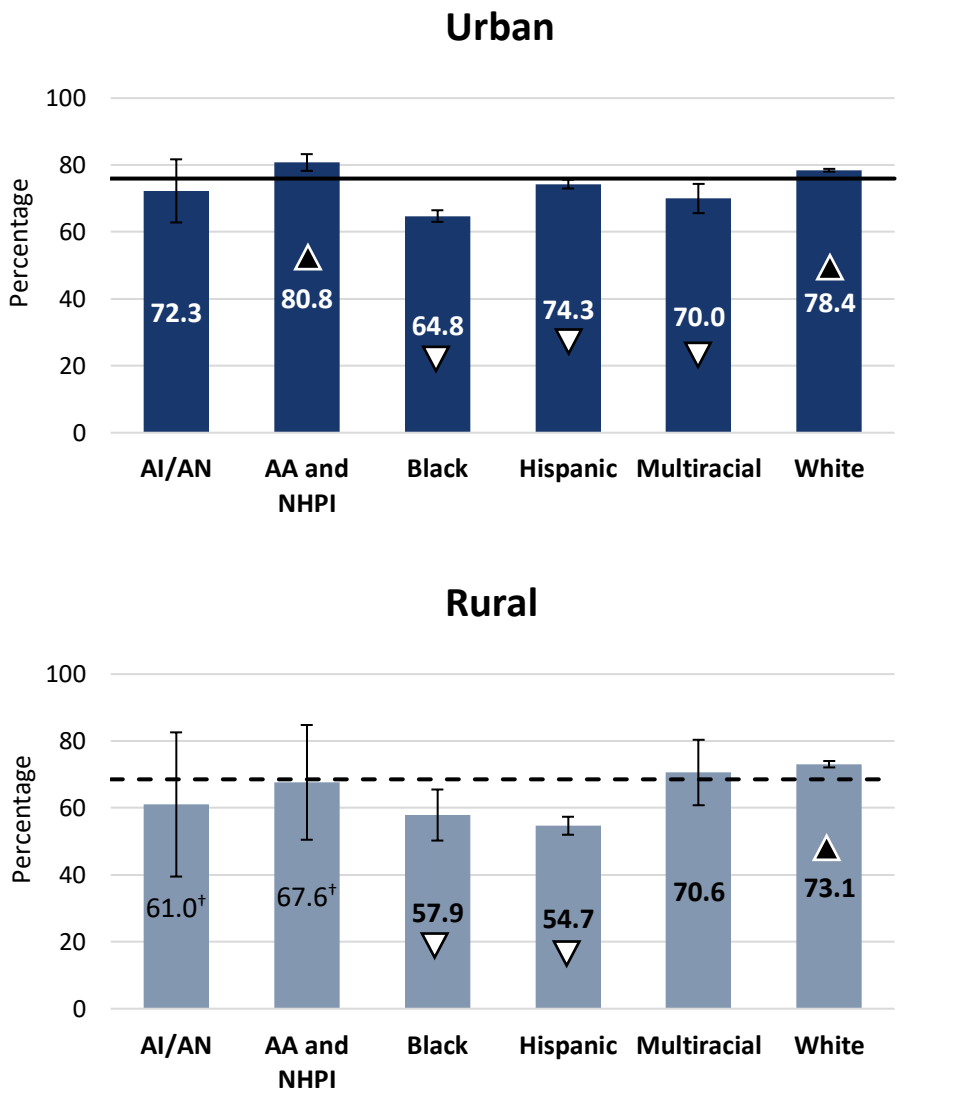
- Hispanic MA enrollees living in urban areas reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees living in urban areas by less than 3 points on a 0–100 scale. Hispanic MA enrollees living in rural areas reported experiences with getting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

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

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

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of AA and NHPI MA enrollees living in urban areas who received a flu vaccine was **above** the national average for all MA enrollees living in urban areas by more than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas who received a flu vaccine was **similar to** the national average for all MA enrollees living in rural areas.

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

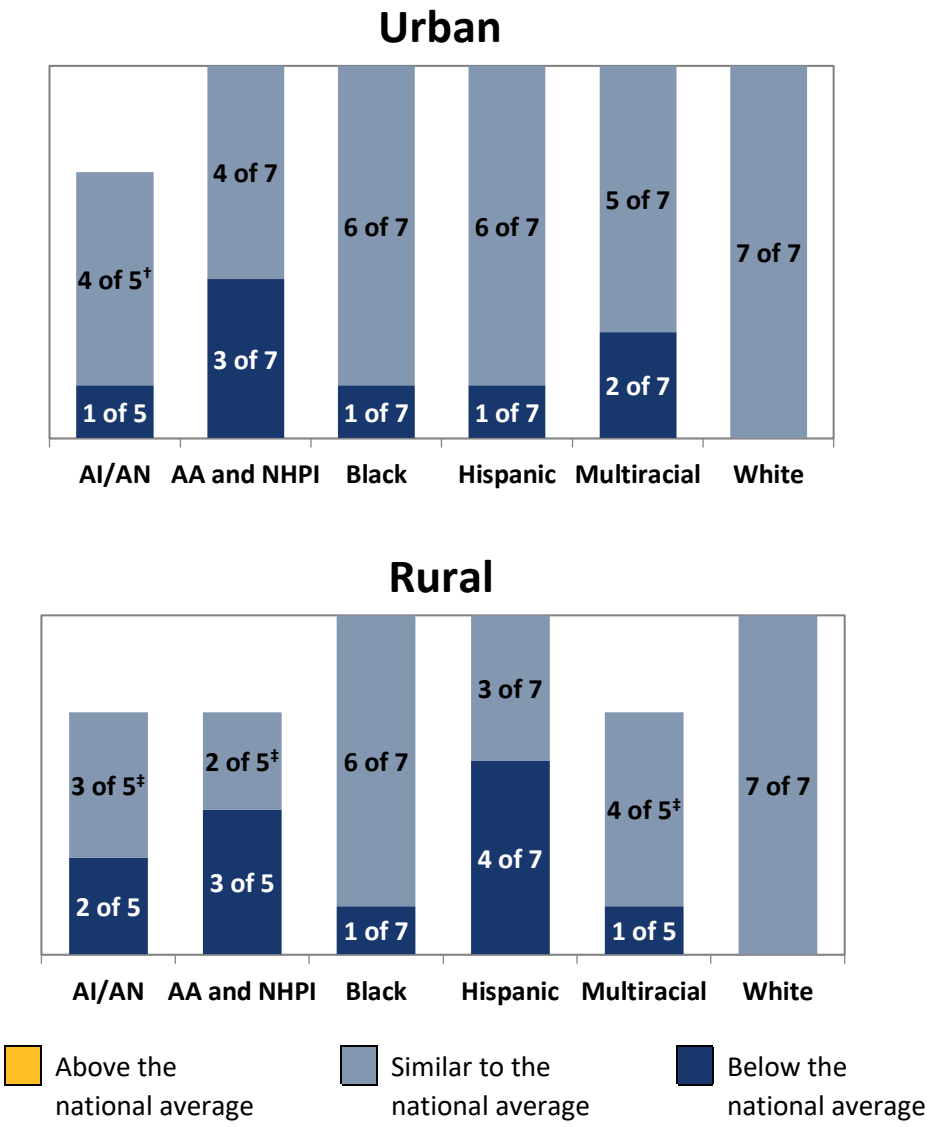
- The percentage of Hispanic MA enrollees living in urban areas who received a flu vaccine was **below** the national average for all MA enrollees living in urban areas by less than 3 percentage points The percentage of Hispanic MA enrollees living in rural areas who received a flu vaccine was **below**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

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

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

Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Medicare FFS

Number of patient experience measures for which people with Medicare FFS coverage from selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all people with Medicare FFS coverage living in the same type of area (urban or rural) in 2021



SOURCE: This chart summarizes data from all people with Medicare FFS coverage nationwide who participated in the 2021 Medicare CAHPS survey.

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

† There were not enough data from AI/AN people with FFS coverage living in urban areas to compare their scores on two measures to scores for all people with FFS coverage living in urban areas.

‡ There were not enough data from AI/AN, AA and NHPI, or Multiracial people with FFS coverage living in rural areas to compare their scores on two measures to scores for all people with FFS coverage living in rural areas.

People with Medicare FFS coverage in each racial and ethnic group were compared with the national average for all MA enrollees separately for rural and urban areas.

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

AI/AN people with FFS coverage living in urban areas had results that were below the national average for all people with FFS coverage living in urban areas
• Getting Needed Care

AA and NHPI people with FFS coverage living in urban areas had results that were below the national average for all people with FFS coverage living in urban areas
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service

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

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

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

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

AI/AN people with FFS coverage living in rural areas had results that were below the national average for all people with FFS coverage living in rural areas

- Getting Needed Care
- Getting Appointments and Care Quickly

AA and NHPI people with FFS coverage living in rural areas had results that were below the national average for all people with FFS coverage living in rural areas

- Getting Needed Care
- Getting Appointments and Care Quickly
- Care Coordination

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

- Annual Flu Vaccine

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

- Getting Needed Care
- Getting Appointments and Care Quickly
- Care Coordination
- Annual Flu Vaccine

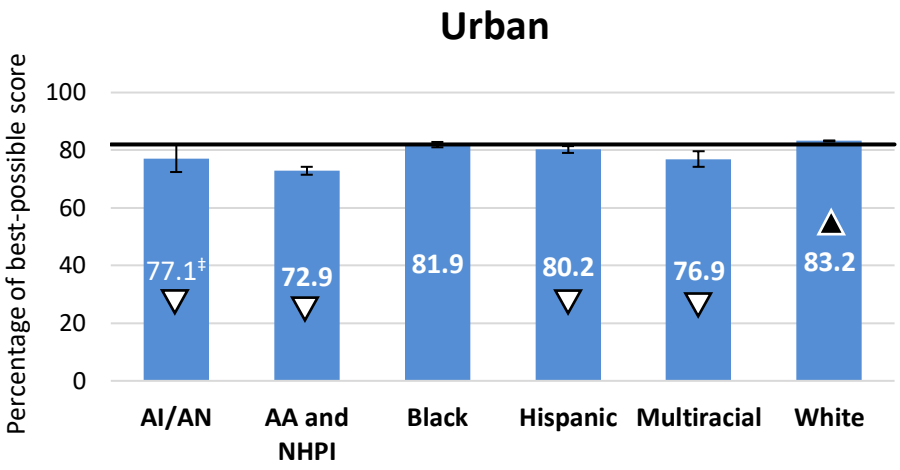
Multiracial people with FFS coverage living in rural areas had results that were below the national average for all people with FFS coverage living in rural areas

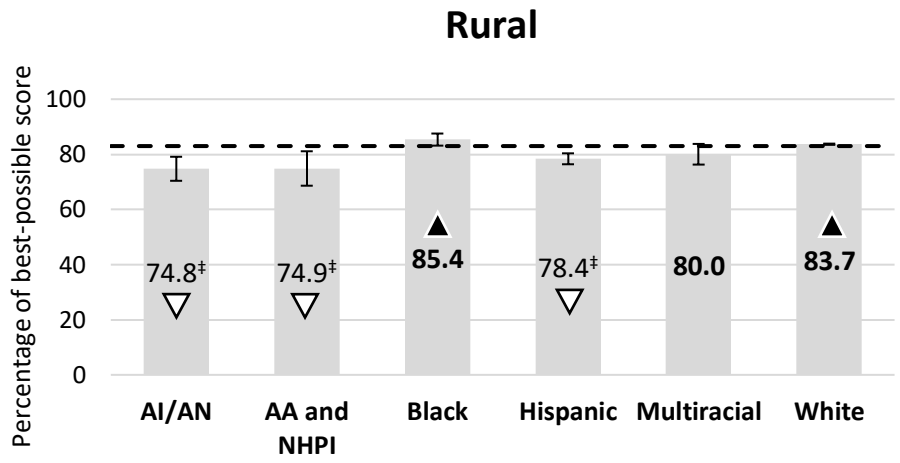
- Annual Flu Vaccine

Patient Experience: Medicare FFS

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity within urban and rural areas, 2021





National average for all people with FFS coverage living in urban areas = 82.0

National average for all people with FFS coverage living in rural areas = 83.0

▲ Significantly above the national average

▽ Significantly below the national average

SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

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

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

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

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

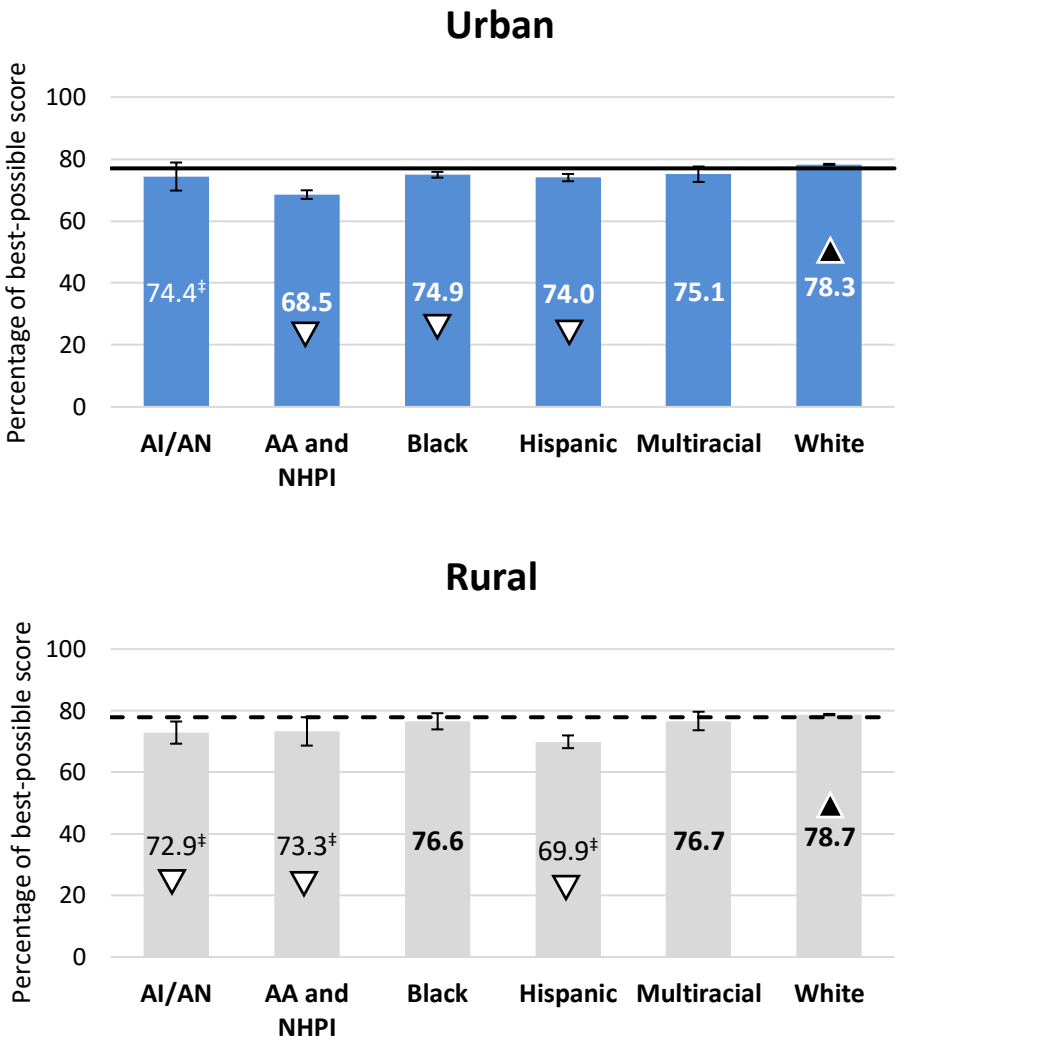
- Multiracial people with FFS coverage living in urban areas reported experiences with getting needed care that were **below** the national average for all people with FFS coverage living in urban areas by more than 3 points on a 0–100 scale. Multiracial people with FFS coverage living in rural areas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

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

[§] Unlike on pages 183–185, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

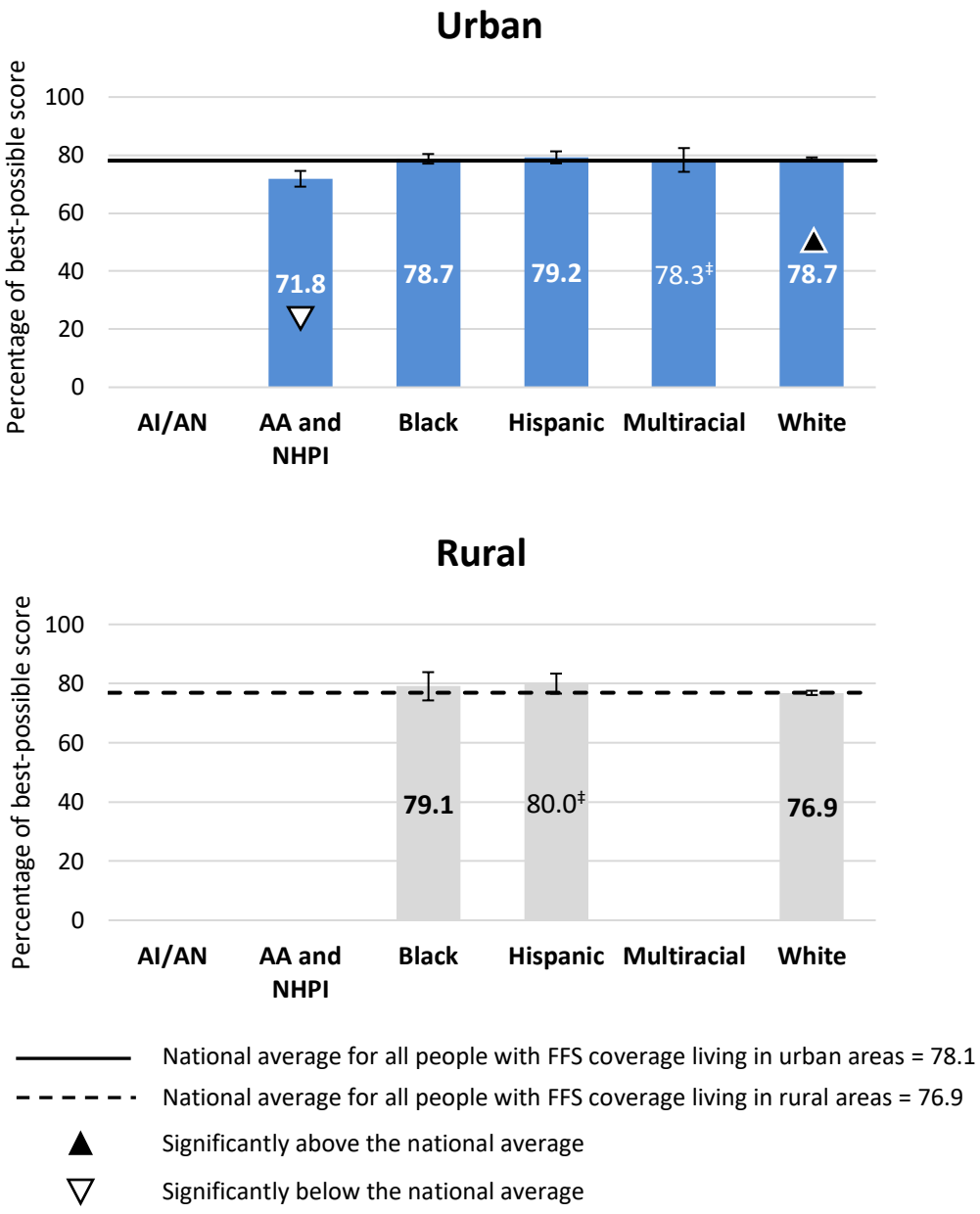
- Hispanic people with FFS coverage living in urban areas reported experiences with getting appointments and care quickly that were **below** the national average for all people with FFS coverage living in urban areas by less than 3 points on a 0–100 scale. Hispanic people with FFS coverage living in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

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

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

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

- There were not enough data from AI/AN people with FFS coverage living in urban areas to compare their score on this measure to the score for all people with FFS coverage living in urban areas. There were not enough data from AI/AN people with FFS coverage living in rural areas to compare their score on this measure to the score for all people with FFS coverage living in rural areas.

- AA and NHPI people with FFS coverage living in urban areas reported experiences with customer service that were **below** the national average for all people with FFS coverage living in urban areas by more than 3 points on a 0–100 scale. There were not enough data from AA and NHPI people with FFS coverage living in rural areas to compare their score on this measure to the score for all people with FFS coverage living in rural areas.

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

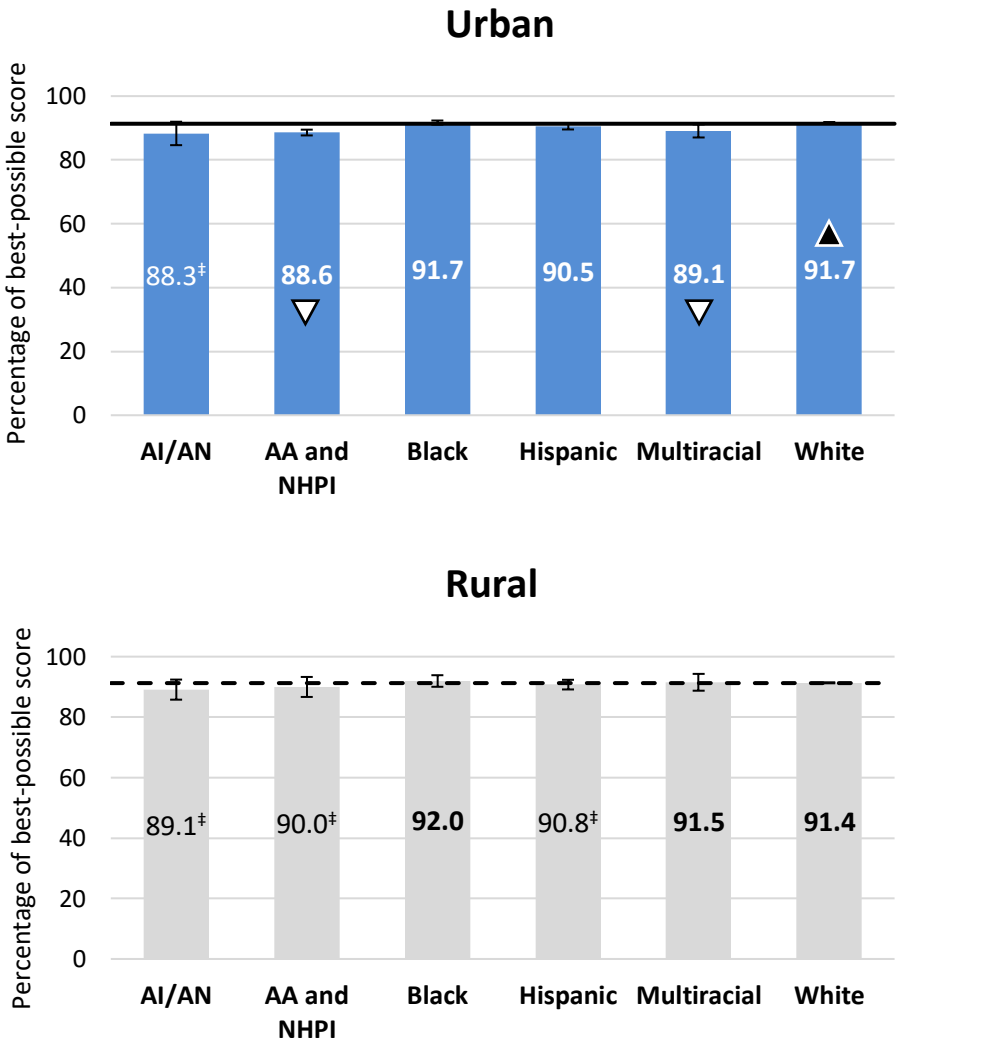
- Hispanic people with FFS coverage living in urban areas reported experiences with customer service that were **similar to** the national average for all people with FFS coverage living in urban areas. Hispanic people with FFS coverage living in rural areas reported experiences with customer service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

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

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

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

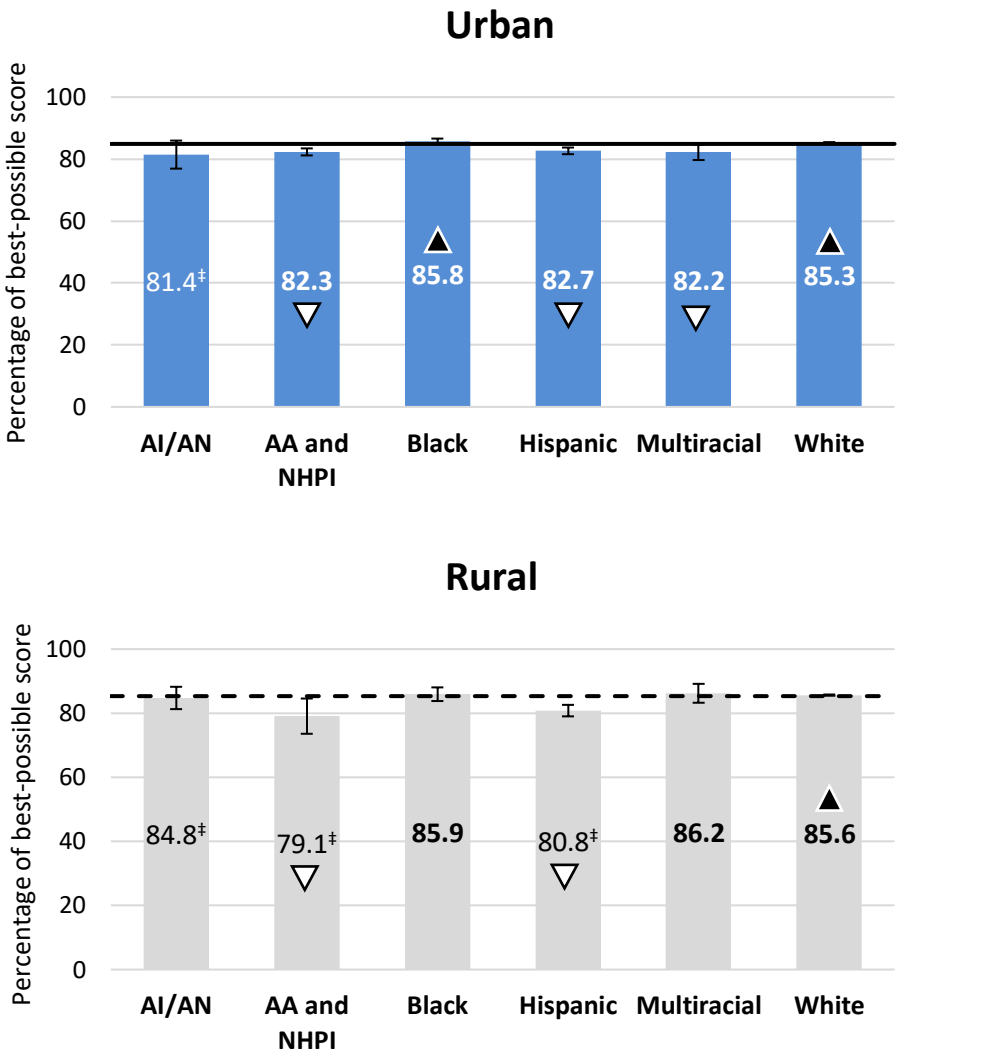
- Hispanic people with FFS coverage living in urban areas reported experiences with doctor communication that were **similar to** the national average for all people with FFS coverage living in urban areas. Hispanic people with FFS coverage living in rural areas reported experiences with doctor communication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

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

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

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well care was coordinated,[†] by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

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

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

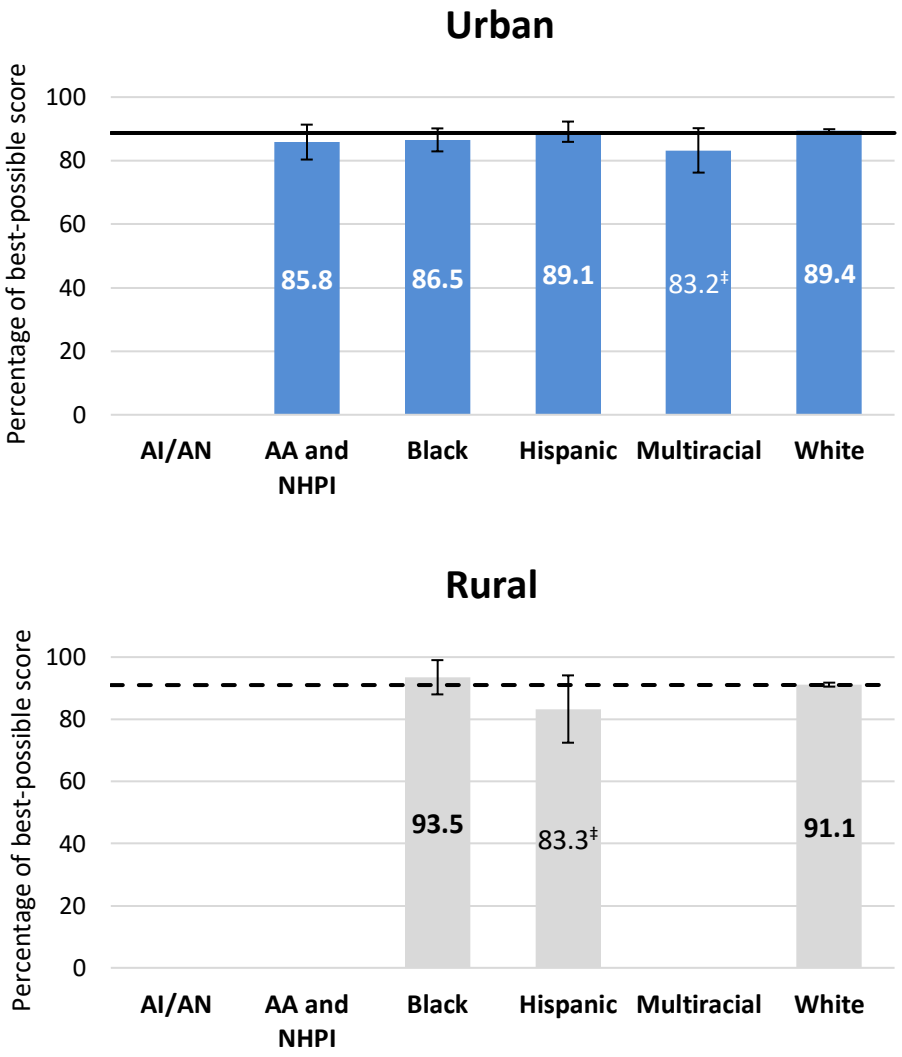
- Hispanic people with FFS coverage living in urban areas reported experiences with care coordination that were **below** the national average for all people with FFS coverage living in urban areas by less than 3 points on a 0–100 scale. Hispanic people with FFS coverage living in rural areas reported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

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

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

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plans,† by race and ethnicity within urban and rural areas, 2021



National average for all people with FFS coverage living in urban areas = 88.7

National average for all people with FFS coverage living in rural areas = 91.0

▲ Significantly above the national average

▽ Significantly below the national average

SOURCE: Data are from the Medicare CAHPS survey, 2021.

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

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

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

Disparities

- There were not enough data from AI/AN people with FFS coverage living in urban areas to compare their score on this measure to the score for all people with FFS coverage living in urban areas. There were not enough data from AI/AN people with FFS coverage living in rural areas to compare their score on this measure to the score for all people with FFS coverage living in rural areas.

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

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

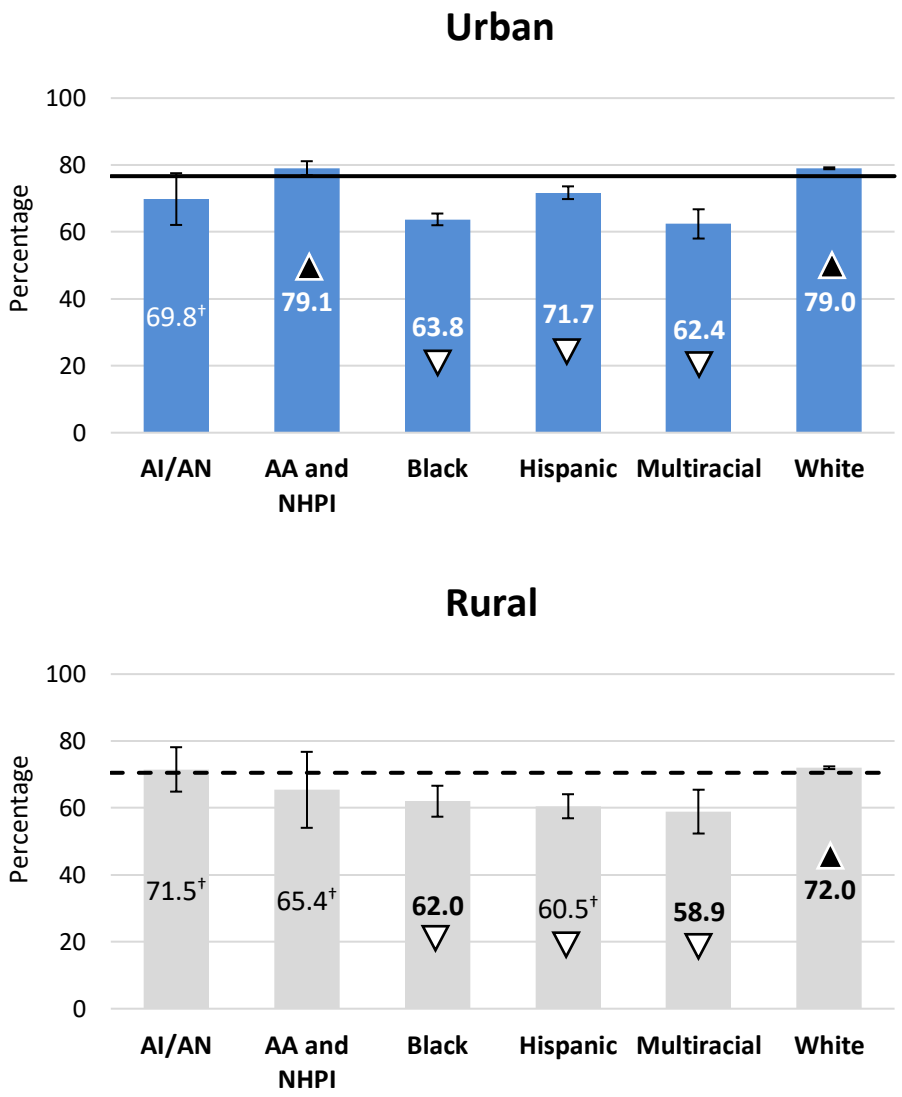
- Hispanic people with FFS coverage living in urban areas reported experiences with getting needed prescription drugs that were **similar to** the national average for all people with FFS coverage living in urban areas. Hispanic people with FFS coverage living in rural areas reported experiences with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

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

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

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by race and ethnicity within urban and rural areas, 2021



SOURCE: Data are from the Medicare CAHPS survey, 2021.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of AA and NHPI people with FFS coverage living in urban areas who received a flu vaccine was **above** the national average for all people with FFS coverage living in urban areas by less than 3 percentage points. The percentage of AA and NHPI people with FFS coverage living in rural areas who received a flu vaccine was **similar to** the national average for all people with FFS coverage living in rural areas.

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

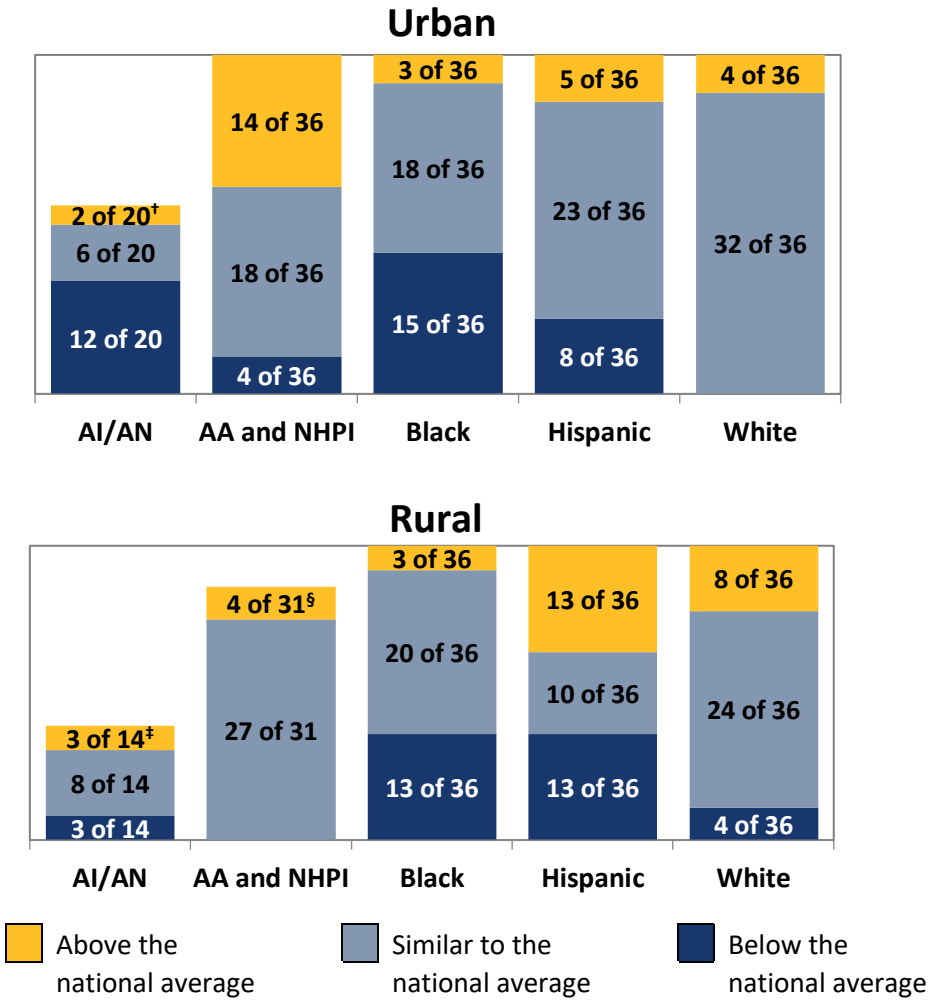
- The percentage of Hispanic people with FFS coverage living in urban areas who received a flu vaccine was **below** the national average for all people with FFS coverage living in urban areas by more than 3 percentage points. The percentage of Hispanic people with FFS coverage living in rural areas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

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

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

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

Number of clinical care measures for which MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all MA enrollees living in the same type of area (urban or rural) in Reporting Year 2021



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian or Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet standards described on pp. 4–5. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

† There were not enough data from AI/AN MA enrollees living in urban areas to compare their scores on 16 measures to scores for all people living in urban areas.
‡ There were not enough data from AI/AN MA enrollees living in rural areas to compare their scores on 22 measures to scores for all people living in rural areas.
§ There were not enough data from AA and NHPI people living in rural areas to compare their scores on five measures to scores for all people living in rural areas.

MA enrollees in each racial and ethnic group were compared with the national average for all MA enrollees separately for rural and urban areas.

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

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

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

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

- Breast Cancer Screening
- Testing to Confirm COPD
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Use of Opioids from Multiple Prescribers

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

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

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Patient Engagement After Inpatient Discharge
- 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 Opioids from Multiple Prescribers

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

- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment

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

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

Black MA enrollees living in urban areas had results that were below the national average for all MA enrollees living in urban areas

- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

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

- Breast Cancer Screening
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Controlling High Blood Pressure
- Statin Use in Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture

Hispanic MA enrollees living in urban areas had results that were below the national average for all MA enrollees living in urban areas

- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- 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

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

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

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

- Initiation of AOD Dependence Treatment
- Engagement of AOD Dependence Treatment
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

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

- Breast Cancer Screening
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins

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

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- 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

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

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

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

- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Rheumatoid Arthritis Management
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information

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

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Rheumatoid Arthritis Management
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Use of Opioids from Multiple Prescribers

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

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Potentially Harmful Drug-Disease Interactions in 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

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

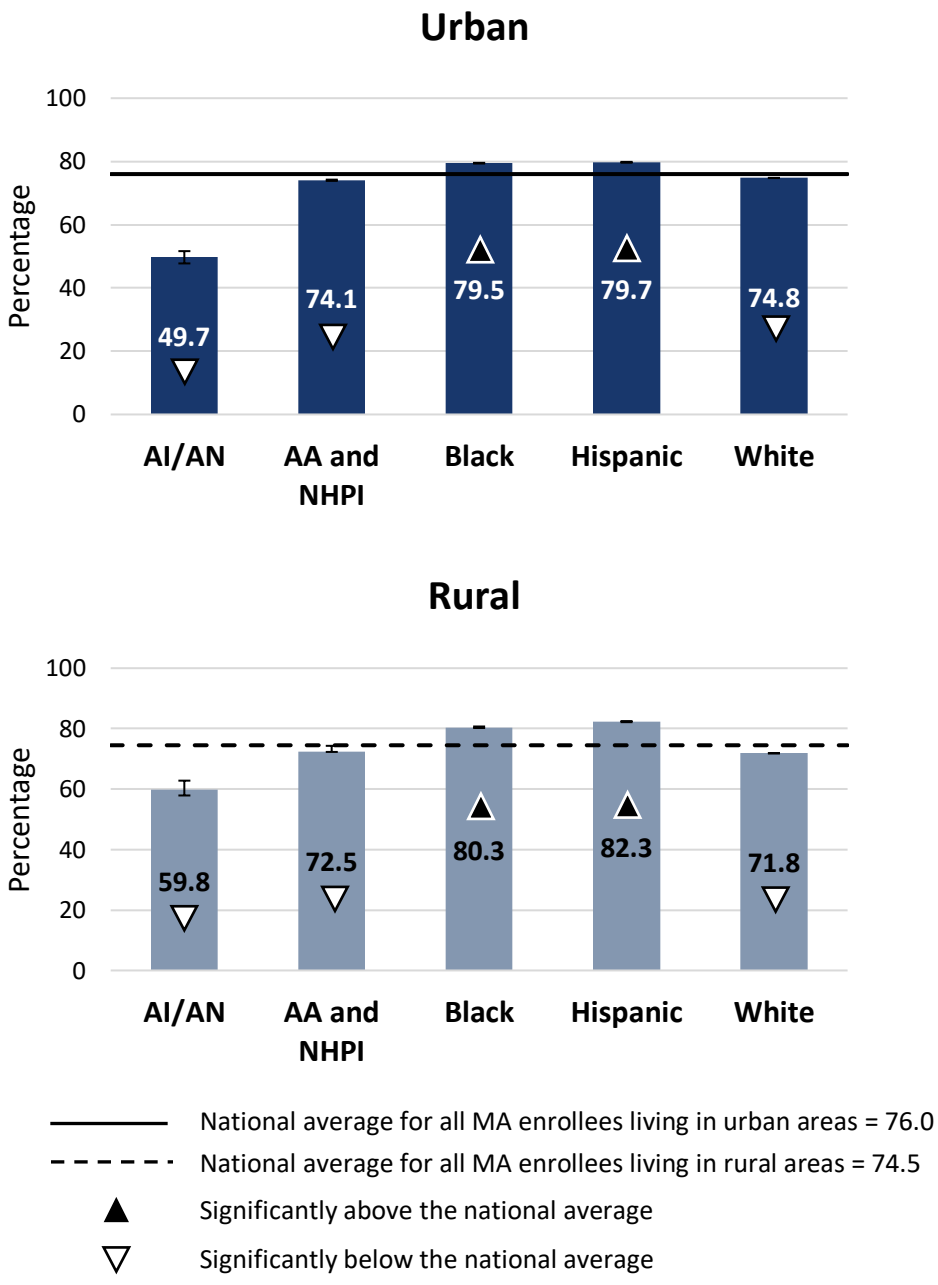
- Medication Adherence for Cardiovascular Disease—Statins
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
- Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

White MA enrollees living in rural areas had results that were below the national average for all MA enrollees living in rural areas
• Controlling High Blood Pressure • Diabetes Care—Eye Exam • Osteoporosis Management in Women Who Had a Fracture • Transitions of Care—Receipt of Discharge Information

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

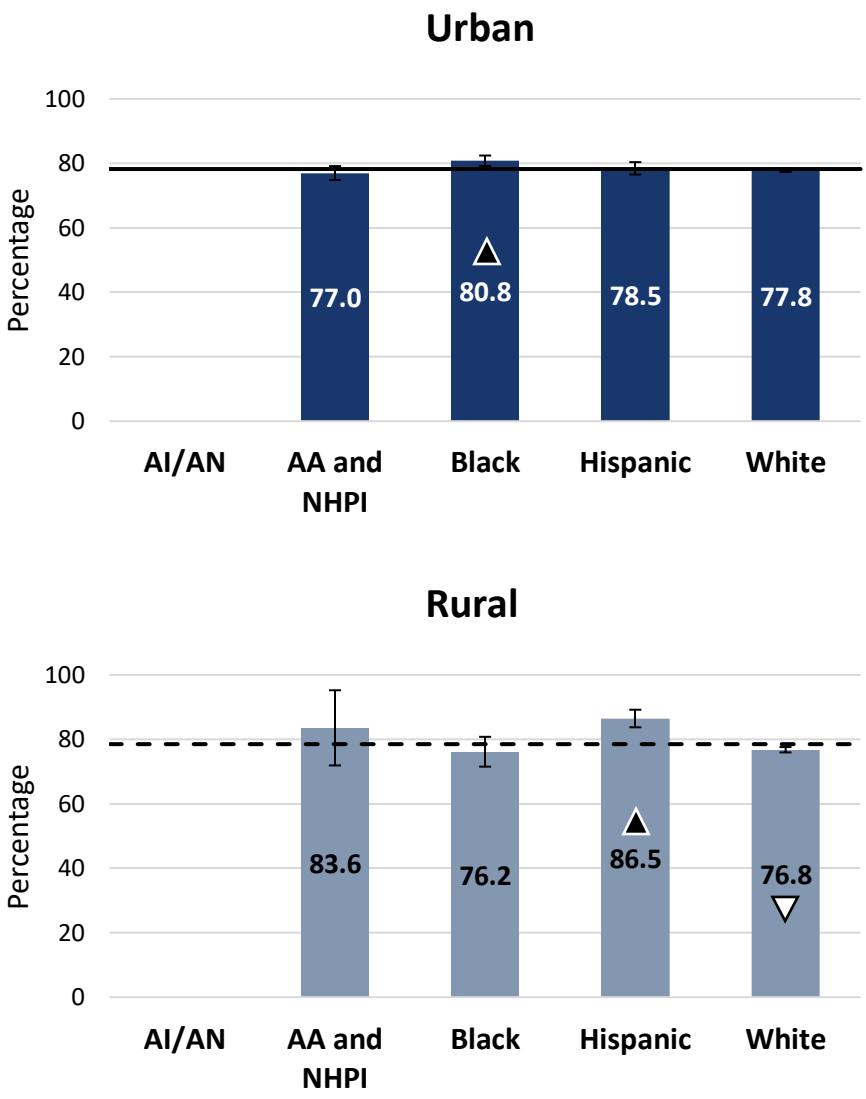
- The percentage of eligible female White MA enrollees living in urban areas who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible female White MA enrollees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

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

[‡] Unlike on pages 200–206, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

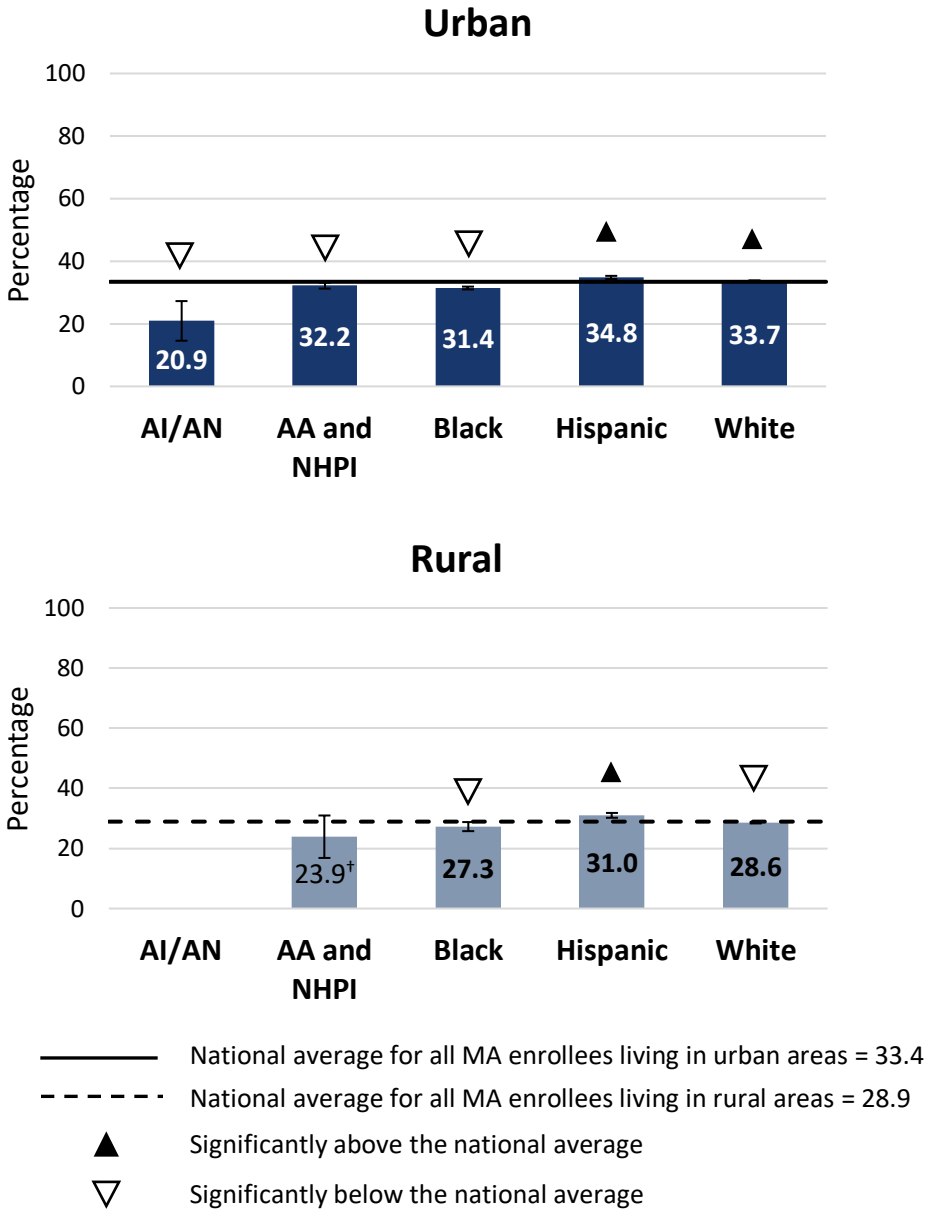
- The percentage of eligible Hispanic MA enrollees living in urban areas who were appropriately screened for colorectal cancer was **similar to** the national average for all MA eligible enrollees living in urban areas. The percentage of eligible Hispanic MA enrollees living in rural areas who were appropriately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

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

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

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

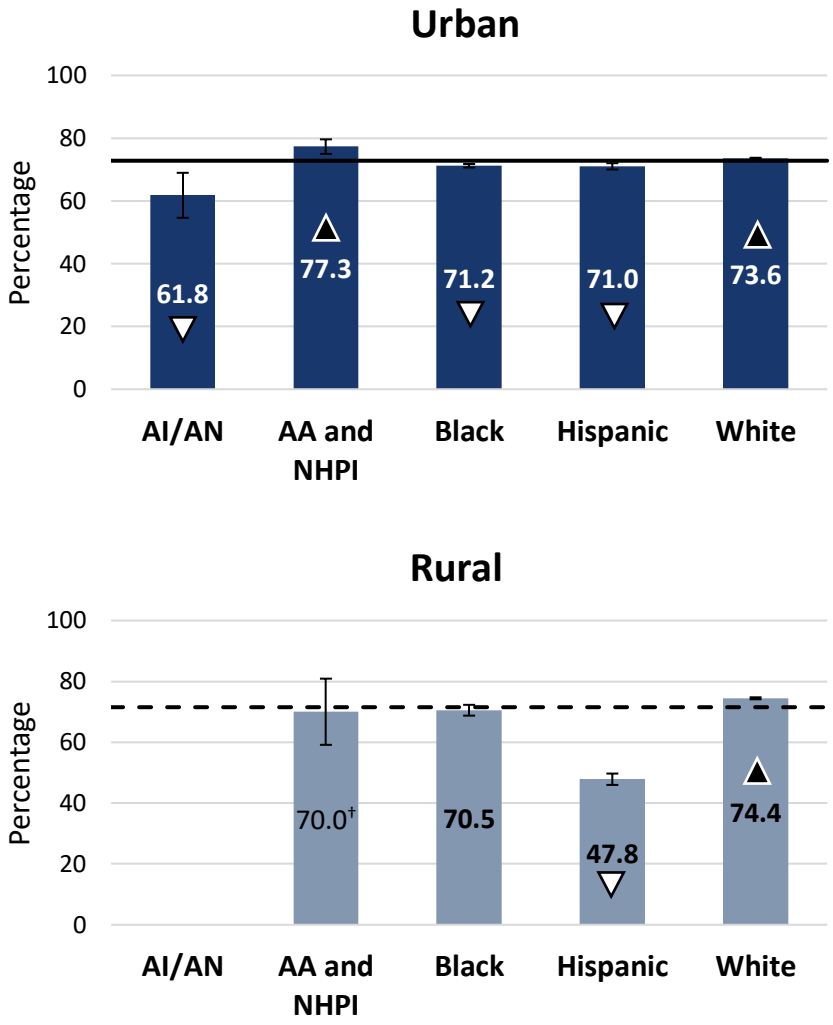
- The percentage of eligible Black MA enrollees living in urban areas who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible Black MA enrollees living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

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

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

Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

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

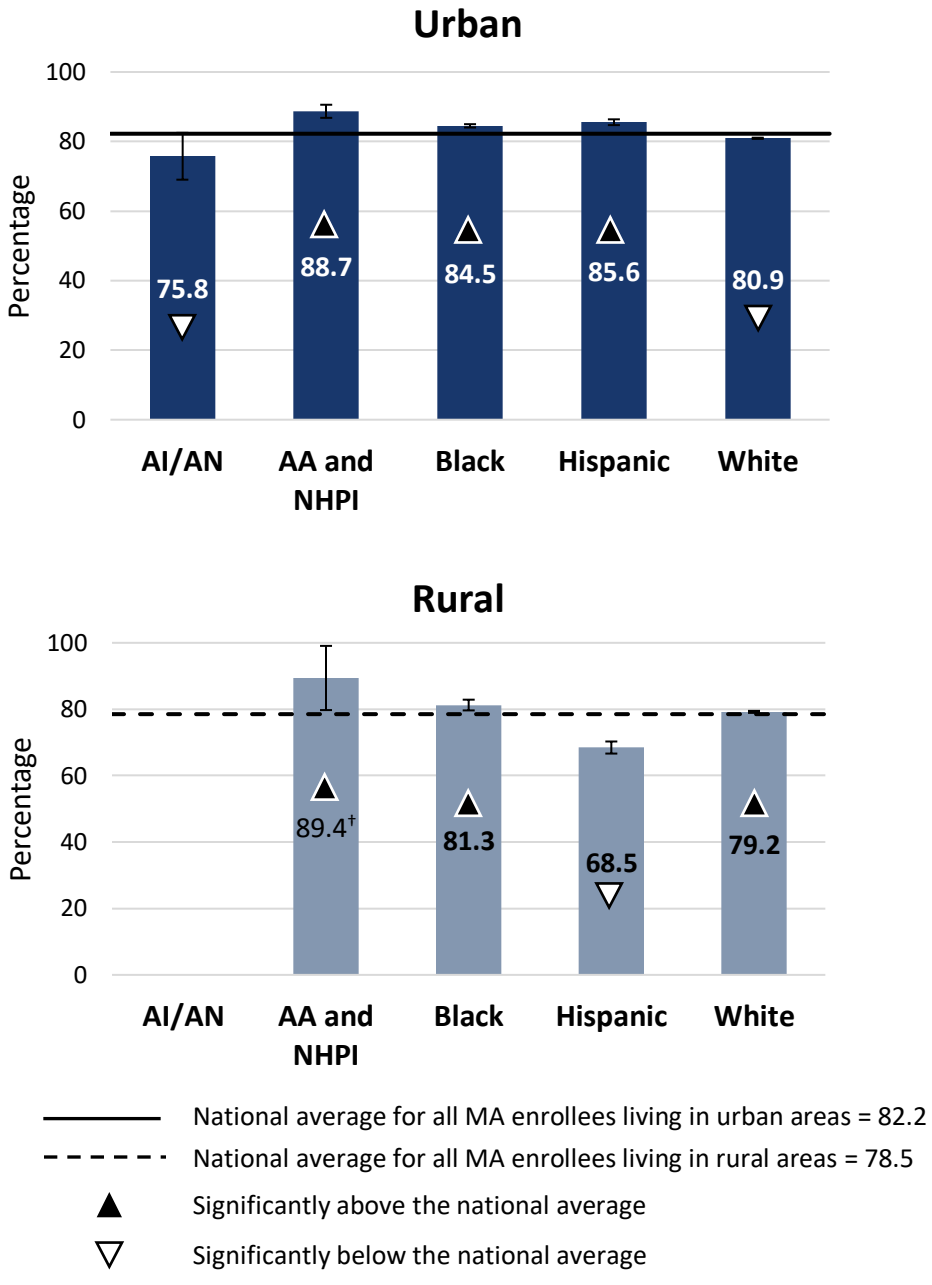
- The percentage of eligible Black MA enrollees living in urban areas who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible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

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

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

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

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

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

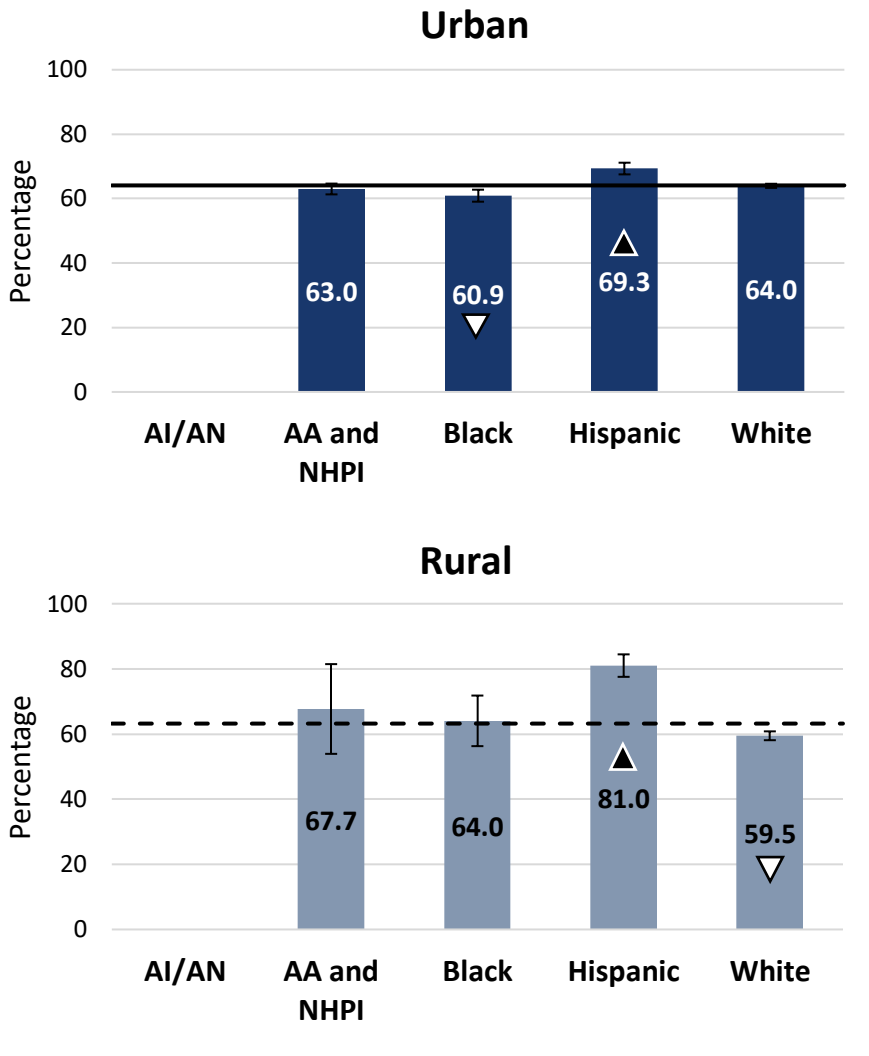
- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible Hispanic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

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

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

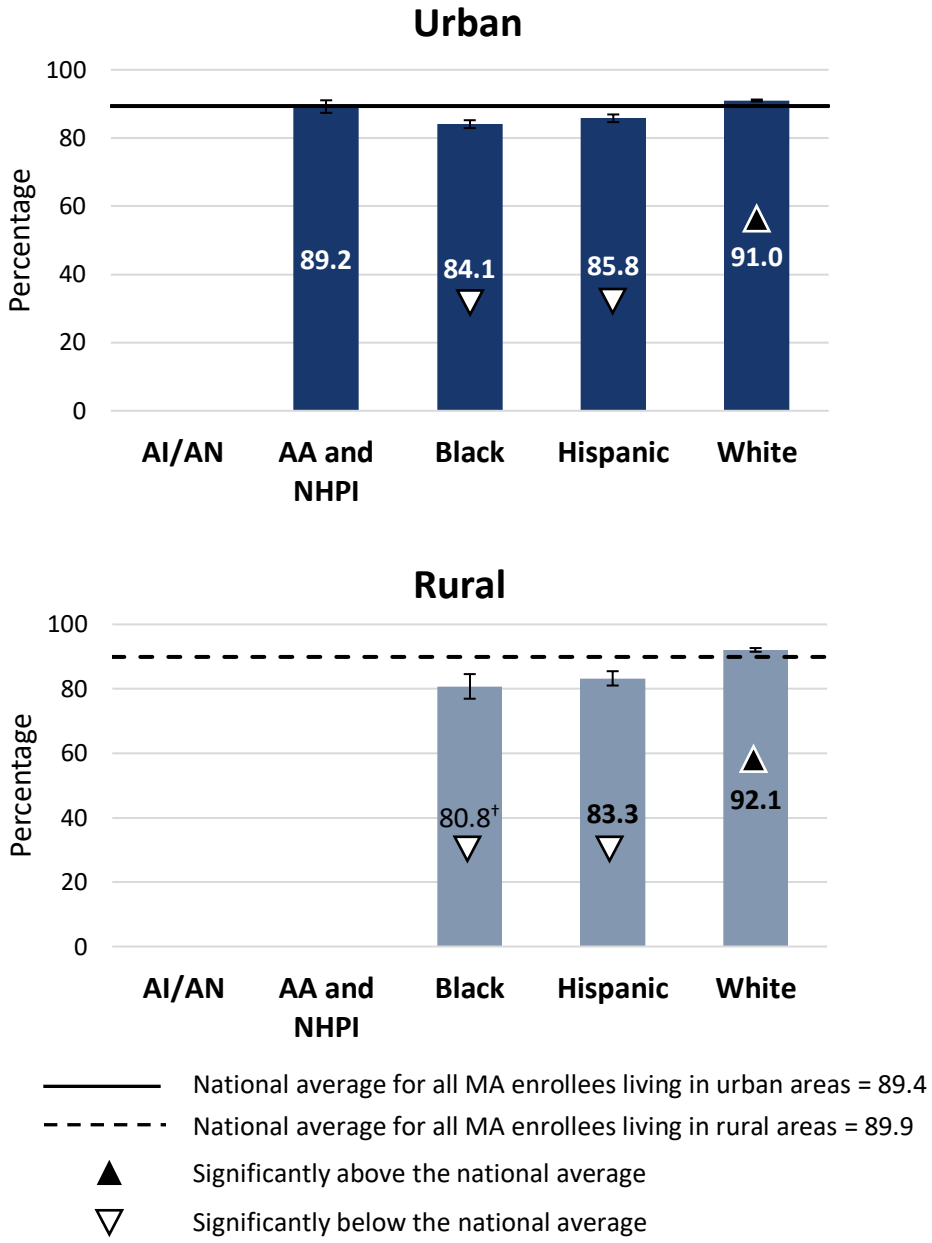
- The percentage of eligible Black MA enrollees living in urban areas who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible Black MA enrollees living in rural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

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

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

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of AMI who received continuous beta-blocker treatment for six months after discharge, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

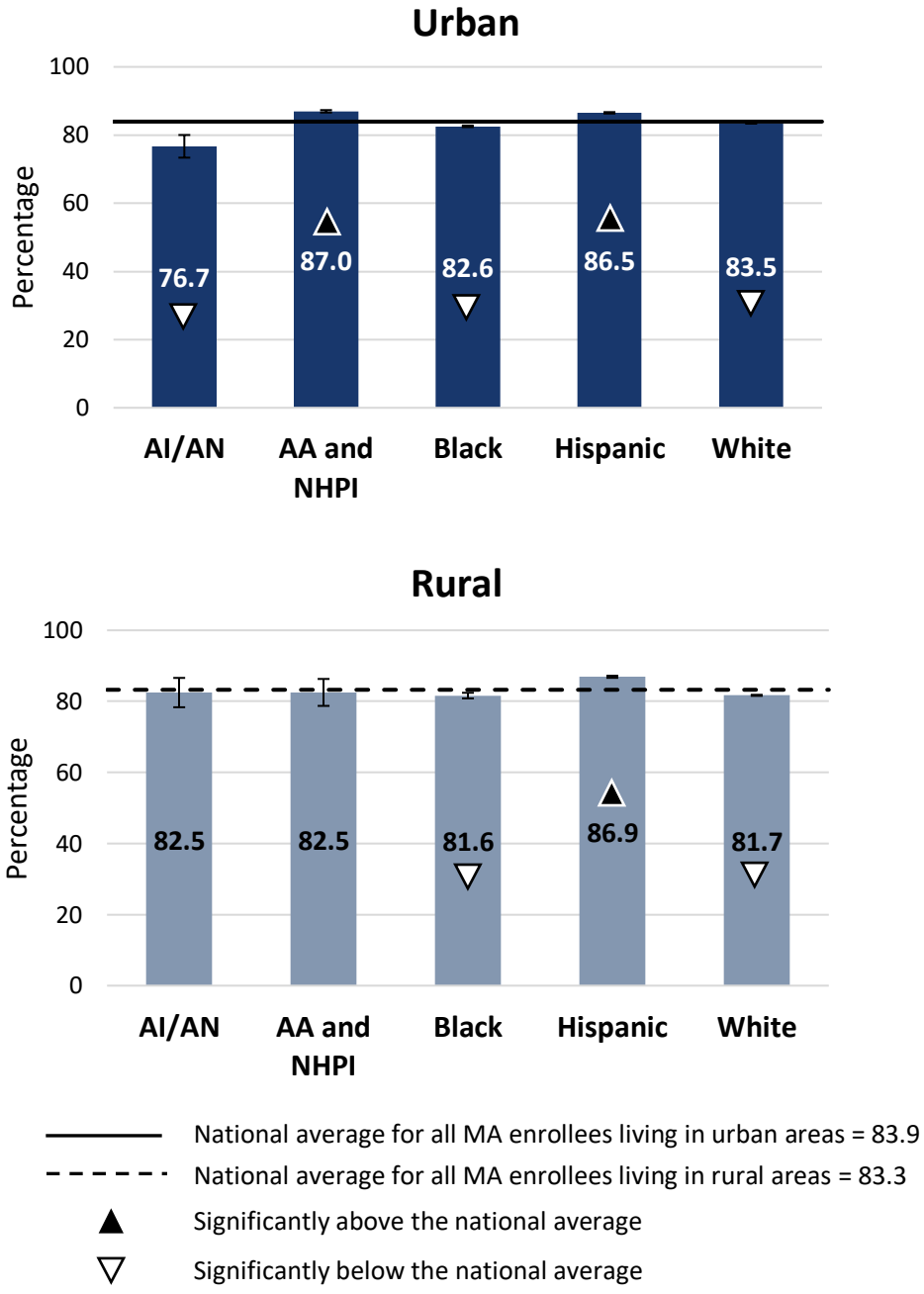
- The percentage of eligible Black MA enrollees living in urban areas who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who received continuous beta-blocker treatment was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who received continuous beta-blocker treatment was **above** the national average for all eligible MA enrollees living in rural areas by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who received statin therapy, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- The percentage of AI/AN MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD living in urban areas by more than 3 percentage points. The percentage of AI/AN MA enrollees with clinical ASCVD living in rural areas who received statin therapy was **similar to** the national average for all MA enrollees with clinical ASCVD living in rural areas.

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

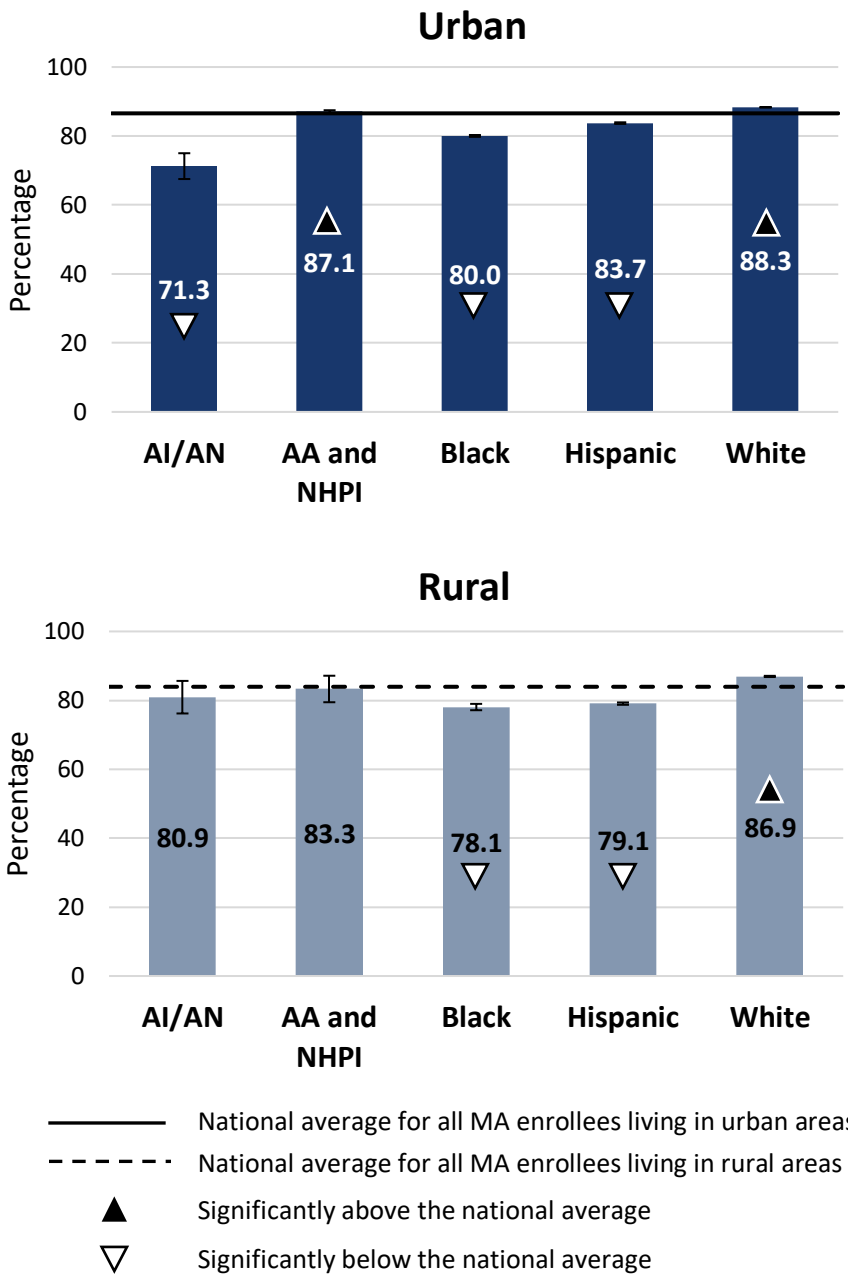
- The percentage of Black MA enrollees with clinical ASCVD living in urban areas who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD living in urban areas by less than 3 percentage points. The percentage of Black MA enrollees with clinical ASCVD living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

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

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

Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

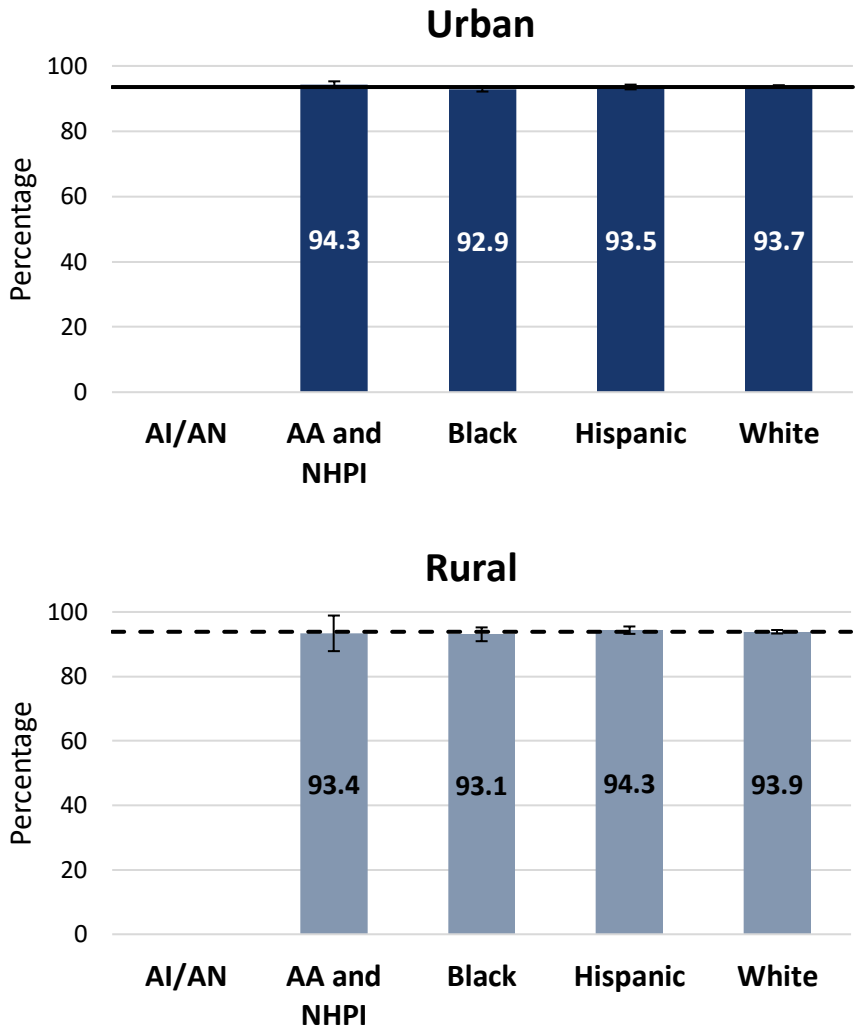
- The percentage of White MA enrollees with clinical ASCVD living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD living in urban areas by less than 3 percentage points. The percentage of White MA enrollees with clinical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

[†] Prior to rounding.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban areas to compare their score on this measure to the score for all MA enrollees with diabetes living in urban areas. There were not enough data from AI/AN MA enrollees with diabetes living in rural areas to compare their score on this measure to the score for all MA enrollees with diabetes living in rural areas.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

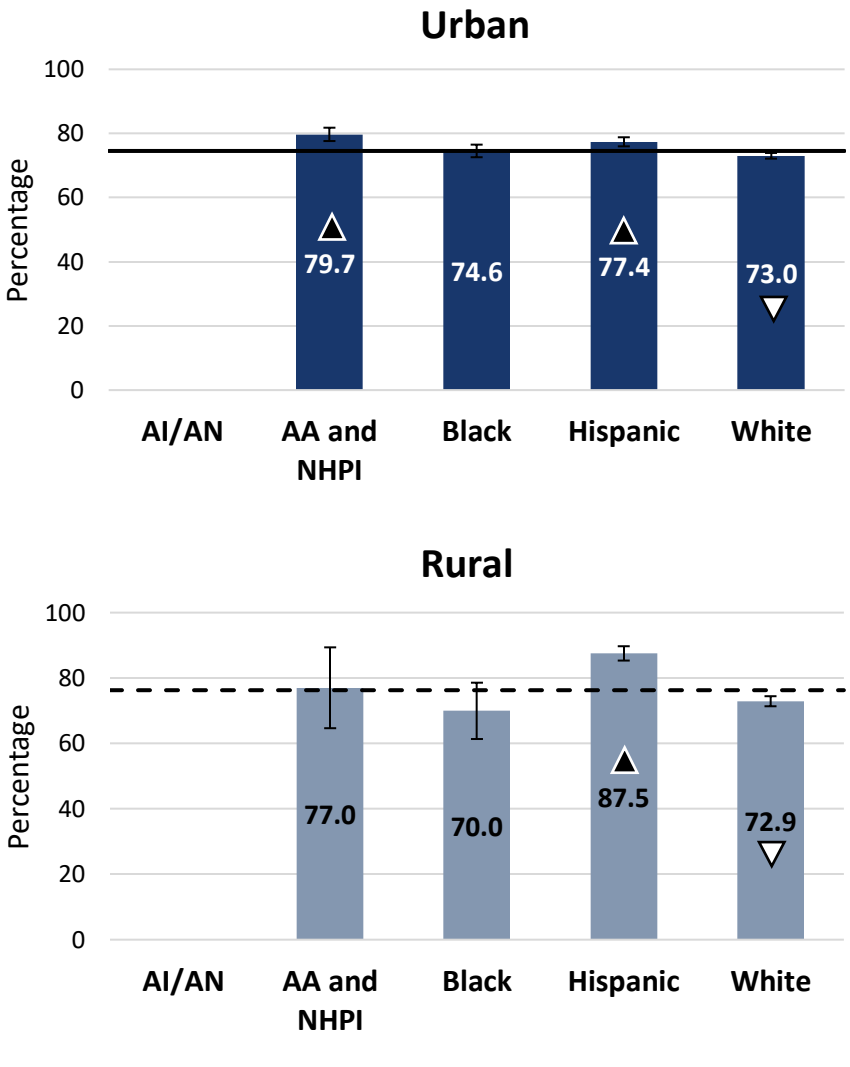
- The percentage of Black MA enrollees with diabetes living in urban areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of Black MA enrollees with diabetes living in rural areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

- The percentage of Hispanic MA enrollees with diabetes living in urban areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of Hispanic MA enrollees with diabetes living in rural areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

- The percentage of White MA enrollees with diabetes living in urban areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of White MA enrollees with diabetes living in rural areas who had their blood sugar tested at least once in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban areas to compare their score on this measure to the score for all MA enrollees with diabetes living in urban areas. There were not enough data from AI/AN MA enrollees with diabetes living in rural areas to compare their score on this measure to the score for all MA enrollees with diabetes living in rural areas.

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

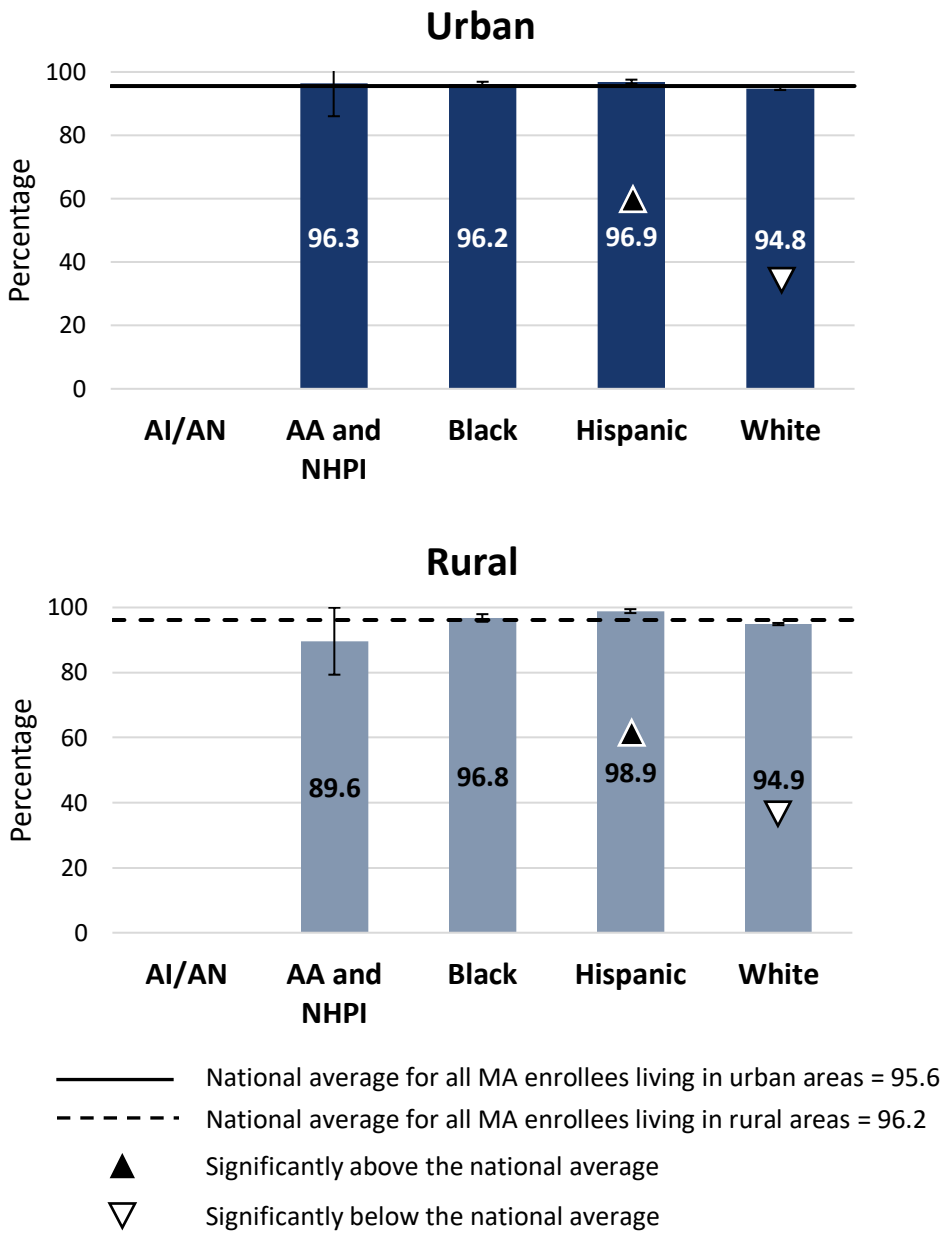
- The percentage of Black MA enrollees with diabetes living in urban areas who had an eye exam in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of Black MA enrollees with diabetes living in rural areas who had an eye exam in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

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

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

Diabetes Care—Kidney Disease Monitoring

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban areas to compare their score on this measure to the score for all MA enrollees with diabetes living in urban areas. There were not enough data from AI/AN MA enrollees with diabetes living in rural areas to compare their score on this measure to the score for all MA enrollees with diabetes living in rural areas.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had medical attention for nephropathy in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had medical attention for nephropathy in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

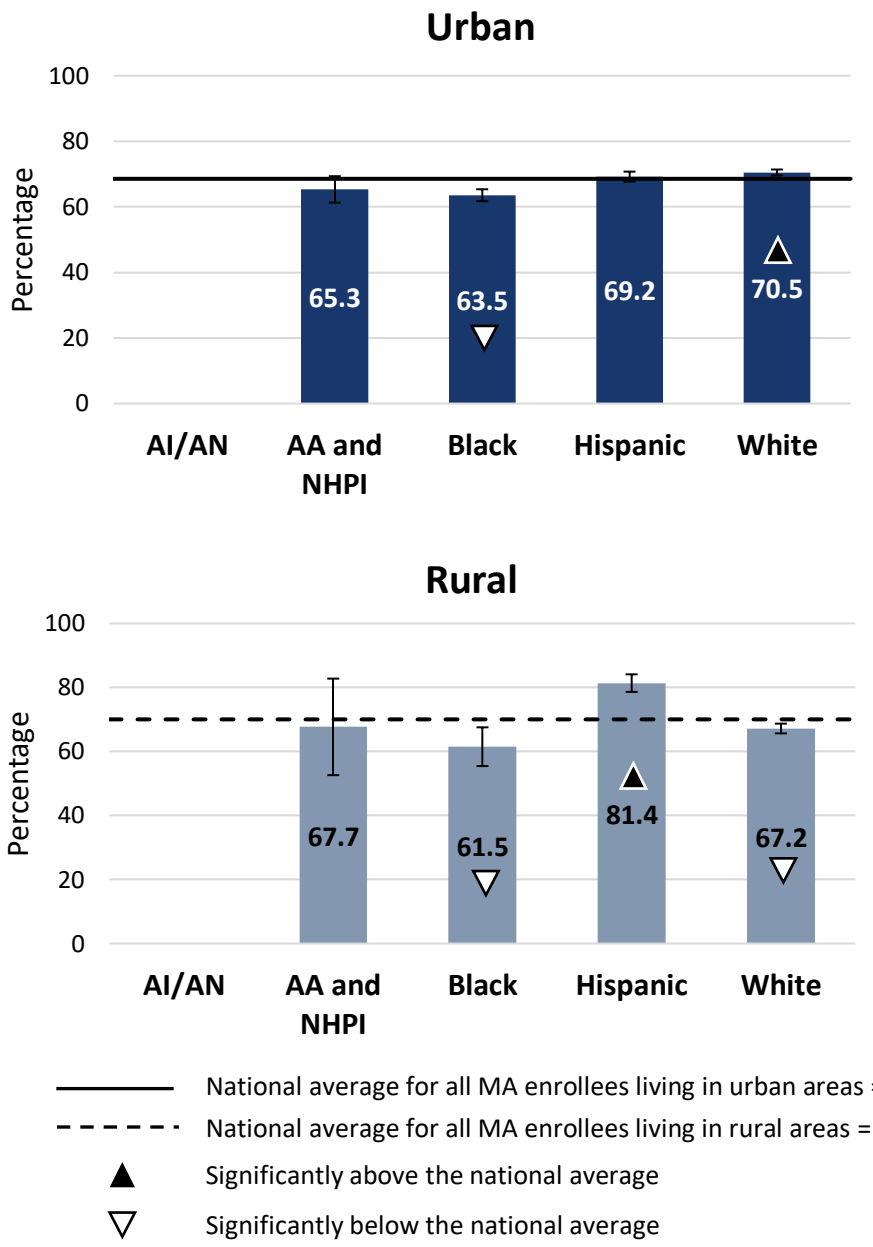
- The percentage of Black MA enrollees with diabetes living in urban areas who had medical attention for nephropathy in the past year was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of Black MA enrollees with diabetes living in rural areas who had medical attention for nephropathy in the past year was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

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

- The percentage of White MA enrollees with diabetes living in urban areas who had medical attention for nephropathy in the past year was **below** the national average for all MA enrollees with diabetes living in urban areas by less than 3 percentage points. The percentage of White MA enrollees with diabetes living in rural areas who had medical attention for nephropathy in the past year was **below** the national average for all MA enrollees with diabetes living in rural areas by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban areas to compare their score on this measure to the score for all MA enrollees with diabetes living in urban areas. There were not enough data from AI/AN MA enrollees with diabetes living in rural areas to compare their score on this measure to the score for all MA enrollees with diabetes living in rural areas.

- The percentage of AA and NHPI MA enrollees with diabetes living in urban areas who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes living in urban areas. The percentage of AA and NHPI MA enrollees with diabetes living in rural areas who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes living in rural areas.

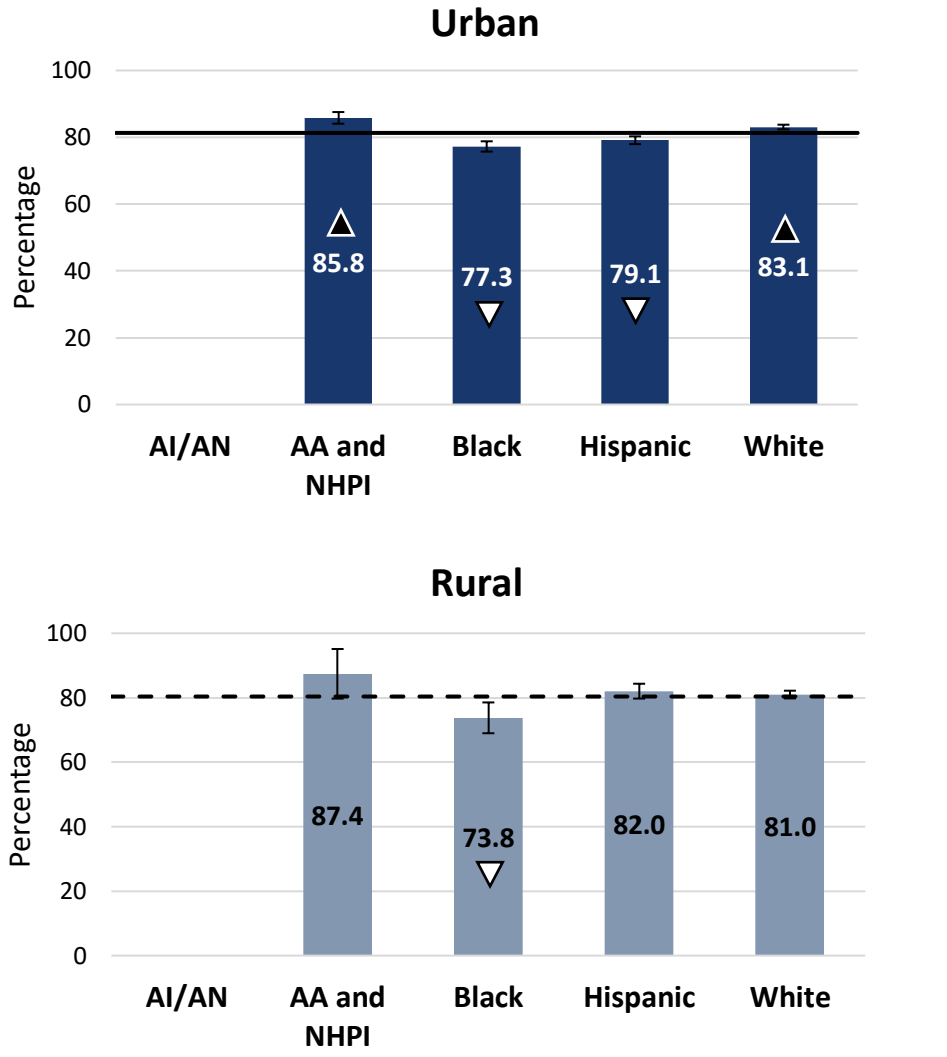
- The percentage of Black MA enrollees with diabetes living in urban areas who had their blood pressure under control was **below** the national average for all MA enrollees with diabetes living in urban areas by more than 3 percentage points. The percentage of Black MA enrollees with diabetes living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

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

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

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

- There were not enough data from AI/AN MA enrollees with diabetes living in urban areas to compare their score on this measure to the score for all MA enrollees with diabetes living in urban areas. There were not enough data from AI/AN MA enrollees with diabetes living in rural areas to compare their score on this measure to the score for all MA enrollees with diabetes living in rural areas.

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

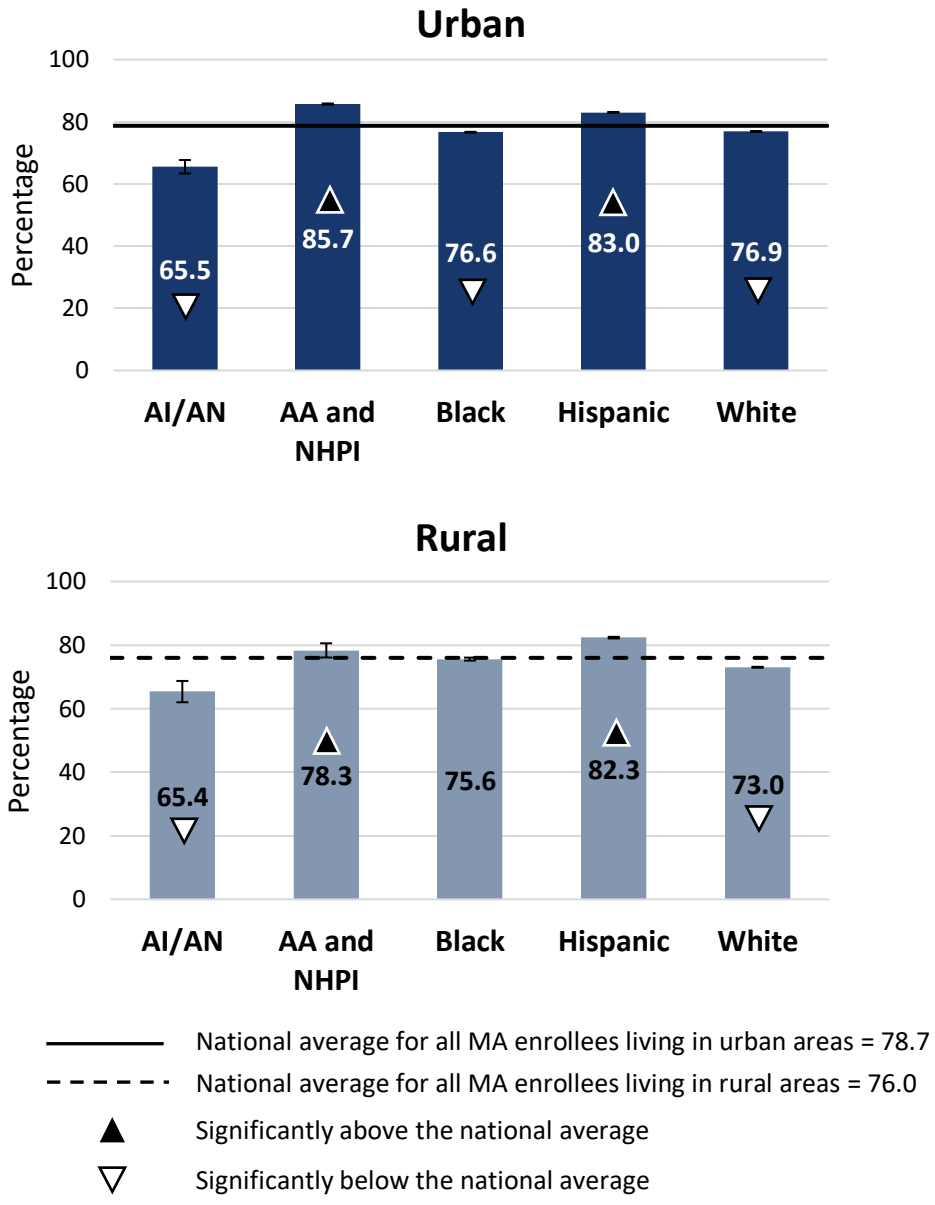
- The percentage of Black MA enrollees with diabetes living in urban areas who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes living in urban areas by more than 3 percentage points. The percentage of Black MA enrollees with diabetes living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

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

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

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who received statin therapy, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] Excludes those who also have clinical ASCVD.

Disparities

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

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

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

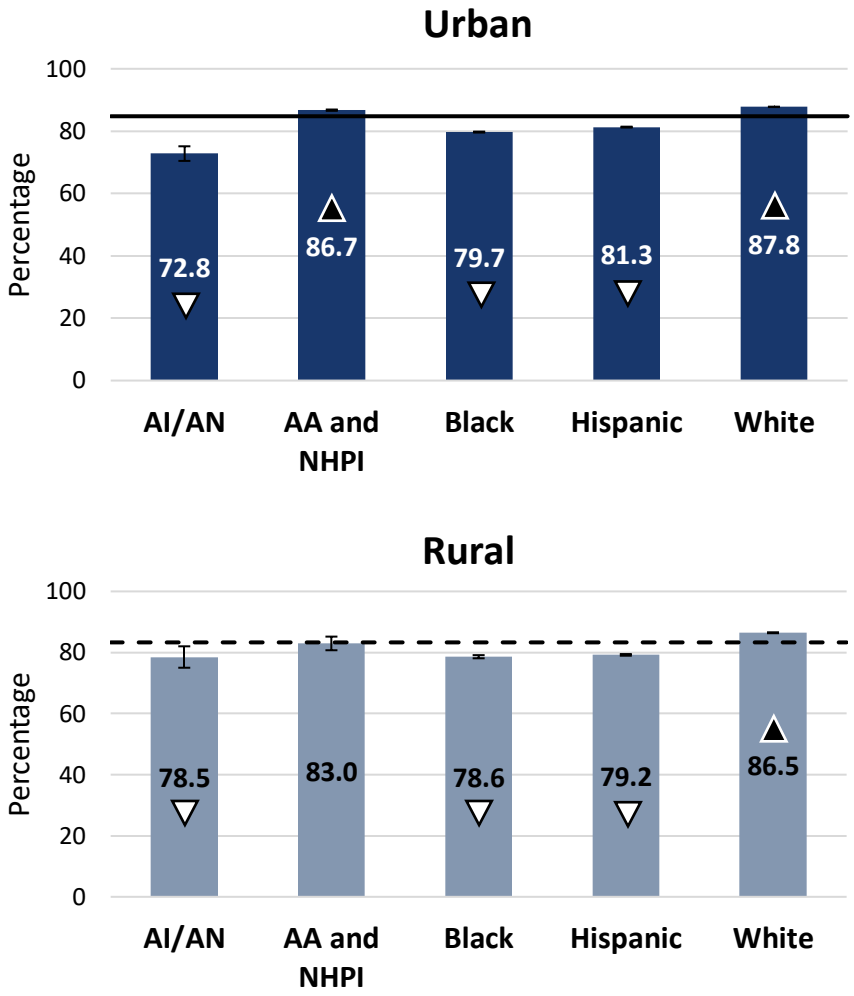
- The percentage of Hispanic MA enrollees with diabetes living in urban areas who received statin therapy was **above** the national average for all MA enrollees with diabetes living in urban areas by more than 3 percentage points. The percentage of Hispanic MA enrollees with diabetes living in rural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

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

[‡] Prior to rounding.

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

† Excludes those who also have clinical ASCVD.

Disparities

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

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

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

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

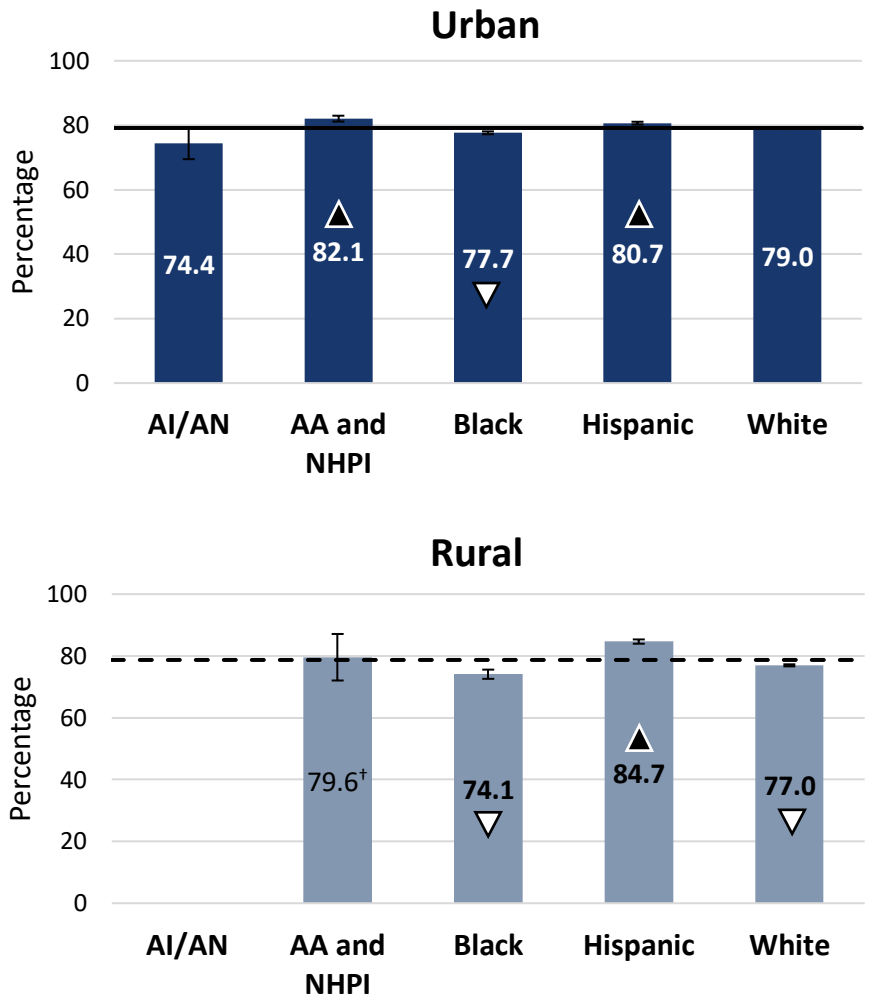
- The percentage of White MA enrollees with diabetes living in urban areas who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes living in urban areas by more than 3 percentage points.[‡] The percentage of White MA enrollees with diabetes living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

[‡] Prior to rounding.

Clinical Care: Musculoskeletal Conditions

Rheumatoid Arthritis Management

Percentage of MA enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a DMARD, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who were dispensed at least one DMARD was **similar to** the national average for all eligible MA enrollees living in urban areas. There were not enough data from eligible AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who were dispensed at least one DMARD was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible AA and NHPI MA enrollees living in rural areas who were dispensed at least one DMARD was **similar to** the national average for all eligible MA enrollees living in rural areas.

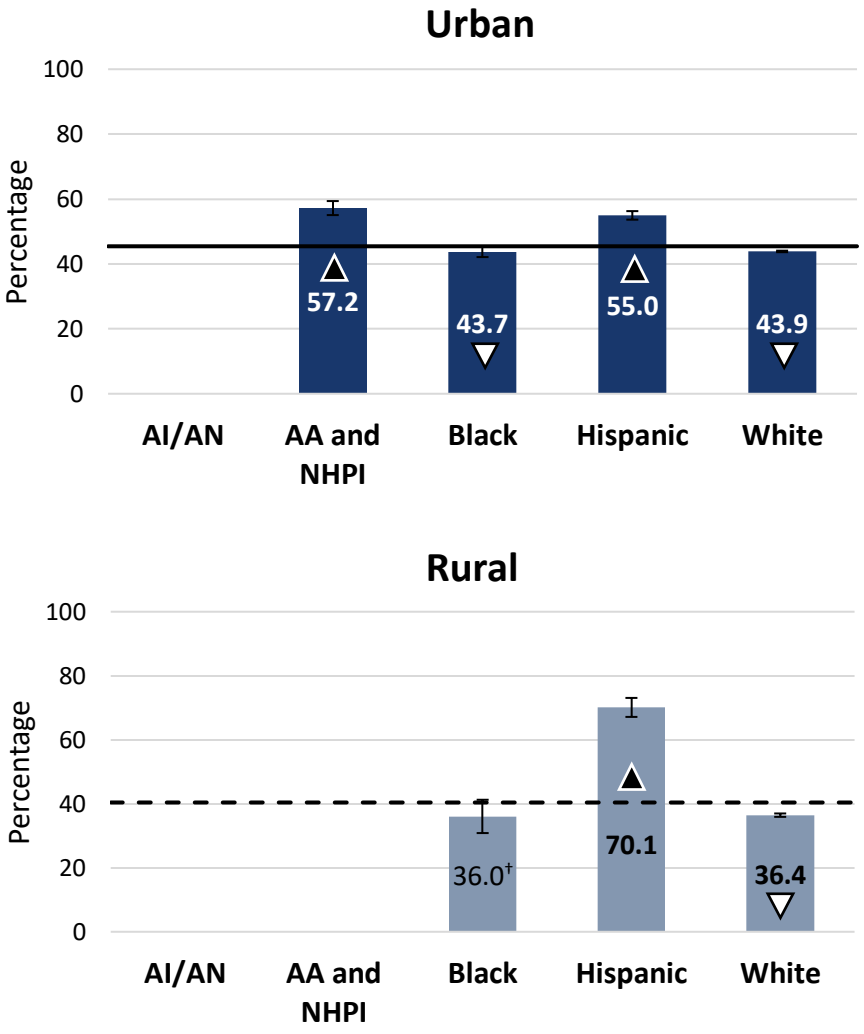
- The percentage of eligible Black MA enrollees living in urban areas who were dispensed at least one DMARD was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who were dispensed at least one DMARD was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas who were dispensed at least one DMARD was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible Hispanic MA enrollees living in rural areas who were dispensed at least one DMARD was **above** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were dispensed at least one DMARD was **similar to** the national average for all eligible MA enrollees living in urban areas. The percentage of eligible White MA enrollees living in rural areas who were dispensed at least one DMARD was **below** the national average for all eligible MA enrollees living in rural areas by less than 3 percentage points.

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of eligible female AA and NHPI MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from eligible female AA and NHPI MA enrollees living in rural areas to compare their score on this measure to the score for all eligible female MA enrollees living in rural areas.

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

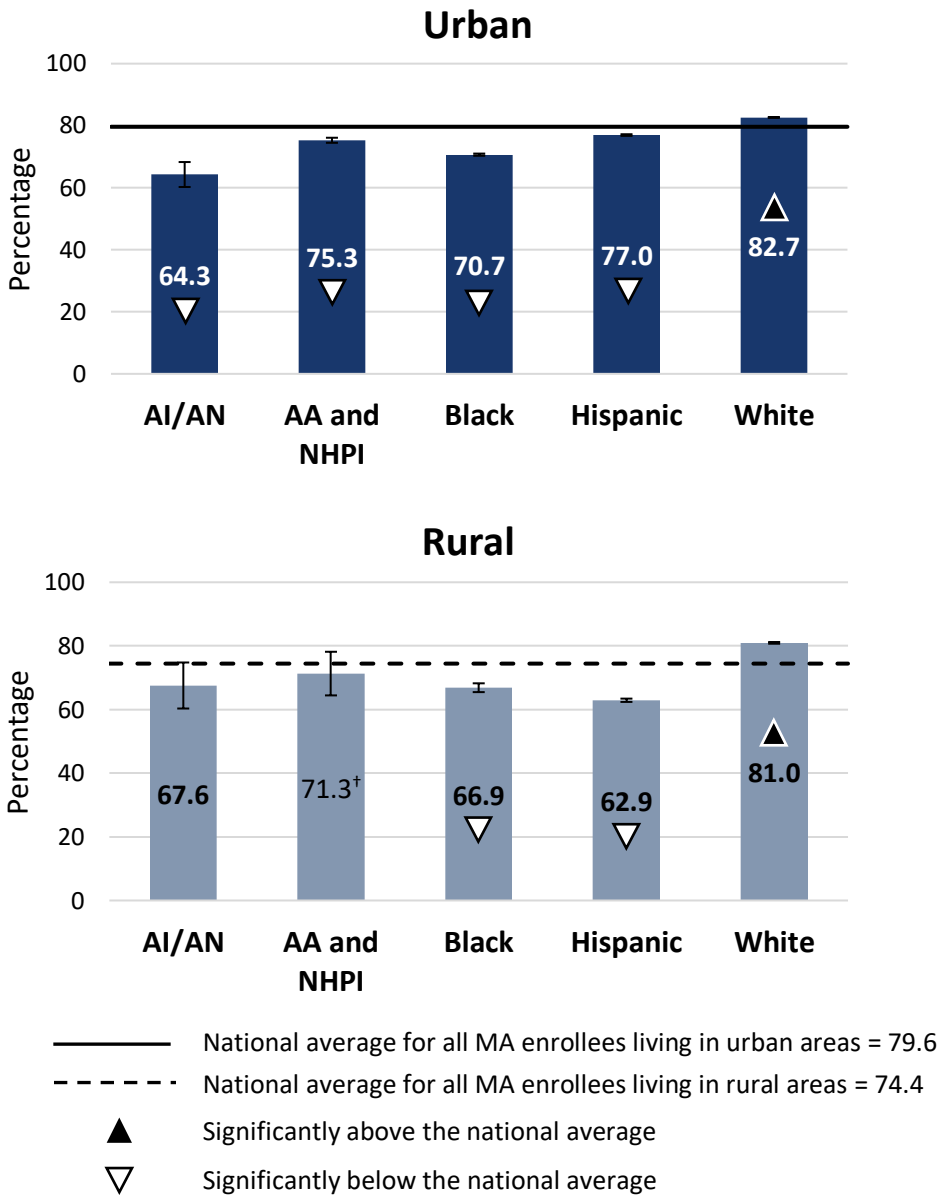
- The percentage of eligible female Hispanic MA enrollees living in urban areas who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees living in urban areas by more than 3 percentage points.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

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

Clinical Care: Behavioral Health

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible AI/AN MA enrollees living in rural areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **similar to** the national average for all eligible MA enrollees living in rural areas.

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

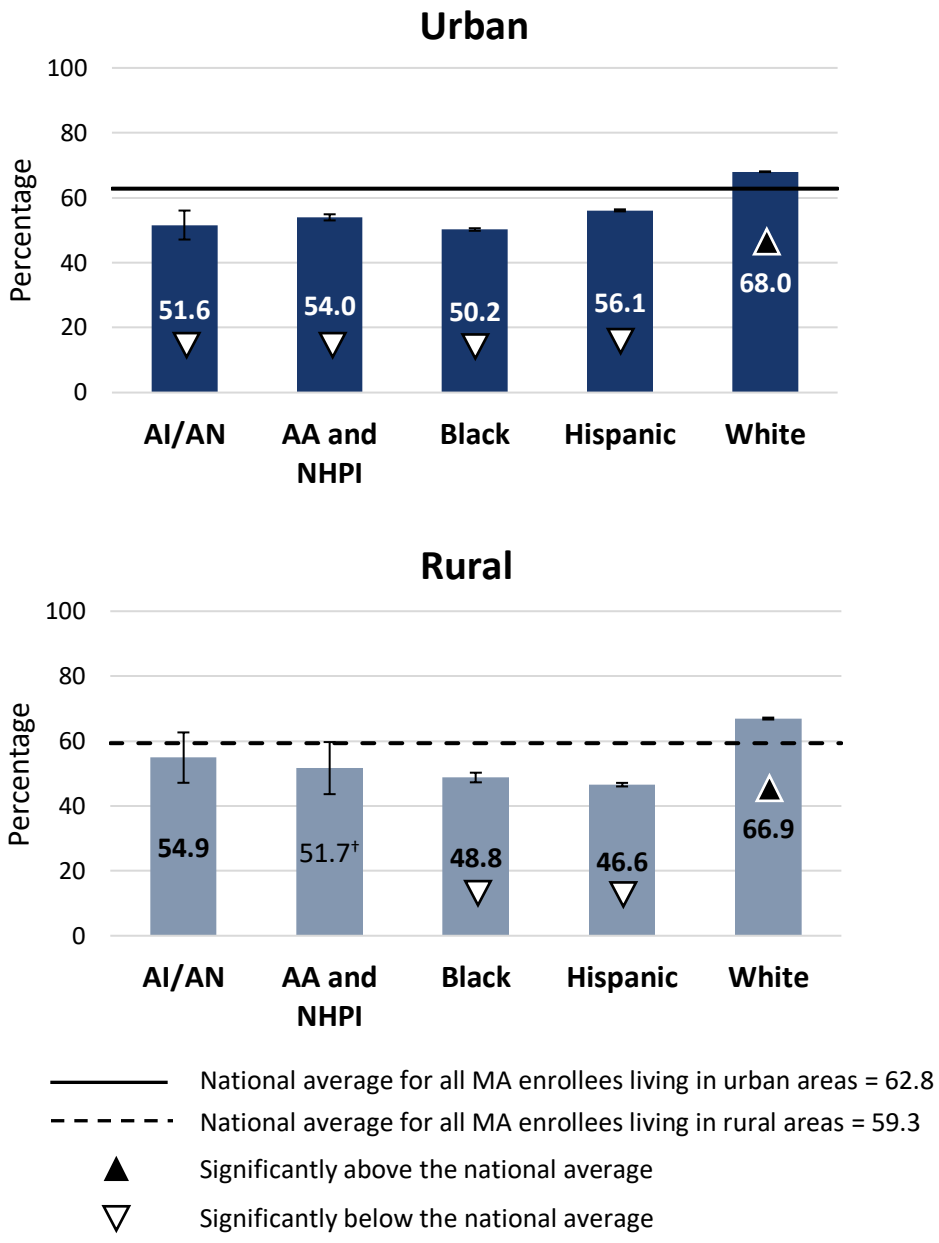
- The percentage of eligible Black MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The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

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

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

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on antidepressant medication for at least 180 days, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of eligible AI/AN MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible AI/AN MA enrollees living in rural areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **similar to** the national average for all eligible MA enrollees living in rural areas.

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

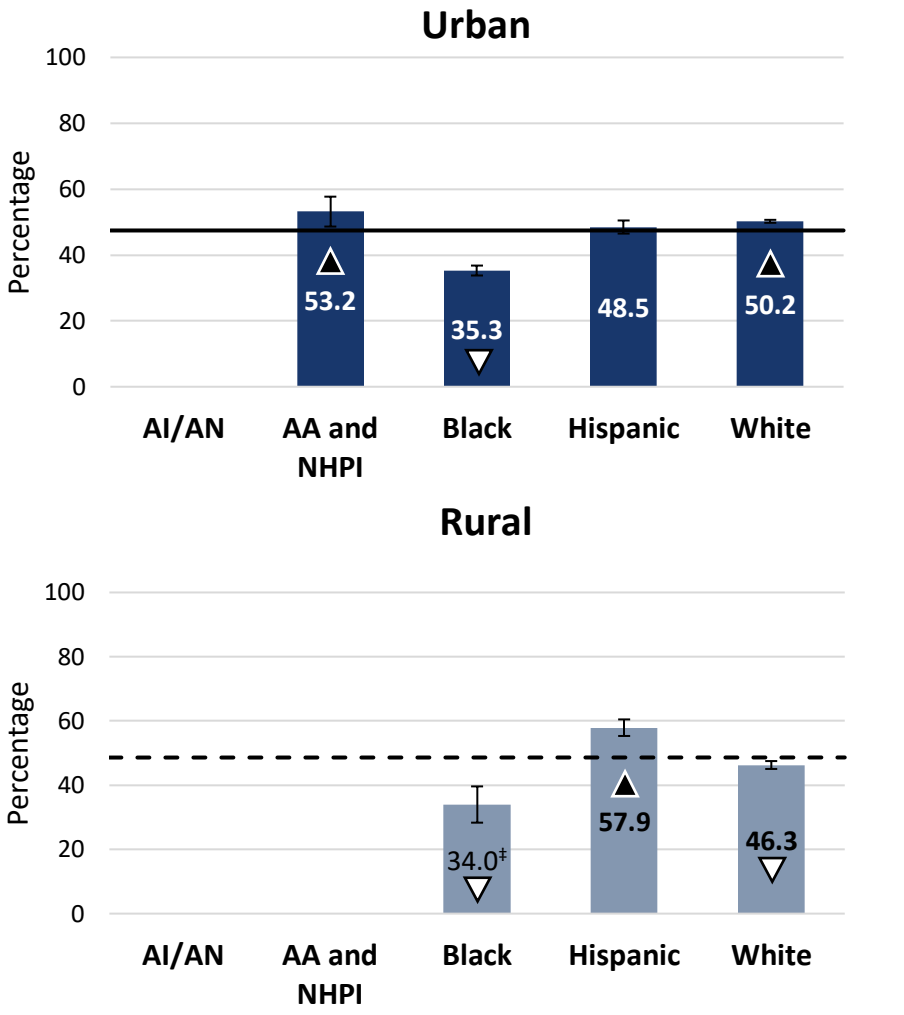
- The percentage of eligible Black MA enrollees living in urban areas who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The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

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
‡ This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

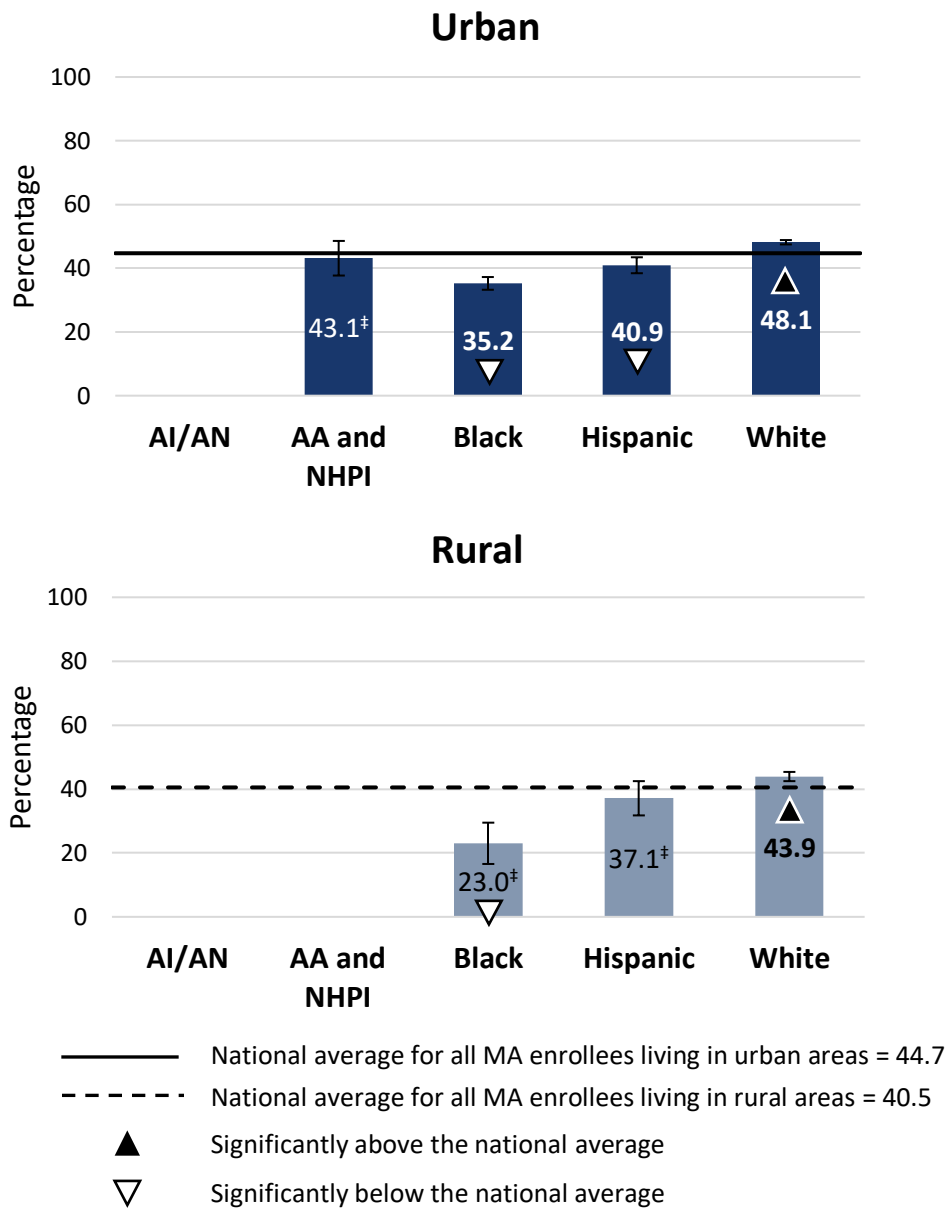
- The percentage of eligible Black MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of eligible Black MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible Hispanic MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible MA enrollees living in urban areas. The percentage of eligible Hispanic MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of eligible White MA enrollees living in urban areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of eligible White MA enrollees living in rural areas who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible MA enrollees living in rural areas by less than 3 percentage points.

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all eligible MA enrollees living in urban areas. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

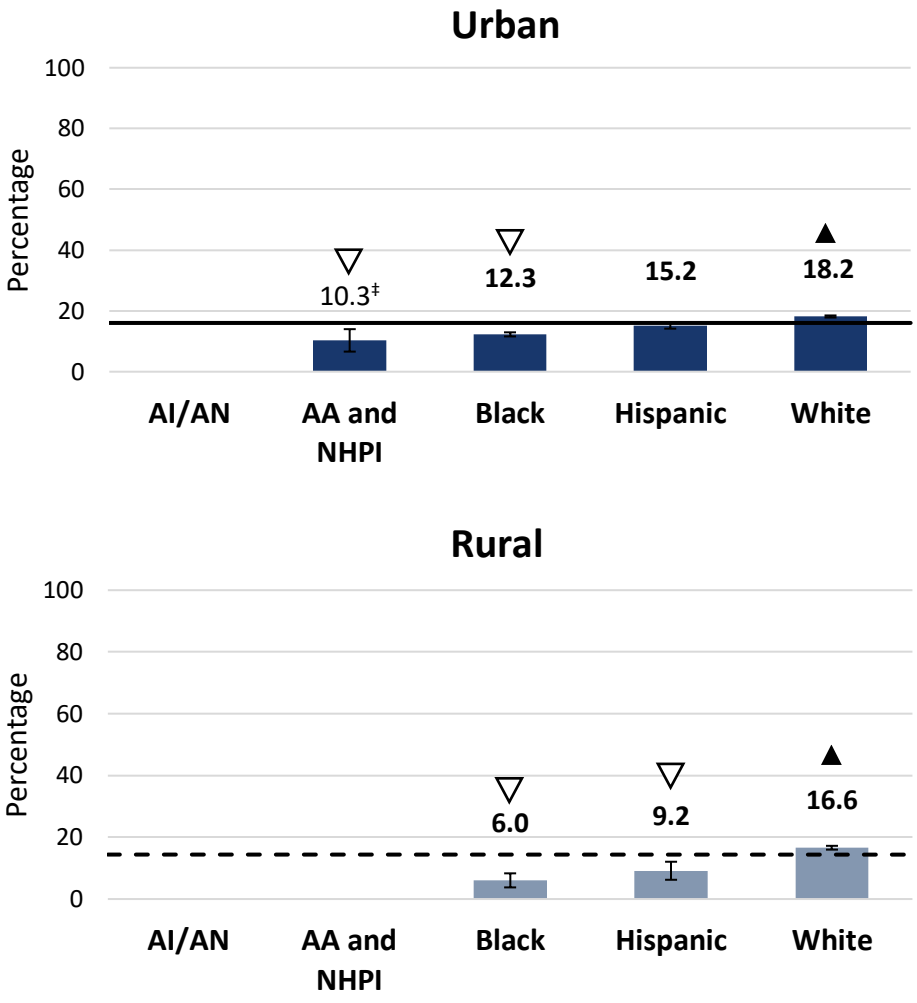
- The percentage of eligible Black MA enrollees living in urban areas who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **below** the national average for all eligible MA enrollees living in urban areas by more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

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

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

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

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.
[‡] This score is based on fewer than 400 completed measures, and thus its precision might be low.

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

Disparities

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

- The percentage of eligible AA and NHPI MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. There were not enough data from eligible AA and NHPI MA enrollees living in rural areas to compare their score on this measure to the score for all eligible MA enrollees living in rural areas.

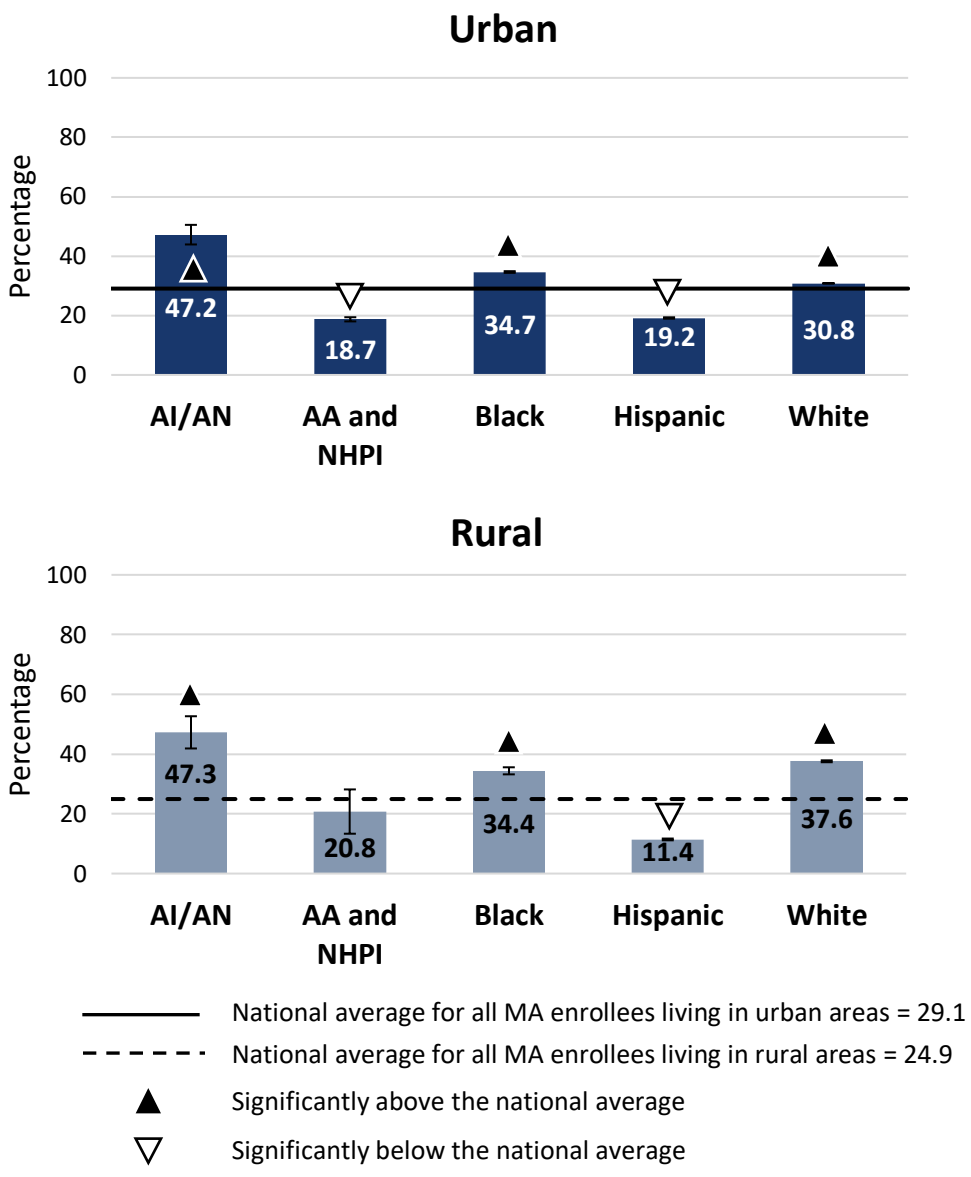
- The percentage of eligible Black MA enrollees living in urban areas who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points.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

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

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

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated[‡] treatment within 14 days of the diagnosis, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

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

Disparities

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

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

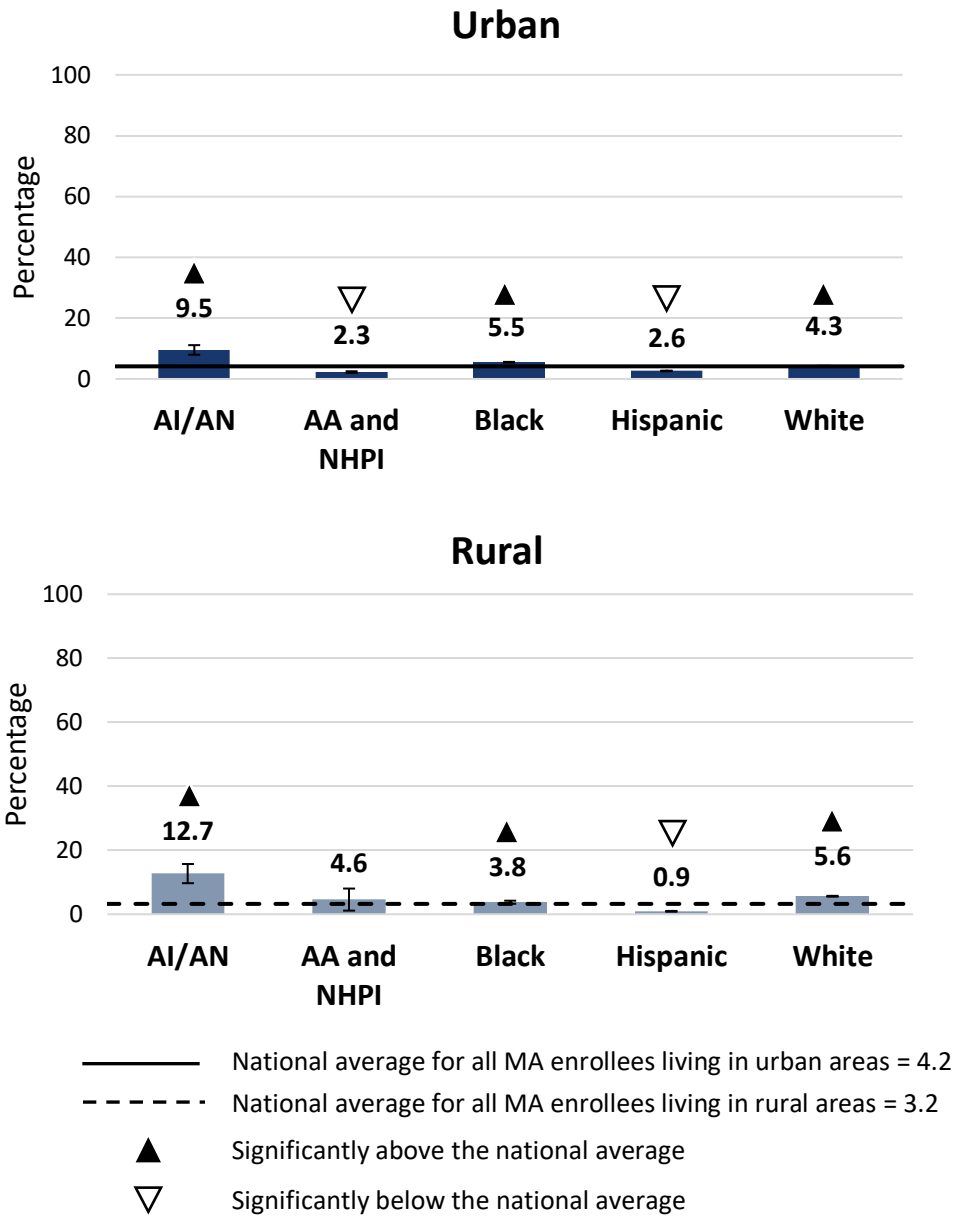
- The percentage of Black MA enrollees living in urban areas who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of Black MA enrollees living in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

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

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

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

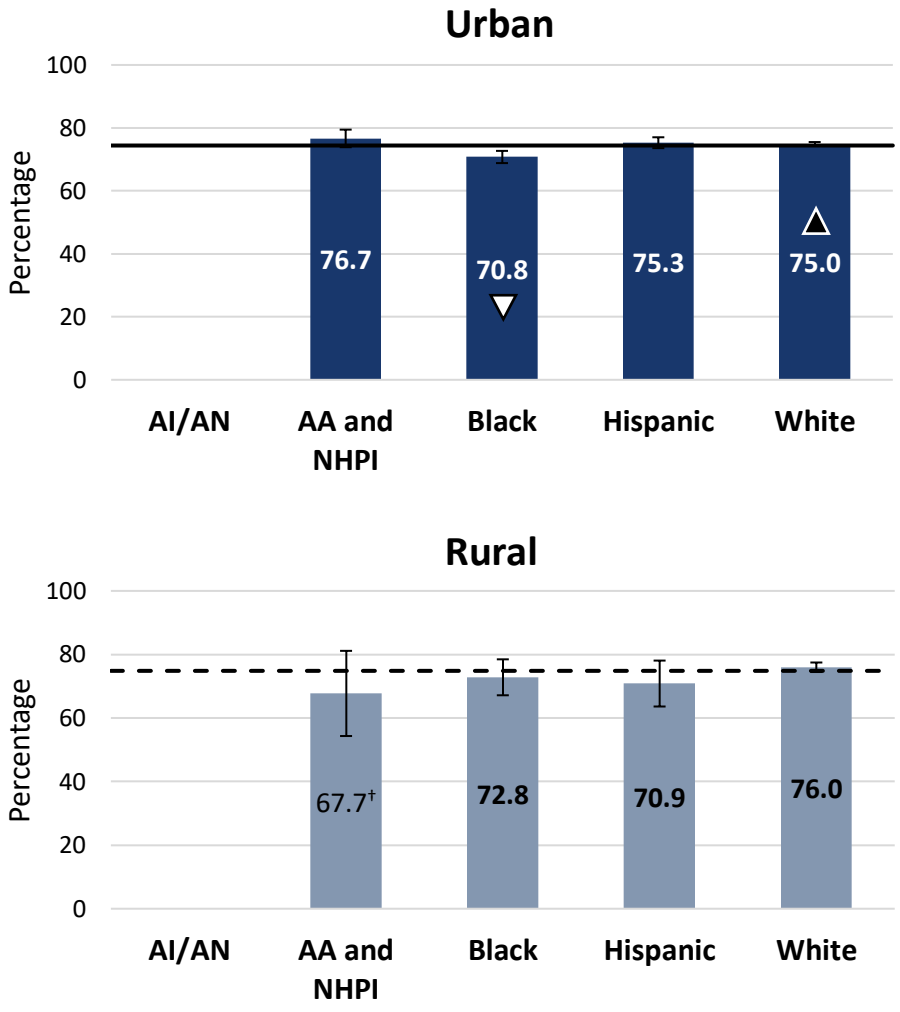
- The percentage of Hispanic MA enrollees living in urban with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage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

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

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

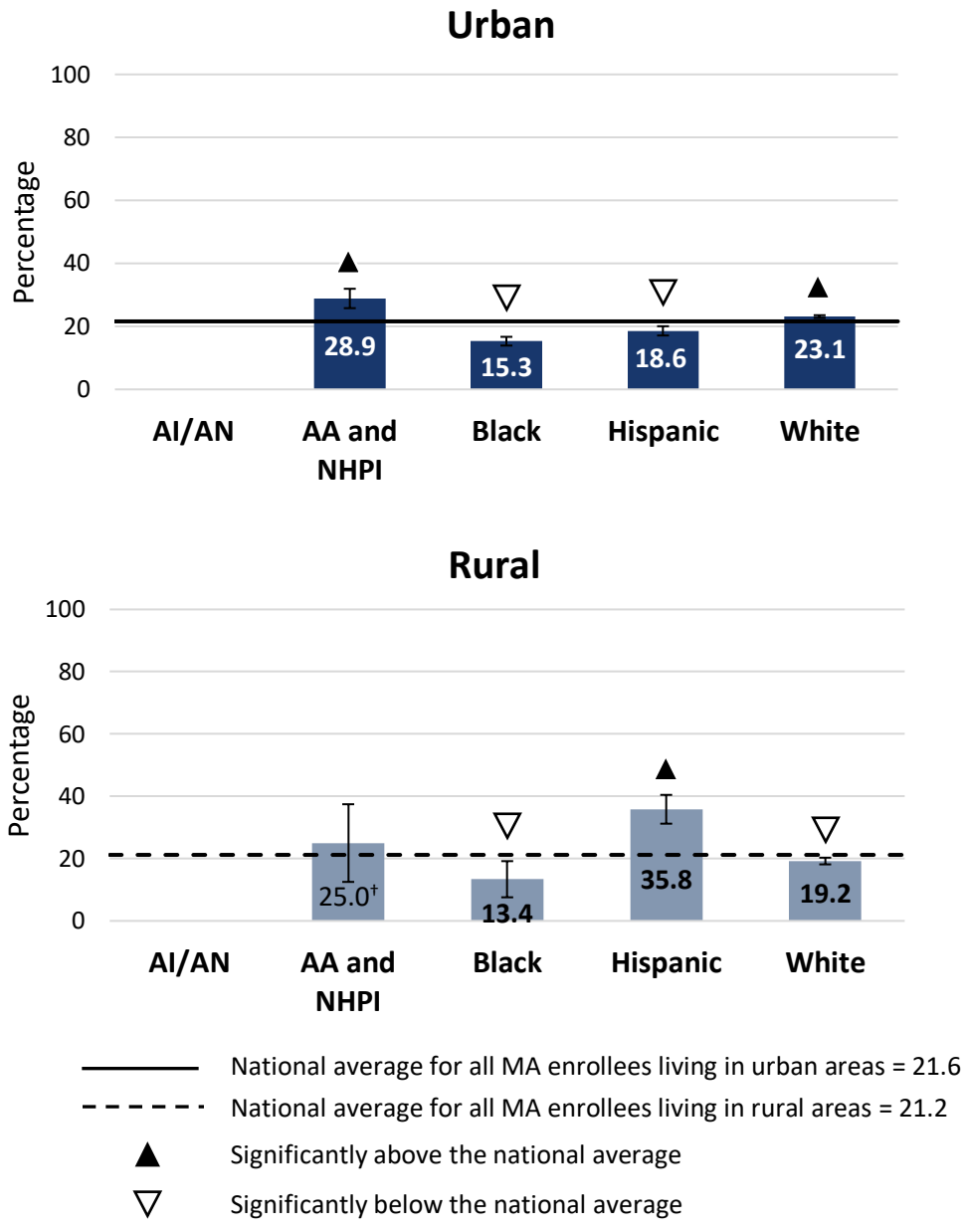
- The percentage of Black MA enrollees living in urban areas who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of Black MA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

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

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

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

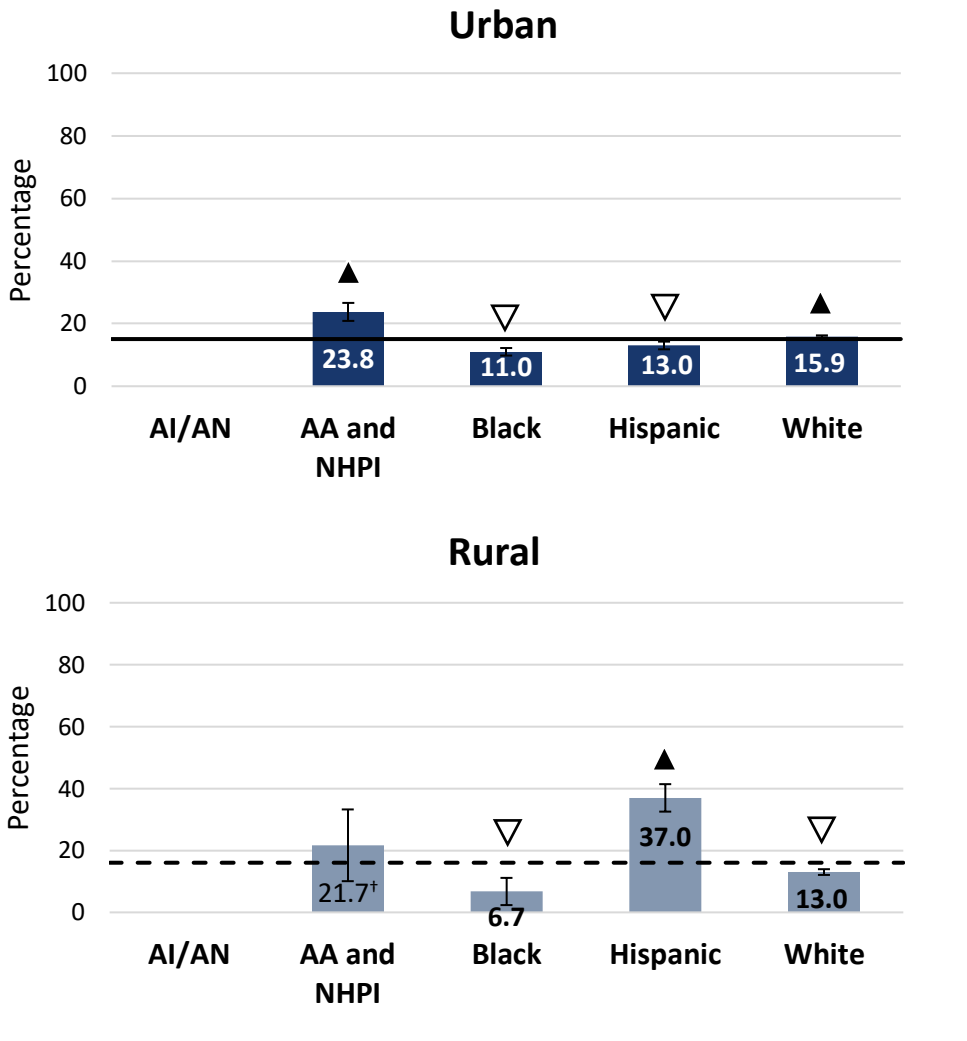
- The percentage of Hispanic MA enrollees living in urban areas who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **below** the national average for all eligible MA enrollees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

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

[‡] Prior to rounding.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of AA and NHPI MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees living in rural areas.

- The percentage of Black MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of Black MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

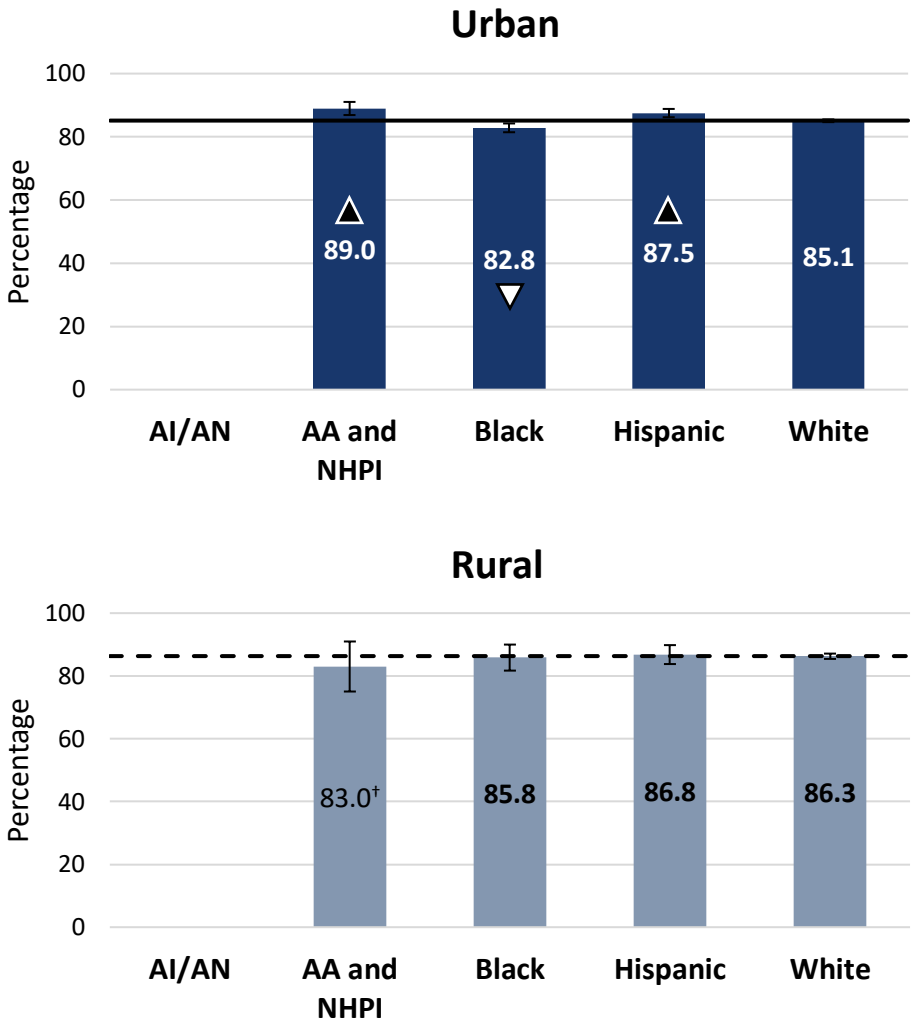
- The percentage of Hispanic MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural area who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.

- The percentage of White MA enrollees living in urban areas who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of White MA enrollees living in rural areas who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in rural areas by more than 3 percentage points.[‡]

[‡] Prior to rounding.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth) was provided within 30 days of discharge, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

- The percentage of AA and NHPI MA enrollees living in urban areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees living in rural areas.

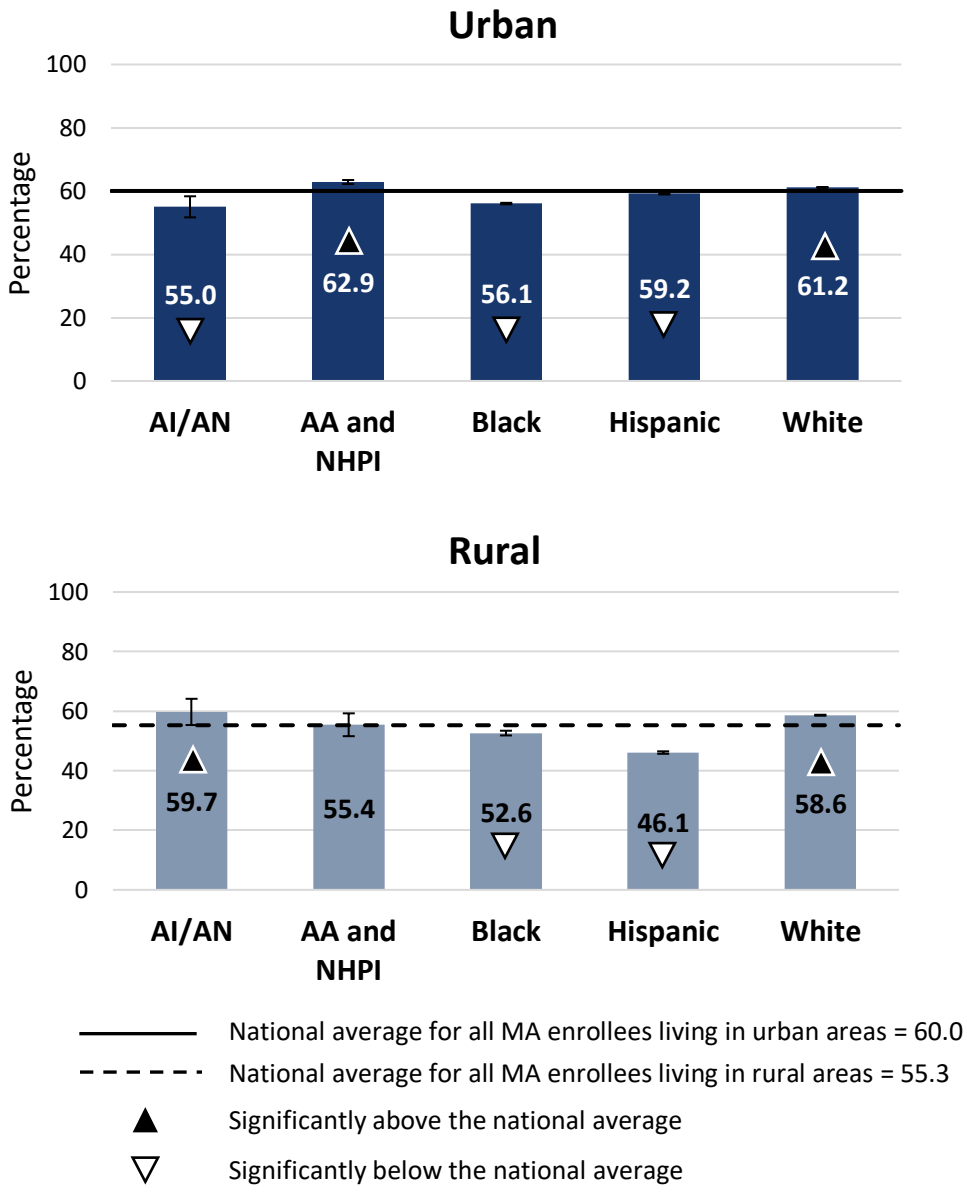
- The percentage of Black MA enrollees living in urban areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees living in rural areas.

- The percentage of Hispanic MA enrollees living in urban areas who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural area who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible MA enrollees living in rural areas.

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

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

Percentage of MA enrollees aged 18 years and older with multiple high-risk chronic conditions[†] who received follow-up care within seven days of an ED visit, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

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

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

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

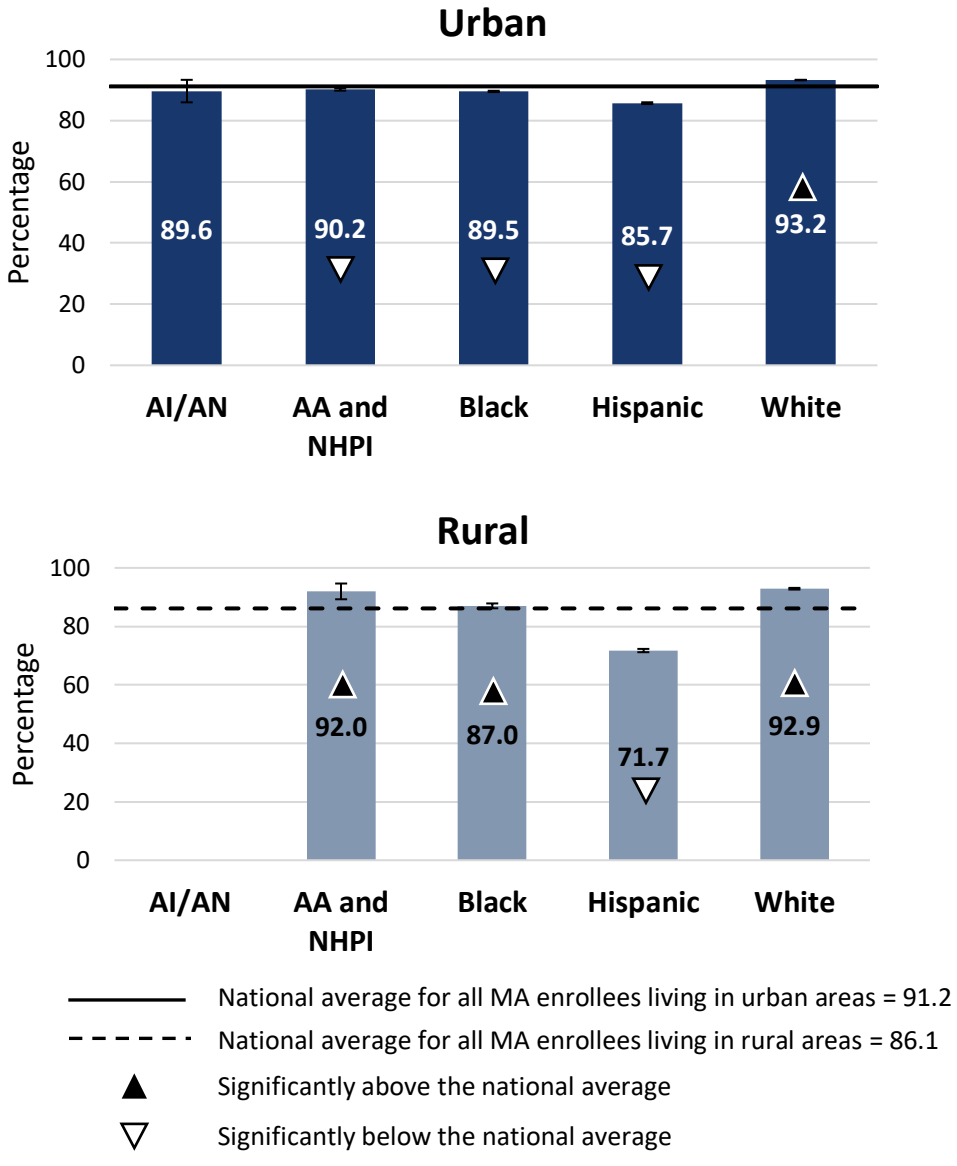
- The percentage of Hispanic MA enrollees with multiple high-risk chronic conditions living in urban areas who received follow-up care within seven days of an ED visit was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage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

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

Clinical Care: Overuse and Appropriate Use of Medications

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

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of elderly AI/AN MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible elderly MA enrollees living in urban areas. There were not enough data from eligible elderly AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible elderly MA enrollees living in rural areas.

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

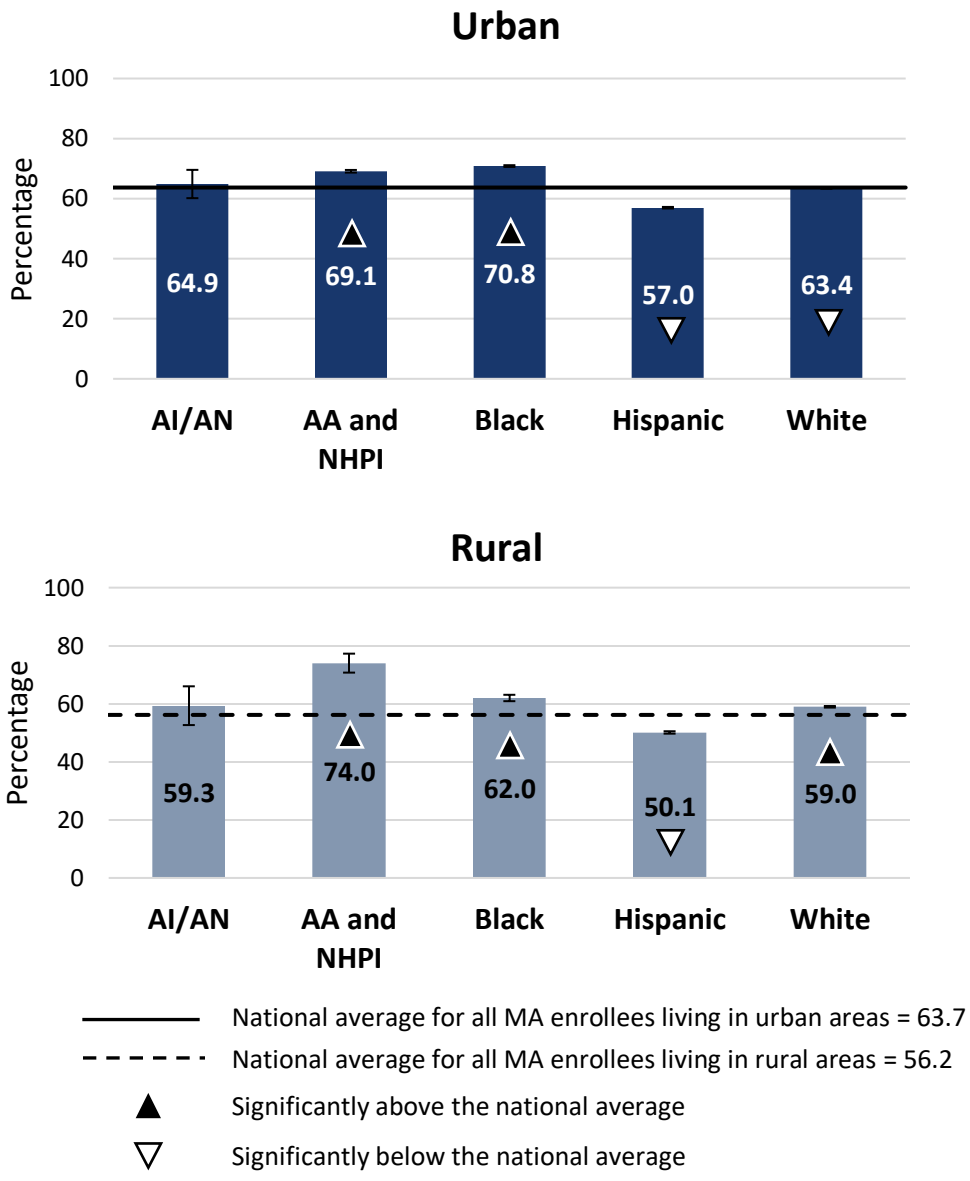
- The percentage of elderly Black MA enrollees with chronic renal failure living in urban areas for whom use of potentially harmful medication was avoided was **below** the national average for all eligible elderly MA enrollees living in urban areas by less than 3 percentage points. The percentage of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

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

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

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

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of elderly AI/AN MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible elderly MA enrollees living in urban areas. The percentage of elderly AI/AN MA enrollees with dementia living in rural areas for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible elderly MA enrollees living in rural areas.

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

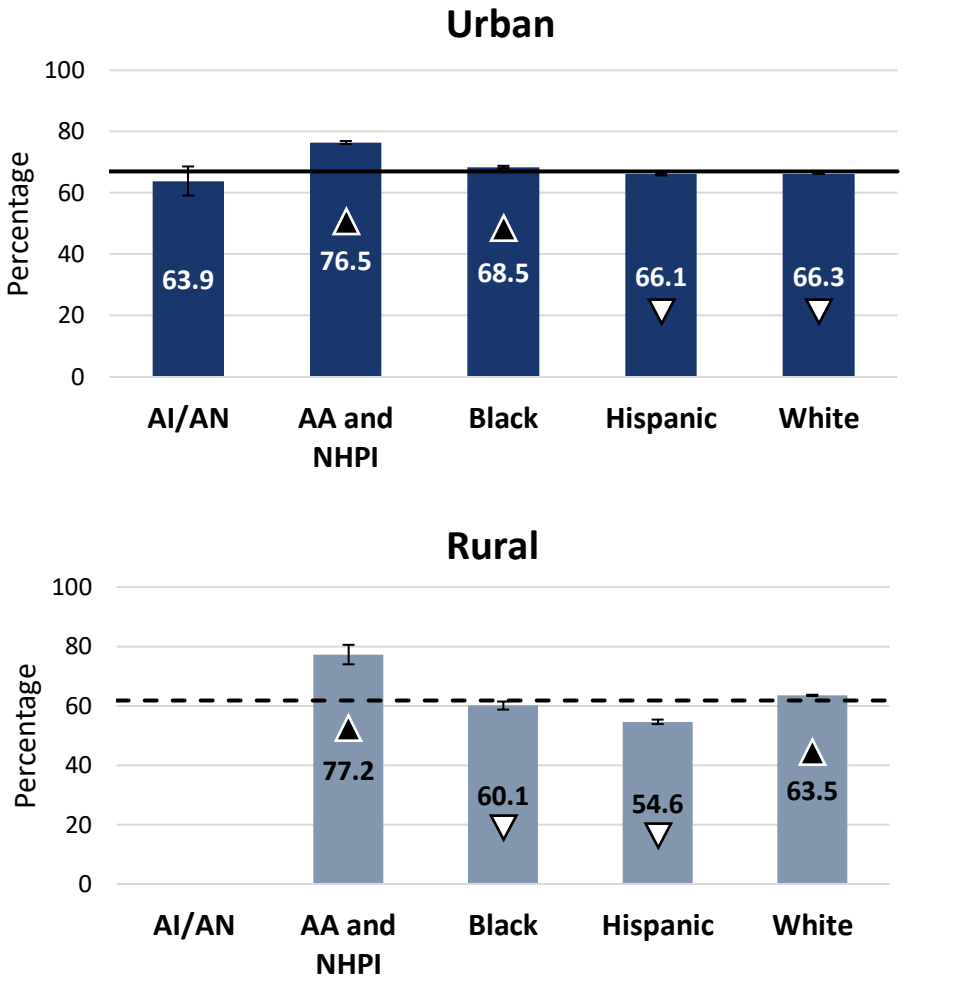
- The percentage of elderly Black MA enrollees with dementia living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly MA enrollees living in urban areas by more than 3 percentage points. The percentage of elderly Black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

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

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

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

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,[†] by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

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

Disparities

- The percentage of elderly AI/AN MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible elderly MA enrollees living in urban areas. There were not enough data from eligible elderly AI/AN MA enrollees living in rural areas to compare their score on this measure to the score for all eligible elderly MA enrollees living in rural areas.

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

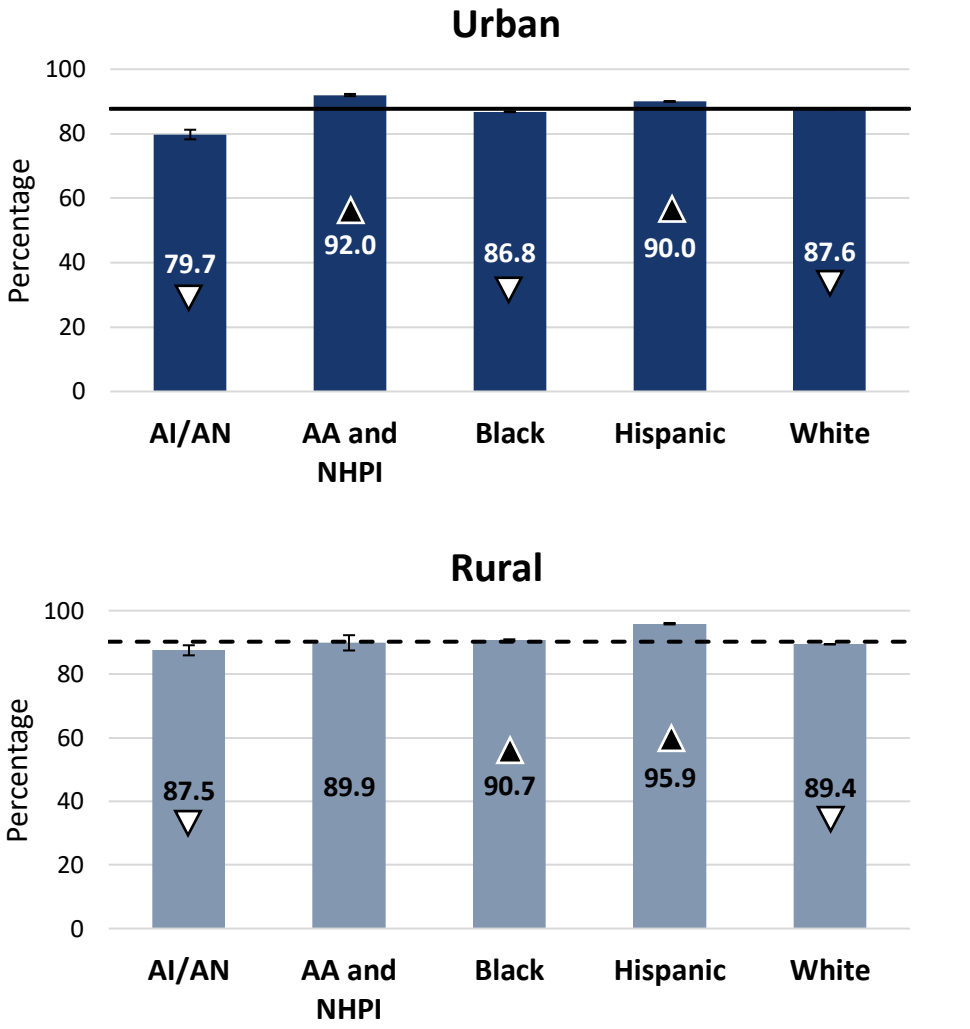
- The percentage of elderly Black MA enrollees with a history of falls living in urban areas for whom use of potentially harmful medication was avoided was **above** the national average for all eligible elderly MA enrollees living in urban areas by less than 3 percentage points. The percentage of elderly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

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

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

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

- The percentage of AA and NHPI MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **above** the national average for all eligible MA enrollees living in urban areas by more than 3 percentage points. The percentage of AA and NHPI MA enrollees living in rural areas for whom use of opioids from multiple prescribers was avoided was **similar to** the national average for all eligible MA enrollees living in rural areas.

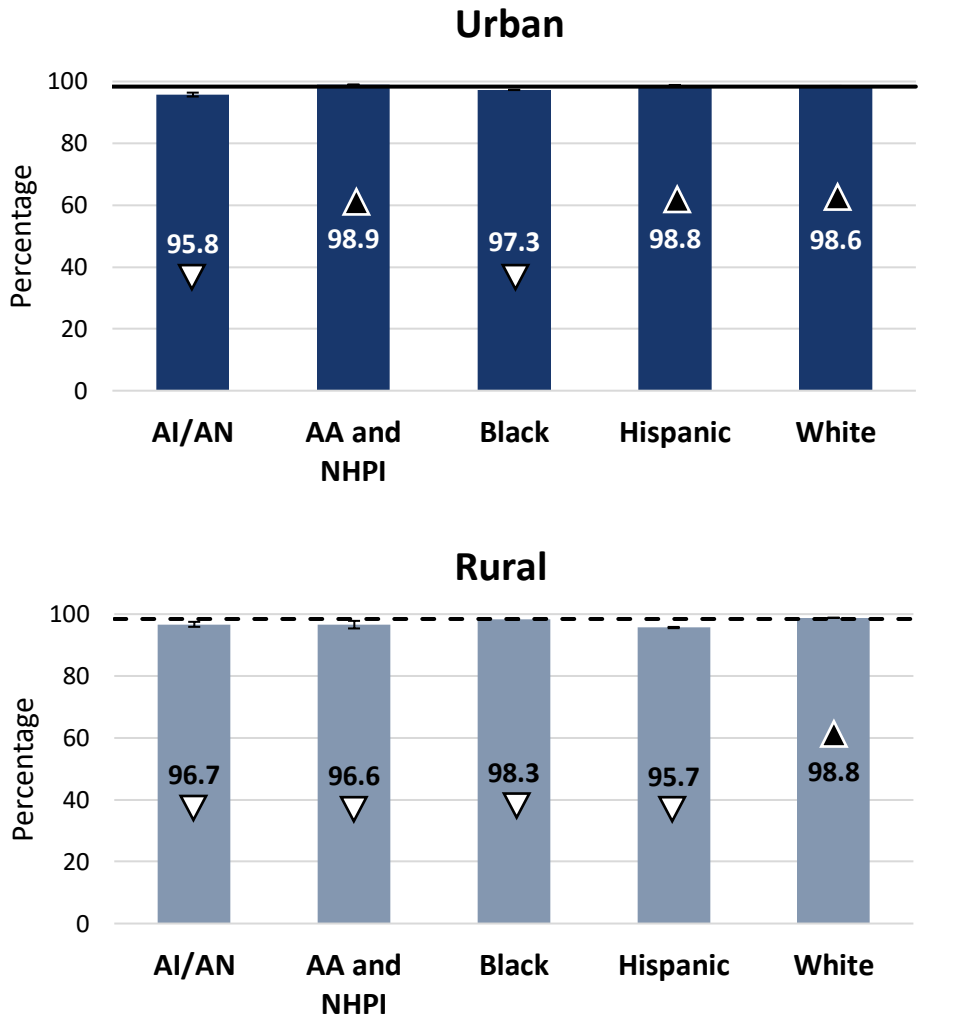
- The percentage of Black MA enrollees living in urban areas for whom use of opioids from multiple prescribers was avoided was **below** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of Black MA enrollees living in rural areas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

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

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

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

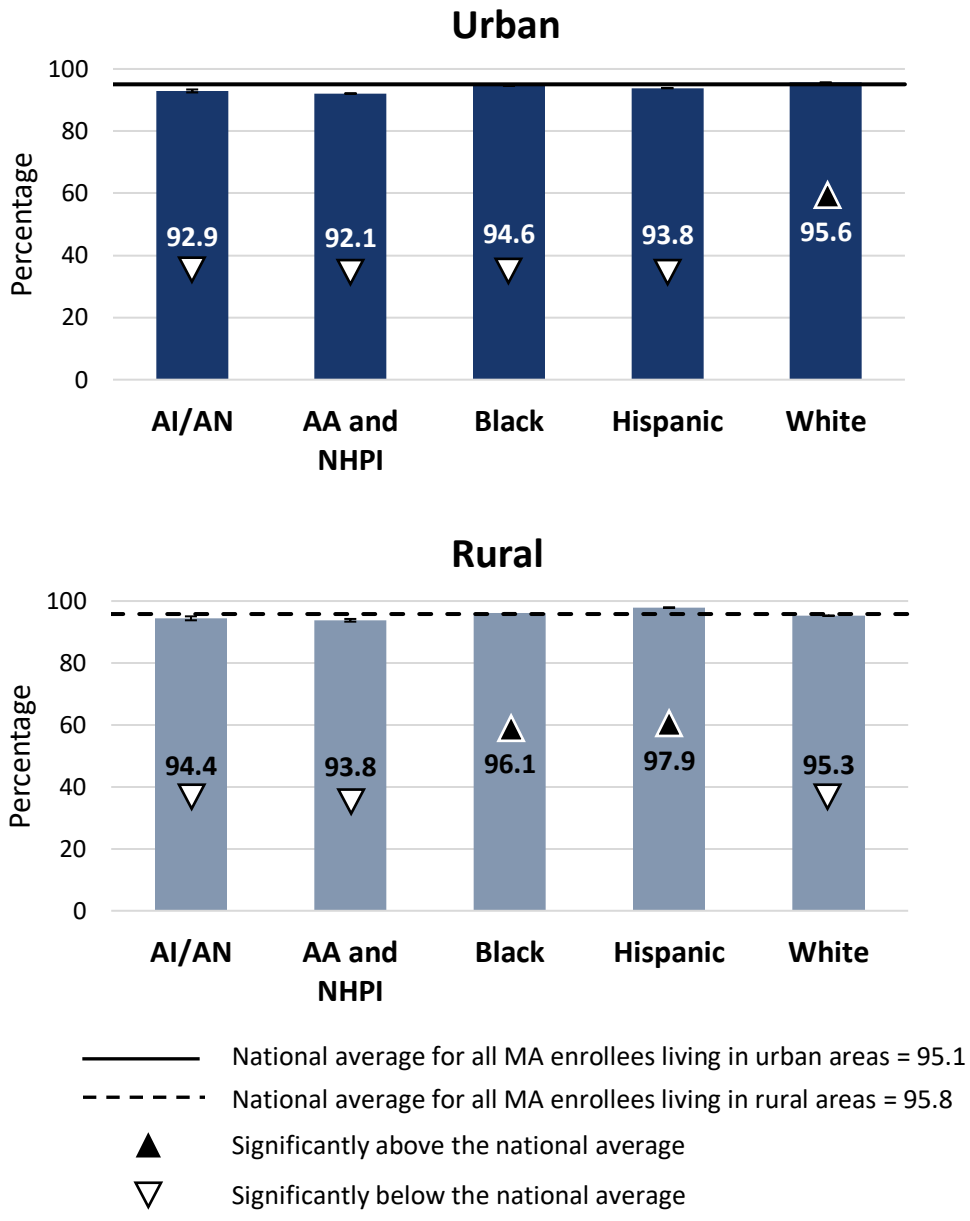
- The percentage of Hispanic MA enrollees living in urban areas for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all eligible MA enrollees living in urban areas by less than 3 percentage points. The percentage of Hispanic MA enrollees living in rural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

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

Clinical Care: Access to and Availability of Care

Older Adults' Access to Preventive/Ambulatory Services

Percentage of MA enrollees aged 65 years and older who had an ambulatory or preventive care visit in the past year, by race and ethnicity within urban and rural areas, Reporting Year 2021



SOURCE: Clinical quality data were collected in 2020 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

Disparities

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

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

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

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

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

[†] Prior to rounding.

Appendix: Data Sources and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems Survey

The Medicare CAHPS survey consists of a set of mail surveys with telephone follow-ups based on a stratified random sample of people with Medicare; contracts (referred to as *plans* in this report) serve as strata for MA enrollees and for people with Medicare FFS coverage who are enrolled in prescription drug plans (PDPs) and states serve as strata for people with Medicare FFS coverage who are not enrolled in PDPs. The 2021 Medicare CAHPS survey attempted to contact 1,053,786 people with Medicare and received responses from 360,559, for a 34.4-percent response rate. The 2021 surveys represent all people with Medicare FFS coverage, MA enrollees from 522 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP enrollees from 58 PDP contracts with at least 1,500 eligible enrollees. The data presented in this report pertain to both MA enrollees and people with FFS coverage.

The Healthcare Effectiveness Data and Information Set

The HEDIS consists of more than 90 measures across six domains of care (National Committee for Quality Assurance, undated). These domains are effectiveness of care, access to and availability of care, experience of care, utilization and risk-adjusted utilization, relative resource use, and health plan descriptive information. HEDIS measures are developed, tested, and validated under the direction of the National Committee for Quality Assurance. Although CAHPS data are collected only via surveys, HEDIS data are gathered both via surveys and via medical charts and insurance claims or encounter data for hospitalizations, medical office visits, and procedures. In selecting HEDIS measures to include in this report, we excluded measures that underwent a recent change in specification, were similar to reported measures preferred by CMS, or were deemed unsuitable for this application by CMS experts. In Reporting Year 2021, there were 649 MA contracts that supplied the 20,316,339 HEDIS measure records used for this report.

Information on Geography

People were classified as living in a rural or urban area based on the ZIP code of their mailing address and the corresponding U.S. Census Bureau CBSA. CBSAs consist of the county or counties or equivalent entities associated with at least one core urban area plus adjacent counties 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 with a population of 50,000 or more. Micropolitan statistical areas contain a core urban area with a population of at least 10,000 but less than 50,000. For this report, anyone living within a metropolitan division or metropolitan statistical area was classified as an urban resident; anyone living in a micropolitan statistical area or outside of a CBSA was classified as a rural resident.

Information on Race and Ethnicity

The 2021 CAHPS survey asked respondents, “Are you of Hispanic or Latino origin or descent?” The response options were: “Yes, Hispanic or Latino” and “No, not Hispanic or Latino.” The survey then asked, “What is your race? Please mark one or more,” with response options of “White,” “Black or African American,” “Asian,” “Native Hawaiian or other Pacific Islander,” and “American Indian or Alaska Native.” We followed a U.S. Census approach, so answers to these two questions were used to classify

respondents into one of seven mutually exclusive categories: AI/AN, AA and NHPI, Black, Hispanic, Multiracial, White, or unknown:

- Respondents who endorsed Hispanic ethnicity were classified as Hispanic regardless of races endorsed.
- Non-Hispanic respondents who endorsed two or more races were classified as Multiracial, with a single exception: Those who selected both "Asian" and "Native Hawaiian or other Pacific Islander" and no other race were classified as "AA and NHPI."
- Non-Hispanic respondents who selected exactly one race were classified as AI/AN, AA and NHPI, Black, or White, according to their responses.
- Respondents without data regarding race and ethnicity (about 4 percent) were classified as unknown.
- Unknown cases were dropped from the analysis.

HEDIS data, unlike CAHPS data, do not contain the patient's self-reported race and ethnicity. Therefore, we imputed race and ethnicity for the HEDIS data using a methodology that combines information from administrative data, first and last name, and residential location (Haas et al., 2019). This methodology is known as Medicare Bayesian Improved Surname Geocoding (MBISG). MBISG 2.1 imputations, which are used for this report, are strongly predictive of self-reported race and ethnicity. Predictive accuracy is measured using the C-statistic, also called the Concordance Statistic or Area Under the Curve, a common metric for the performance of classification models. The C-statistic summarizes the algorithm's sensitivity and specificity, with values of 0.5, 0.7, 0.8, 0.9, and 1.0 indicating chance, acceptable, excellent, outstanding, and perfect prediction, respectively (Hosmer, Lemeshow, and Sturdivant, 2013). C-statistics for MBISG 2.1 are outstanding for AA and NHPI, Black, Hispanic, and White MA enrollees (0.96–0.99), and excellent for AI/AN MA enrollees (0.85). Estimates of membership in the Multiracial group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for Multiracial MA enrollees on the clinical care measures.

Analytic Approach

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

We present estimates for rural and urban residents within coverage type (MA or FFS). CAHPS patient experience estimates for rural and urban residents are from case mix–adjusted linear regression models that contained an indicator for rurality and the following case-mix adjustors: age, education, self-rated general and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. In keeping with how the measure is officially scored, no case-mix adjustment was made for the annual flu vaccine measure.

CAHPS estimates for different racial and ethnic groups living in rural and urban areas are from linear regression models, stratified by race and ethnicity. These models were constructed in the same manner as the overall rural and urban models. The models for rural and urban AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White people yielded a statistical test of each group's score against the national average for all people in the respective racial/ethnic group with the same coverage type.

CAHPS estimates for rural and urban residents of different racial and ethnic backgrounds are from linear regression models, case mix–adjusted for the patient experience measures, that were stratified by rurality. Within each stratum (i.e., rural and urban), models were run six times, with AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White people successively serving as the focal racial or ethnic group. Each time the model was run, it contained records for people of all racial and ethnic groups in a rurality stratum; what changed were predictors. These linear regression models contained an indicator for the focal racial/ethnic group, plus the set of case-mix adjustors described earlier for patient experience measures. These models yielded estimates of each racial and ethnic group's score in each rurality stratum and a statistical test of the difference between that score and the national average for all rural or urban residents (depending on the stratum) with the same coverage type.

HEDIS measures are available only for MA enrollees. None of the HEDIS measures reported is case mix–adjusted. HEDIS estimates for rural and urban residents are from logistic regression models that contained only an indicator for rurality. To generate national HEDIS estimates for different racial and ethnic groups, each logistic regression model was run five times, each time focusing on a single racial/ethnic group: AI/AN, AA and NHPI, Black, Hispanic, and White. That is, the sole predictor in these logistic regression models was the MBISG-predicted probability that a person belonged to the focal racial/ethnic group for that model. HEDIS estimates for rural and urban MA enrollees of different racial and ethnic groups are from a series of logistic regression models, with AI/AN, AA and NHPI, Black, Hispanic, and White people successively serving as the focal racial/ethnic group. These logistic regression models contained an indicator for the focal racial/ethnic group, rurality, and an interaction between the indicator for race/ethnicity and rurality. These models generated scores for the focal racial/ethnic group in rural and urban areas.

In comparisons of estimated scores with the national average, a difference is denoted as statistically significant if there is less than a 5-percent chance that the difference could have resulted because of sampling error alone. Differences that are statistically significant and larger than 3 points on a 0–100 scale (CAHPS) or larger than 3 percentage points (HEDIS) are further denoted as practically significant. In the summary charts that appear in the Executive Summary and at the beginning of each section that shows measure-by-measure results, the focus is on practically significant differences. In the charts that present results on individual measures of patient experience (CAHPS) and clinical care (HEDIS), the focus is on statistically significant differences. In the bullet-point summaries that appear below these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

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