



Rural-Urban Disparities in Health Care in Medicare

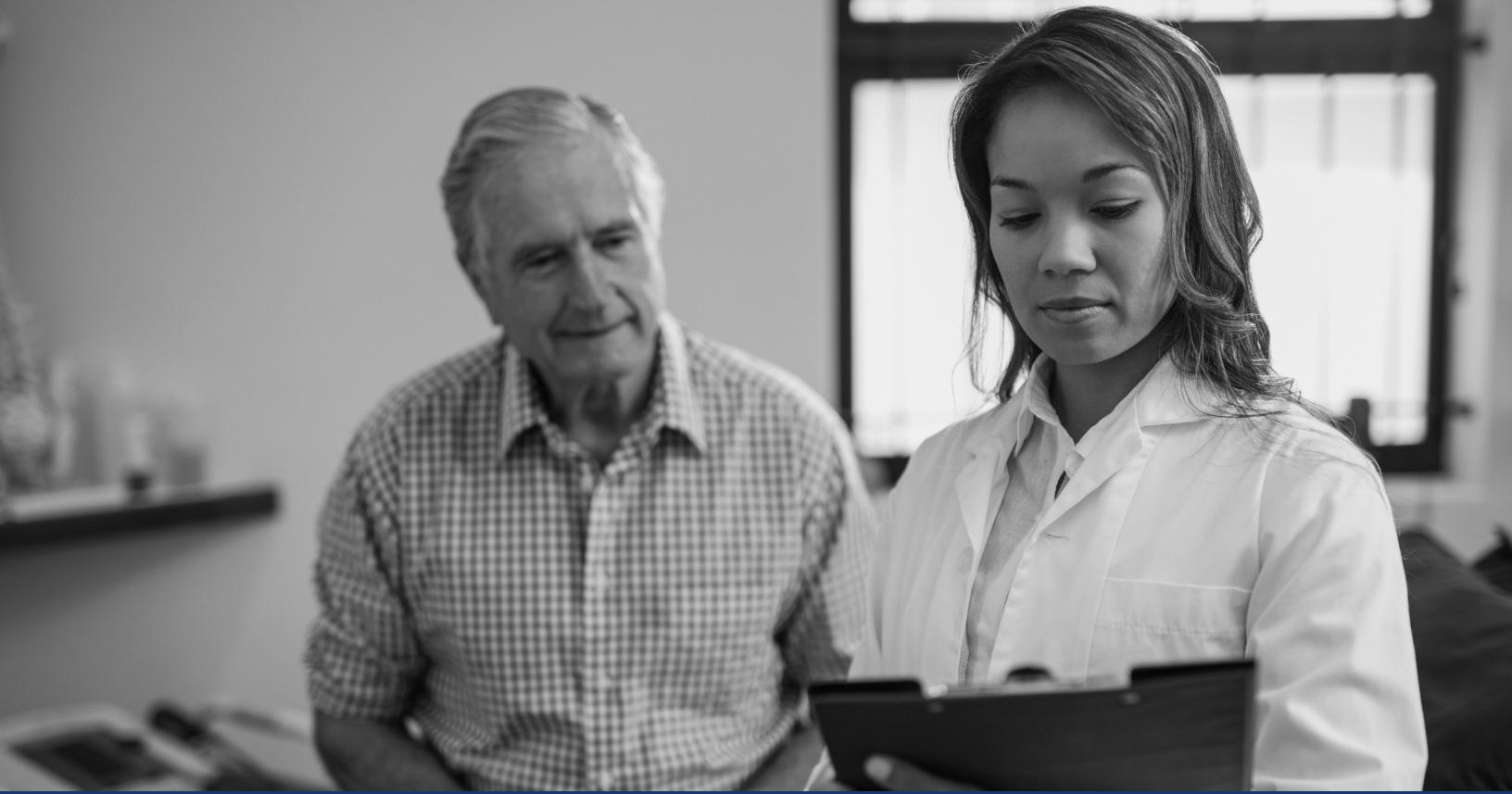
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Executive Summary



Introduction

This report presents summary information on the quality of health care received by Medicare beneficiaries nationwide. It uses annual health care data collected in 2019 and references care received since the 2018 data collection. The report highlights (a) rural-urban¹ differences in health care experiences and clinical care, (b) how rural-urban differences vary by race and ethnicity, and (c) how racial and ethnic differences 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 health care experiences (e.g., ease of getting needed care, how well providers communicate, and getting needed prescription drugs) of Medicare beneficiaries across the nation. 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 technical quality of care that Medicare beneficiaries receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. Whereas Medicare CAHPS data are available for beneficiaries enrolled in Medicare fee-for-service (FFS) and managed care (Medicare Advantage [MA]) plans, HEDIS data are available only for beneficiaries enrolled in MA plans.

Rural-Urban Disparities in Health Care in Medicare

With just one exception, both FFS and MA beneficiaries living in rural areas reported health care experiences that were similar to the experiences reported by FFS and MA beneficiaries living in urban areas (see Figure 1). The exception pertained to annual flu vaccination rates, which were higher for urban than for rural FFS and MA beneficiaries. Rural-urban disparities in clinical care were more common: compared with MA beneficiaries living in urban areas, MA beneficiaries living in rural areas had poorer results on 14 of 39 clinical quality measures, similar results on 23 measures, and better results on just two measures.² The largest differences were for three clinical care measures with substantial deficits among rural residents, namely (a) avoiding potentially harmful drug-disease interactions in elderly patients with dementia (an 11-percentage-point deficit), (b) initiation of alcohol and other drug treatment (a 10-percentage-point deficit), and (c) controlling high blood pressure among patients with diabetes (a 10-percentage-point deficit).

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

The overall pattern of rural and urban residents reporting similar experiences with care generally held across racial and ethnic groups (American Indian or Alaska Native [AI/AN], Asian or Pacific Islander [API], Black, Hispanic, and White) and coverage types (Medicare FFS and MA). One notable exception involved

¹ Beneficiaries were classified as living in a rural or urban area based on the zip code of their mailing address and the corresponding 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, any beneficiary residing within a metropolitan statistical area was classified as an urban resident; any beneficiary living in a micropolitan statistical area or outside of a CBSA was classified as a rural resident.

² Here, “similar” is used to characterize differences that are not statistically significant, fall below a magnitude threshold, or both, as described in the appendix. “Worse” and “better” are used to characterize differences that are statistically significant and exceed a magnitude threshold.

Hispanic beneficiaries enrolled in MA. In that group, rural residents reported better experiences with getting appointments and care quickly and getting needed prescription drugs than urban residents reported (see Figure 2).

While the pattern of generally worse results for clinical care in rural than urban areas held for all racial and ethnic groups,³ the pattern was more pronounced for Hispanic beneficiaries than for other groups (see Figure 3). Among API, Black, and White beneficiaries, rural beneficiaries had worse results on about a quarter to a third of clinical care measures and better results on less than 5 percent of clinical care measures. In contrast, among Hispanic beneficiaries, rural residents had worse results on 54 percent of clinical measures and better results on 13 percent of clinical care measures.

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

Patterns of racial and ethnic differences (compared with White beneficiaries) in patient experience were similar in urban and rural areas for API and Black beneficiaries but not for AI/AN and Hispanic beneficiaries. Disparities in patient experience for AI/AN beneficiaries versus White beneficiaries were more common in rural than in urban areas, regardless of coverage type (see Figures 4 and 5). Rural Hispanic beneficiaries typically reported experiences with care that were similar to the experiences reported by rural White beneficiaries, regardless of coverage type. Urban Hispanic MA beneficiaries typically reported experiences with care that were similar to the experiences reported by urban White MA beneficiaries, whereas urban Hispanic FFS beneficiaries often reported experiences with care that were worse than the experiences reported by urban White FFS beneficiaries. Regardless of coverage type and geography, API beneficiaries typically reported experiences with care that were worse than or similar to the experiences reported by White beneficiaries. Regardless of coverage type and geography, Black beneficiaries typically reported experiences with care that were similar to the experiences reported by White beneficiaries.

Patterns of racial and ethnic differences (compared with White beneficiaries) in clinical care were similar in urban versus rural areas for API and Black beneficiaries but not for Hispanic beneficiaries (see Figure 6). Regardless of geography, API beneficiaries had worse results than White beneficiaries on 10 percent or less of the clinical care measures and better results on 18–25 percent of the clinical care measures. Regardless of geography, Black beneficiaries had worse results than White beneficiaries on about 40 percent of the clinical care measures and better results on about 5–8 percent of the clinical care measures. In urban areas, Hispanic beneficiaries had worse results than White beneficiaries on 28 percent of the clinical care measures and better results on 15 percent of the clinical care measures. In rural areas, Hispanic beneficiaries had worse results than White beneficiaries on 46 percent of the clinical care measures and better results on 31 percent of the clinical care measures.

³ 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 of membership in the AI/AN group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for AI/AN beneficiaries on the clinical care measures.

Conclusion

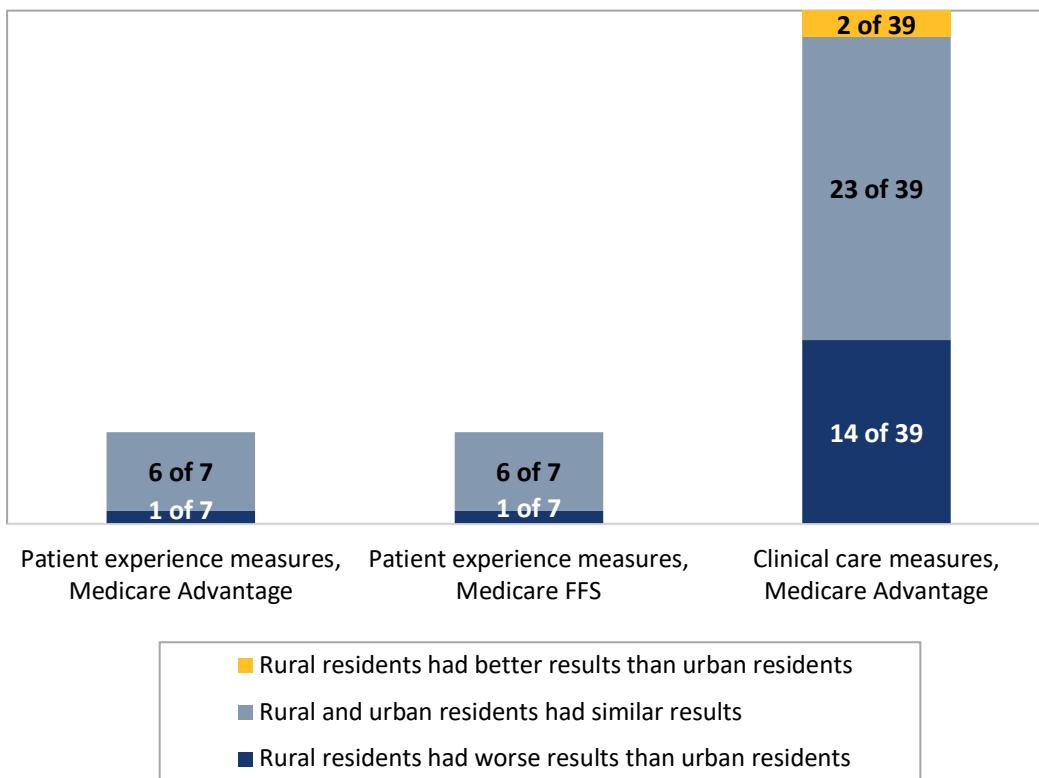
This analysis of national rural-urban differences in the quality of health care received by Medicare beneficiaries in 2019 found that rural residents reported experiences with care that were similar to the experiences reported by urban residents but often had worse results for clinical care than urban residents (deficits on several clinical care measures exceeded 10 percentage points). Future research is needed to understand whether this pattern reflects poorer dissemination of clinical practice guidelines to rural areas, poorer translation of those guidelines into clinical practice, difficulty accessing care in rural areas, or some other cause. The difference between rural and urban residents in quality of clinical care received was most pronounced among Hispanic beneficiaries.

This analysis also revealed notable geographic variation in AI/AN-White disparities in patient experience. Specifically, whereas urban AI/AN beneficiaries typically reported experiences with care that were similar to the experiences of care reported by urban White beneficiaries, rural AI/AN beneficiaries typically reported experiences with care that were worse than the experiences reported by rural White beneficiaries. There was also notable geographic variation in Hispanic-White disparities in clinical care. Specifically, whereas Hispanic beneficiaries generally had worse results than White beneficiaries, the difference between these groups was evident far more often in rural areas than in urban areas.

Overall, these results suggest that quality improvement efforts should focus on improving clinical care for all rural residents and should put special emphasis on addressing the care experiences of rural AI/AN beneficiaries and the clinical care needs of rural Hispanic beneficiaries.

Figure 1. Rural-Urban Disparities in Care: All Patient Experience and Clinical Care Measures

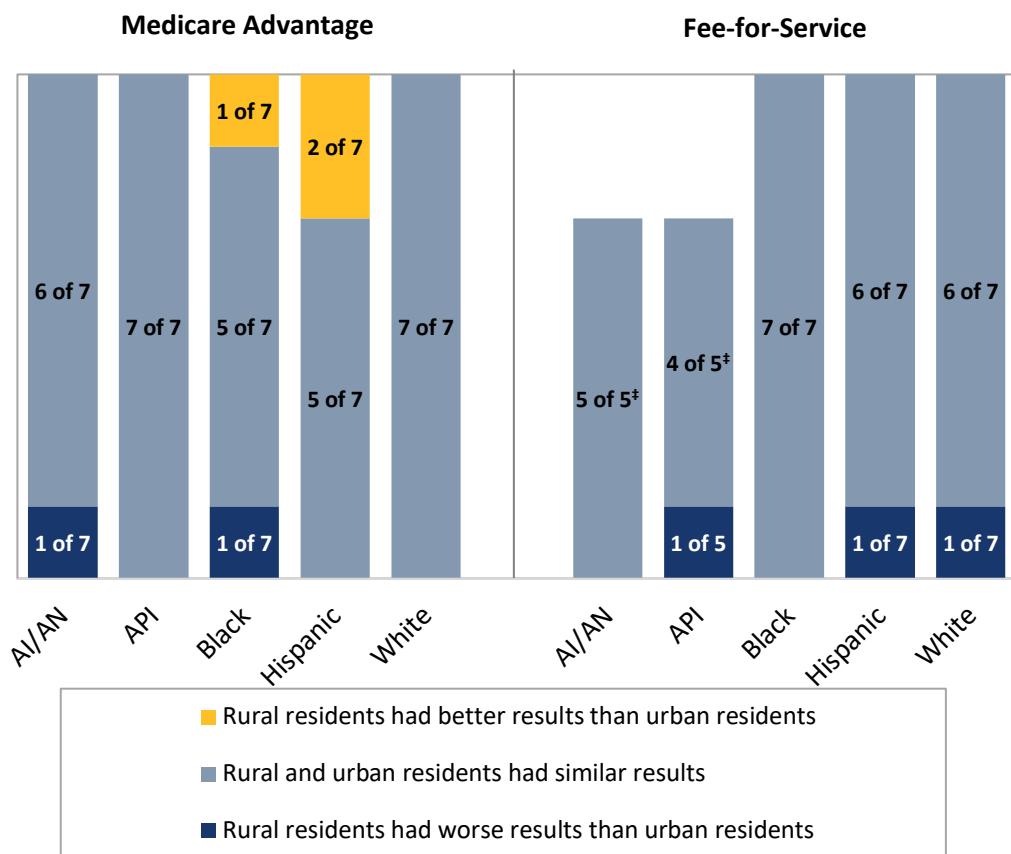
Number of patient experience measures and clinical care measures for which rural residents had results that were worse than, similar to, or better than results for urban residents in 2019



SOURCES: The bar on the left summarizes patient experience data from all MA beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey. The bar in the middle summarizes patient experience data from all FFS beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey. The bar on the right summarizes clinical quality (HEDIS) data collected in 2019 from MA plans nationwide. Clinical quality data are not available for Medicare FFS beneficiaries.

Figure 2. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Patient Experience Measures

Number of patient experience measures for which rural AI/AN, API, Black, Hispanic, and White beneficiaries reported experiences that were worse than, similar to, or better than the experiences reported by urban AI/AN, API, Black, Hispanic, and White beneficiaries in 2019



SOURCE: This chart summarizes data from all FFS Medicare and MA beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey.

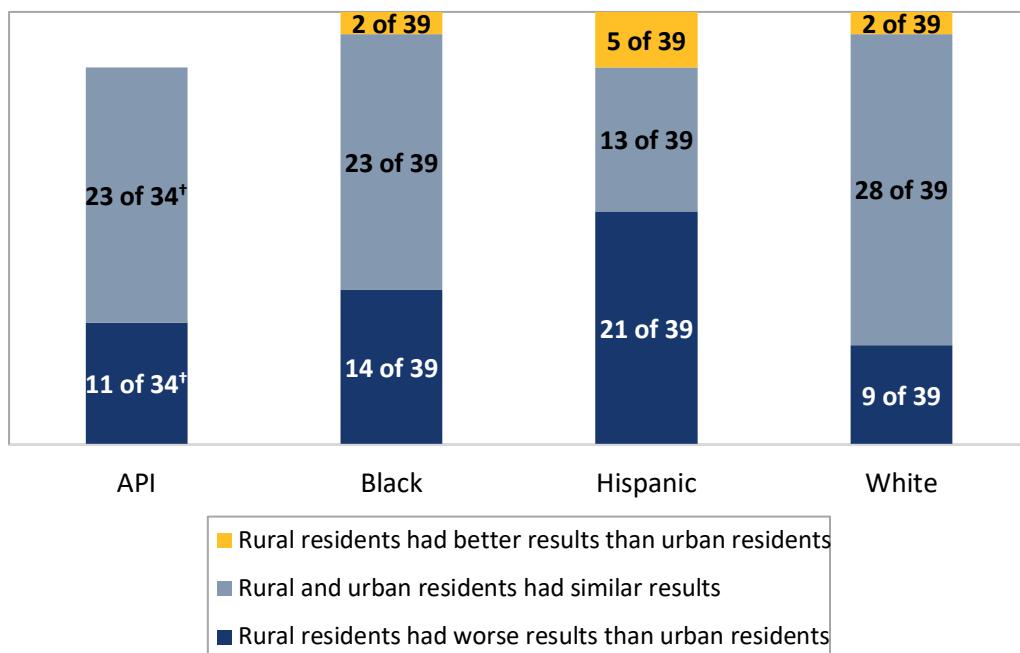
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of races selected.

[†] There were not enough data from AI/AN beneficiaries enrolled in FFS to make a rural-urban comparison on two patient experience measures.

[‡] There were not enough data from rural API beneficiaries enrolled in FFS to make rural-urban comparisons on two patient experience measures.

Figure 3. Rural-Urban Disparities in Care by Racial and Ethnic Group: All Clinical Care Measures

Number of clinical care measures for which rural Asian and Pacific Islander (API), Black, Hispanic, and White MA beneficiaries had results that were worse than, similar to, or better than results for urban API, Black, Hispanic, and White MA beneficiaries in 2019



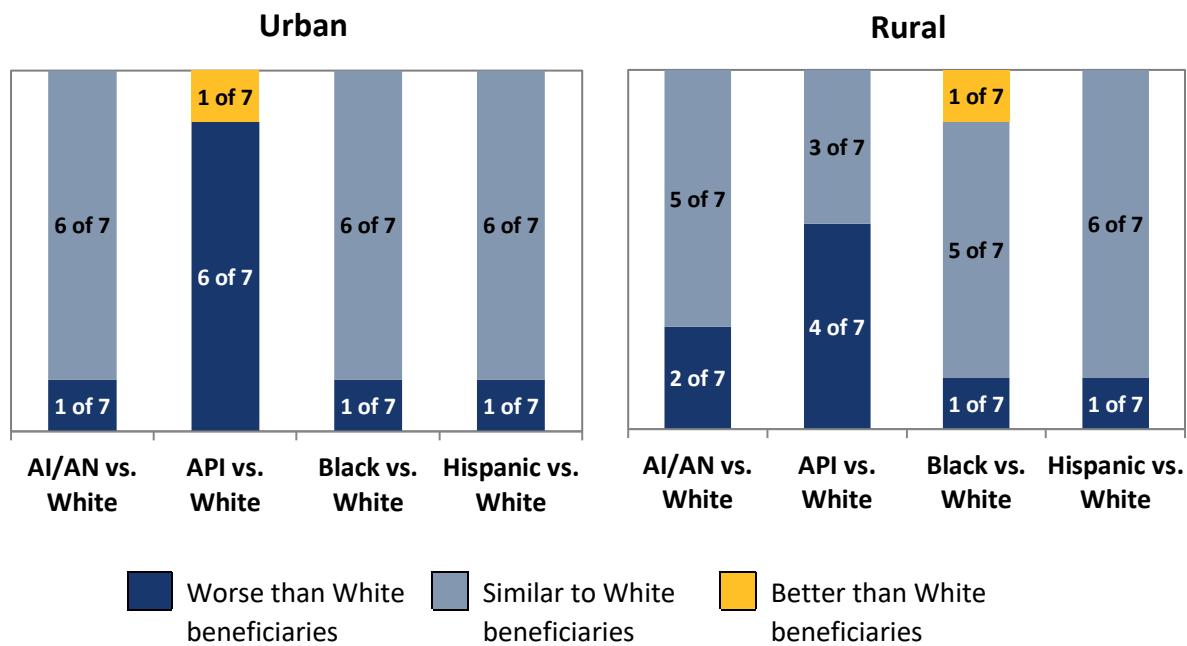
SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2019 from MA plans nationwide. Clinical quality data are not available for Medicare FFS beneficiaries.

NOTES: API = Asian or 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 of membership in AI/AN group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for AI/AN beneficiaries on the clinical care measures. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

[†] There were only enough data from rural API beneficiaries to make rural-urban comparisons on 34 of the 39 clinical care measures.

Figure 4. Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Medicare Advantage

Number of patient experience measures for which urban and rural residents of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White urban and rural residents in 2019

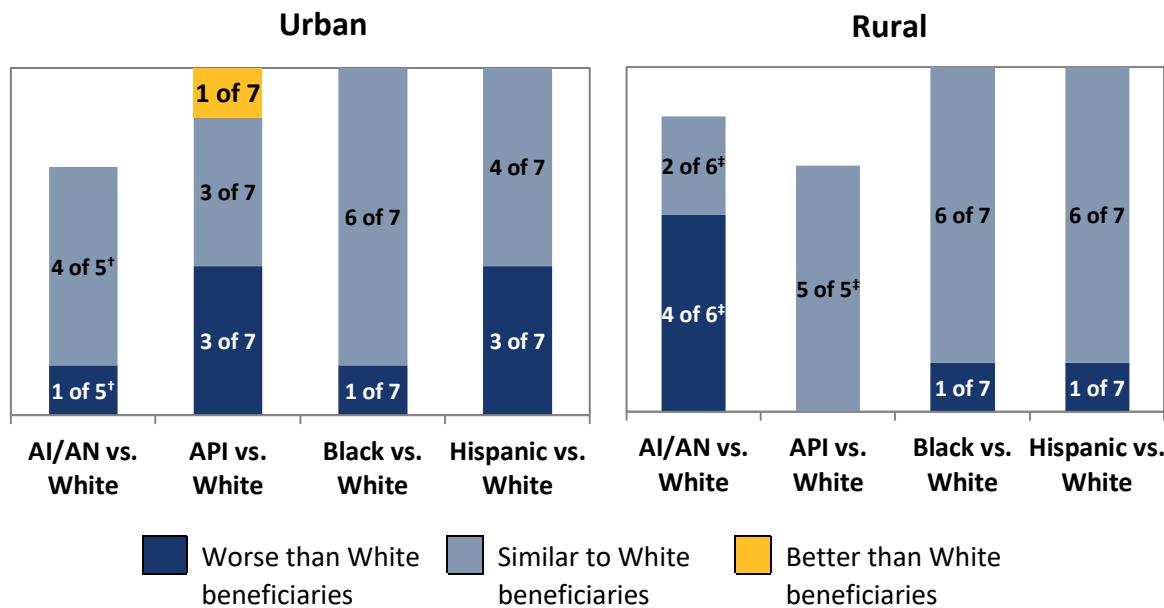


SOURCE: Data from the 2019 Medicare CAHPS survey.

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

Figure 5. Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Fee-for-Service

Number of patient experience measures for which urban and rural residents of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White urban and rural residents in 2019



SOURCE: Data from the 2019 Medicare CAHPS survey.

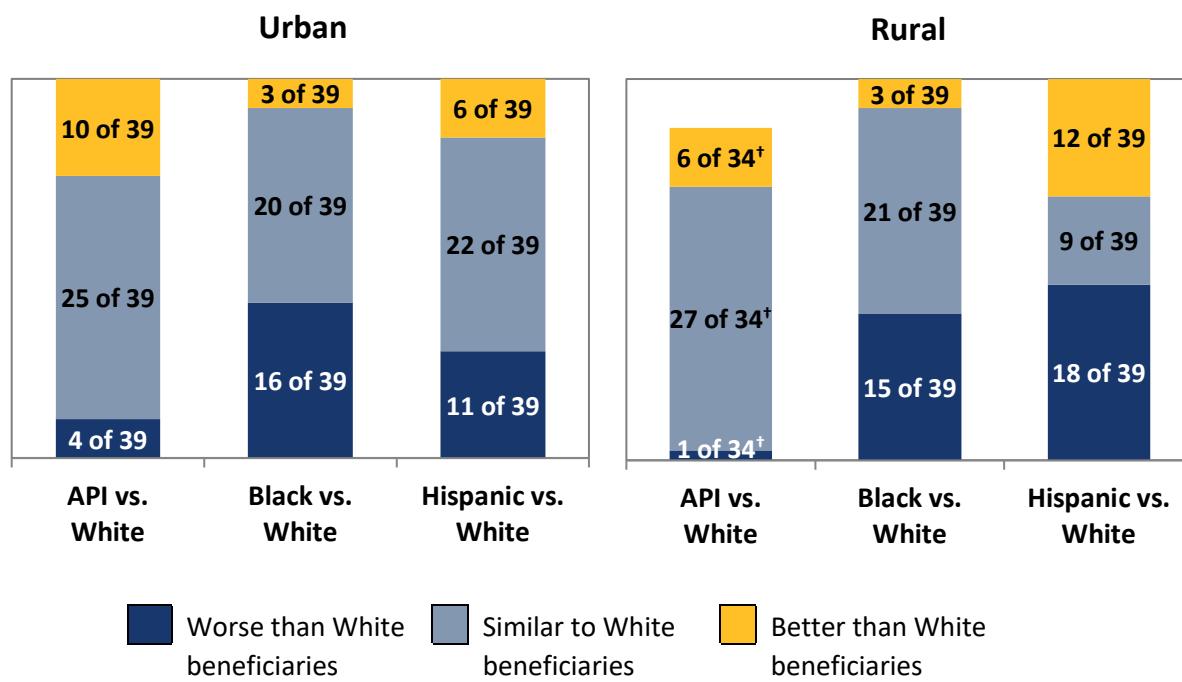
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race selected.

[†] For two patient experience measures, there were not enough data from urban FFS AI/AN beneficiaries to compare their experiences to those of urban FFS White beneficiaries.

[‡] For one patient experience measure, there were not enough data from rural FFS AI/AN beneficiaries to compare their experiences to those of rural FFS White beneficiaries. For two patient experience measures, there were not enough data from rural FFS API beneficiaries to compare their experiences to those of rural FFS White beneficiaries.

Figure 6. Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Clinical Care Measures

Number of clinical care measures for which urban and rural residents of selected racial and ethnic minority groups had results that were worse than, similar to, or better than results for White urban and rural residents in 2019



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2019 from MA plans nationwide. Clinical quality data are not available for Medicare FFS beneficiaries.

NOTES: API = Asian or 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 of membership in AI/AN group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for AI/AN beneficiaries on the clinical care measures. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

[†] There were only enough data from rural API beneficiaries to make rural-urban comparisons on 34 of the 39 clinical care measures.

Patient Experience and Clinical Care Measures Included in This Report

Patient Experience Measures

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs
- Annual flu vaccine

Clinical Care Measures

Prevention and Screening

- Adult body mass index (BMI) assessment
- 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
- Statin use in patients with cardiovascular disease
- Medication adherence for cardiovascular disease—statins

Diabetes

- Diabetes care—blood sugar testing
- Diabetes care—eye exam
- Diabetes care—kidney disease monitoring
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Medication adherence for diabetes—statins

Musculoskeletal Conditions

- Rheumatoid arthritis management
- Osteoporosis management in women who had a fracture

Behavioral Health

- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after hospital stay for mental illness (within 30 days of discharge)
- Follow-up after 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

- Medication reconciliation after hospital discharge
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Transitions of care—patient engagement after inpatient discharge
- Follow-up after ED visit for people with high-risk multiple chronic conditions

Overuse/Appropriate Use

- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia

Patient Experience and Clinical Care Measures Included in This Report (continued)

Clinical Care Measures

Overuse/Appropriate Use

- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of high-risk medications in the elderly
- Avoiding use of opioids at high dosage
- Avoiding use of opioids from multiple prescribers
- Avoiding use of opioids from multiple pharmacies

Access/Availability of Care

- Older adults' access to preventive/ambulatory services

Abbreviations Used in This Report

AI/AN	American Indian or Alaska Native
AMI	acute myocardial infarction
AOD	alcohol or other drug
API	Asian or Pacific Islander
ASCVD	atherosclerotic cardiovascular disease
BMI	body mass index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBSA	core-based statistical area
COPD	chronic obstructive pulmonary disease
DMARD	disease-modifying antirheumatic drug
ED	emergency department
FFS	fee-for-service
MA	Medicare Advantage
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 Medicare beneficiaries nationwide. It uses annual health care data collected in 2019 and references care received since the 2018 data collection. Previous versions of this report presented information on the quality of health care received by Medicare beneficiaries nationwide based on data collected in 2017 and 2018. Two types of quality of care data are included: (1) measures of patient experience, which describe how well the care 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. Patient experience data are presented for beneficiaries enrolled in Medicare fee-for-service (FFS) as well as those enrolled in managed care (Medicare Advantage [MA]) plans; clinical data are presented only for beneficiaries enrolled in MA plans.

The Institute of Medicine (now the National Academy of Medicine) has identified the equitable delivery of care as a hallmark of quality (Institute of Medicine, 2001). Assessing equity of care delivery requires making comparisons of quality by patient characteristics such as urban or rural residence, race, and ethnicity. Prior studies have found higher rates of chronic illness and poorer overall health in rural communities compared with urban populations. One possible source of these differences in morbidity is disparate experiences with health care and differences in access to high-quality care between rural and urban areas (Meit et al., 2014). There is also evidence that the health care disadvantages faced by those living in rural areas are sometimes greater for racial and ethnic minorities compared with those who are non-Hispanic White, and that racial and ethnic disparities are sometimes greater in rural than in 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 residents is compared with quality of care for urban residents. In the second, quality of care for rural residents is compared with quality of care for urban residents of the same race or ethnicity. In the third, quality of care for racial and ethnic minority beneficiaries is compared with quality of care for White beneficiaries separately within rural and urban areas. The focus of this report is on differences in quality of care that exist at the national level. Interested readers can find information about health care quality for specific Medicare plans at <https://www.medicare.gov/plan-compare>.

Data Sources

In all, this report provides data regarding seven patient experience measures and 39 clinical care measures. The set of patient experience measures presented in this report is the same as the set reported on in the 2018 and 2019 reports (reporting 2017 and 2018 data, respectively). To minimize redundancy among the clinical care measures, five measures that were included in the 2019 report are excluded from this report. The five excluded measures are Follow-up After Hospital Stay for Mental Illness (within seven days of discharge), Follow-up After ED Visit for Mental Illness (within seven days of discharge), Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence (within seven days of discharge), Transitions of Care: Medication Reconciliation After Hospital Discharge, and Avoiding Use of Opioids from Multiple Prescribers and Pharmacies.⁴

⁴ This report presents data on (a) versions of each of the first three measures that pertain to follow-up received within 30 days of discharge, (b) a separate but similar measure on medication reconciliation after hospital discharge, and (c) a pair of measures that pertain separately to avoiding use of opioids from multiple prescribers and avoiding use of opioids from multiple pharmacies.

Patient experience data were collected from a national survey of Medicare beneficiaries, known as the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This survey is administered each year to both Medicare FFS and MA beneficiaries. The data in this report are from the 2019 Medicare CAHPS survey. Examples of patient experience measures include how easy it is to get needed care, how well doctors communicate with beneficiaries, and how easy it is for beneficiaries to get information from their drug plans about prescription drug coverage and cost.

Clinical care data were gathered through medical records and insurance claims for hospitalizations, medical office visits, and procedures. These data, which are collected each year from MA plans nationwide, are part of the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS data are not available for FFS beneficiaries. 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/appropriateness, and access/availability of care. Although the annual flu vaccination measure is a HEDIS measure, it is collected via the Medicare CAHPS survey and so is included with the patient experience measures in this report. The HEDIS data reported here were collected in 2019. Whereas all patient experience measures are applicable to beneficiaries aged 18 years and older, certain HEDIS measures apply to beneficiaries in a more limited age range, as noted throughout the report.

Beneficiaries were classified as living in a rural or urban area based on the zip code of their mailing address and the corresponding 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, any beneficiary residing within a metropolitan statistical area was classified as an urban resident; any beneficiary living in a micropolitan statistical area or outside of a CBSA was classified as a rural resident. By this definition, 15.6 percent (approximately 2.8 million) of MA beneficiaries and 21.5 percent (approximately 7.0 million) of FFS beneficiaries were rural residents in 2019. Of all Medicare beneficiaries residing in rural areas in 2019, 28.4 percent were enrolled in MA; of beneficiaries residing in urban areas, 36.9 percent were enrolled in MA.

The 2019 CAHPS survey asked beneficiaries to report their race and ethnicity. Survey responses were used to classify respondents into one of seven mutually exclusive categories: Hispanic, multiracial, American Indian/Alaska Native (AI/AN), Asian/Pacific Islander (API), Black, White, or unknown. The appendix provides detail on the survey questions and classification scheme. Unknown cases were dropped from the analysis. The multiracial group was included in the analysis, but estimates for this group are not presented in this report. 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, surname, and residential location (Haas et al., 2019). This methodology is recommended for estimating racial and ethnic disparities for Black, Hispanic, API, and White beneficiaries, but not for AI/AN or multiracial beneficiaries. Thus, this report does not show scores for AI/AN beneficiaries on the clinical care measures.

Reportability of Information

Sample size criteria were used to determine whether a score on a measure was reportable for a particular group. Scores based on 400 or more observations were considered sufficiently precise for reporting as is. Scores based on more than 99 but fewer than 400 observations were considered low in precision and were flagged as such. In this report, flagged scores—which should be regarded as

tentative information—are shown unbolded with a superscript symbol appended; the symbol links to a note at the bottom of the chart that cautions about the precision of the score. Scores based on 99 or fewer observations are suppressed (i.e., not reported). When a score is suppressed for a particular group, a note appears at the bottom of the relevant chart saying that there were not enough data from that group to make a rural-urban or racial and ethnic comparison on the measure.

Rural-Urban Disparities in Health Care in Medicare

Section I of the report begins with a stacked bar chart showing the number of patient experience measures (out of seven) and the number of clinical care measures (out of 39) for which rural residents had results that were worse than, similar to, or better than results for urban residents.⁵ In this chart, information on patient experience is presented separately for Medicare FFS and MA beneficiaries. Following the stacked bar chart are separate, unstacked bar charts for each patient experience and clinical care measure. Charts for patient experience measures show the average score for rural and urban FFS and MA beneficiaries on a 0–100 scale. The average score represents the percentage of the best possible score for a given group for that 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 $([3.5 - 1] / [4 - 1]) \times 100 = 83.3$. Charts for clinical care measures show the percentage of rural and urban MA beneficiaries whose care met the standard called for by the specific measure (e.g., receiving a clinically indicated test or treatment).

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

Section II of the report shows how rural-urban gaps in health care vary from one racial or ethnic group to another. Section II begins with a set of stacked bar charts that show, separately for American Indian or Alaska Native (AI/AN), Asian or Pacific Islander (API), Black, Hispanic, and White Medicare FFS and MA beneficiaries, the number of patient experience measures for which rural residents reported experiences of care that were worse than, similar to, or better than the experiences reported by urban residents. There was enough information from Black, Hispanic, and White FFS and MA beneficiaries, and from AI/AN and API MA beneficiaries, to compare rural and urban residents on all seven measures. Rural-urban comparisons among AI/AN and API FFS beneficiaries were possible for five measures. Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for AI/AN, API, Black, Hispanic, and White FFS and MA beneficiaries, the average score for rural and urban residents on a 0–100 scale. After the patient experience measures, Section II presents a set of stacked bar charts that show, separately for API, Black, Hispanic, and White MA beneficiaries, the number of clinical care measures for which rural residents had results that were worse than, similar to, or better than results for urban residents. There was enough information from Black, Hispanic, and White beneficiaries to compare rural and urban residents on all 39 clinical care measures. Rural-urban comparisons among API beneficiaries were possible for 34 clinical care measures. Following the stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for API (where available), Black, Hispanic, and White MA beneficiaries, the percentage of rural and urban residents whose care met the standard called for by the measure.

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

⁵ Here, “similar” is used to characterize differences that are not statistically significant, fall below a magnitude threshold, or both, as described in the appendix. “Worse” and “better” are used to characterize differences that are statistically significant and exceed a magnitude threshold.

Section III of the report begins with four stacked bar charts that show, separately for rural and urban Medicare FFS and MA beneficiaries, the number of patient experience measures for which members of each racial and ethnic minority group reported experiences of care that were worse than, similar to, or better than the experiences reported by White beneficiaries. There was enough information from rural and urban MA and FFS beneficiaries to compare Black and Hispanic beneficiaries to White beneficiaries on all seven measures. There was also enough information from rural and urban AI/AN MA beneficiaries, rural and urban API MA beneficiaries, and urban API FFS beneficiaries to compare them to White beneficiaries on all seven measures. There was enough information from rural API FFS beneficiaries to compare them to White beneficiaries on six measures, and there was enough information from urban AI/AN FFS beneficiaries and rural API FFS beneficiaries to compare them to White beneficiaries on five measures. Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for rural and urban MA and FFS beneficiaries, the average score for each racial and ethnic group on a 0–100 scale. After the patient experience measures, Section III presents a pair of stacked bar charts that show, separately for rural and urban MA beneficiaries, the number of clinical care measures for which members of each racial and ethnic minority group had results that were worse than, similar to, or better than results for White beneficiaries. There was enough information from rural and urban Black and Hispanic beneficiaries and from urban API beneficiaries to compare them to White beneficiaries on all 39 measures. Rural API-White comparisons were possible for 34 measures. Following these stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for rural and urban MA beneficiaries, the percentage of beneficiaries 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

Rural residents, regardless of race or ethnicity, often had worse clinical care results than urban residents. Although patient experience scores are adjusted for a broad set of case-mix variables (see the appendix), clinical care scores are not. It is therefore possible that the differences observed between rural and urban residents in the quality of clinical care are attributable to factors that are not accounted for in the analysis. Future research is needed to understand whether this pattern reflects poorer dissemination of clinical practice guidelines to rural areas, poorer translation of those guidelines into clinical practice, or some other cause. Findings from that research would be useful for informing efforts to address these disparities. The difference between rural and urban residents in clinical care results was most pronounced among Hispanic beneficiaries. Future research is therefore also needed to determine why rural Hispanic beneficiaries are at especially high risk for poor clinical care. Rural-urban differences in experiences of care were much more limited, both overall and for each racial and ethnic group.

This analysis also revealed notable geographic variation in AI/AN-White disparities in patient experience. Specifically, whereas urban AI/AN beneficiaries typically reported experiences with care that were similar to the experiences of care reported by urban White beneficiaries, rural AI/AN beneficiaries typically reported experiences with care that were worse than the experiences reported by rural White beneficiaries. There was also notable geographic variation in Hispanic-White disparities in clinical care. Specifically, whereas Hispanic beneficiaries generally had worse clinical care results than White beneficiaries, the difference between these groups was evident far more often in rural areas than in urban areas. These results suggest the need to give special attention to addressing the care experiences of rural AI/AN beneficiaries and the clinical care needs of rural Hispanic beneficiaries.



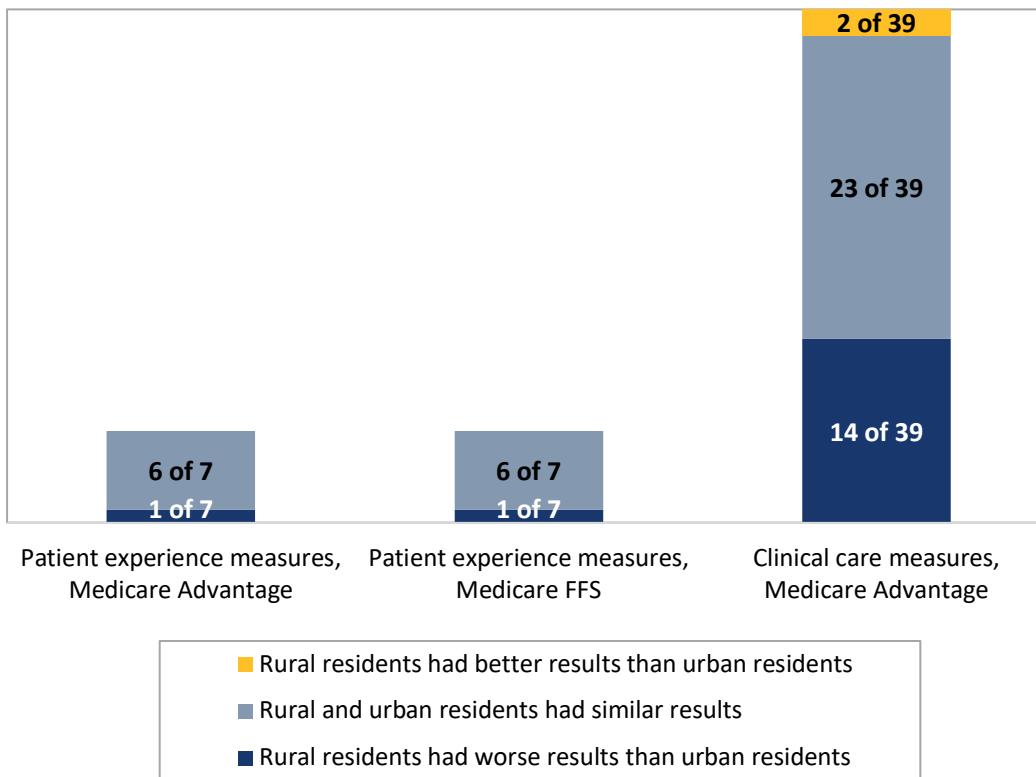
Section I:

Rural-Urban Disparities in Health Care in Medicare



Rural-Urban Disparities in Care: All Patient Experience and Clinical Care Measures

Number of patient experience measures and clinical care measures for which rural residents had results that were worse than, similar to, or better than results for urban residents in 2019



SOURCES: The bar on the left summarizes patient experience data from all MA beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey. The bar in the middle summarizes patient experience data from all FFS beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey. The bar on the right summarizes clinical quality (HEDIS) data collected in 2019 from MA plans nationwide. Clinical quality data are not available for Medicare FFS beneficiaries.

The relative difference between rural and urban is used to assess disparities.

- **Better** = Rural residents had better results than urban residents. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points[†] on a 0–100 scale, and favor rural residents.
- **Similar** = Rural and urban residents had similar results. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Rural residents had worse results than urban residents. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor urban residents.

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

Rural residents had worse results than urban residents

- Annual flu vaccination
- Testing to confirm COPD
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroid
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Osteoporosis management in women who had a fracture
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after emergency department visit for mental illness (within 30 days of discharge)
- Initiation of alcohol and other drug dependence treatment
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls

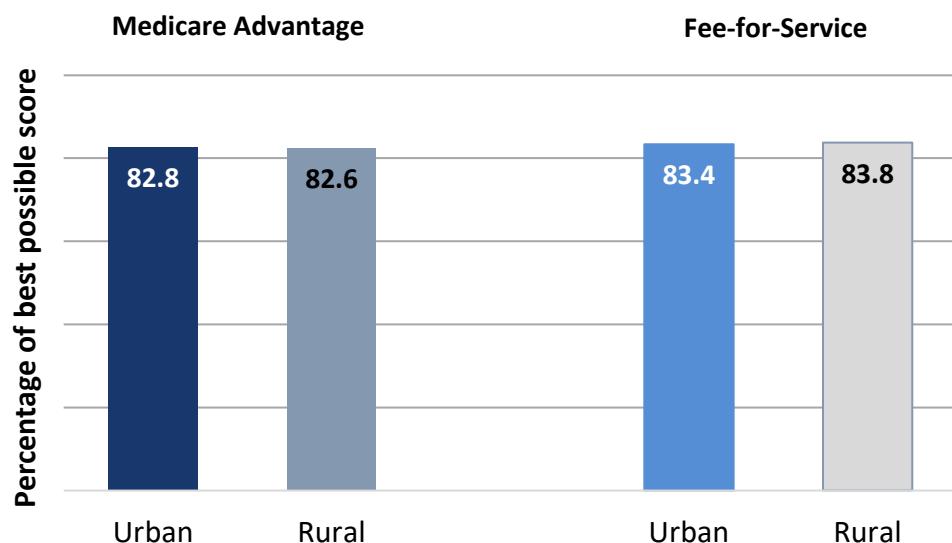
Rural residents had better results than urban residents

- Follow-up after hospital stay for mental illness (within 30 days of discharge)
- Avoiding use of opioids from multiple prescribers

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, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

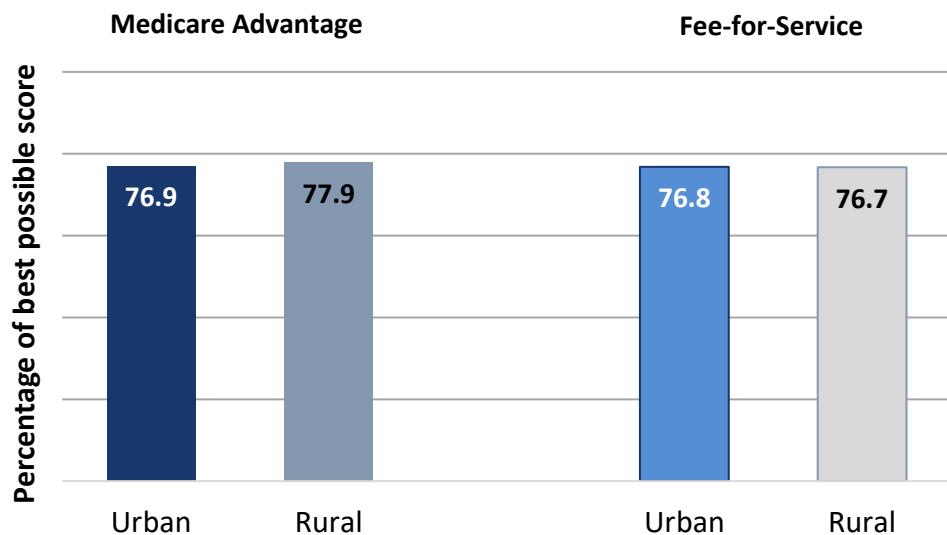
Disparities

- Among both MA and FFS beneficiaries, rural and urban residents reported similar experiences with getting needed care.

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

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,[†] by geography within coverage type, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

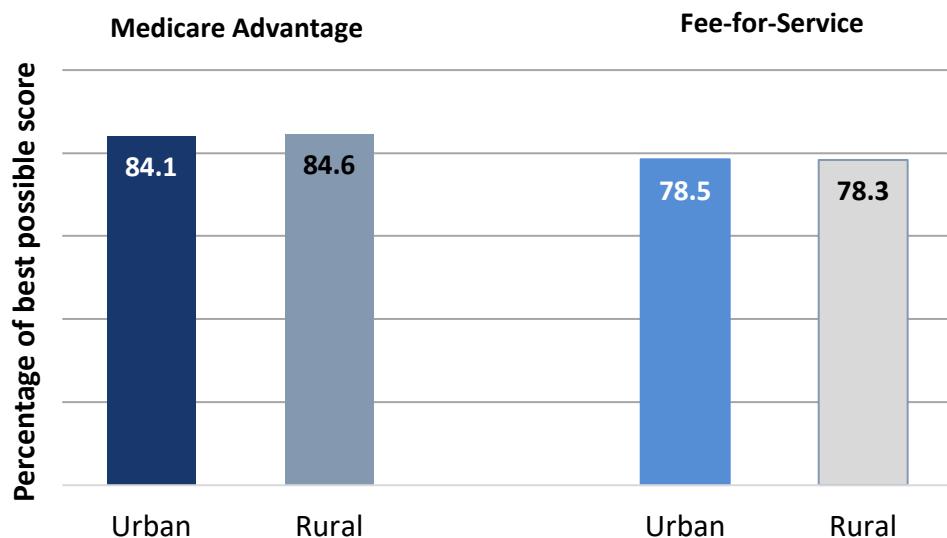
Disparities

- Among both MA and FFS beneficiaries, rural and urban residents reported similar experiences with getting appointments and care quickly.

[†] 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, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

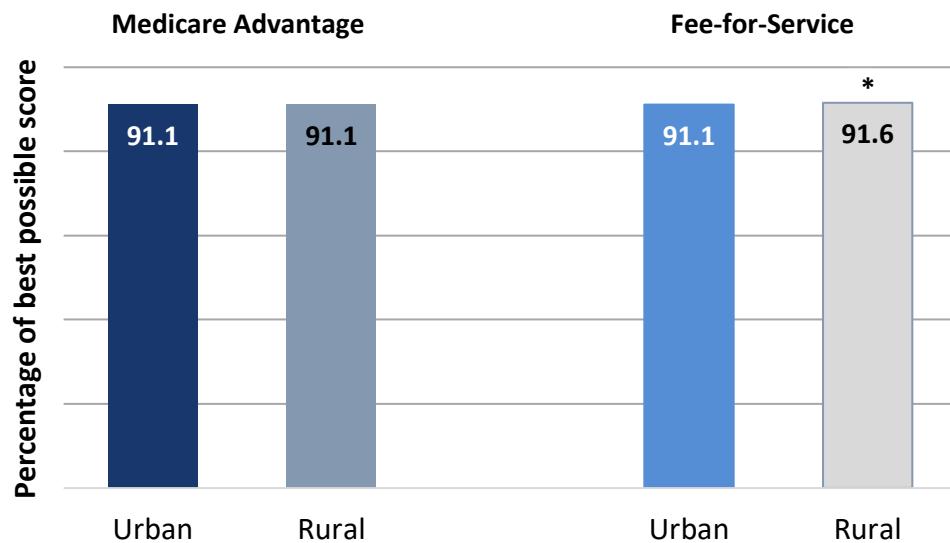
Disparities

- Among both MA and FFS beneficiaries, rural and urban residents reported similar experiences with customer service.

[†] This includes how often in the last six months health plan customer service staff provided the information or the help that beneficiaries needed, how often beneficiaries 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, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

Disparities

- Among MA beneficiaries, rural and urban residents reported similar experiences with doctor communication.
- Among FFS beneficiaries, rural residents reported better[‡] experiences with doctor communication than urban residents reported. The difference between rural and urban residents was less than 3 points on a 0–100 scale.

* Significantly different from the score for urban residents ($p < 0.05$).

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

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

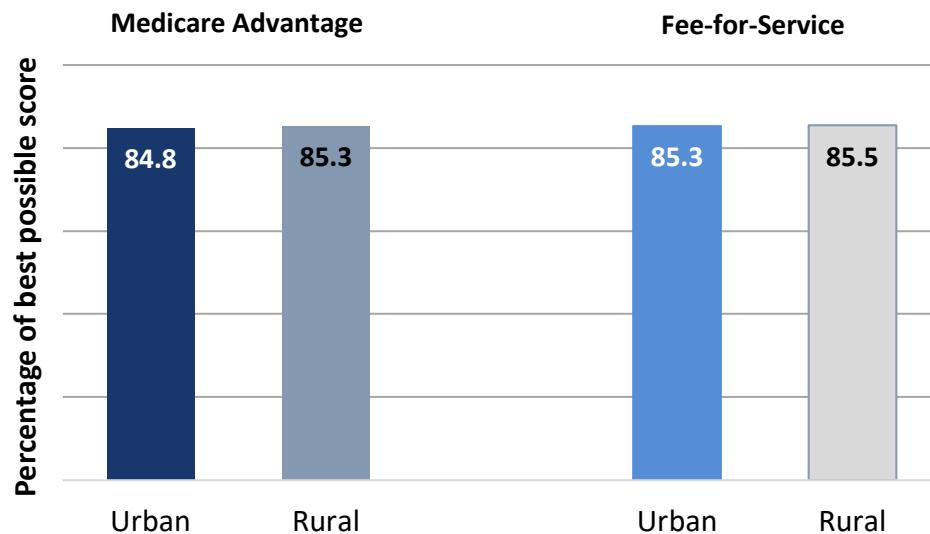
(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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.

[‡] Unlike on pages 7–8, we use the terms “better” or “worse” to describe all statistically significant differences on individual patient experience measures. We note in the “Disparities” section for each of these measures where differences are greater or less than 3 points.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patient care is coordinated,[†] by geography within coverage type, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

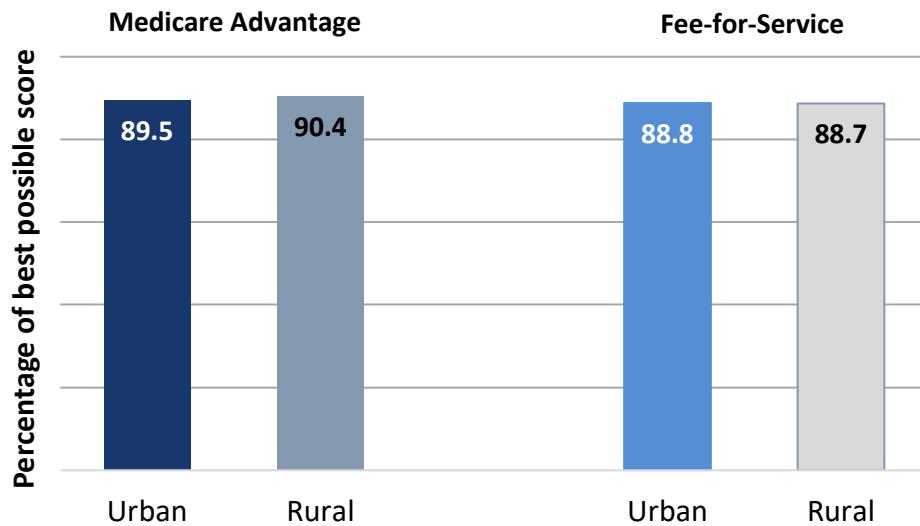
Disparities

- Among both MA and FFS beneficiaries, rural and urban residents reported similar experiences with care coordination.

[†] 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 beneficiaries to get the prescription drugs they need using their plans,[†] by geography within coverage type, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

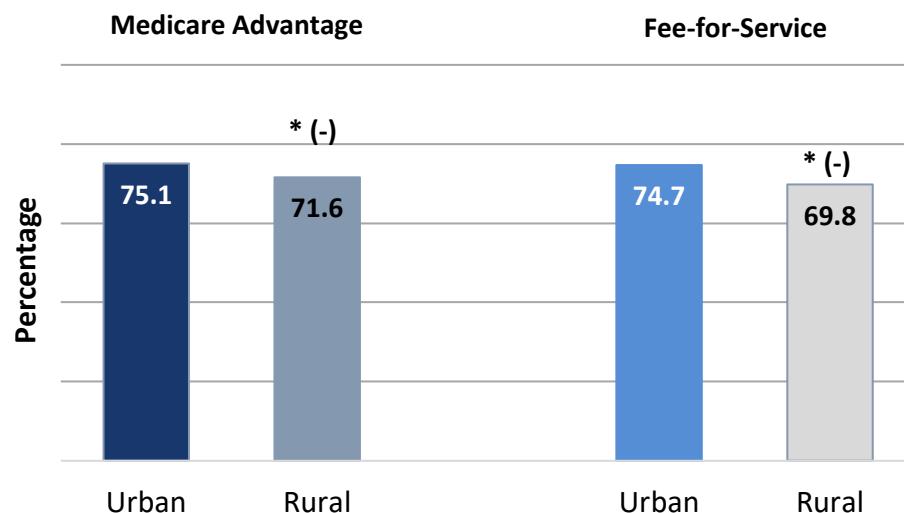
Disparities

- Among both MA and FFS beneficiaries, rural and urban residents reported similar experiences with getting needed prescription drugs.

[†] 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 Medicare enrollees who got a vaccine (flu shot),
by geography within coverage type, 2019**



SOURCE: Data from the Medicare CAHPS survey, 2019.

Disparities

- Among both MA and FFS beneficiaries, rural residents were less likely than urban residents to have received the flu vaccine. In each case, the difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

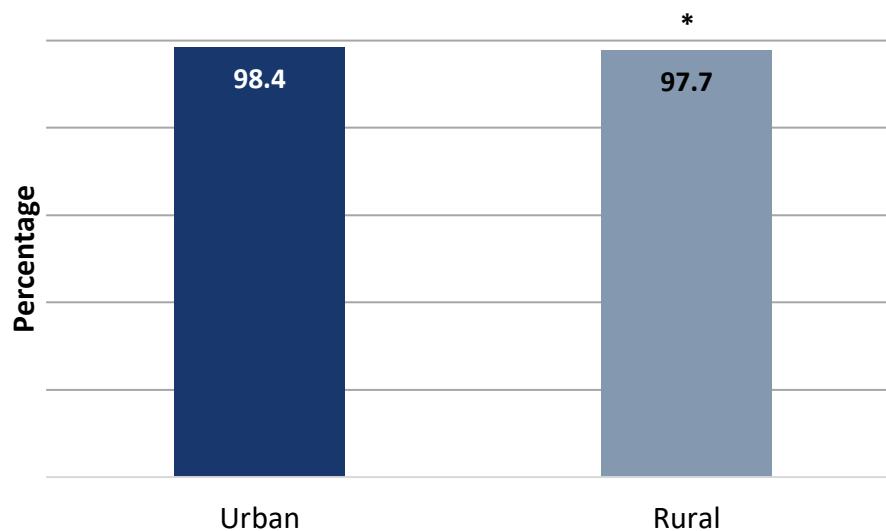
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Prevention and Screening

Adult BMI Assessment

Percentage of MA enrollees aged 18 to 74 years who had an outpatient visit whose body mass index (BMI) was documented in the past two years, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for FFS Medicare beneficiaries.

Disparities

- Rural residents were less likely than urban residents to have had their BMIs documented. The difference between rural and urban residents was less than 3 percentage points.

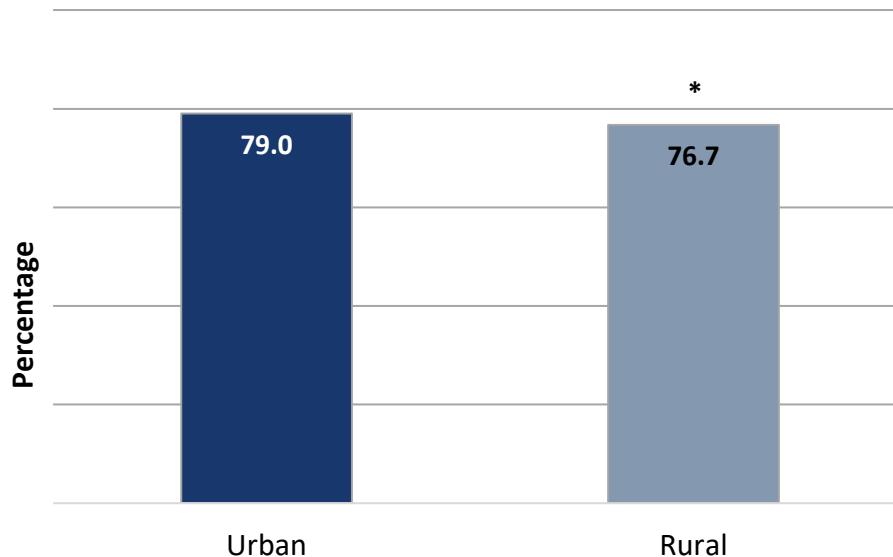
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Breast Cancer Screening

Percentage of MA enrollees (women) aged 50 to 74 years who had appropriate screening for breast cancer, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural women were less likely than urban women to have been appropriately screened for breast cancer. The difference between rural and urban women was less than 3 percentage points.

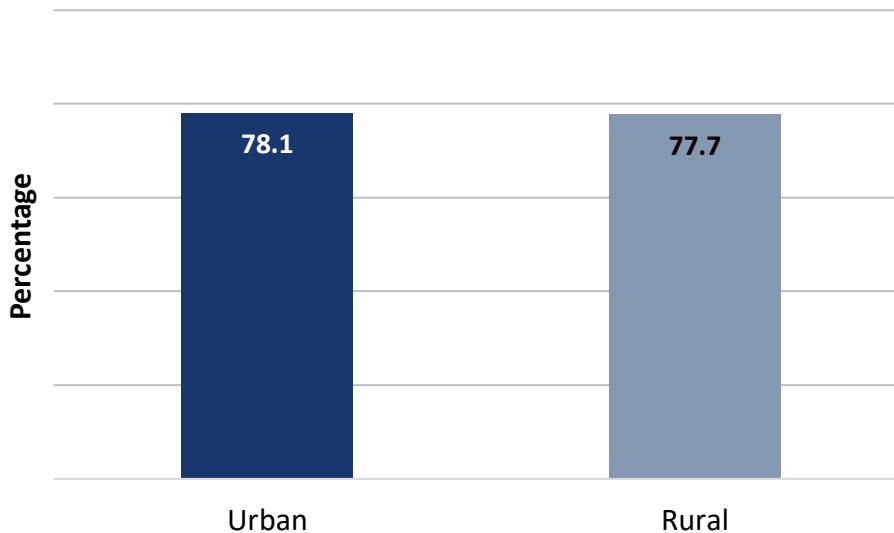
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

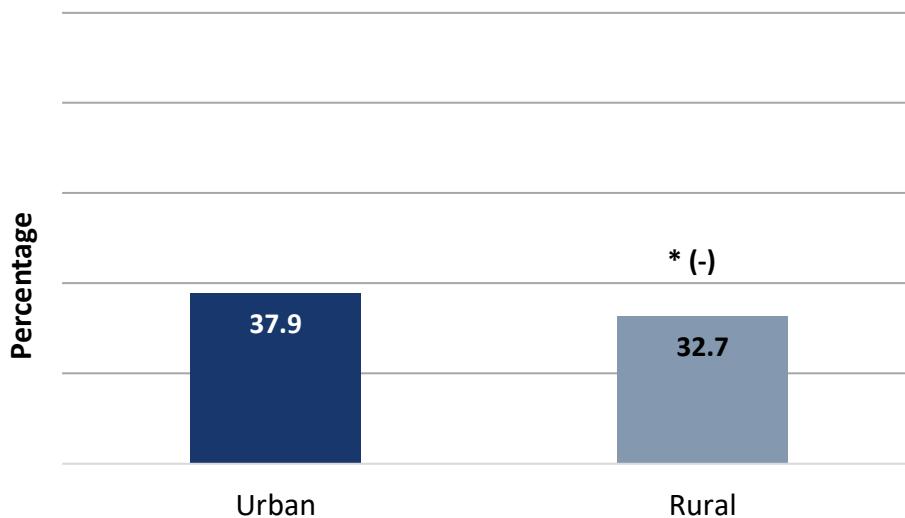
Disparities

- Rural residents were about as likely as urban residents to have been appropriately screened for colorectal cancer.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with a new diagnosis of COPD or newly active COPD were less likely than urban residents with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between rural and urban residents was greater than 3 percentage points.

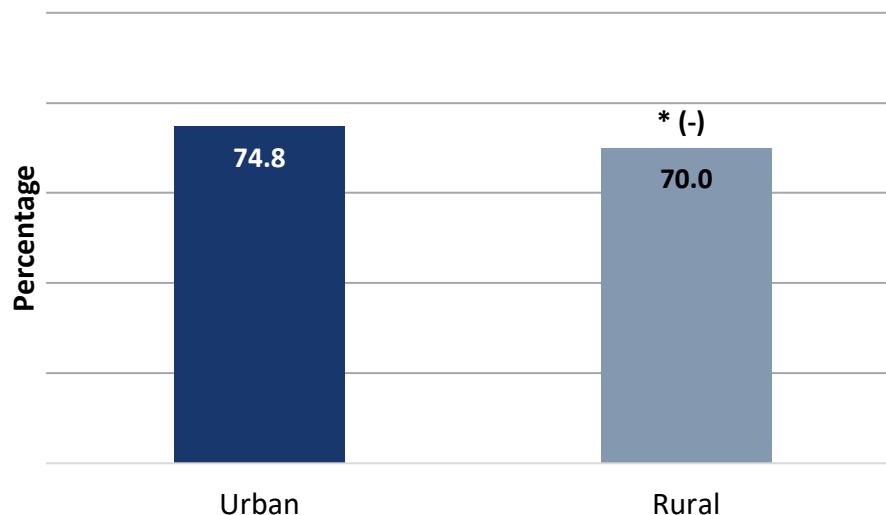
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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 encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who experienced a COPD exacerbation were less likely than urban residents who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between rural and urban residents was greater than 3 percentage points.

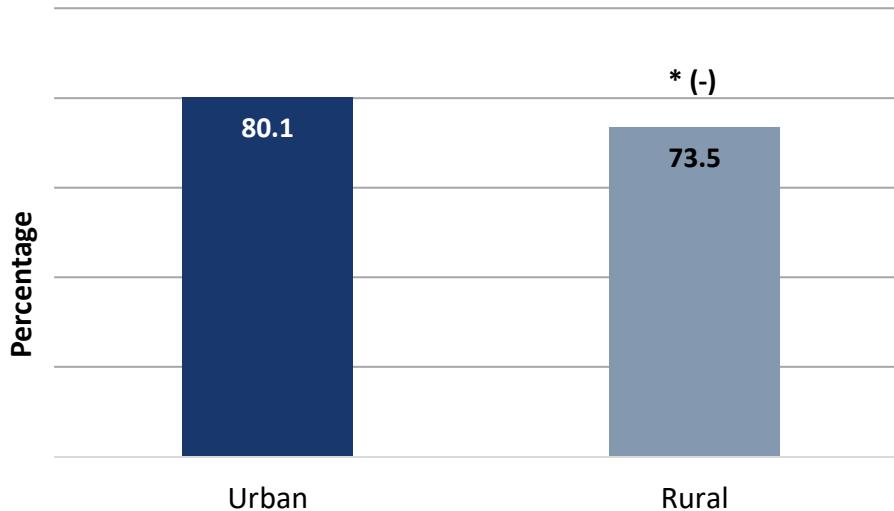
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who experienced a COPD exacerbation were less likely than urban residents who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

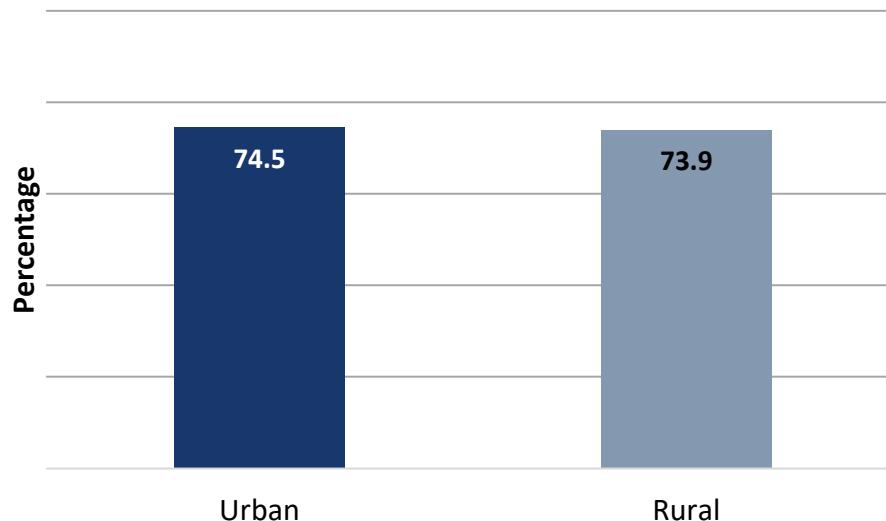
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

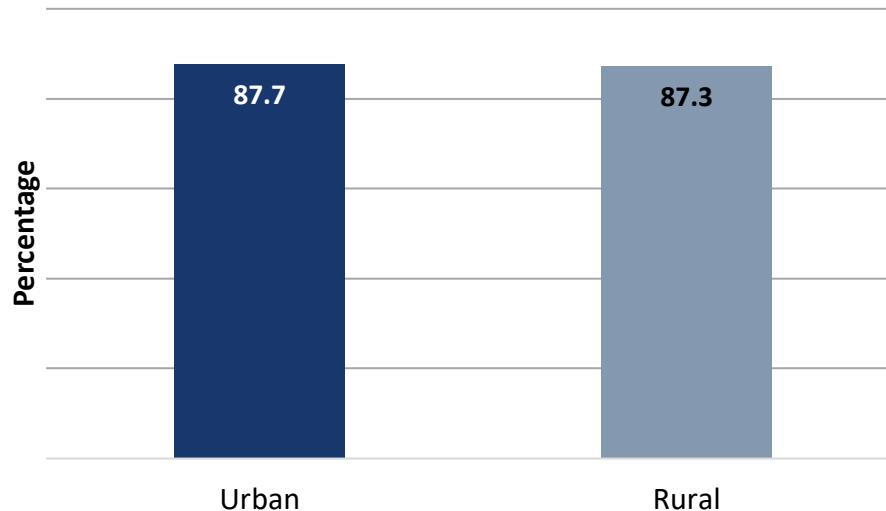
Disparities

- Rural residents who had a diagnosis of hypertension were about as likely as urban residents who had a diagnosis of hypertension to have had their blood pressure adequately controlled.

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

Continuous Beta-Blocker Treatment

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (AMI) who received persistent beta-blocker treatment for six months after discharge, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

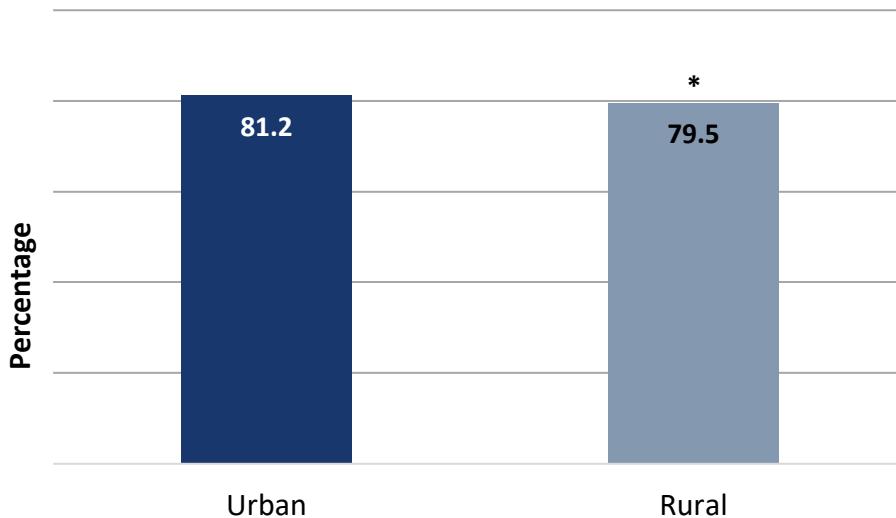
NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were hospitalized for a heart attack were about as likely as urban residents who were hospitalized for a heart attack to have received persistent beta-blocker treatment.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with ASCVD were less likely than urban residents with ASCVD to have received statin therapy. The difference between rural and urban residents was less than 3 percentage points.

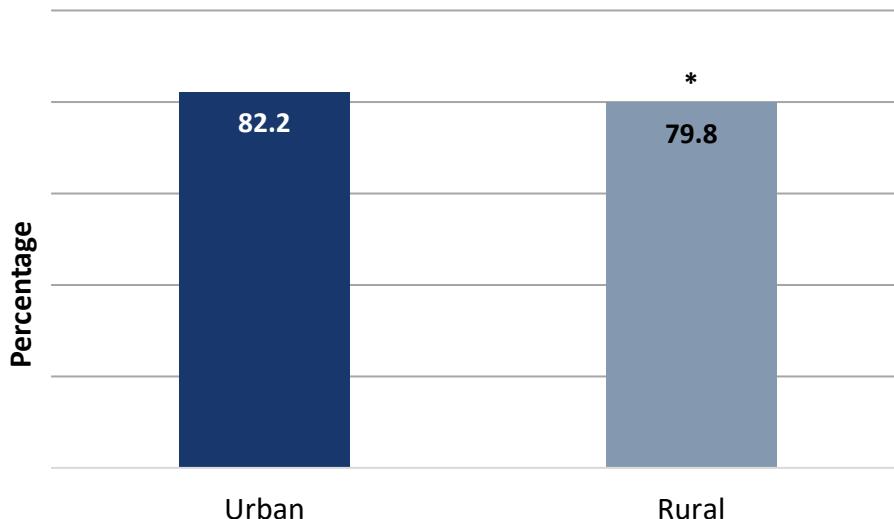
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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 atherosclerotic cardiovascular disease (ASCVD) who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with ASCVD were less likely than urban residents with ASCVD to have had proper statin medication adherence. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

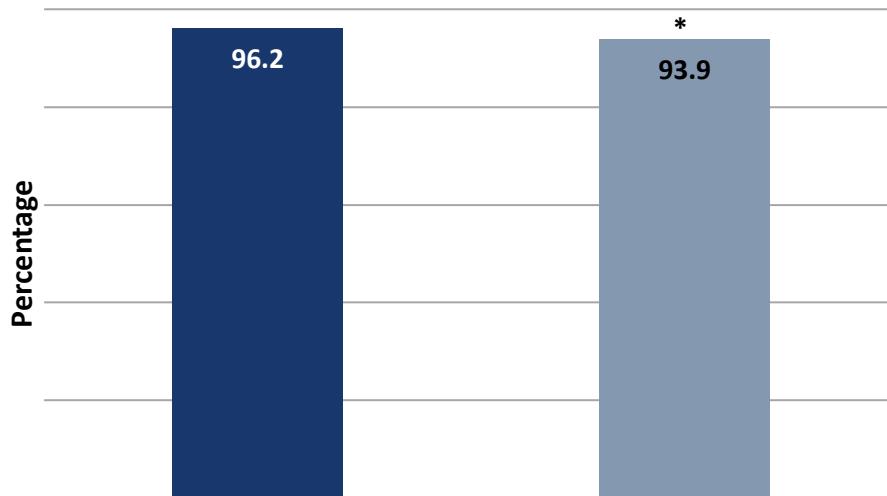
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have had their blood sugar tested at least once in the past year. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

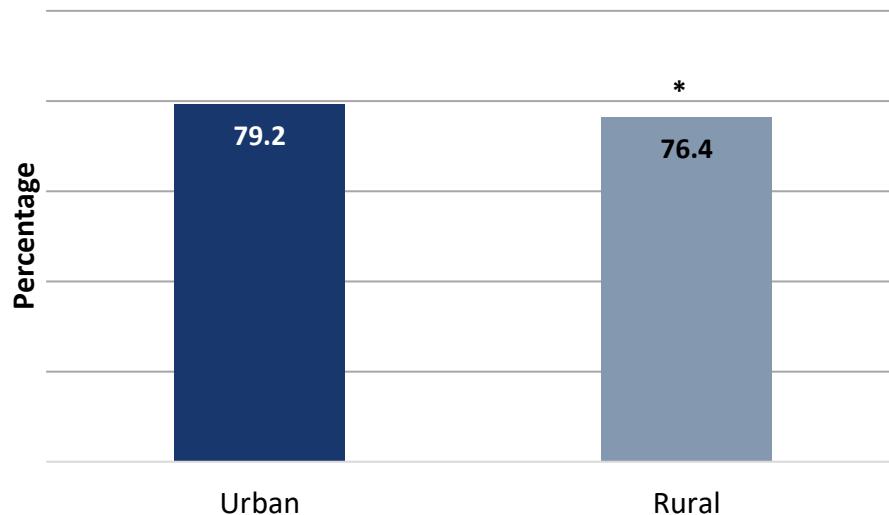
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have had an eye exam in the past year. The difference between rural and urban residents was less than 3 percentage points.

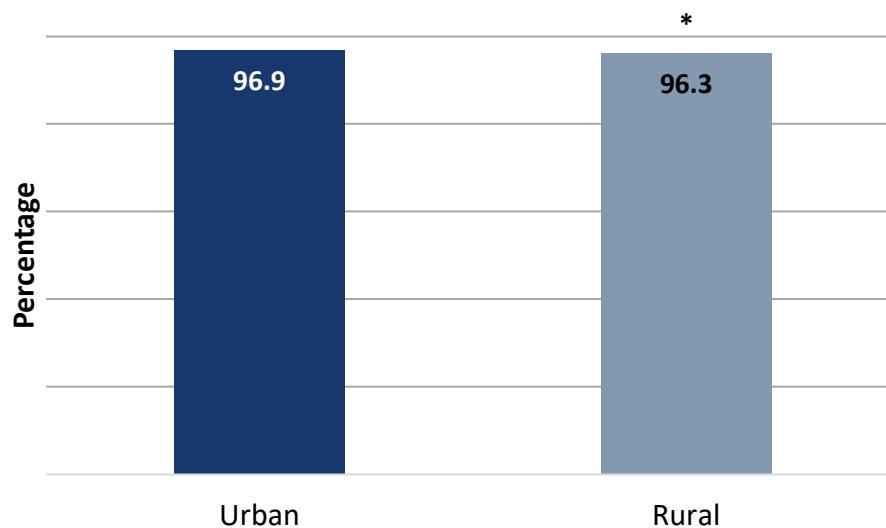
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have had medical attention for nephropathy in the past year. The difference between rural and urban residents was less than 3 percentage points.

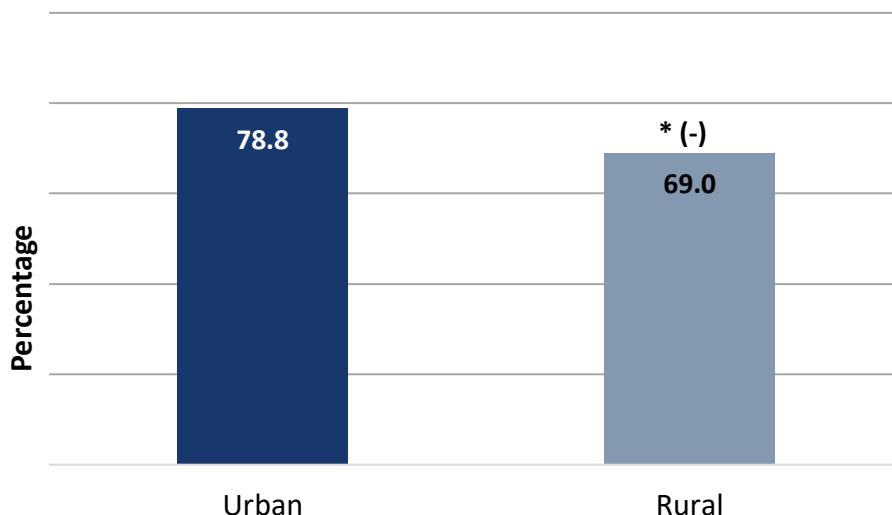
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have their blood pressure under control. The difference between rural and urban residents was greater than 3 percentage points.

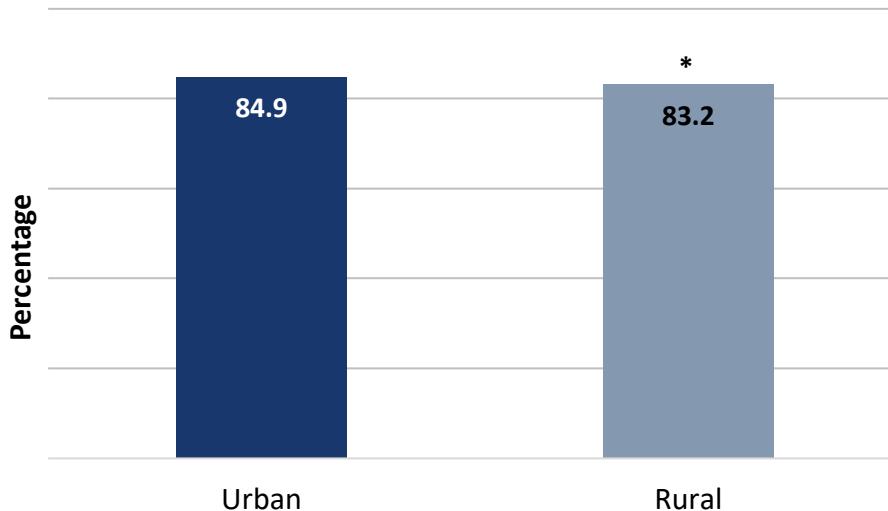
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have their blood sugar levels under control. The difference between rural and urban residents was less than 3 percentage points.

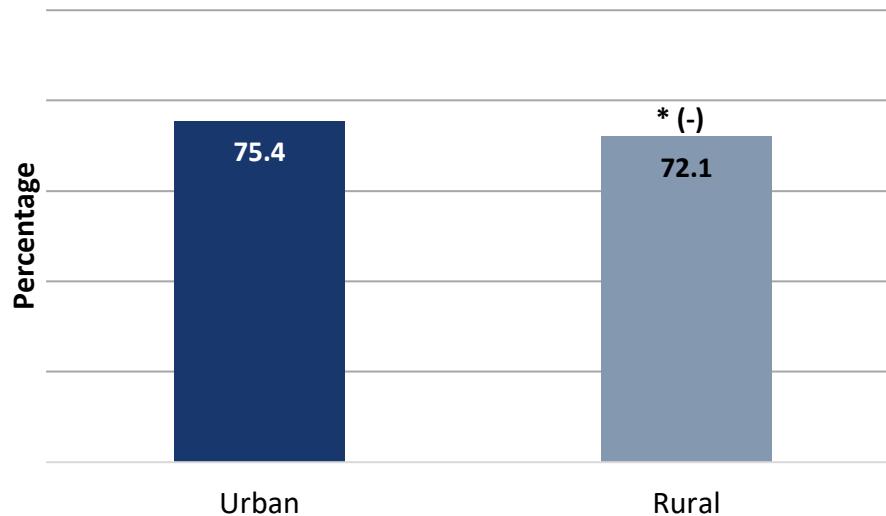
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have received statin therapy. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

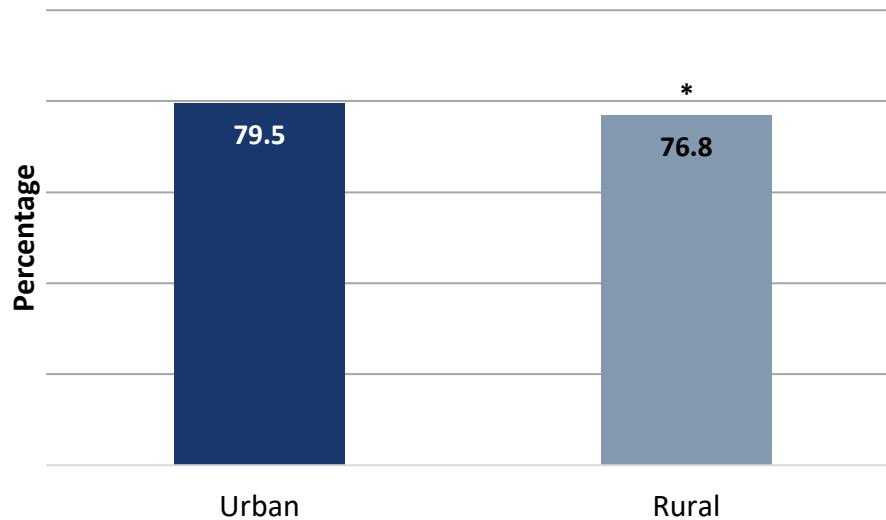
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with diabetes were less likely than urban residents with diabetes to have had proper statin medication adherence. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

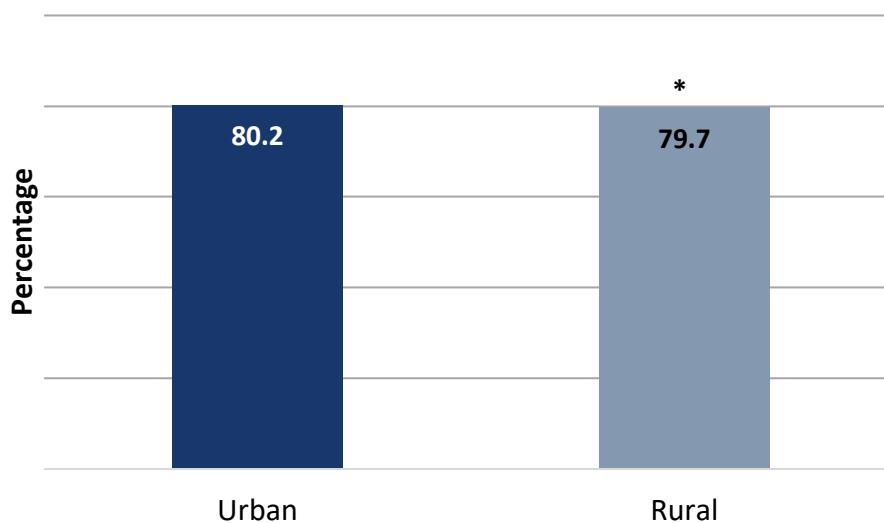
- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were diagnosed with rheumatoid arthritis were less likely than urban residents who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

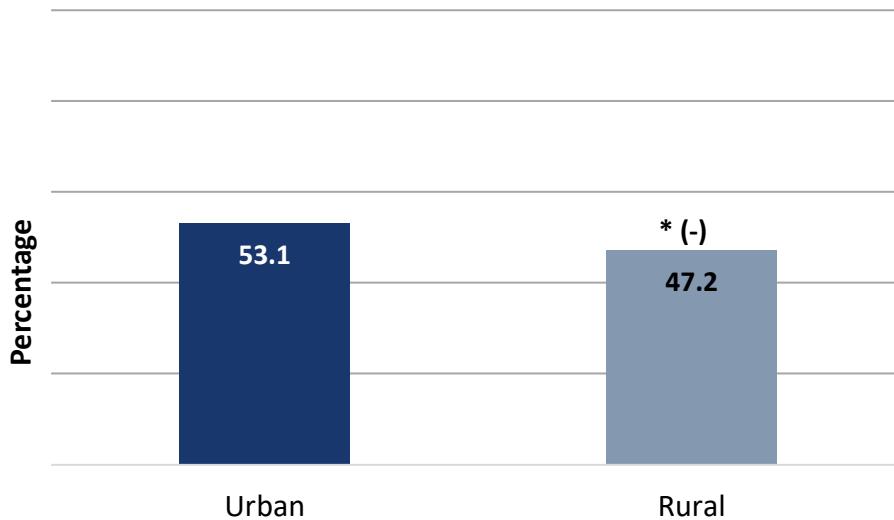
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Osteoporosis Management in Women Who Had a Fracture

Percentage of MA enrollees (women) 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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural women who suffered a fracture were less likely than urban women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

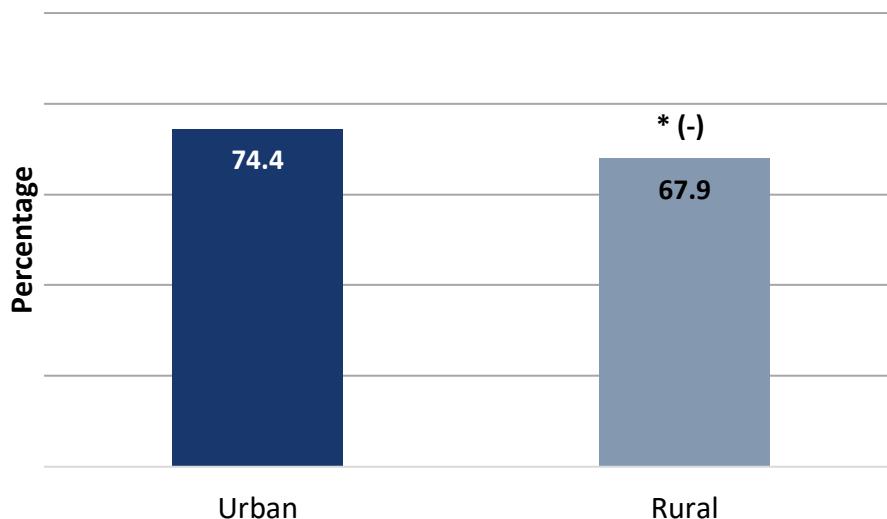
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were diagnosed with a new episode of major depression were less likely than urban residents who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

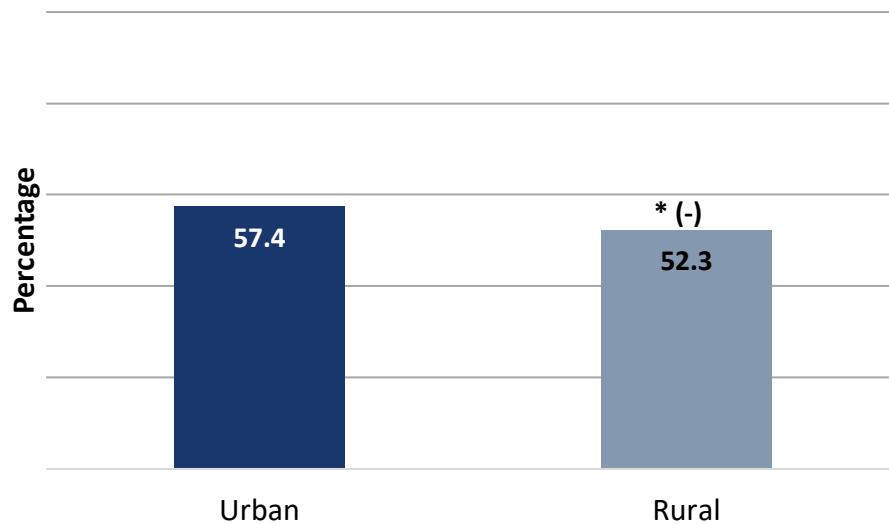
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were diagnosed with a new episode of major depression were less likely than urban residents who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between rural and urban residents was greater than 3 percentage points.

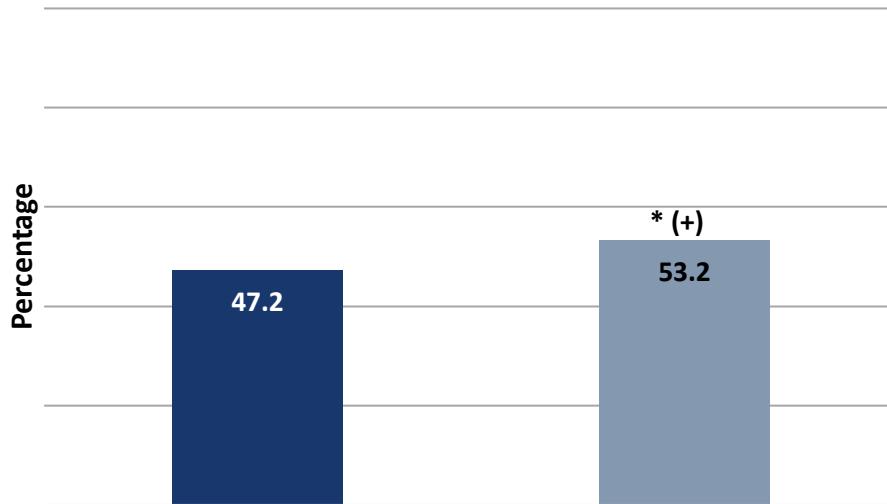
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were hospitalized for a mental health disorder were more likely than urban residents who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

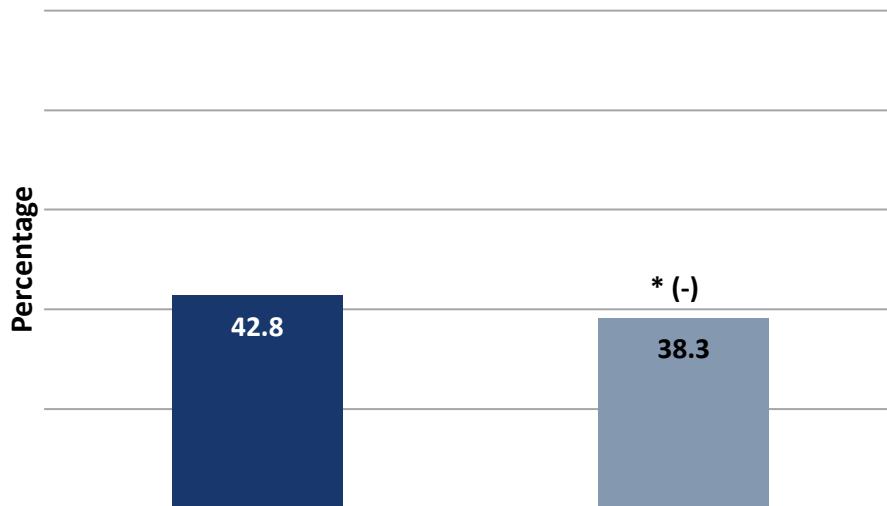
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

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

* Significantly different from the score for urban residents ($p < 0.05$).

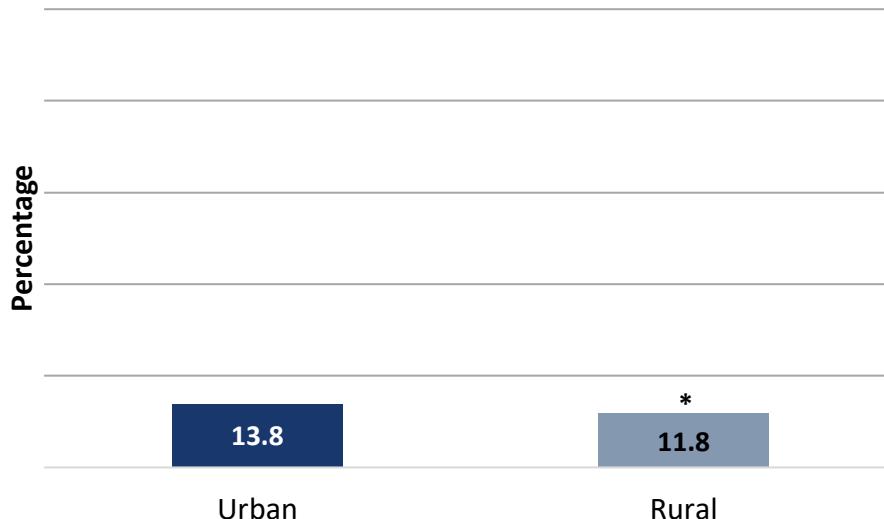
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who had an ED visit for AOD abuse or dependence were less likely than urban residents who had an ED visit for AOD abuse or dependence to have had a follow-up visit for AOD abuse or dependence within 30 days of being discharged. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

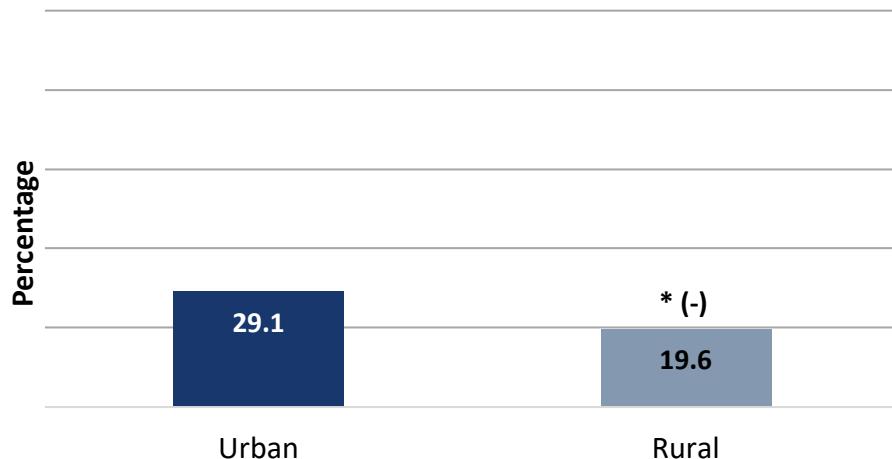
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Initiation of Alcohol and Other Drug Dependence (AOD) 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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with a new episode of AOD dependence were less likely than urban residents with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

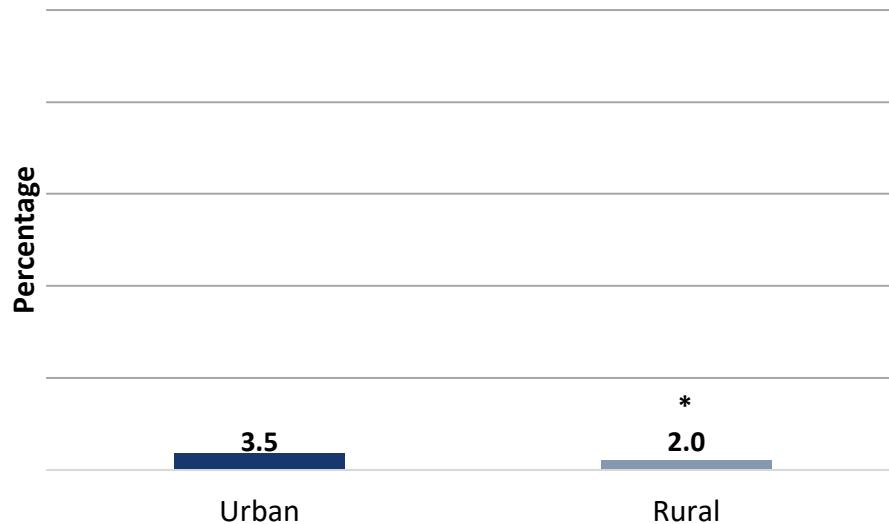
- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

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

Engagement of Alcohol and Other Drug Dependence (AOD) 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 AOD services or medication-assisted treatments within 30 days of the initiation visit, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Overall performance on this measure was lower than on any other measure: Less than 4 percent of those who initiated treatment for AOD dependence received two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. Rural residents with a new episode of AOD dependence who initiated treatment were less likely than urban residents with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

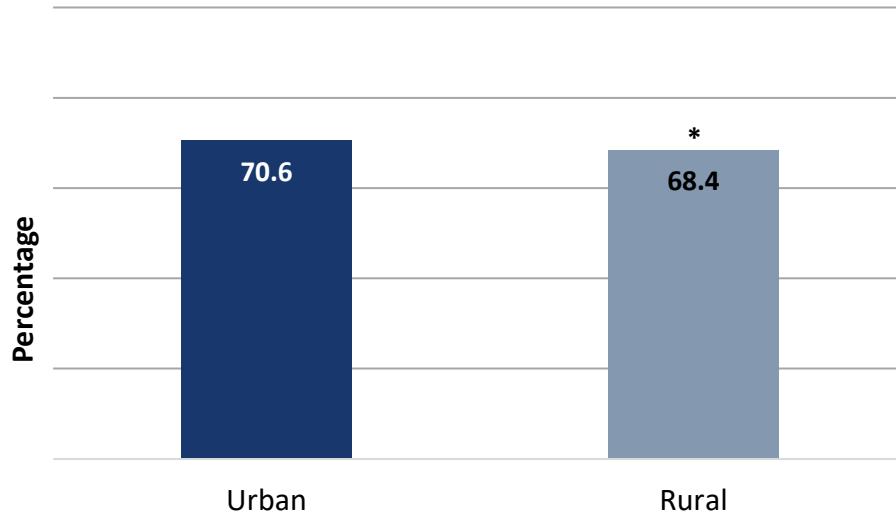
- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Clinical Care: Medication Management and Care Coordination

Medication Reconciliation After Hospital Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were discharged from an inpatient facility were less likely than urban residents who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between rural and urban residents was less than 3 percentage points.

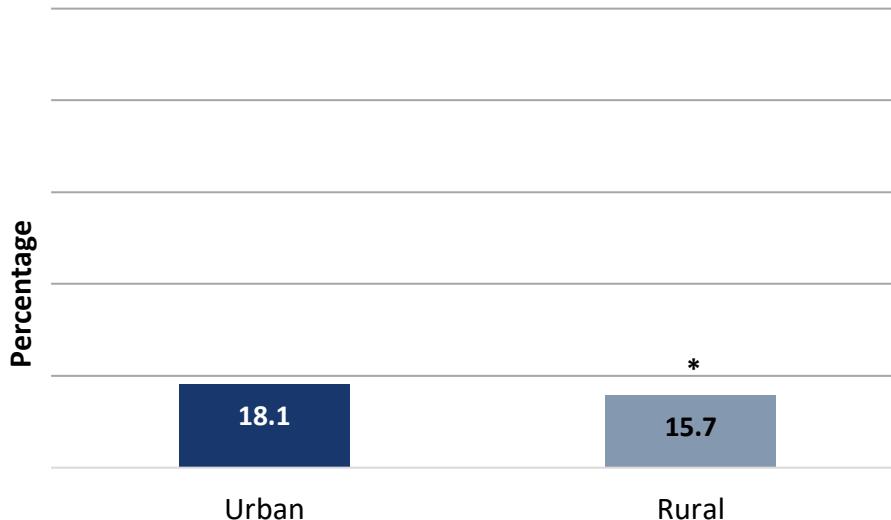
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

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

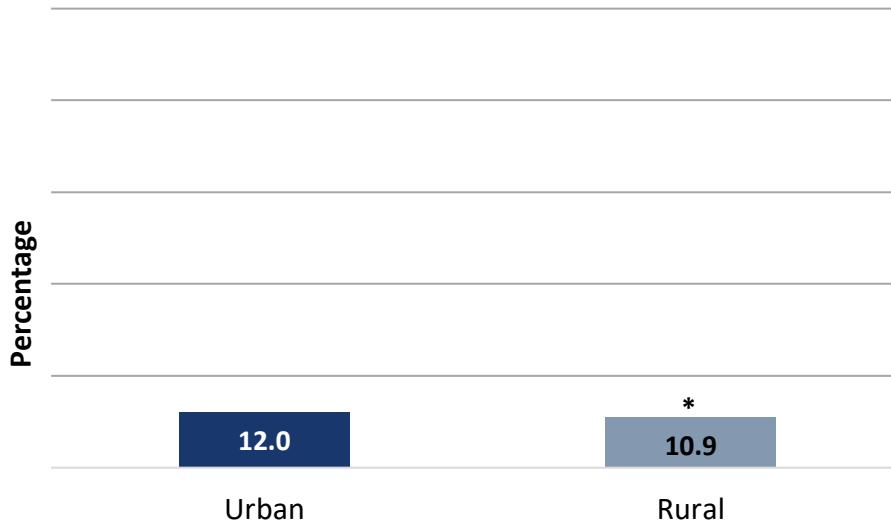
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were discharged from an inpatient facility were less likely than urban residents who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. The difference between rural and urban residents was less than 3 percentage points.

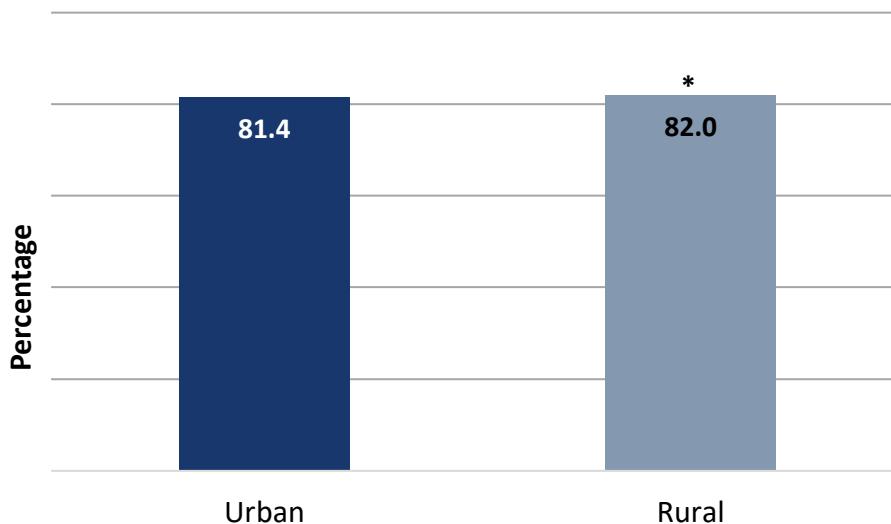
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents who were discharged from an inpatient facility were more likely than urban residents who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between rural and urban residents was less than 3 percentage points.

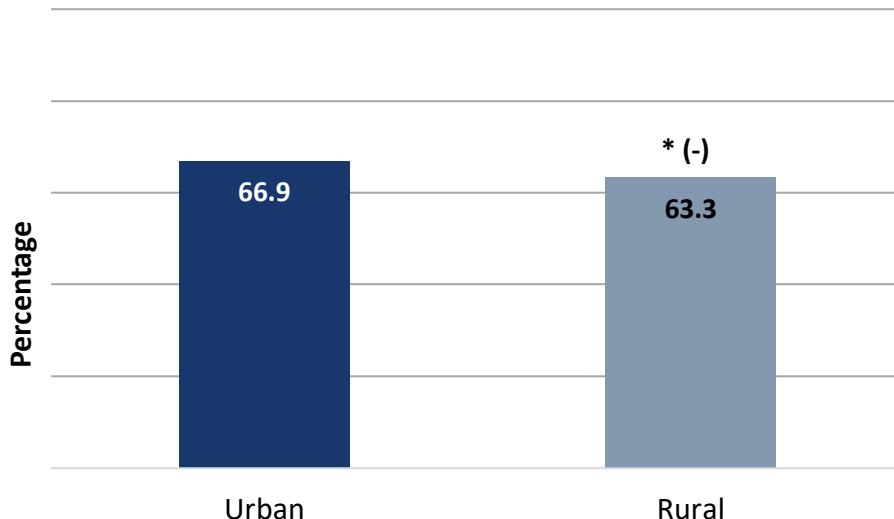
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Rural residents with multiple high-risk chronic conditions were less likely than urban residents with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit. The difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

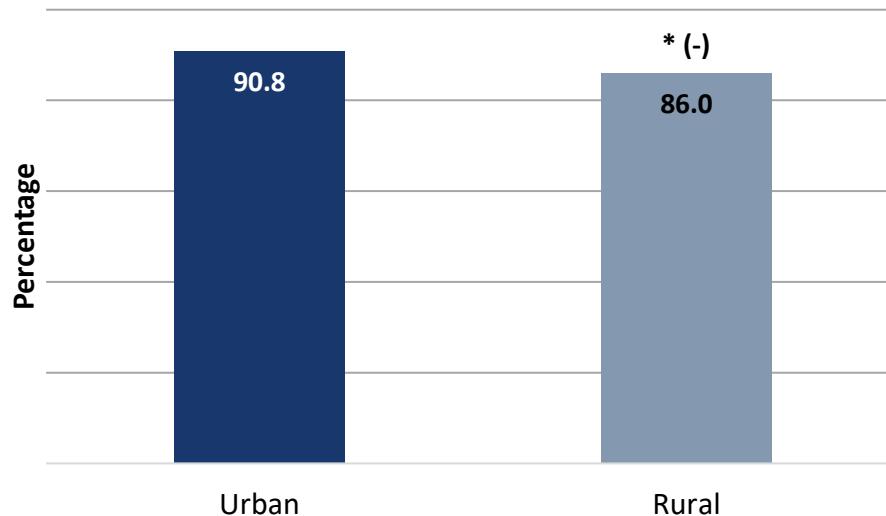
- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Clinical Care: Overuse/Appropriateness

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of potentially harmful medication was avoided less often for elderly rural residents with chronic renal failure than for elderly urban residents with chronic renal failure. The difference between elderly rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

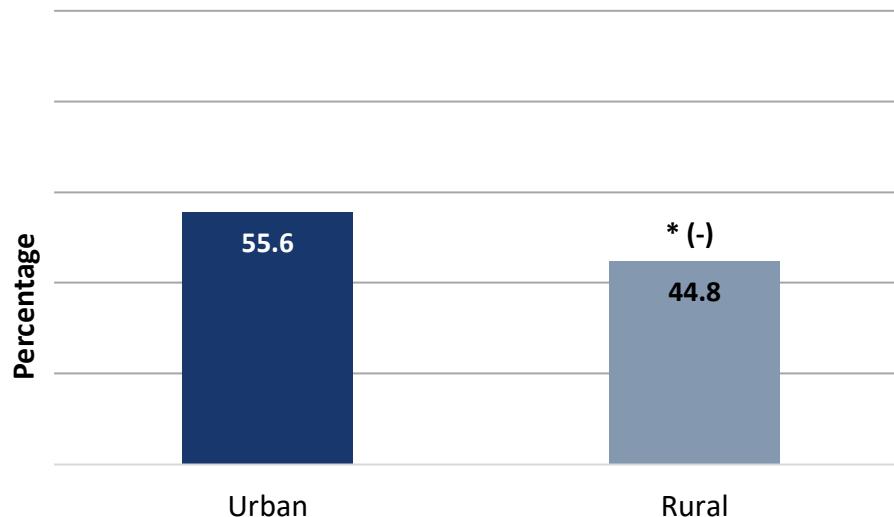
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) and 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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of potentially harmful medication was avoided less often for elderly rural residents with dementia than for elderly urban residents with dementia. The difference between elderly rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

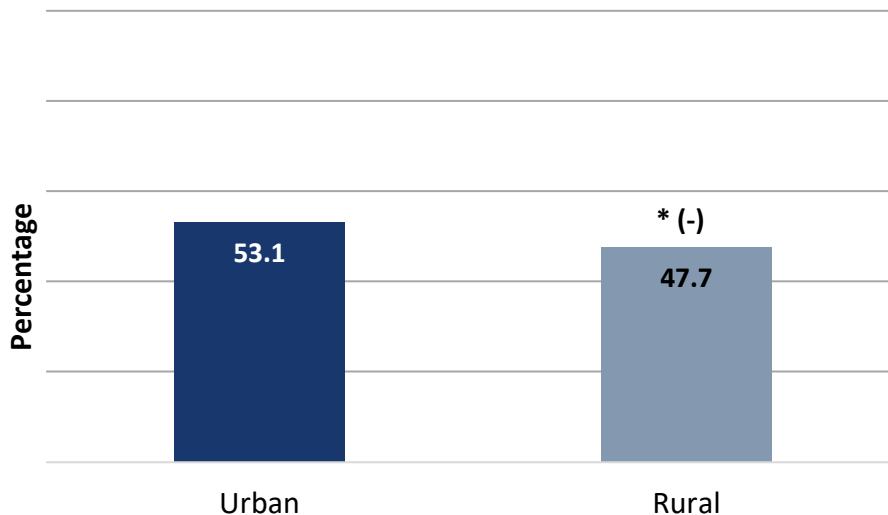
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of potentially harmful medication was avoided less often for elderly rural residents with a history of falls than for elderly urban residents with a history of falls. The difference between elderly rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

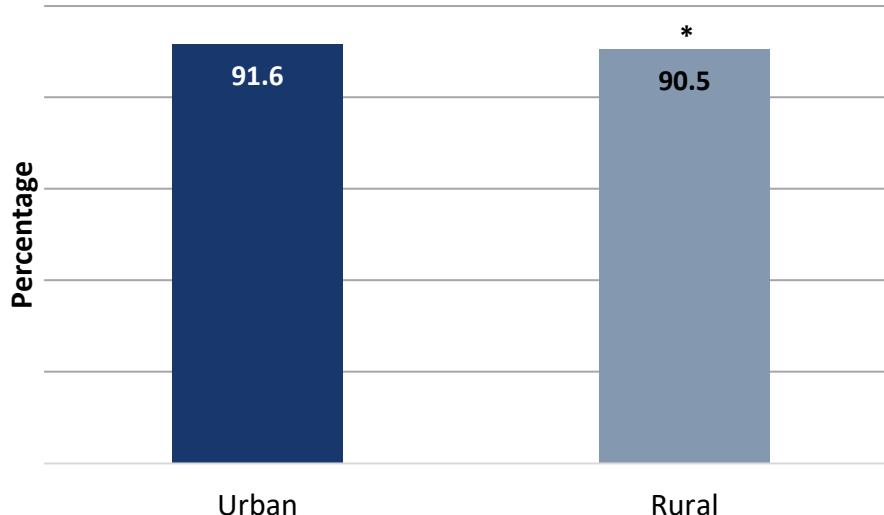
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA enrollees aged 65 years and older who were not prescribed a high-risk medication, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of high-risk medication was avoided less often for elderly rural residents than for elderly urban residents. The difference between elderly rural and urban residents was less than 3 percentage points.

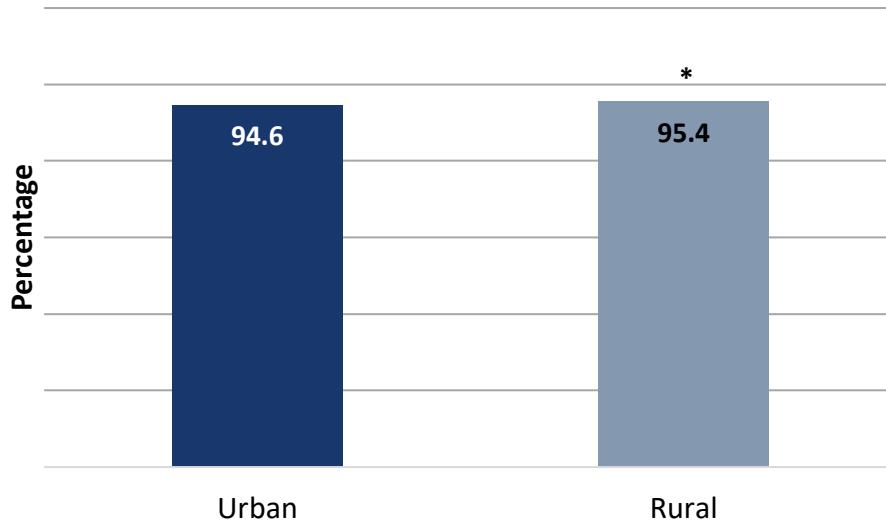
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage[†] for more than 14 days, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of opioids at a high dosage for more than 14 days was avoided more often for rural residents than for urban residents. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

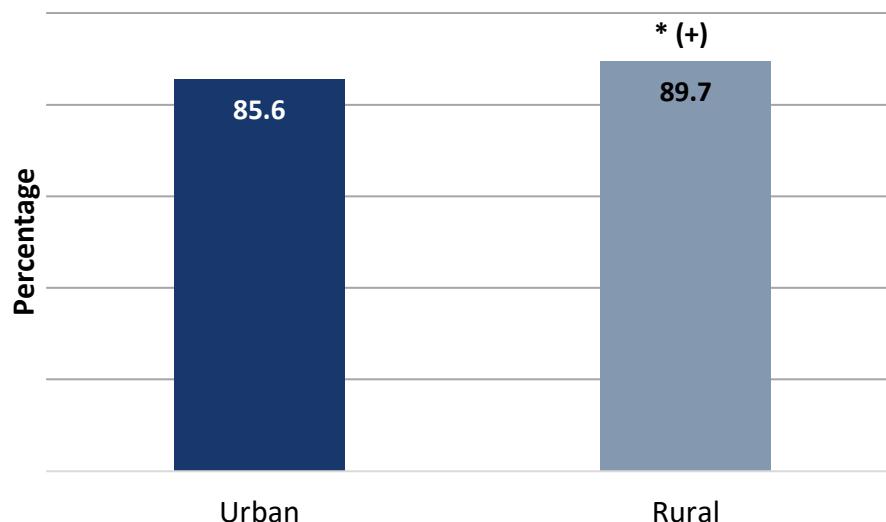
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Average morphine equivalent dose > 120 mg.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by geography, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of opioids from multiple prescribers was avoided more often for rural residents than for urban residents. The difference between rural and urban residents was greater than 3 percentage points.

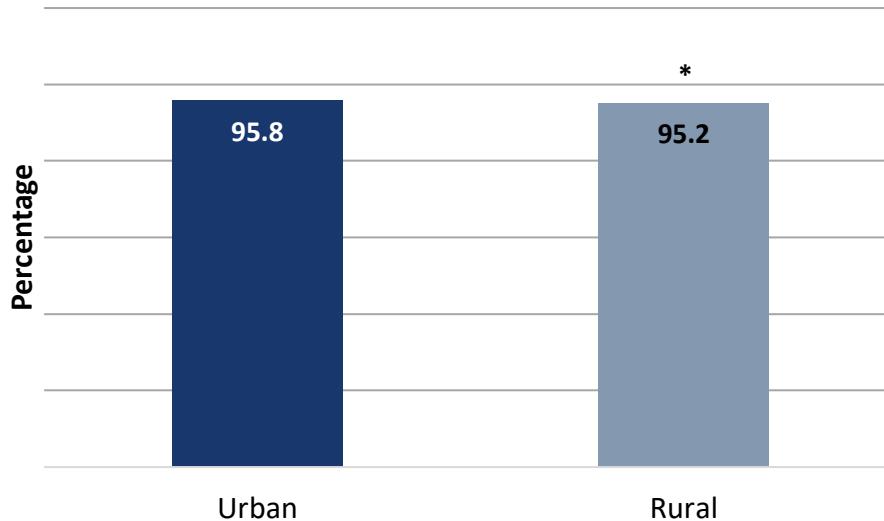
* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of opioids from multiple pharmacies was avoided less often for rural residents than for urban residents. The difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

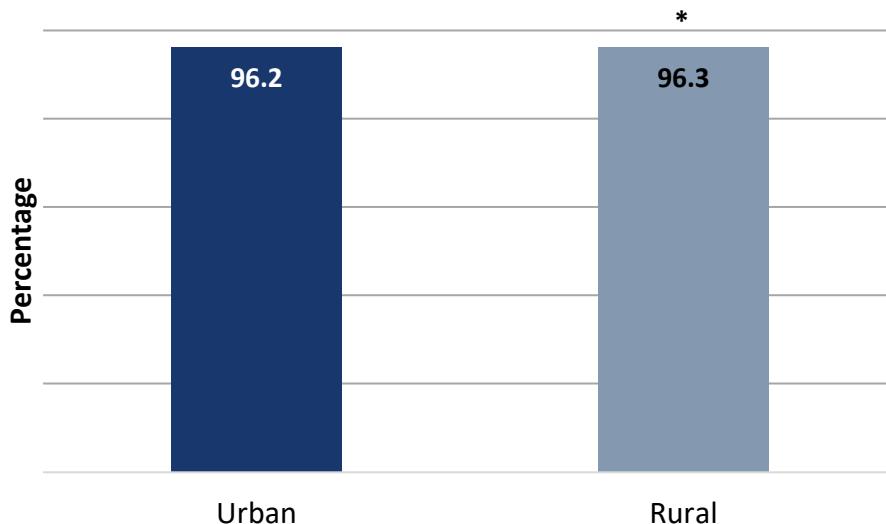
For differences that are statistically significant, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Access/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, 2019



SOURCE: Clinical quality data collected in 2019 from MA plans nationwide.

NOTE: Clinical quality data are not available for Medicare FFS beneficiaries.

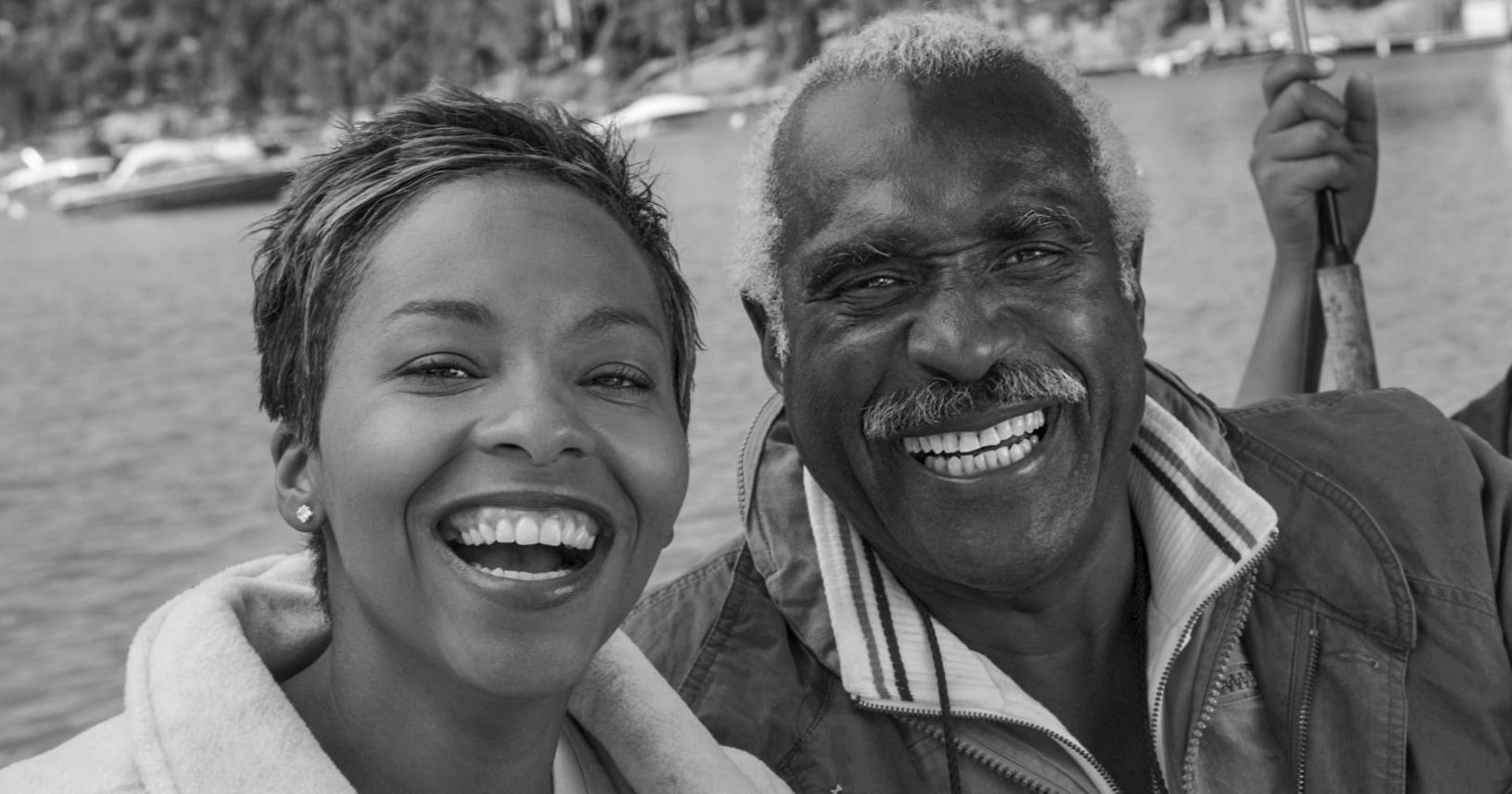
Disparities

- Rural older adults were more likely than urban older adults to have had an ambulatory or preventive care visit. The difference between rural and urban older adults was less than 3 percentage points.

* Significantly different from the score for urban residents ($p < 0.05$).

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

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

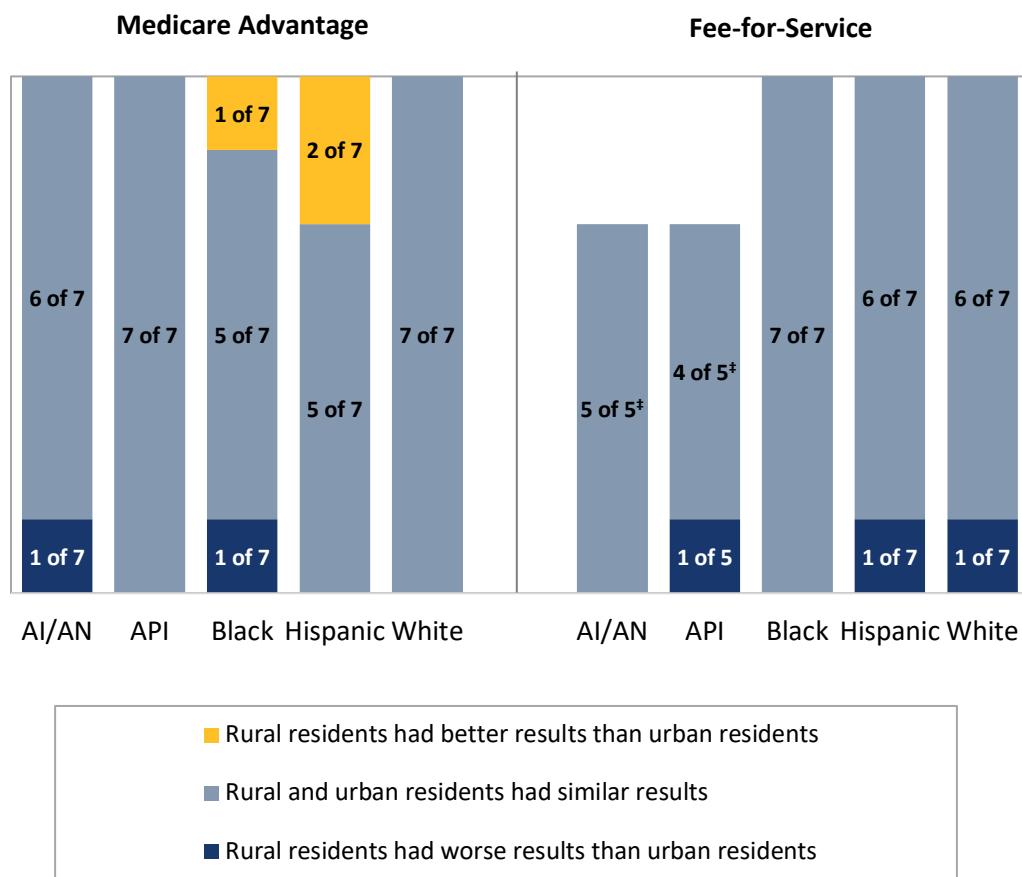


Section II: **Rural-Urban Disparities in Health Care in Medicare by Racial and Ethnic Group**



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

Number of patient experience measures for which rural AI/AN, API, Black, Hispanic, and White beneficiaries reported experiences that were worse than, similar to, or better than the experiences reported by urban AI/AN, API, Black, Hispanic, and White beneficiaries in 2019



SOURCE: This chart summarizes data from all FFS Medicare and MA beneficiaries nationwide who participated in the 2019 Medicare CAHPS survey.

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

[†] There were not enough data from AI/AN beneficiaries enrolled in FFS to make a rural-urban comparison on two patient experience measures.

[‡] There were not enough data from rural API beneficiaries enrolled in FFS to make rural-urban comparisons on two patient experience measures.

Rural AI/AN MA beneficiaries had worse results than urban AI/AN MA beneficiaries

- Care coordination

Rural Black MA beneficiaries had worse results than urban Black MA beneficiaries

- Annual flu vaccine

Rural Black MA beneficiaries had better results than urban Black MA beneficiaries

- Customer service

Rural Hispanic MA beneficiaries had better results than urban Hispanic MA beneficiaries

- Getting appointments and care quickly
- Getting needed prescription drugs

Rural API FFS beneficiaries had worse results than urban API FFS beneficiaries

- Annual flu vaccine

Rural Hispanic FFS beneficiaries had worse results than urban Hispanic FFS beneficiaries

- Annual flu vaccine

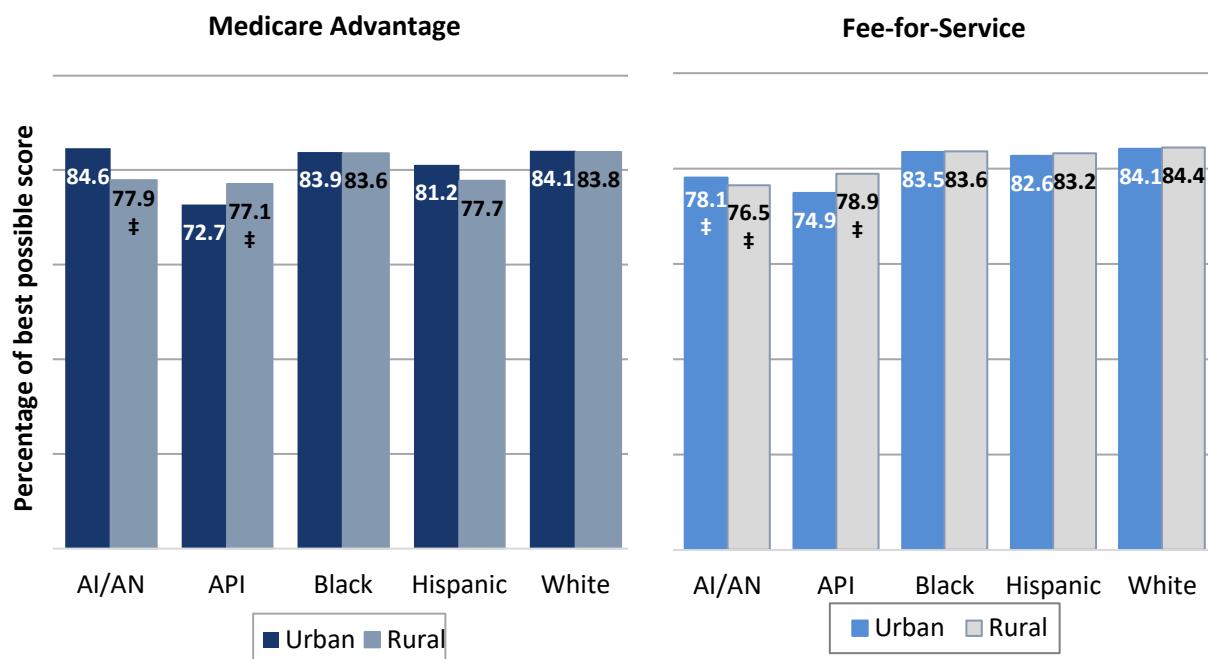
Rural White FFS beneficiaries had worse results than urban White FFS beneficiaries

- 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 racial and ethnic group, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

Disparities

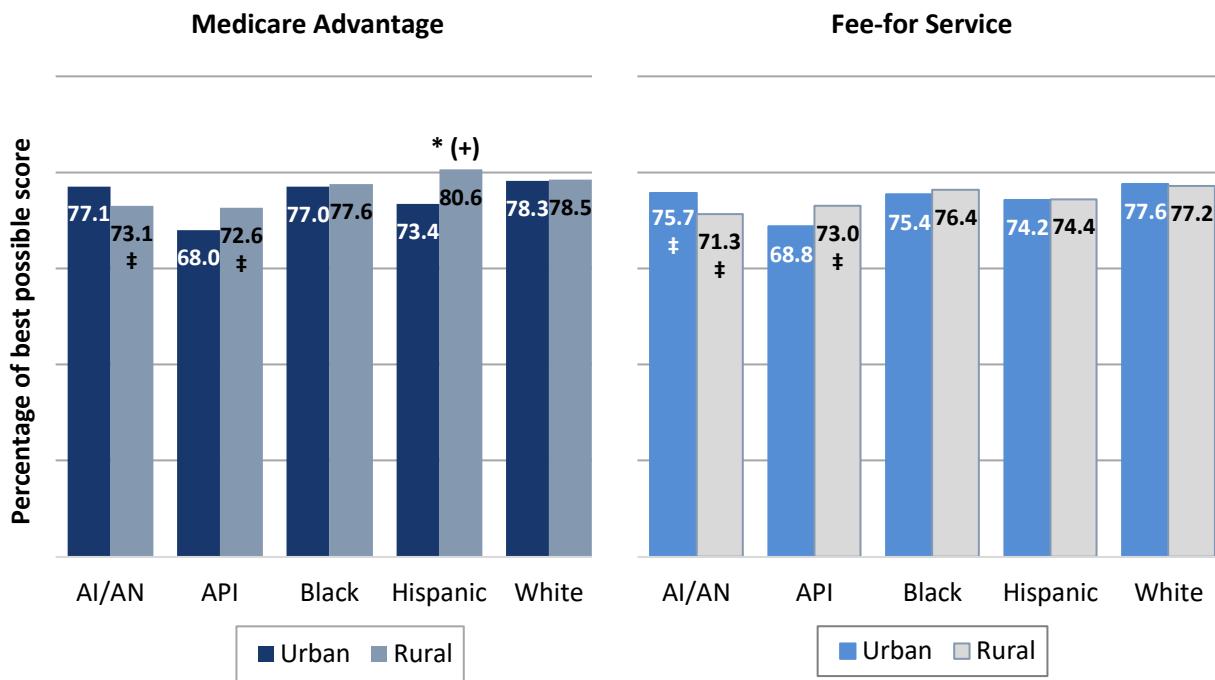
- In both MA and FFS, AI/AN beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by AI/AN beneficiaries residing in urban areas.
- In both MA and FFS, API beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by API beneficiaries residing in urban areas.
- In both MA and FFS, Black beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by Black beneficiaries residing in urban areas.
- In both MA and FFS, Hispanic beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by Hispanic beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by White beneficiaries residing in urban areas.

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

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,[†] by geography within racial and ethnic group, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

Disparities

- In both MA and FFS, AI/AN beneficiaries residing in rural areas reported experiences getting appointments and care quickly that were similar to the experiences reported by AI/AN beneficiaries residing in urban areas.
- In both MA and FFS, API beneficiaries residing in rural areas reported experiences getting appointments and care quickly that were similar to the experiences reported by API beneficiaries residing in urban areas.
- In both MA and FFS, Black beneficiaries residing in rural areas reported experiences getting appointments and care quickly that were similar to the experiences reported by Black beneficiaries residing in urban areas.
- Hispanic MA beneficiaries residing in rural areas reported better[‡] experiences getting appointments and care quickly than Hispanic MA beneficiaries residing in urban areas. The difference between rural and urban Hispanic MA beneficiaries was greater than 3 points on a 0–100 scale. Hispanic FFS beneficiaries residing in rural areas reported experiences getting appointments and care quickly that were similar to the experiences reported by Hispanic FFS beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences getting appointments and care quickly that were similar to the experiences reported by White beneficiaries residing in urban areas.

* Significantly different from the score for urban residents of the same racial and ethnic group and coverage type ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity and coverage type, the following symbols are also used when applicable:

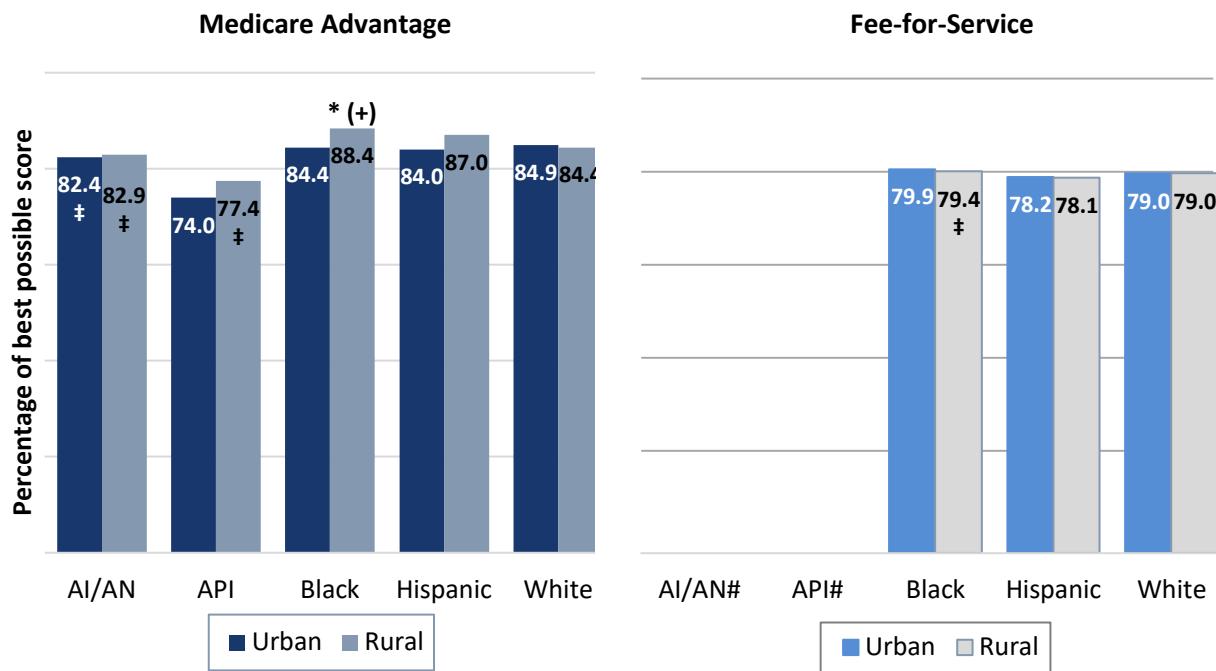
- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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.

[‡] Unlike on pages 56–57, we use the terms “better” or “worse” to describe all statistically significant differences on individual patient experience measures. We note in the “Disparities” section for each of these measures where differences are greater or less than 3 points.

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, 2019**



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

* There were not enough data from AI/AN FFS beneficiaries or API FFS beneficiaries to make rural-urban comparisons on this measure.

Disparities

- AI/AN MA beneficiaries residing in rural areas reported experiences with customer service that were similar to the experiences reported by AI/AN MA beneficiaries residing in urban areas.
- API MA beneficiaries residing in rural areas reported experiences with customer service that were similar to the experiences reported by API MA beneficiaries residing in urban areas.
- Black MA beneficiaries residing in rural areas reported better experiences with customer service than Black MA beneficiaries residing in urban areas. The difference between rural and urban Black MA beneficiaries was greater than 3 points on a 0–100 scale. Black FFS beneficiaries residing in rural areas reported experiences with customer service that were similar to the experiences reported by Black FFS beneficiaries residing in urban areas.
- In both MA and FFS, Hispanic beneficiaries residing in rural areas reported experiences with customer service that were similar to the experiences reported by Hispanic beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences with customer service that were similar to the experiences reported by White beneficiaries residing in urban areas.

* Significantly different from the score for urban residents of the same racial and ethnic group and coverage type ($p < 0.05$).

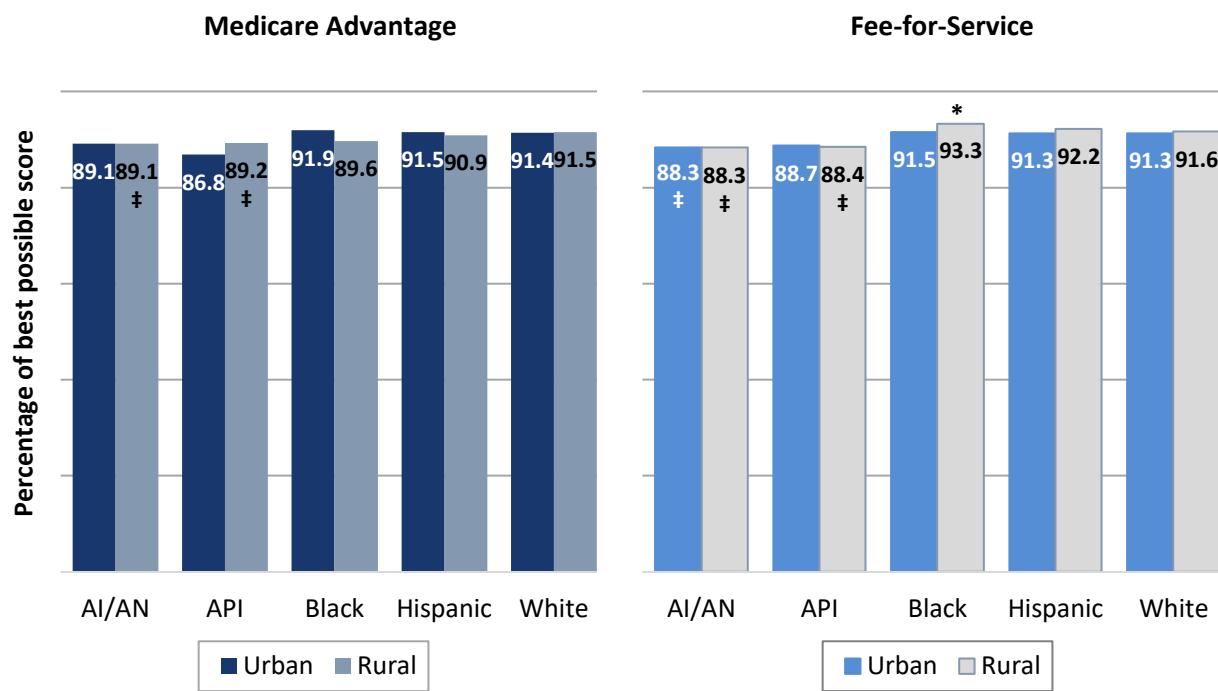
For statistically significant differences between rural and urban residents of the same race or ethnicity and coverage type, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] This includes how often in the last six months health plan customer service staff provided the information or help that beneficiaries needed, how often beneficiaries 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 racial and ethnic group, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

Disparities

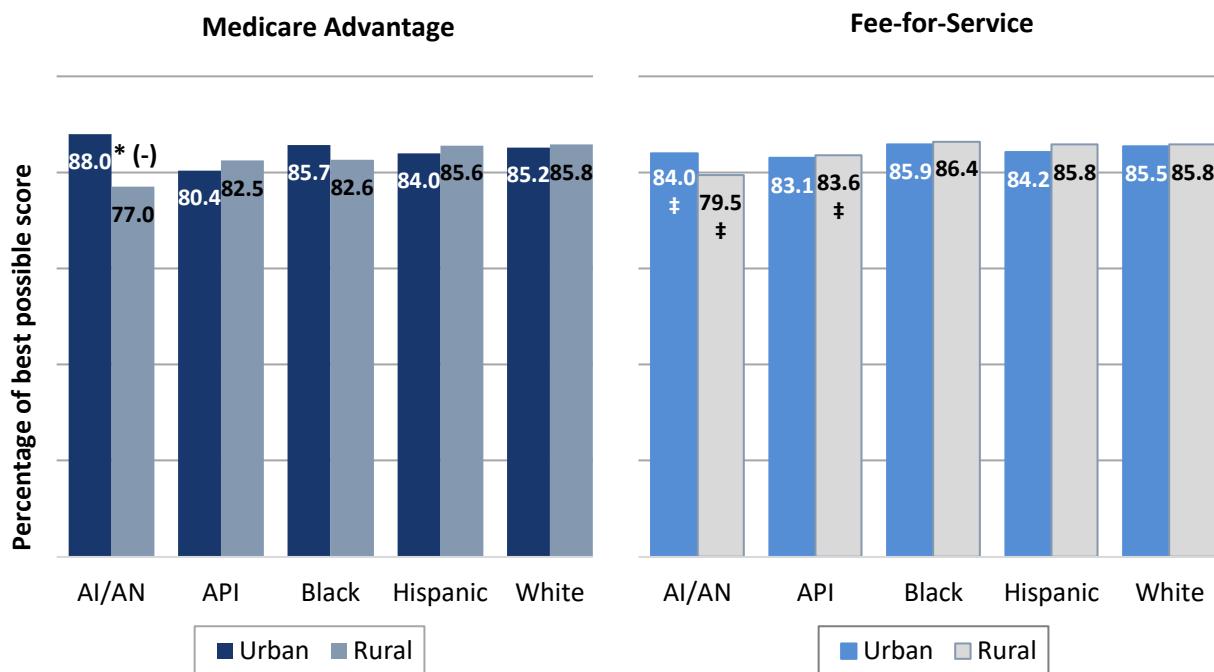
- In both MA and FFS, AI/AN beneficiaries residing in rural areas reported experiences with doctor communication that were similar to the experiences reported by AI/AN beneficiaries residing in urban areas.
- In both MA and FFS, API beneficiaries residing in rural areas reported experiences with doctor communication that were similar to the experiences reported by API beneficiaries residing in urban areas.
- Black MA beneficiaries residing in rural areas reported experiences with doctor communication that were similar to the experiences reported by Black MA beneficiaries residing in urban areas. Black FFS beneficiaries residing in rural areas reported better experiences with doctor communication than Black FFS beneficiaries residing in urban areas. The difference between rural and urban Black FFS beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, Hispanic beneficiaries residing in rural areas reported experiences with doctor communication that were similar to the experiences reported by Hispanic beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences with doctor communication that were similar to the experiences reported by White beneficiaries residing in urban areas.

[†] 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 patient care was coordinated,[†] by geography within racial and ethnic group, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

^{*} This score is based on fewer than 400 completed measures, and thus its precision may be low.

Disparities

- AI/AN MA beneficiaries residing in rural areas reported worse experiences with care coordination than AI/AN MA beneficiaries residing in urban areas. The difference between rural and urban AI/AN MA beneficiaries was greater than 3 points on a 0–100 scale. AI/AN FFS beneficiaries residing in rural areas reported experiences with care coordination that were similar to the experiences reported by AI/AN FFS beneficiaries residing in urban areas.
- In both MA and FFS, API beneficiaries residing in rural areas reported experiences with care coordination that were similar to the experiences reported by API beneficiaries residing in urban areas.
- In both MA and FFS, Black beneficiaries residing in rural areas reported experiences with care coordination that were similar to the experiences reported by Black beneficiaries residing in urban areas.
- In both MA and FFS, Hispanic beneficiaries residing in rural areas reported experiences with care coordination that were similar to the experiences reported by Black beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences with care coordination that were similar to the experiences reported by White beneficiaries residing in urban areas.

* Significantly different from the score for urban residents of the same racial and ethnic group and coverage type ($p < 0.05$).

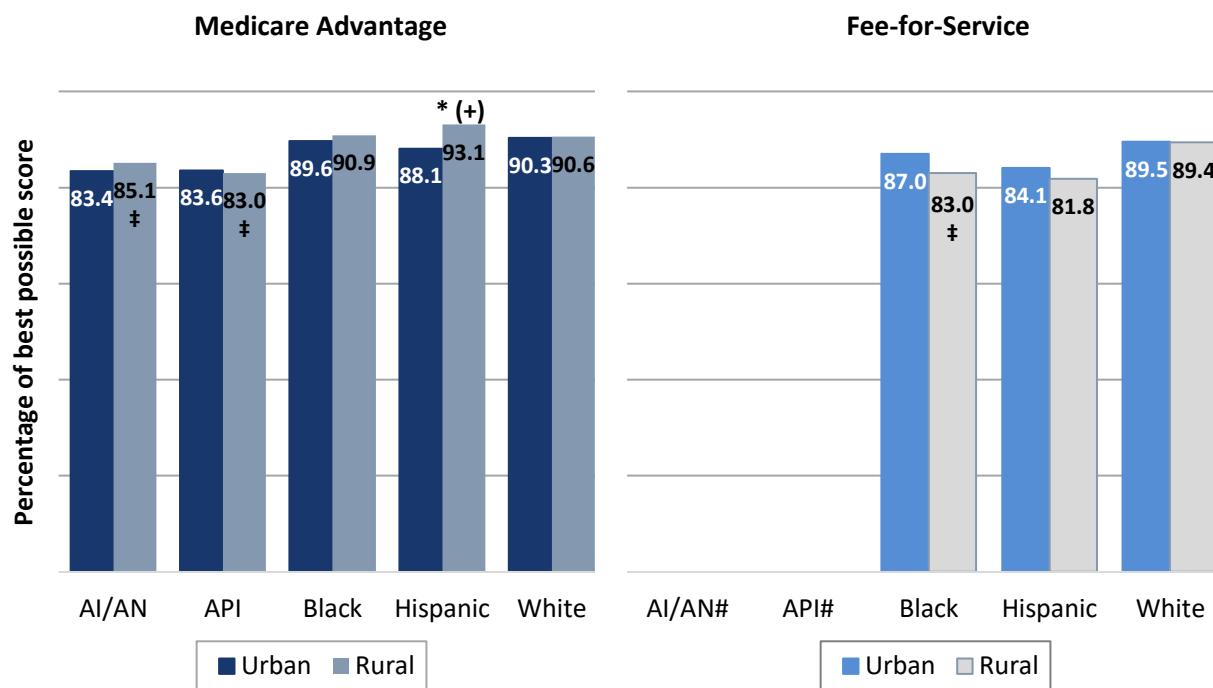
For statistically significant differences between rural and urban residents of the same race or ethnicity and coverage type, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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 beneficiaries to get the prescription drugs they need using their plans,[†] by geography within racial and ethnic group, 2019



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

There were not enough data from AI/AN FFS beneficiaries or API FFS beneficiaries to make rural-urban comparisons on this measure.

Disparities

- AI/AN MA beneficiaries residing in rural areas reported experiences getting needed prescription drugs that were similar to the experiences reported by AI/AN MA beneficiaries residing in urban areas.
- API MA beneficiaries residing in rural areas reported experiences getting needed prescription drugs that were similar to the experiences reported by API MA beneficiaries residing in urban areas.
- In both MA and FFS, Black beneficiaries residing in rural areas reported experiences getting needed prescription drugs that were similar to the experiences reported by Black beneficiaries residing in urban areas.
- Hispanic MA beneficiaries residing in rural areas reported better experiences getting needed prescription drugs than Hispanic beneficiaries residing in urban areas. The difference between rural and urban Hispanic MA beneficiaries was greater than 3 points on a 0–100 scale. Hispanic FFS beneficiaries residing in rural areas reported experiences getting needed

prescription drugs that were similar to the experiences reported by Hispanic FFS beneficiaries residing in urban areas.

- In both MA and FFS, White beneficiaries residing in rural areas reported experiences getting needed prescription drugs that were similar to the experiences reported by White beneficiaries residing in urban areas.

* Significantly different from the score for urban residents of the same racial and ethnic group and coverage type ($p < 0.05$).

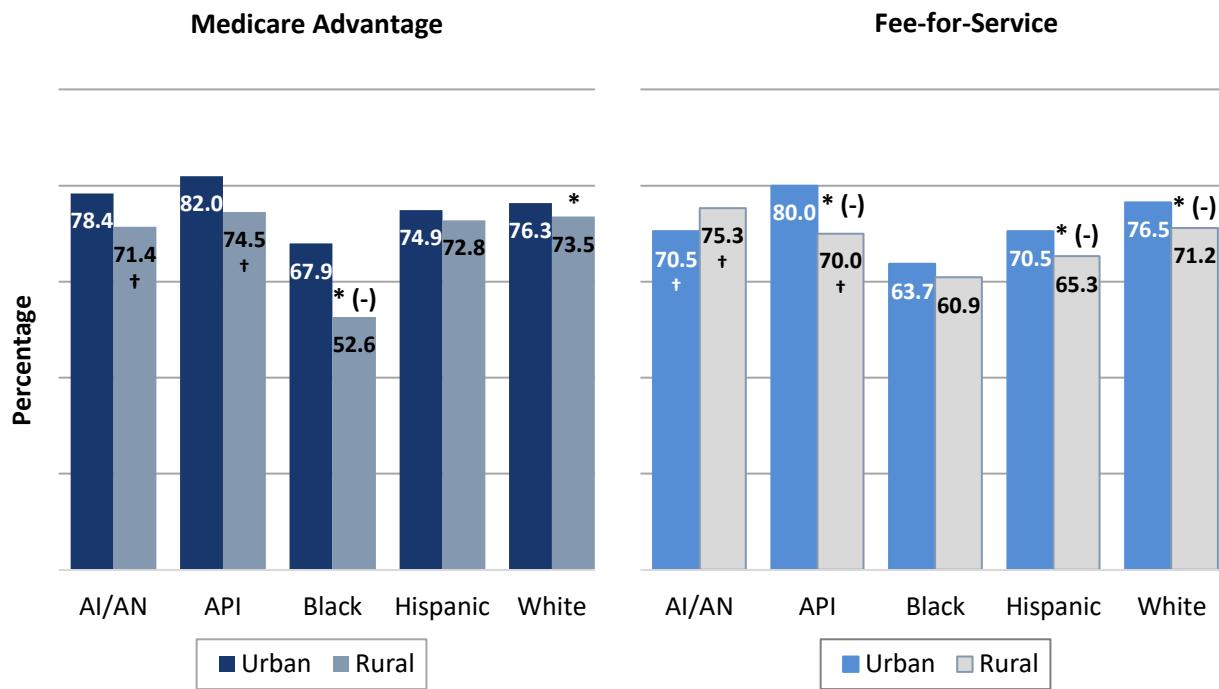
For statistically significant differences between rural and urban residents of the same race or ethnicity and coverage type, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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 Medicare enrollees who got a vaccine (flu shot), by geography
within racial and ethnic group, 2019**



SOURCE: Data from the Medicare CAHPS survey, 2019.

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

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

Disparities

- In both MA and FFS, AI/AN beneficiaries residing in rural areas were about as likely as AI/AN beneficiaries residing in urban areas to have received the flu vaccine.
- API MA beneficiaries residing in rural areas were about as likely as API MA beneficiaries residing in urban areas to have received the flu vaccine. API FFS beneficiaries residing in rural areas were less likely than API FFS beneficiaries residing in urban areas to have received the flu vaccine. The difference between rural and urban API FFS beneficiaries was greater than 3 percentage points.
- Black MA beneficiaries residing in rural areas were less likely than Black MA beneficiaries residing in urban areas to have received the flu vaccine. The difference between rural and urban Black MA beneficiaries was greater than 3 percentage points. Black FFS beneficiaries residing in rural areas were about as likely as Black FFS beneficiaries residing in urban areas to have received the flu vaccine.
- Hispanic MA beneficiaries residing in rural areas were about as likely as Hispanic MA beneficiaries residing in urban areas to have received the flu vaccine. Hispanic FFS beneficiaries residing in rural areas were less likely than Hispanic FFS beneficiaries residing in urban areas to have received the flu vaccine.

urban areas to have received the flu vaccine. The difference between rural and urban Hispanic FFS beneficiaries was greater than 3 percentage points.

- In both MA and FFS, White beneficiaries residing in rural areas were less likely than White beneficiaries residing in urban areas to have received the flu vaccine. In MA, the difference between rural and urban White beneficiaries was less than 3 percentage points. In FFS, the difference between rural and urban White beneficiaries was greater than 3 percentage points.

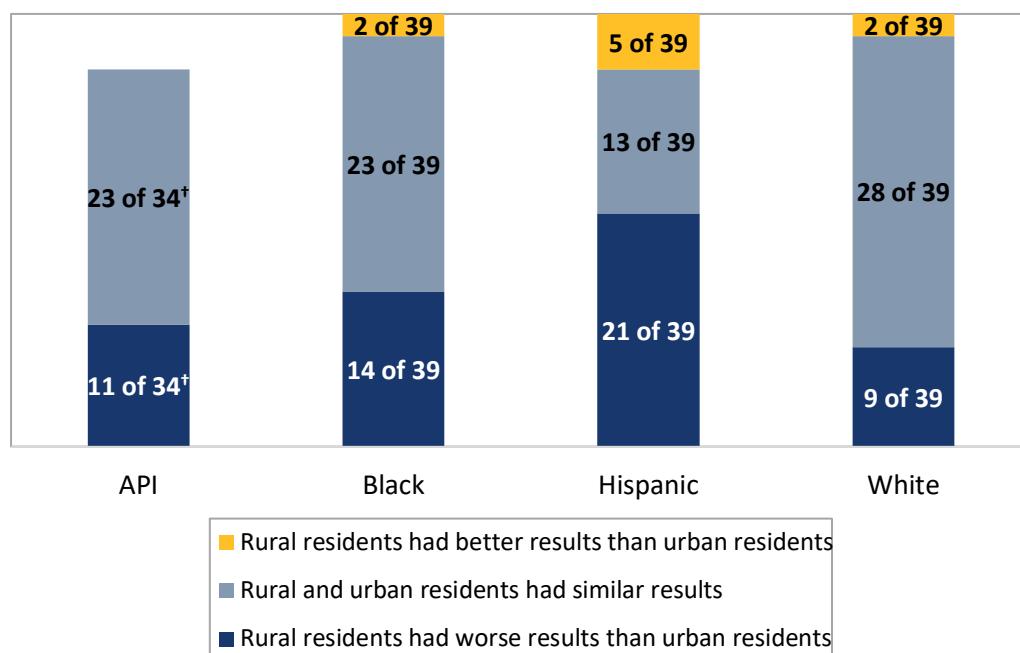
* Significantly different from the score for urban residents of the same racial and ethnic group and coverage type ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity and coverage type, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Number of clinical care measures for which rural Asian and Pacific Islander (API), Black, Hispanic, and White MA beneficiaries had results that were worse than, similar to, or better than results for urban API, Black, Hispanic, and White MA beneficiaries in 2019



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

[†] There were only enough data from rural API beneficiaries to make rural-urban comparisons on 34 of the 39 clinical care measures.

Within each racial or ethnic group, the relative difference between rural and urban residents is used to assess disparities.

- **Better** = Rural residents had better results than urban residents. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points[‡] on a 0–100 scale, and favor rural residents.
- **Similar** = Rural and urban residents had similar results. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Rural residents had worse results than urban residents. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor urban residents.

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

Rural API beneficiaries had worse results than urban API beneficiaries

- Breast cancer screening
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Controlling high blood pressure
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Medication adherence for diabetes—statins
- Antidepressant medication management—acute phase treatment
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls

Rural Black beneficiaries had worse results than urban Black beneficiaries

- Testing to confirm COPD
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroid
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Diabetes care—blood pressure controlled
- Osteoporosis management in women who had a fracture
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence (within 30 days of discharge)
- Initiation of alcohol and other drug dependence treatment
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of high-risk medication in the elderly

Rural Black beneficiaries had better results than urban Black beneficiaries

- Avoiding use of opioids from multiple prescribers
- Avoiding use of opioids from multiple pharmacies

Rural Hispanic beneficiaries had worse results than urban Hispanic beneficiaries

- Testing to confirm COPD
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroid
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Continuous beta-blocker treatment after a heart attack
- Medication adherence for cardiovascular disease—statins
- Diabetes care—blood sugar testing
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Medication adherence for diabetes—statins
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol and other drug dependence treatment
- Medication reconciliation after hospital discharge
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Transitions of care—patient engagement after inpatient discharge
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of opioids from multiple pharmacies

Rural Hispanic beneficiaries had better results than urban Hispanic beneficiaries

- Colorectal cancer screening
- Controlling high blood pressure
- Osteoporosis management in women who had a fracture
- Follow-up after hospital stay for mental illness (within 30 days of discharge)
- Avoiding use of opioids from multiple prescribers

Rural White beneficiaries had worse results than urban White beneficiaries

- Breast cancer screening
- Testing to confirm COPD
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Osteoporosis management in women who had a fracture
- Follow-up after emergency department visit for mental illness (within 30 days of 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

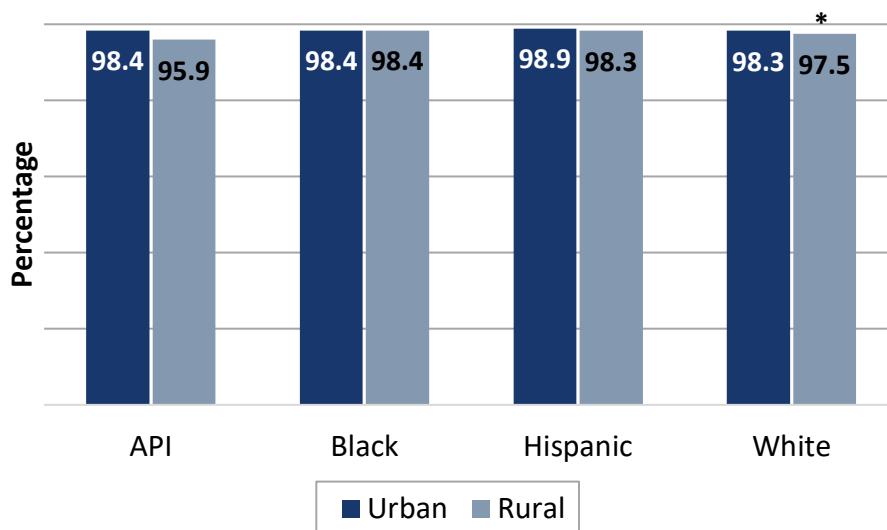
Rural White beneficiaries had better results than urban White beneficiaries

- Initiation of alcohol and other drug dependence treatment
- Avoiding use of opioids from multiple prescribers

Clinical Care: Prevention and Screening

Adult BMI Assessment

Percentage of MA enrollees aged 18 to 74 years who had an outpatient visit whose body mass index (BMI) was documented in the past two years, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and Hispanic beneficiaries, rural residents were about as likely as urban residents to have had their BMIs documented.
- Among White beneficiaries, rural residents were less likely than urban residents to have had their BMIs documented. The difference between rural and urban White residents was less than 3 percentage points.

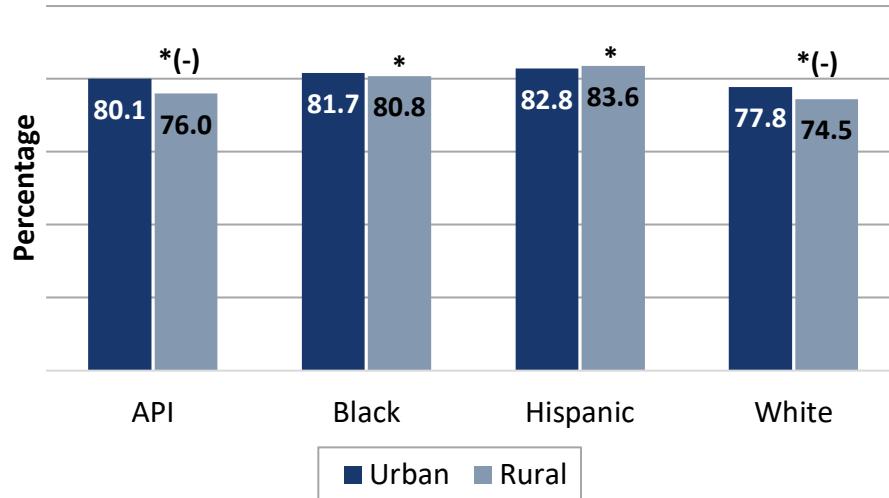
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Breast Cancer Screening

Percentage of MA enrollees (women) aged 50 to 74 years who had appropriate screening for breast cancer, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and White women, rural residents were less likely than urban residents to have been appropriately screened for breast cancer. The difference between rural and urban API women was greater than 3 percentage points, as was the difference between rural and urban White women. The difference between rural and urban Black women was less than 3 percentage points.
- Among Hispanic women, rural residents were more likely than urban residents to have been appropriately screened for breast cancer. The difference between rural and urban Hispanic women was less than 3 percentage points.

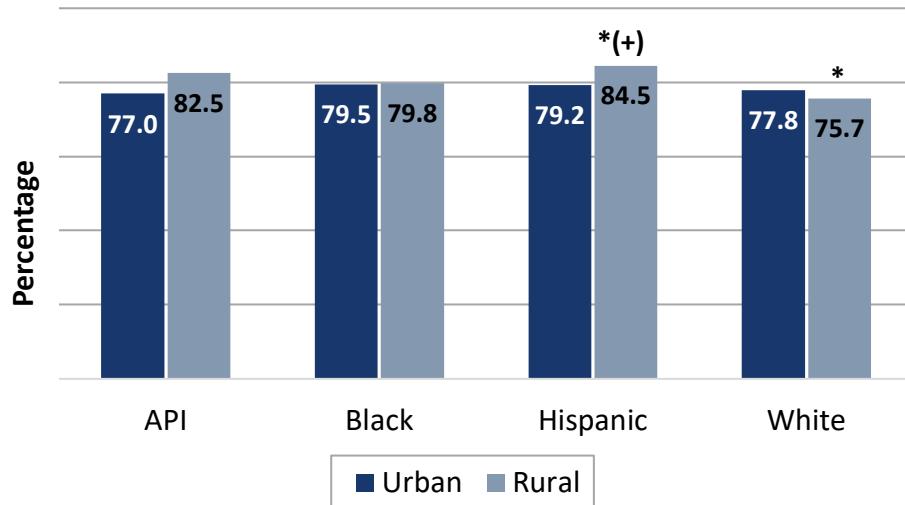
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API and Black beneficiaries, rural residents were about as likely as urban residents to have been appropriately screened for colorectal cancer.
- Among Hispanic beneficiaries, rural residents were more likely than urban residents to have been appropriately screened for colorectal cancer. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.
- Among White beneficiaries, rural residents were less likely than urban residents to have been appropriately screened for colorectal cancer. The difference between rural and urban White beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

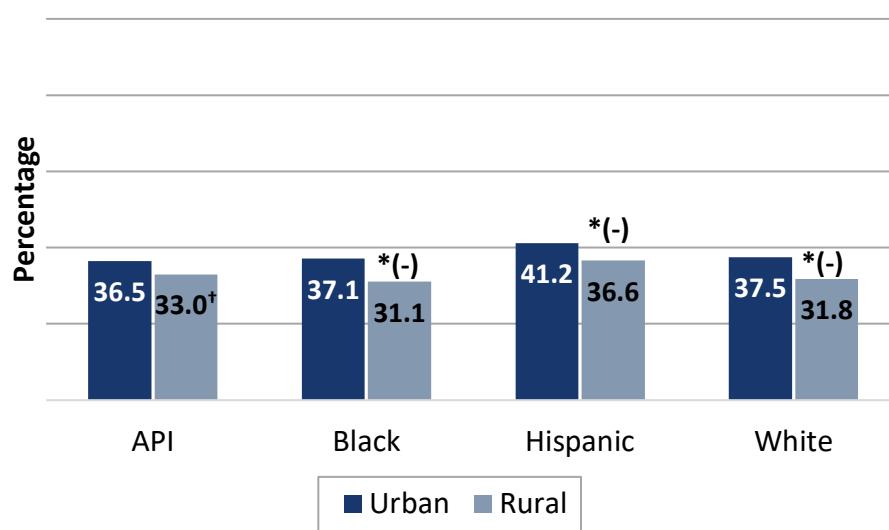
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Among API beneficiaries, rural residents with a new diagnosis of COPD or newly active COPD were about as likely as urban residents with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis.
- Among Black, Hispanic, and White beneficiaries, rural residents with a new diagnosis of COPD or newly active COPD were less likely than urban residents with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. For each of these racial and ethnic groups, the difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

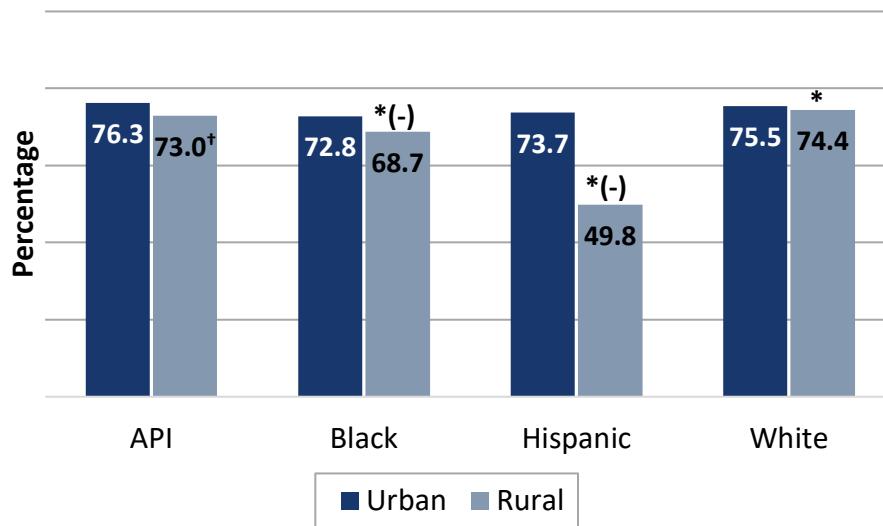
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: 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 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,

2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

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

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

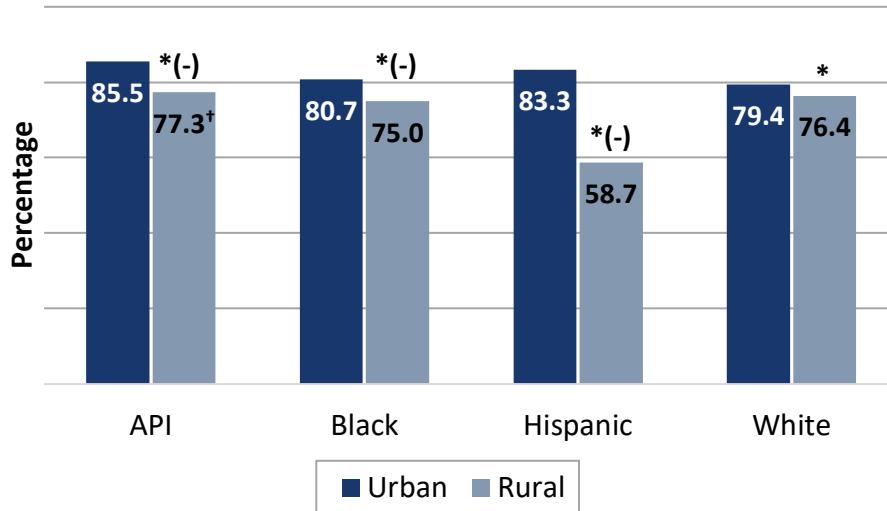
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Among API, Black, Hispanic, and White beneficiaries, rural residents who experienced a COPD exacerbation were less likely than urban residents who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. For API, Black, and Hispanic beneficiaries, the difference between rural and urban residents was greater than 3 percentage points. For White beneficiaries, the difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

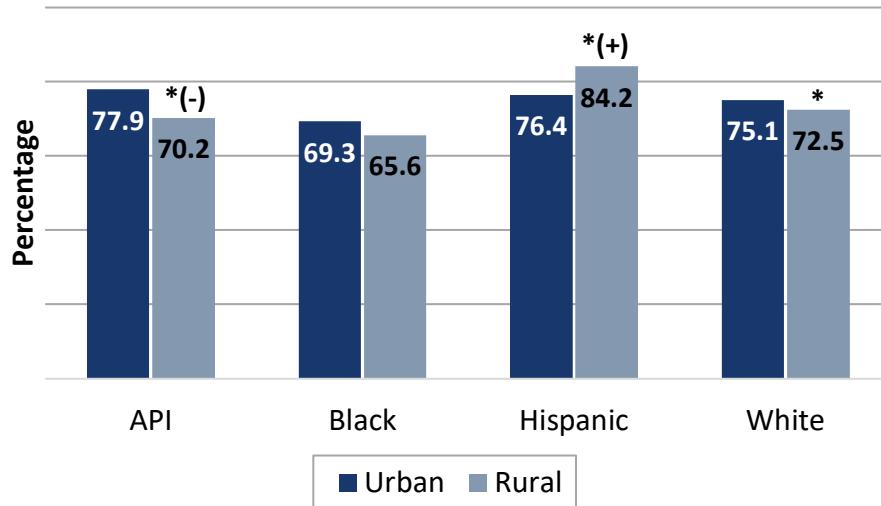
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API and White beneficiaries, rural residents with a diagnosis of hypertension were less likely than urban residents with a diagnosis of hypertension to have had their blood pressure adequately controlled. For API beneficiaries, the difference between rural and urban residents was greater than 3 percentage points. For White beneficiaries, the difference between rural and urban residents was less than 3 percentage points.
- Among Black beneficiaries, rural residents with a diagnosis of hypertension were about as likely as urban residents with a diagnosis of hypertension to have had their blood pressure adequately controlled.
- Among Hispanic beneficiaries, rural residents with a diagnosis of hypertension were more likely than urban residents with a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

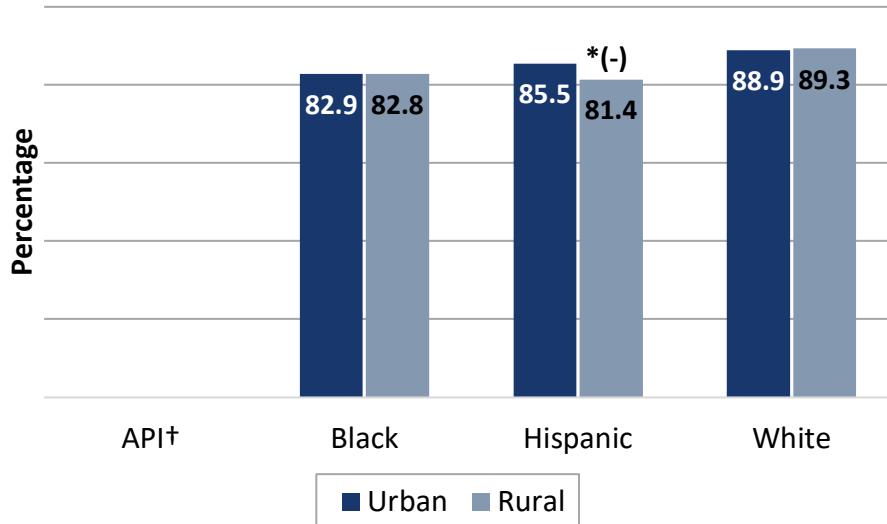
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Continuous Beta-Blocker Treatment

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (AMI) who received persistent beta-blocker treatment for six months after discharge, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

† There were not enough data from API beneficiaries to make a rural-urban comparison on this measure.

Disparities

- Among Black and White beneficiaries, rural residents who were hospitalized for a heart attack were about as likely as urban residents who were hospitalized for a heart attack to have received persistent beta-blocker treatment.
- Among Hispanic beneficiaries, rural residents who were hospitalized for a heart attack were less likely than urban residents who were hospitalized for a heart attack to have received persistent beta-blocker treatment. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.

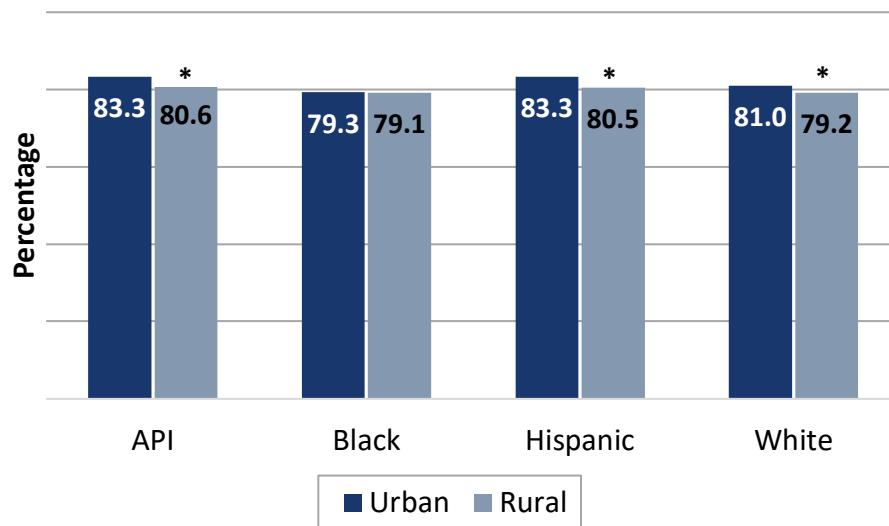
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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 within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Hispanic, and White beneficiaries, rural residents with ASCVD were less likely than urban residents with ASCVD to have received statin therapy. For each of these racial and ethnic groups, the difference between rural and urban residents was less than 3 percentage points.
- Rural Black beneficiaries with ASCVD were about as likely as urban Black beneficiaries with ASCVD to have received statin therapy.

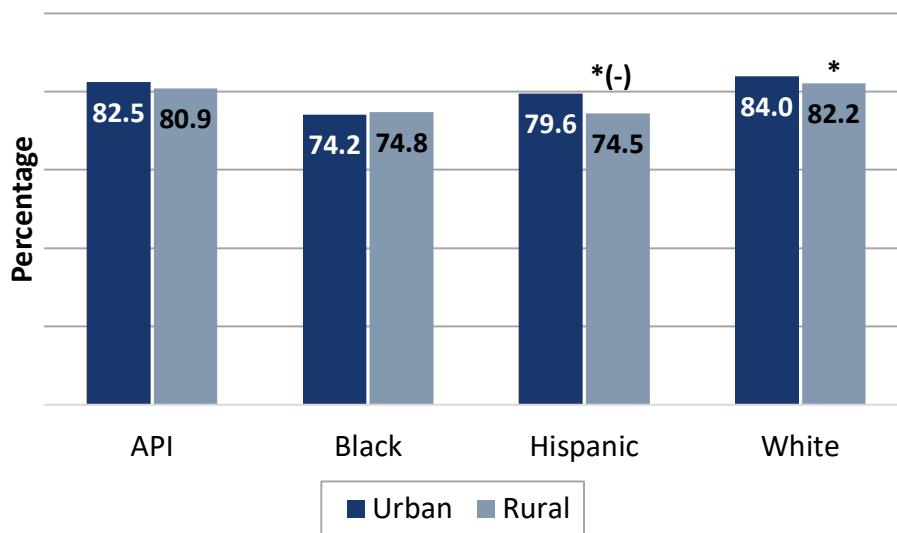
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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 atherosclerotic cardiovascular disease (ASCVD) who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API and Black beneficiaries, rural residents with ASCVD were about as likely as urban residents with ASCVD to have had proper statin medication adherence.
- Among Hispanic and White beneficiaries, rural residents with ASCVD were less likely than urban residents with ASCVD to have had proper statin medication adherence. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points. The difference between rural and urban White beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

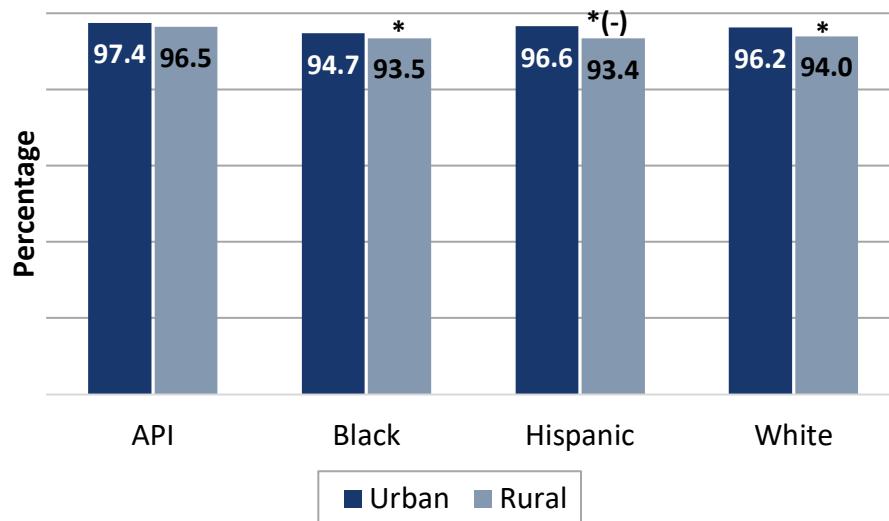
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of Medicare Advantage 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, rural residents with diabetes were about as likely as urban residents with diabetes to have had their blood sugar tested at least once in the past year.
- Among Black, Hispanic, and White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have had their blood sugar tested at least once in the past year. The difference between rural and urban Black beneficiaries was less than 3 percentage points, as was the difference between rural and urban White beneficiaries. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

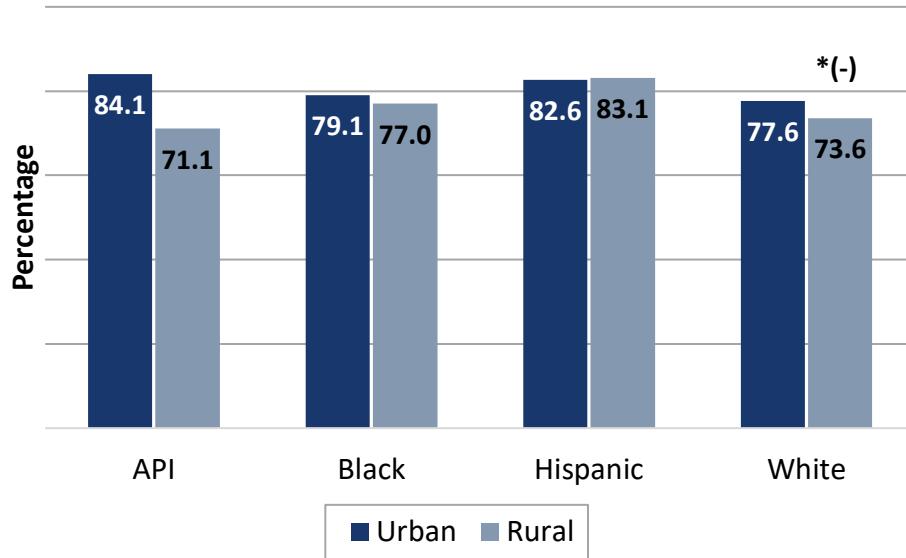
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

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

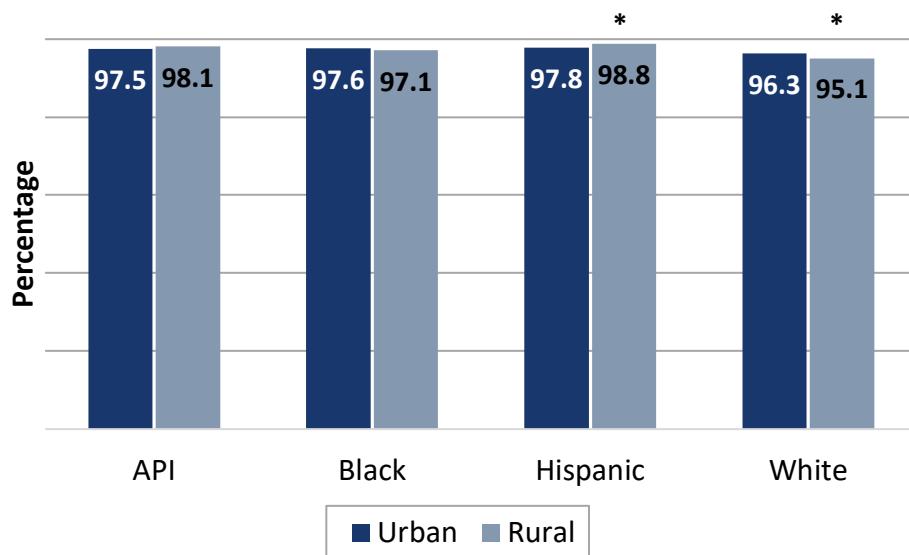
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API and Black beneficiaries, rural residents with diabetes were about as likely as urban residents with diabetes to have had medical attention for nephropathy in the past year.
- Among Hispanic beneficiaries, rural residents with diabetes were more likely than urban residents with diabetes to have had medical attention for nephropathy in the past year. The difference between rural and urban Hispanic beneficiaries was less than 3 percentage points.
- Among White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have had medical attention for nephropathy in the past year. The difference between rural and urban White beneficiaries was less than 3 percentage points.

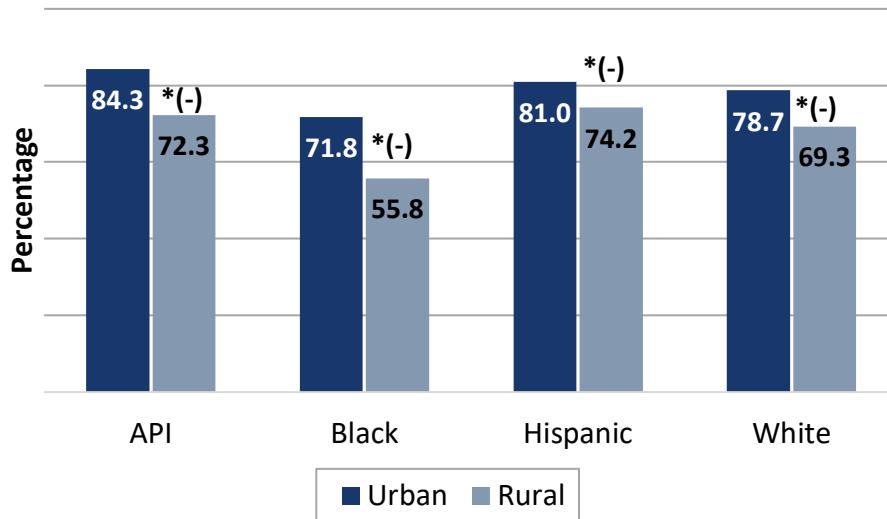
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have their blood pressure under control. For each of these racial and ethnic groups, the difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

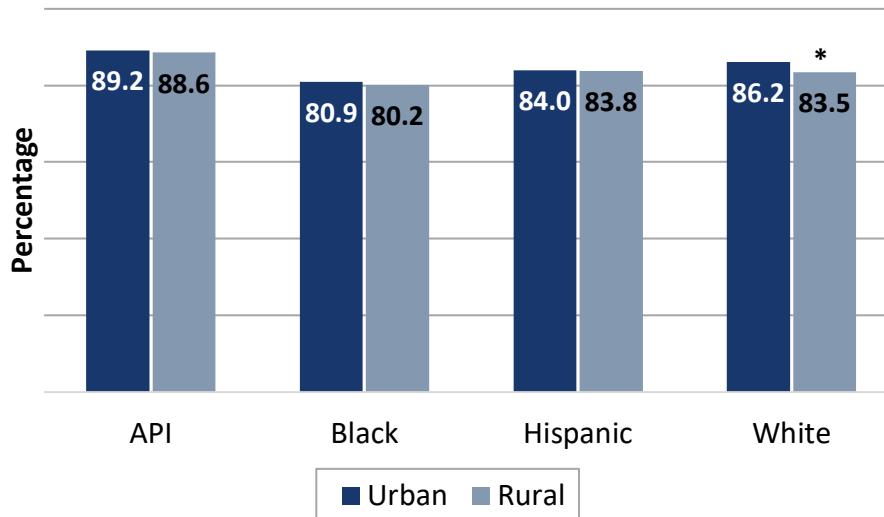
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and Hispanic beneficiaries, rural residents with diabetes were about as likely as urban residents with diabetes to have their blood sugar levels under control.
- Among White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have their blood sugar levels under control. The difference between rural and urban White beneficiaries was less than 3 percentage points.

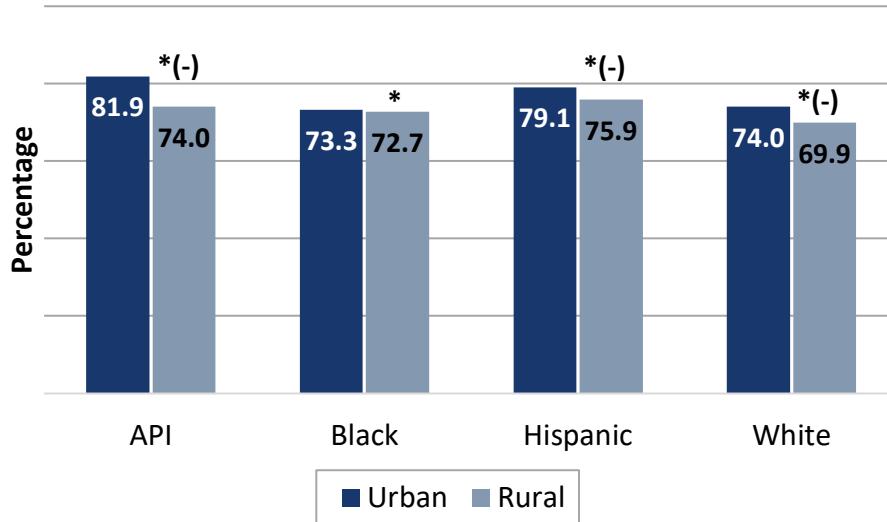
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have received statin therapy. The difference between rural and urban API beneficiaries was greater than 3 percentage points, as were the differences between rural and urban Hispanic beneficiaries and rural and urban White beneficiaries. The difference between rural and urban Black beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

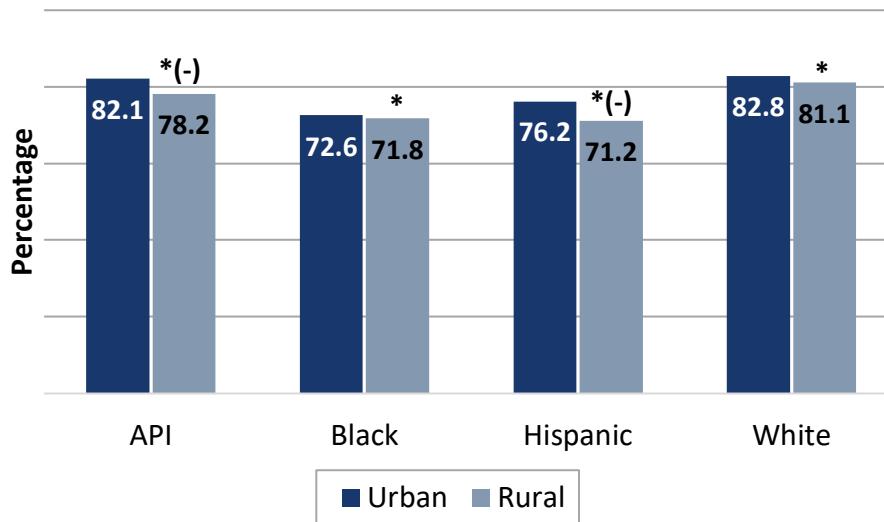
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, rural residents with diabetes were less likely than urban residents with diabetes to have had proper statin medication adherence. The difference between rural and urban API beneficiaries was greater than 3 percentage points, as was the difference between rural and urban Hispanic beneficiaries. The difference between rural and urban Black beneficiaries was less than 3 percentage points, as was the difference between rural and urban White beneficiaries.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

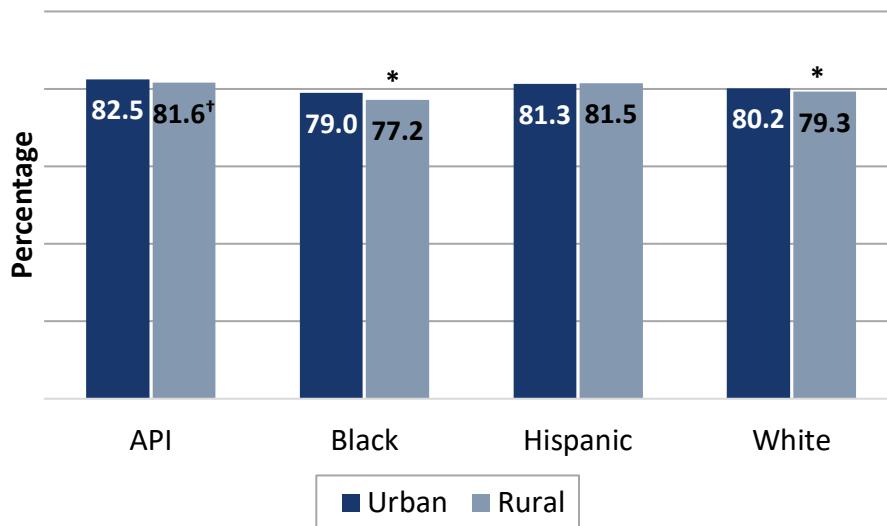
(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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 within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Among API and Hispanic beneficiaries, rural residents diagnosed with rheumatoid arthritis were about as likely as urban residents diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.
- Among Black and White beneficiaries, rural residents diagnosed with rheumatoid arthritis were less likely than urban residents diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. In each case, the difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

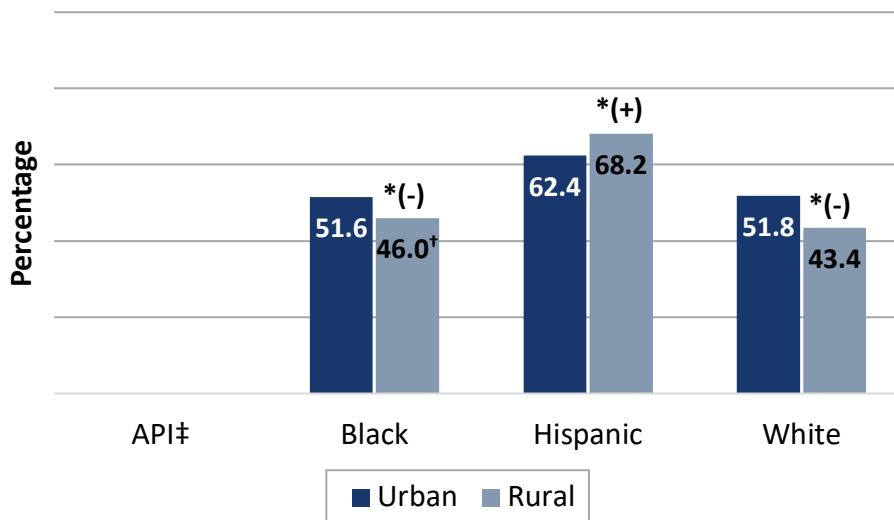
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Osteoporosis Management in Women Who Had a Fracture

Percentage of MA enrollees (women) 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[‡] There were not enough data from API beneficiaries to make a rural-urban comparison on this measure.

Disparities

- Among Black and White women, rural residents who suffered a fracture were less likely than urban residents who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between rural and urban Black women was greater than 3 percentage points, as was the difference between rural and urban White women.
- Rural Hispanic women who suffered a fracture were more likely than urban Hispanic women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between rural and urban Hispanic women was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

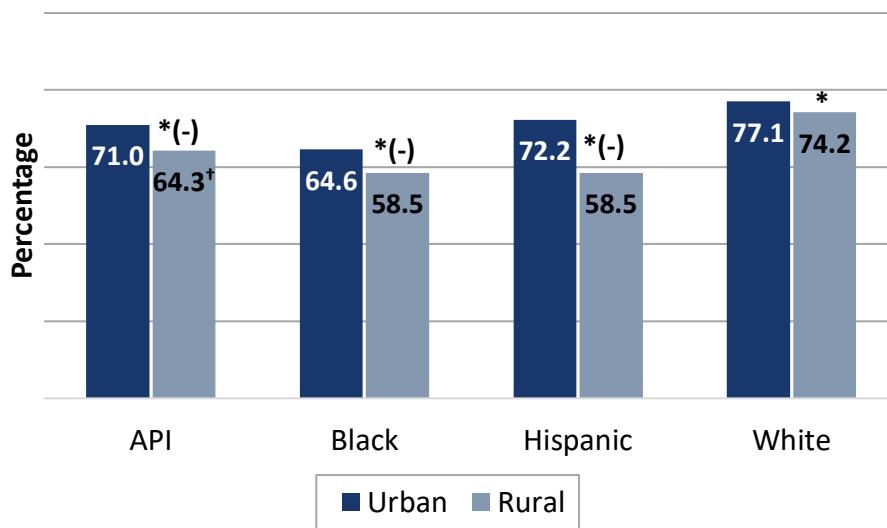
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

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

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

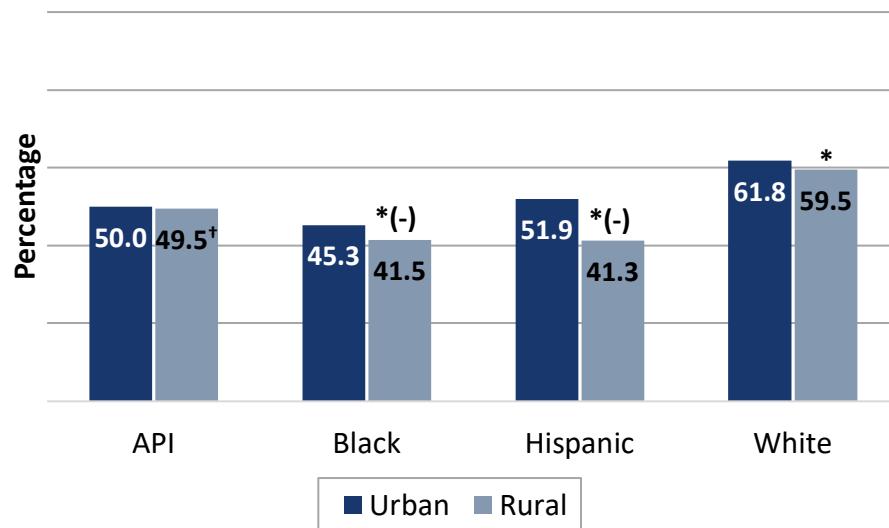
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

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

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

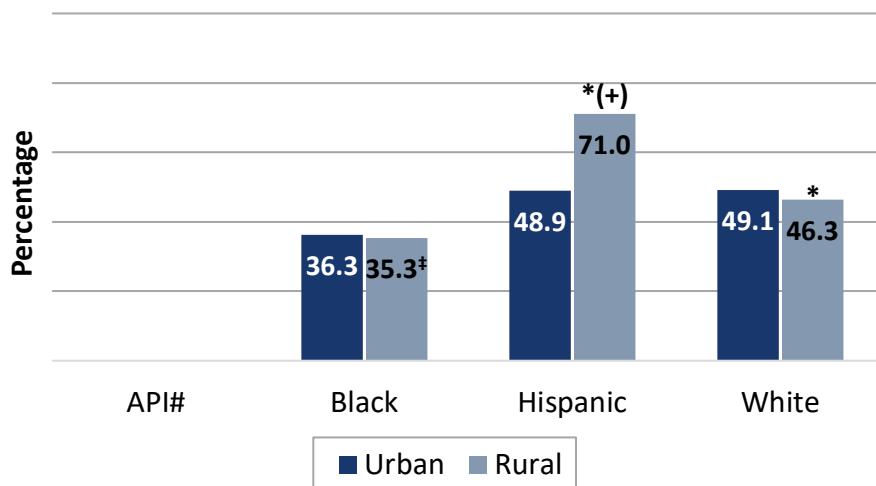
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[#] There were not enough data from API beneficiaries to make a rural-urban comparison on this measure.

Disparities

- Among Black beneficiaries, rural residents who were hospitalized for a mental health disorder were about as likely as urban residents who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge.
- Among Hispanic beneficiaries, rural residents who were hospitalized for a mental health disorder were more likely than urban residents who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.
- Among White beneficiaries, rural residents who were hospitalized for a mental health disorder were less likely than urban residents who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. The difference between rural and urban White beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

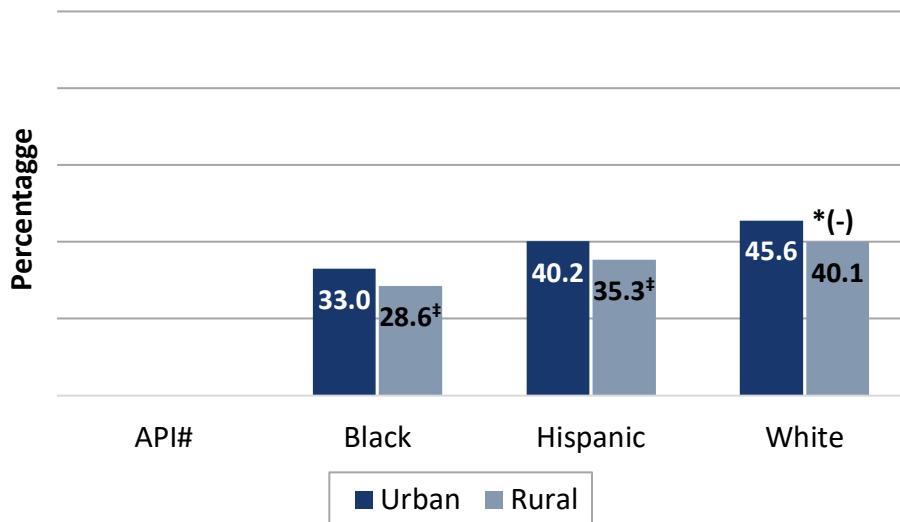
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[#] There were not enough data from API beneficiaries to make a rural-urban comparison on this measure.

Disparities

- Among Black and Hispanic beneficiaries, rural residents who had an ED visit for a mental health disorder were about as likely as urban residents who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit.
- Among White beneficiaries, rural residents who had an ED visit for a mental health disorder were less likely than urban residents who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. The difference between rural and urban White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

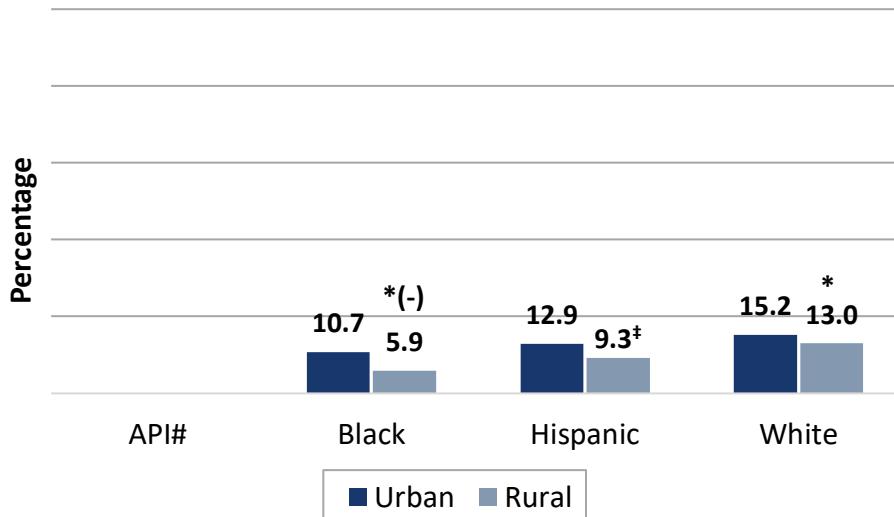
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Follow-up After Emergency Department (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 within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[‡] There were not enough data from API beneficiaries to make a rural-urban comparison on this measure.

Disparities

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

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

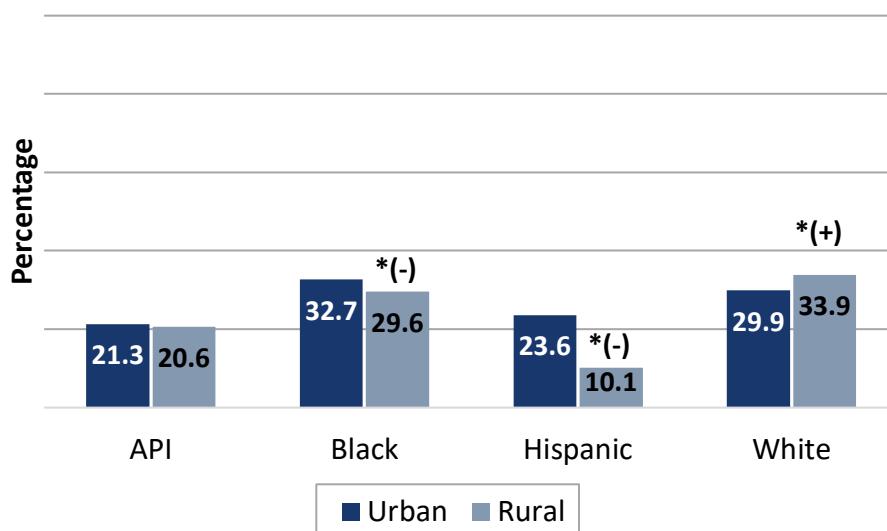
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Initiation of Alcohol and Other Drug Dependence (AOD) Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiate[‡] treatment within 14 days of the diagnosis, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, rural residents with a new episode of AOD dependence were about as likely as urban residents with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis.
- Among Black and Hispanic beneficiaries, rural residents with a new episode of AOD dependence were less likely than urban residents with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. In each case, the difference between rural and urban residents was greater than 3 percentage points.
- Among White beneficiaries, rural residents with a new episode of AOD dependence were more likely than urban residents with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. The difference between rural and urban White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

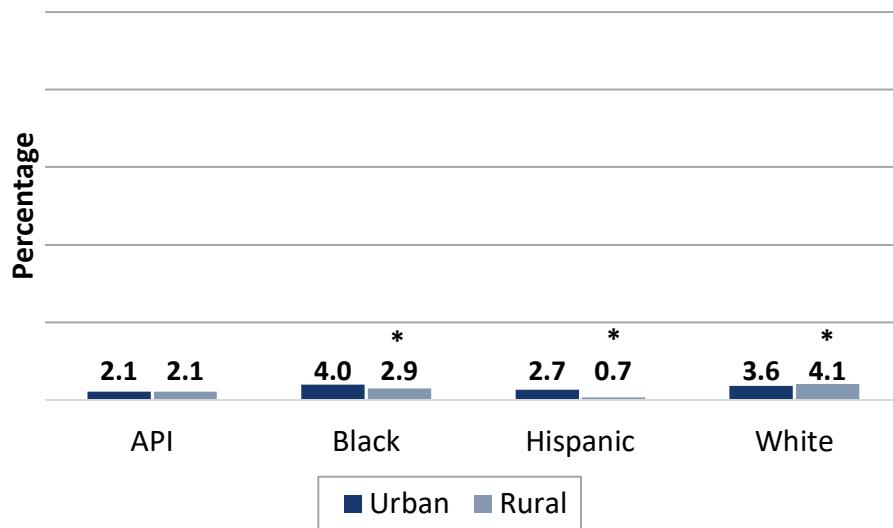
(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

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

Engagement of Alcohol and Other Drug Dependence (AOD) 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 AOD services or medication-assisted treatments within 30 days of the initiation visit, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, rural residents with a new episode of AOD dependence who initiated treatment were about as likely as urban residents with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment.
- Among Black and Hispanic beneficiaries, rural residents with a new episode of AOD dependence who initiated treatment were less likely than urban residents with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. In each case, the difference between rural and urban residents was less than 3 percentage points.
- Among White beneficiaries, rural residents with a new episode of AOD dependence who initiated treatment were more likely than urban residents with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. The difference between rural and urban White beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

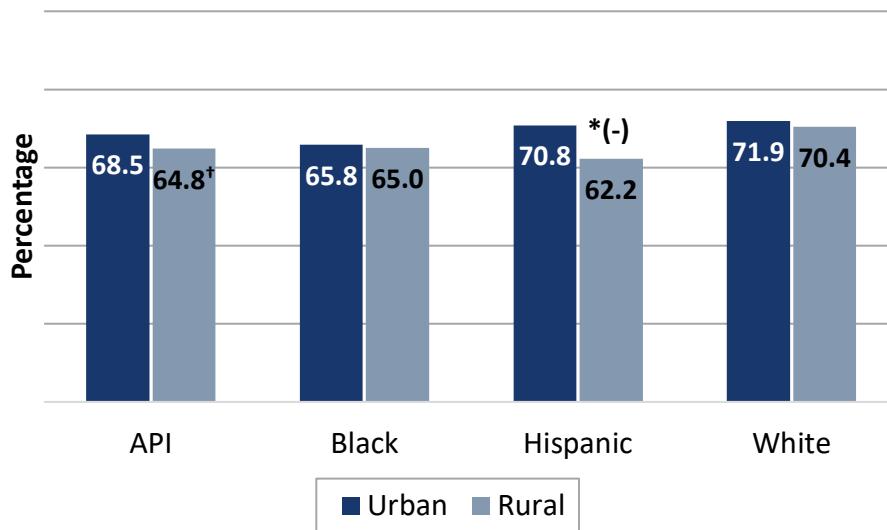
(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Clinical Care: Medication Management and Care Coordination

Medication Reconciliation After Hospital Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and White beneficiaries, rural residents who were discharged from an inpatient facility were about as likely as urban residents who were discharged from an inpatient facility to have had their medications reconciled within 30 days.
- Among Hispanic beneficiaries, rural residents who were discharged from an inpatient facility were less likely than urban residents who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

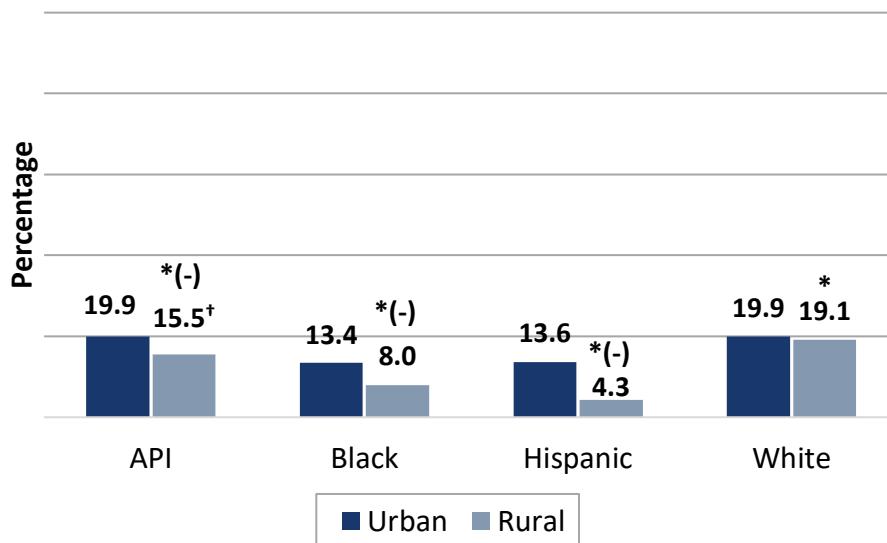
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Among API, Black, Hispanic, and White beneficiaries, the primary or ongoing care providers of rural residents who were discharged from an inpatient facility were less likely than the primary or ongoing care providers of urban residents who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. For API, Black, and Hispanic beneficiaries, the difference was greater than 3 percentage points. For White beneficiaries, the difference was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

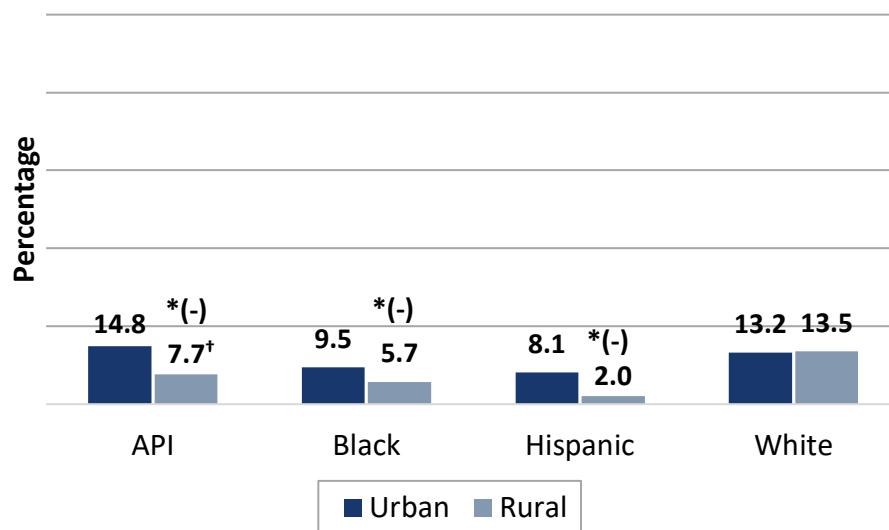
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Among API, Black, and Hispanic beneficiaries, rural residents who were discharged from an inpatient facility were less likely than urban residents who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. For each of these racial and ethnic groups, the difference between rural and urban residents was greater than 3 percentage points.
- Rural White beneficiaries who were discharged from an inpatient facility were about as likely as urban White beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge.

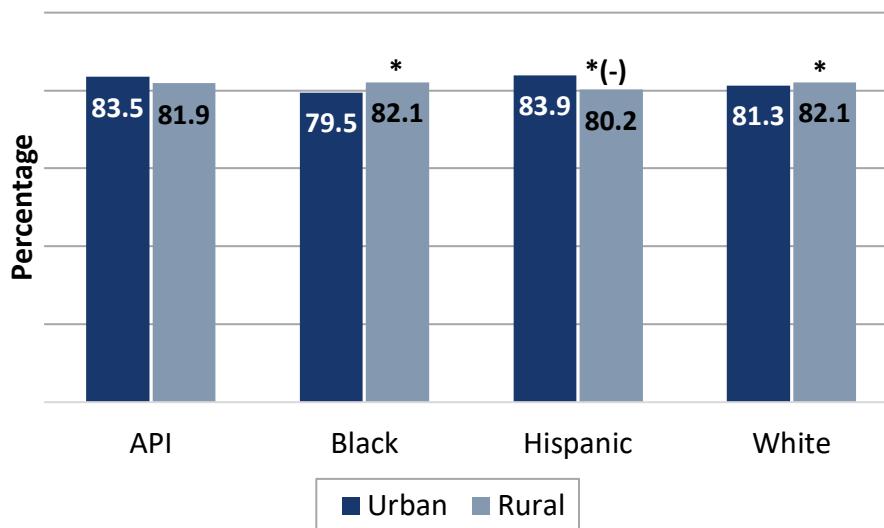
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

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

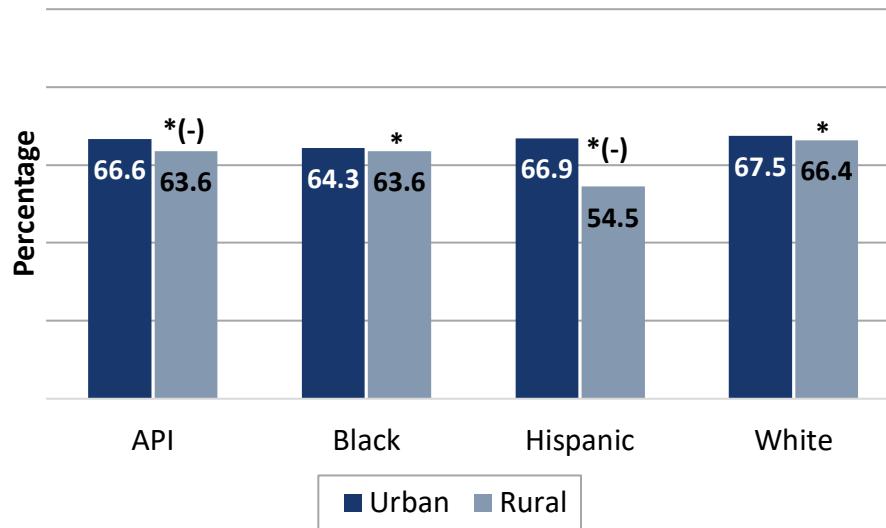
* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, rural residents with multiple high-risk chronic conditions were less likely than urban residents with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit. The difference between rural and urban API beneficiaries was greater than 3 percentage points, as was the difference between rural and urban Hispanic beneficiaries. The difference between rural and urban Black beneficiaries was less than 3 percentage points, as was the difference between rural and urban White beneficiaries.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

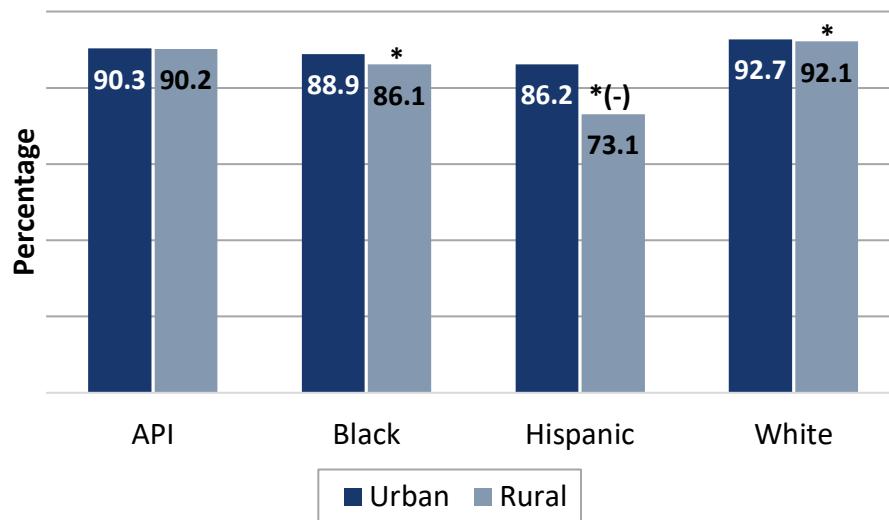
(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Clinical Care: Overuse/Appropriateness

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, use of potentially harmful medication was avoided about as often for elderly rural residents with chronic renal failure as for elderly urban residents with chronic renal failure.
- Among Black, Hispanic, and White beneficiaries, use of potentially harmful medication was avoided less often for elderly rural residents with chronic renal failure than for elderly urban residents with chronic renal failure. The difference between elderly rural and urban Black beneficiaries was less than 3 percentage points, as was the difference between rural and urban elderly White beneficiaries. The difference between rural and urban elderly Hispanic beneficiaries was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

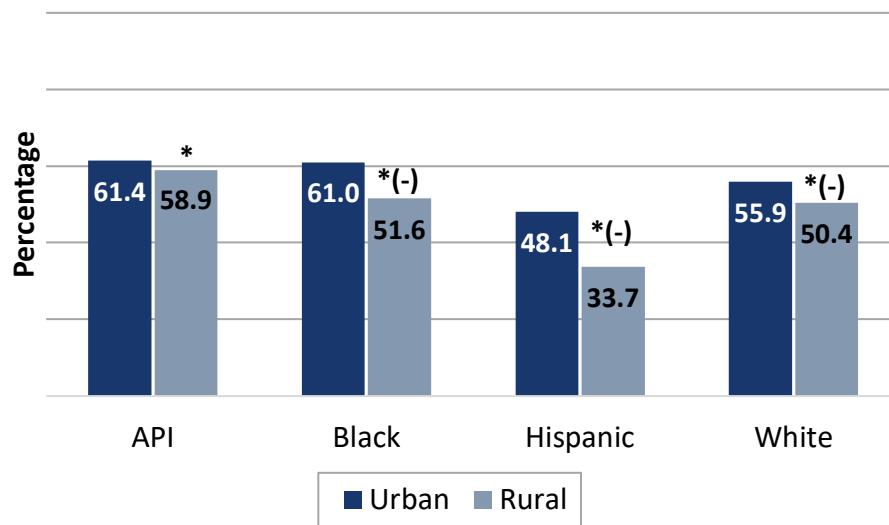
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) and 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 within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, use of potentially harmful medication was avoided less often for elderly rural residents with dementia than for elderly urban residents with dementia. The difference between elderly rural API beneficiaries and elderly urban API beneficiaries was less than 3 percentage points. The difference between elderly rural and urban Black beneficiaries was greater than 3 percentage points, as were the differences between elderly rural and urban Hispanic beneficiaries and elderly rural and urban White beneficiaries.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

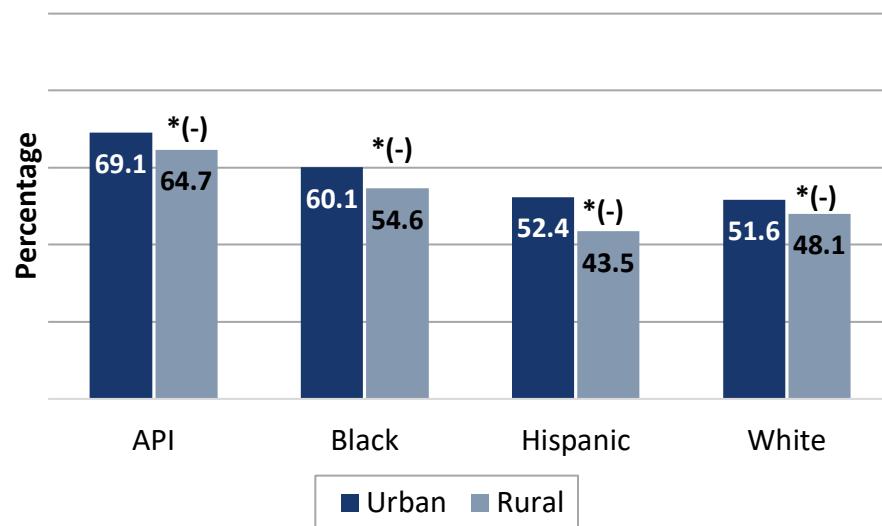
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] 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 within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, Hispanic, and White beneficiaries, use of potentially harmful medication was avoided less often for elderly rural residents with a history of falls than for elderly urban residents with a history of falls. For each of these racial and ethnic groups, the difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

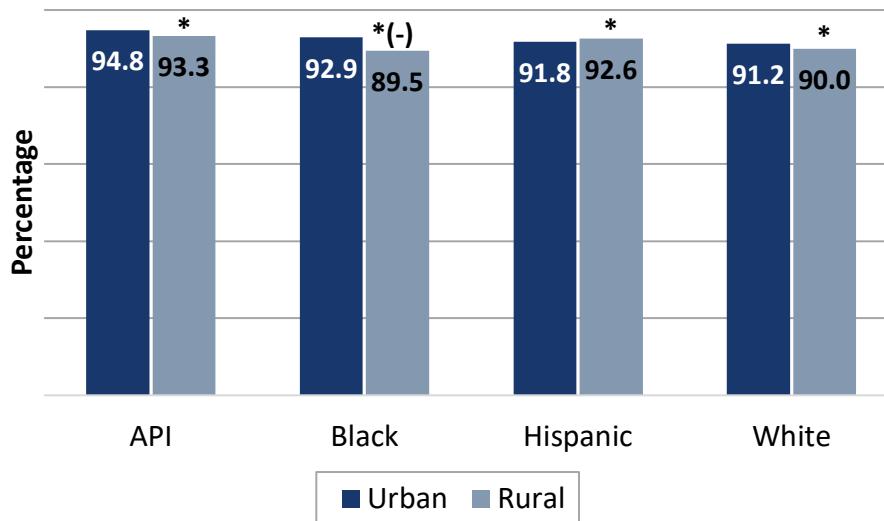
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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

Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA enrollees aged 65 years and older who were not prescribed a high-risk medication, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and White beneficiaries, use of high-risk medication was avoided less often for elderly rural residents than for elderly urban residents. The difference between elderly rural and urban API beneficiaries was less than 3 percentage points, as was the difference between elderly rural and urban White beneficiaries. The difference between elderly rural and urban Black beneficiaries was greater than 3 percentage points.
- Among Hispanic beneficiaries, use of high-risk medication was avoided more often for elderly rural residents than for elderly urban residents. The difference between elderly rural and urban Hispanic beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

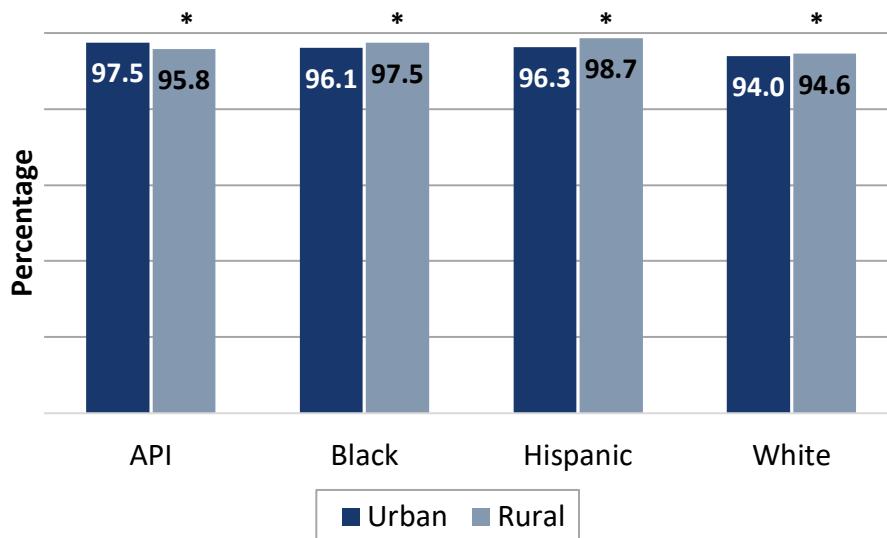
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage[†] for more than 14 days, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, use of opioids at a high dosage for more than 14 days was avoided less often for rural residents than for urban residents. The difference between rural and urban API beneficiaries was less than 3 percentage points.
- Among Black, Hispanic, and White beneficiaries, use of opioids at a high dosage for more than 14 days was avoided more often for rural residents than for urban residents. For each of these racial and ethnic groups, the difference between rural and urban residents was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

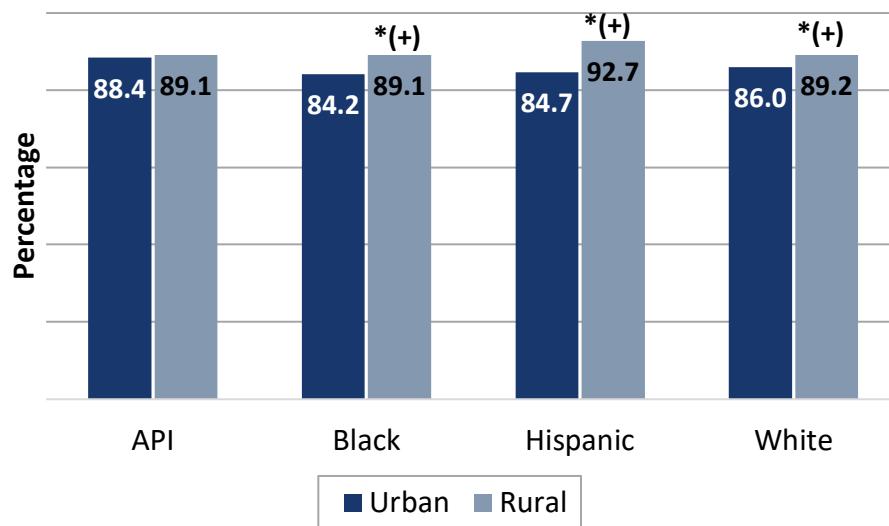
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

- (+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.
- (-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

[†] Average morphine equivalent dose > 120 mg.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by geography within racial and ethnic group, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API beneficiaries, use of opioids from multiple prescribers was avoided about as often for rural residents as for urban residents.
- Among Black, Hispanic, and White beneficiaries, use of opioids from multiple prescribers was avoided more often for rural residents than for urban residents. For each of these racial and ethnic groups, the difference between rural and urban residents was greater than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

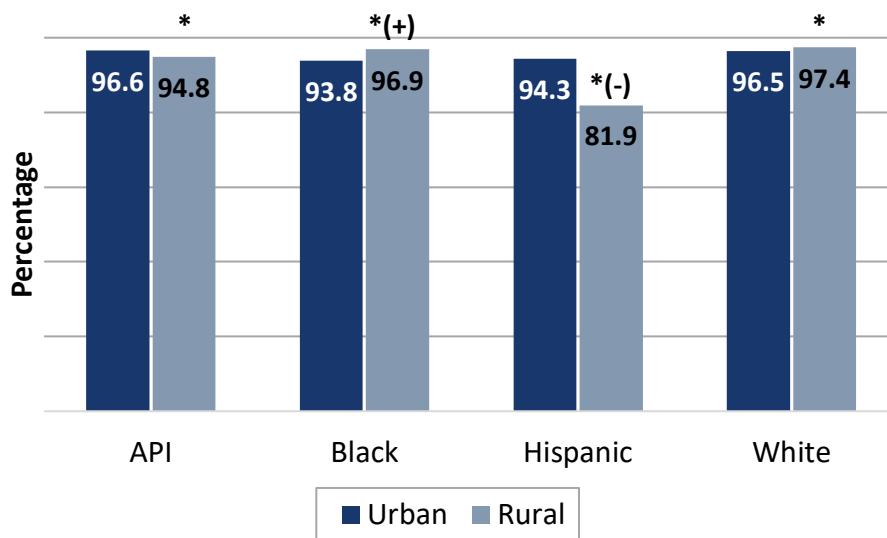
For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API and Hispanic beneficiaries, use of opioids from multiple pharmacies was avoided less often for rural residents than for urban residents. The difference between rural and urban API beneficiaries was less than 3 percentage points. The difference between rural and urban Hispanic beneficiaries was greater than 3 percentage points.
- Among Black and White beneficiaries, use of opioids from multiple pharmacies was avoided more often for rural residents than for urban residents. The difference between rural and urban Black beneficiaries was greater than 3 percentage points. The difference between rural and urban White beneficiaries was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

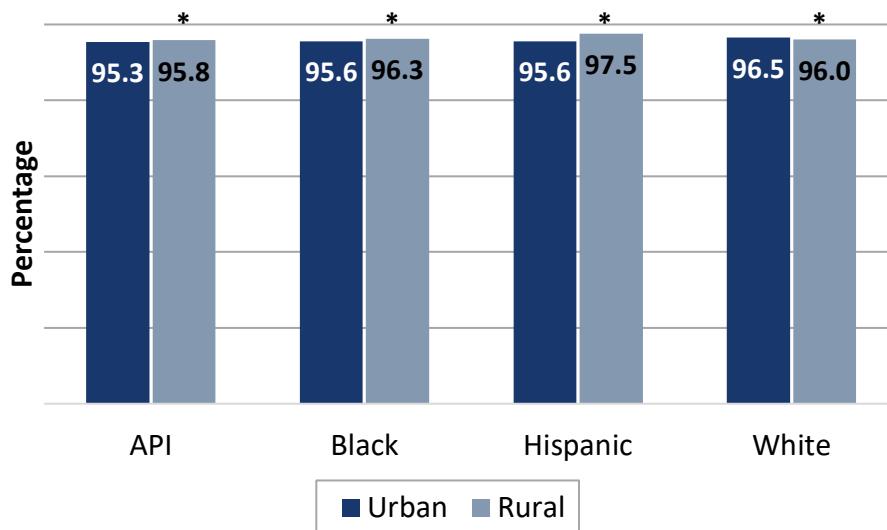
(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.

Clinical Care: Access/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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Among API, Black, and Hispanic beneficiaries, rural older adults were more likely than urban older adults to have had an ambulatory or preventive care visit. For each of these racial and ethnic groups, the difference between rural and urban older adults was less than 3 percentage points.
- Among White beneficiaries, rural older adults were less likely than urban older adults to have had an ambulatory or preventive care visit. The difference between rural and urban White older adults was less than 3 percentage points.

* Significantly different from the score for urban residents of the same racial and ethnic group ($p < 0.05$).

For statistically significant differences between rural and urban residents of the same race or ethnicity, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (prior to rounding) and favors rural residents.

(-) Difference is equal to or larger than 3 points (prior to rounding) and favors urban residents.



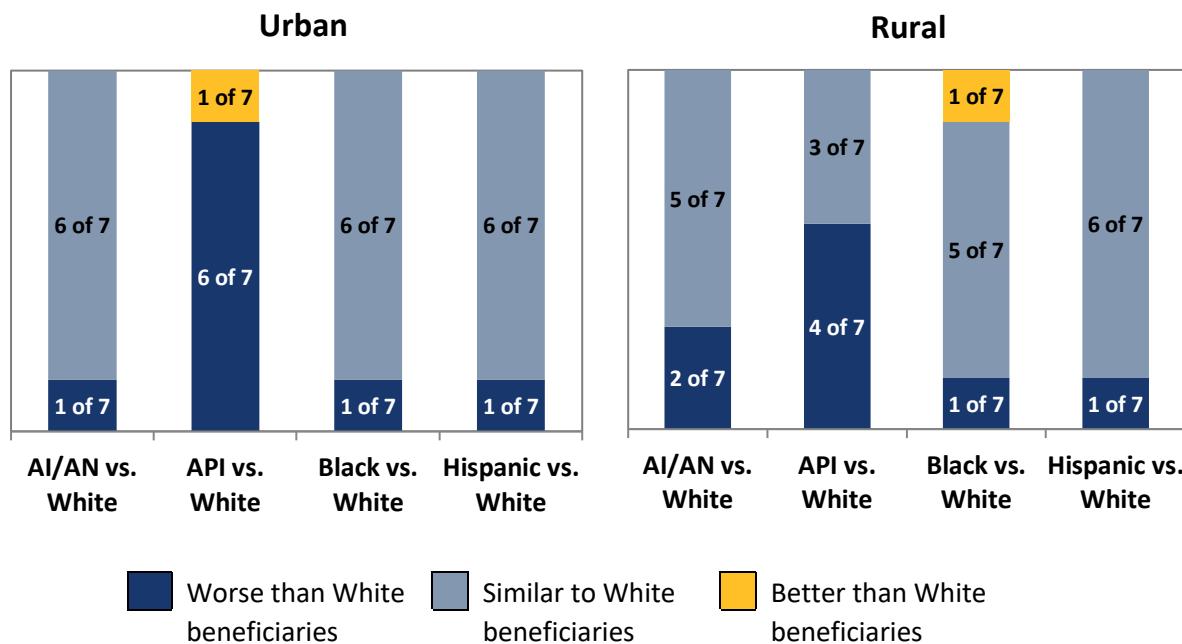
Section III:

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 for which urban and rural residents of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White urban and rural residents in 2019



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

Urban AI/AN MA beneficiaries had worse results than urban White MA beneficiaries

- Getting needed prescription drugs

Urban API MA beneficiaries had worse results than urban White MA beneficiaries

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs

Urban API MA beneficiaries had better results than urban White MA beneficiaries

- Annual flu vaccine

Urban Black MA beneficiaries had worse results than urban White MA beneficiaries

- Annual flu vaccine

Urban Hispanic MA beneficiaries had worse results than urban White MA beneficiaries

- Getting appointments and care quickly

Rural AI/AN MA beneficiaries had worse results than rural White MA beneficiaries

- Getting needed care
- Care coordination

Rural API MA beneficiaries had worse results than rural White MA beneficiaries

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Getting needed prescription drugs

Rural Black MA beneficiaries had worse results than rural White MA beneficiaries

- Annual flu vaccine

Rural Black MA beneficiaries had better results than rural White MA beneficiaries

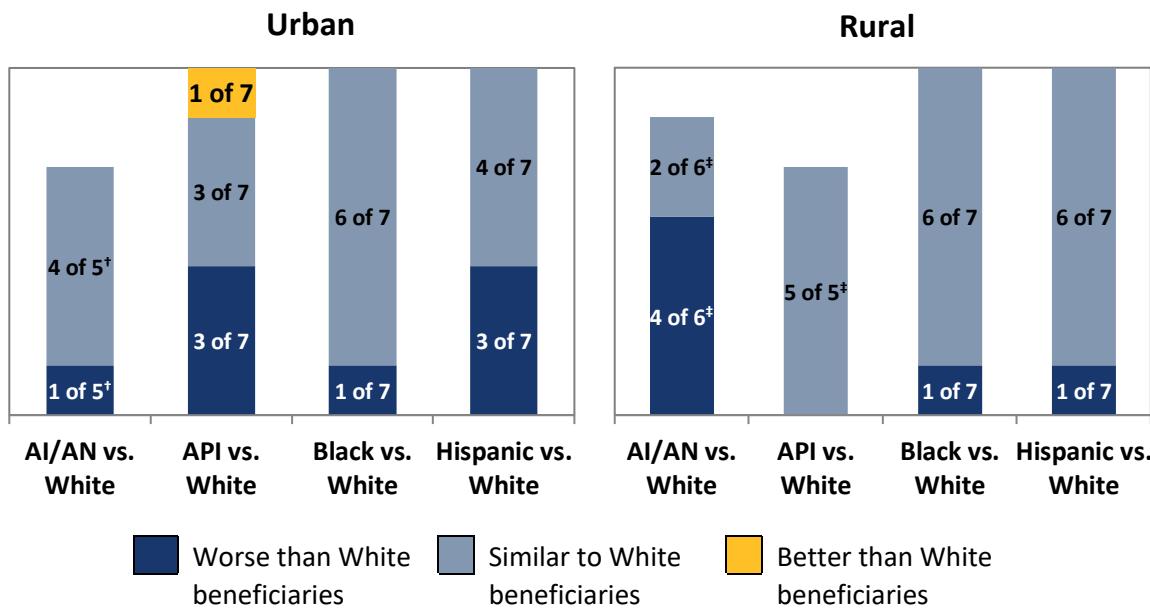
- Customer service

Rural Hispanic MA beneficiaries had worse results than rural White MA beneficiaries

- Getting needed care

Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Patient Experience Measures, Fee-for-Service

Number of patient experience measures for which urban and rural residents of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White urban and rural residents in 2019



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

[†] For two patient experience measures, there were not enough data from urban FFS AI/AN beneficiaries to compare their experiences to those of urban FFS White beneficiaries.

[‡] For one patient experience measure, there were not enough data from rural FFS AI/AN beneficiaries to compare their experiences to those of rural FFS White beneficiaries. For two patient experience measures, there were not enough data from rural FFS API beneficiaries to compare their experiences to those of rural FFS White beneficiaries.

Urban AI/AN FFS beneficiaries had worse results than urban White FFS beneficiaries

- Getting needed care

Urban API FFS beneficiaries had worse results than urban White FFS beneficiaries

- Getting needed care
- Getting appointments and care quickly
- Customer service

Urban API FFS beneficiaries had better results than urban White FFS beneficiaries

- Annual flu vaccine

Urban Black FFS beneficiaries had worse results than urban White FFS beneficiaries

- Annual flu vaccine

Urban Hispanic FFS beneficiaries had worse results than urban White FFS beneficiaries

- Getting appointments and care quickly
- Getting needed prescription drugs
- Annual flu vaccine

Rural AI/AN FFS beneficiaries had worse results than rural White FFS beneficiaries

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Care coordination

Rural Black FFS beneficiaries had worse results than rural White FFS beneficiaries

- Annual flu vaccine

Rural Hispanic FFS beneficiaries had worse results than rural White FFS beneficiaries

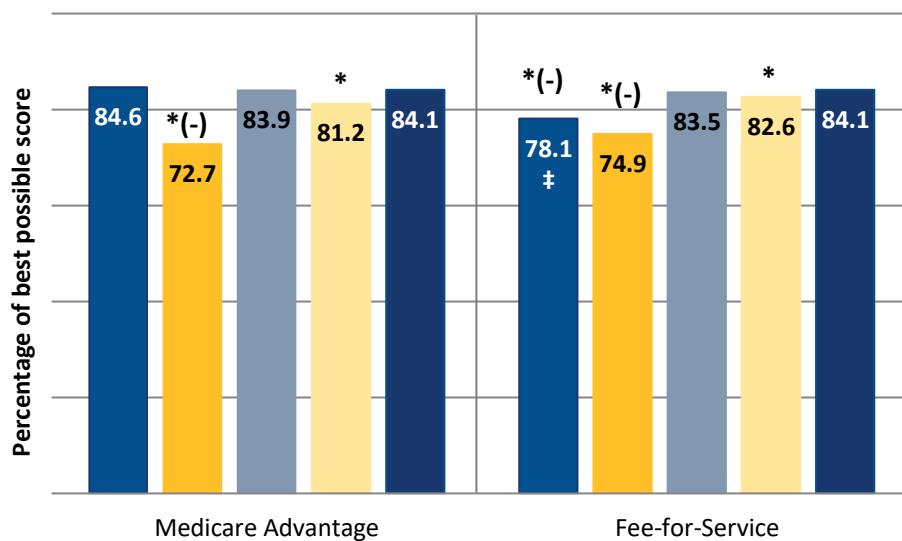
- Annual flu vaccine

Patient Experience

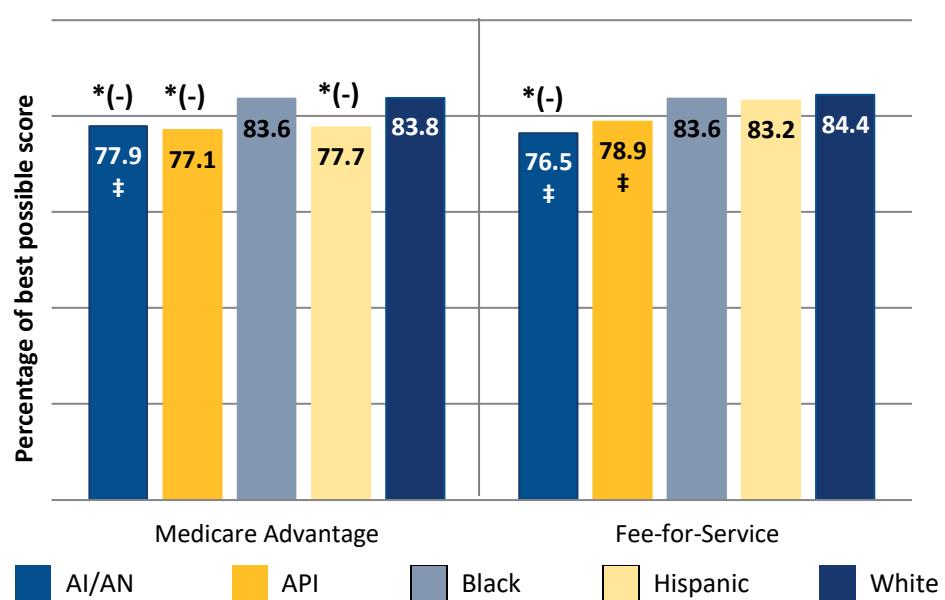
Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity within urban and rural areas, 2019

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

Disparities

- AI/AN MA beneficiaries residing in urban areas reported experiences getting needed care that were similar to the experiences reported by White beneficiaries residing in urban areas. AI/AN FFS beneficiaries residing in urban areas reported experiences getting needed care that were worse[‡] than the experiences reported by White FFS beneficiaries residing in urban areas. The difference between urban AI/AN and urban White FFS beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, AI/AN beneficiaries residing in rural areas reported experiences getting needed care that were worse than the experiences reported by White beneficiaries residing in rural areas. In each case, the difference between rural AI/AN and rural White beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, API beneficiaries residing in urban areas reported experiences getting needed care that were worse than the experiences reported by White beneficiaries residing in urban areas. In each case, the difference between urban API and urban White beneficiaries was greater than 3 points on a 0–100 scale.
- API MA beneficiaries residing in rural areas reported experiences getting needed care that were worse than the experiences reported by White MA beneficiaries residing in rural areas. The difference between rural API and rural White MA beneficiaries was greater than 3 points on a 0–100 scale. API FFS beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by White FFS beneficiaries residing in rural areas.
- In both MA and FFS, Black beneficiaries residing in urban areas reported experiences getting needed care that were similar to the experiences reported by White beneficiaries residing in urban areas.
- In both MA and FFS, Black beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by White beneficiaries residing in rural areas.
- In both MA and FFS, Hispanic beneficiaries residing in urban areas reported experiences getting needed care that were worse than the experiences reported by White beneficiaries residing in urban areas. The difference between urban Hispanic and urban White MA beneficiaries was less than 3 points on a 0–100 scale, as was the difference between urban Hispanic and urban White FFS beneficiaries.
- Hispanic MA beneficiaries residing in rural areas reported experiences getting needed care that were worse than the experiences reported by White MA beneficiaries residing in urban areas. The difference between rural Hispanic and rural White MA beneficiaries was greater than 3 points on a 0–100 scale. Hispanic FFS beneficiaries residing in rural areas reported experiences getting needed care that were similar to the experiences reported by White FFS beneficiaries residing in rural areas.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

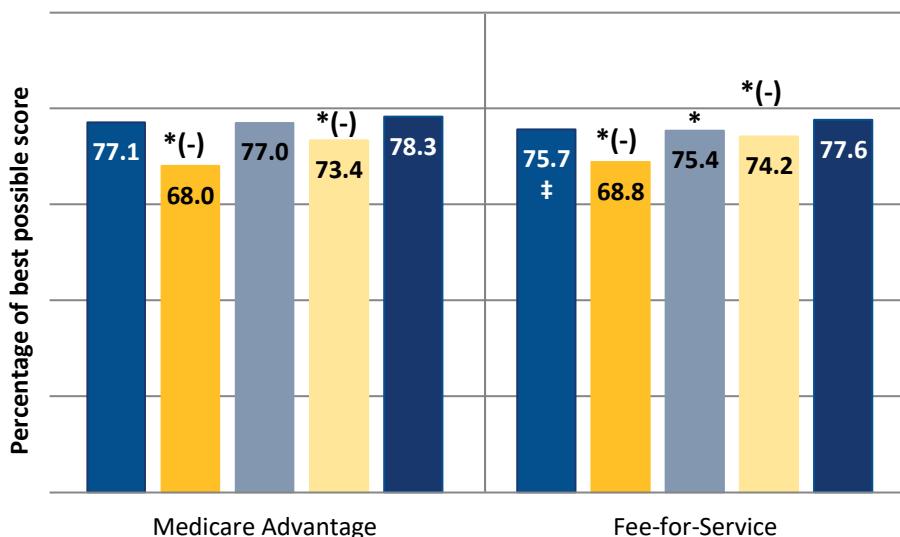
[†] This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

^{*} Unlike on pages 116–119, we use the terms “better” or “worse” to describe all statistically significant differences on individual patient experience measures. We note in the “Disparities” section for each of these measures where differences are greater or less than 3 points.

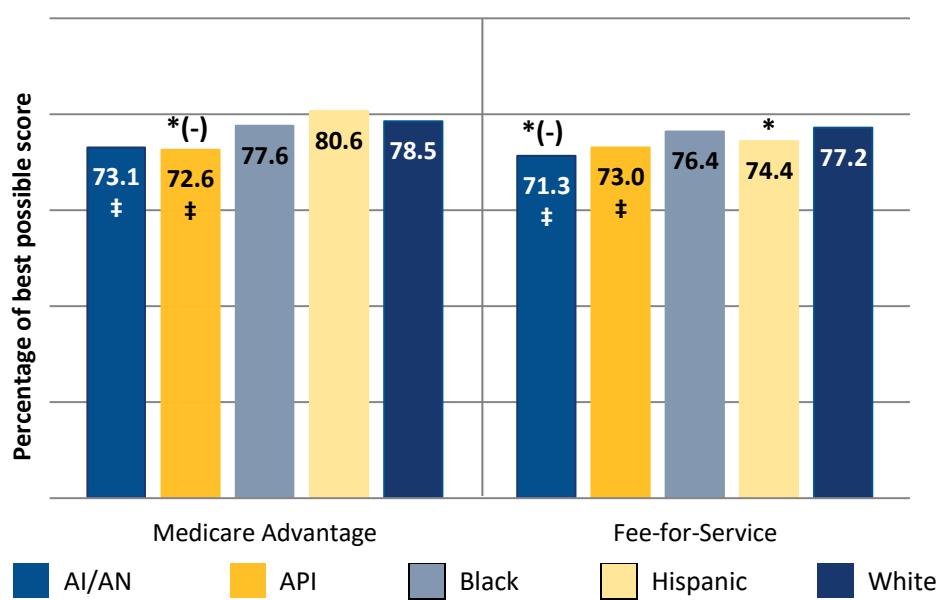
Getting Appointments and Care Quickly

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, 2019

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

Disparities

- In both MA and FFS, urban AI/AN beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by urban White beneficiaries.
- Rural AI/AN MA beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by rural White MA beneficiaries. Rural AI/AN FFS beneficiaries reported worse experiences with getting appointments and care quickly than rural White FFS beneficiaries. The difference between rural AI/AN and rural White FFS beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, urban API beneficiaries reported worse experiences with getting appointments and care quickly than urban White beneficiaries. In each case, the difference between urban API and urban White beneficiaries was greater than 3 points on a 0–100 scale.
- Rural API MA beneficiaries reported worse experiences with getting appointments and care quickly than rural White MA beneficiaries. The difference between rural API and rural White MA beneficiaries was greater than 3 points on a 0–100 scale. Rural API FFS beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by rural White FFS beneficiaries.
- Urban Black MA beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by urban White MA beneficiaries. Urban Black FFS beneficiaries reported worse experiences with getting appointments and care quickly than urban White FFS beneficiaries. The difference between urban Black and urban White FFS beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, rural Black beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban Hispanic beneficiaries reported worse experiences with getting appointments and care quickly than urban White beneficiaries. In each case, the difference between urban Hispanic and urban White beneficiaries was greater than 3 points on a 0–100 scale.
- Rural Hispanic MA beneficiaries reported experiences with getting appointments and care quickly that were similar to the experiences reported by rural White MA beneficiaries. Rural Hispanic FFS beneficiaries reported worse experiences with getting appointments and care quickly than rural White FFS beneficiaries. The difference between rural Hispanic and rural White FFS beneficiaries was less than 3 points on a 0–100 scale.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

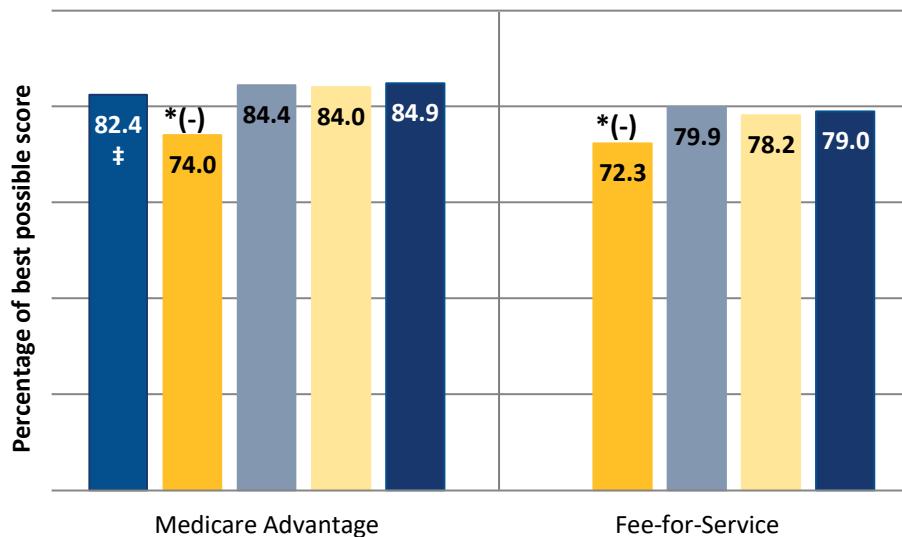
- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

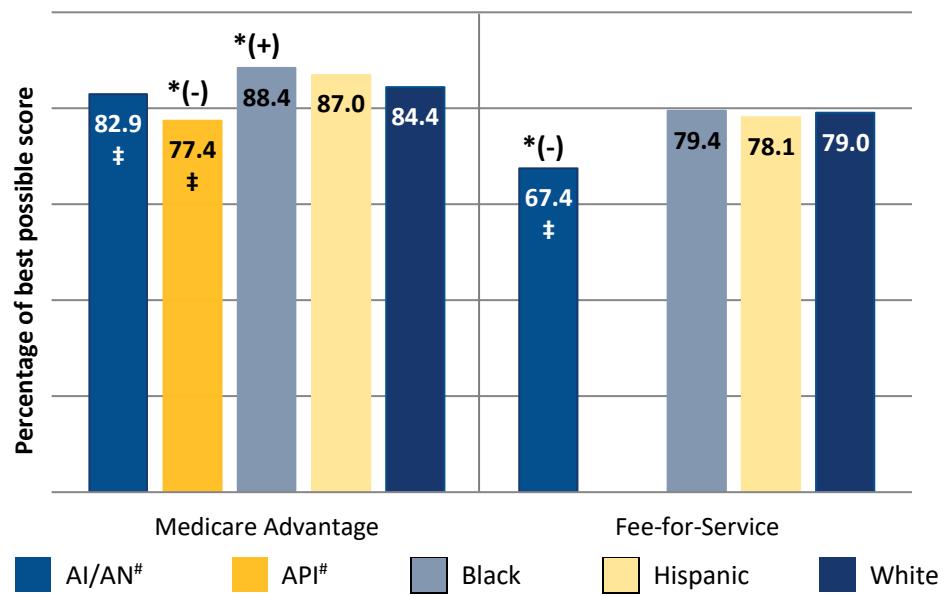
Customer Service

**Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,[†]
by race and ethnicity within urban and rural areas, 2019**

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

[#] There were not enough data from urban AI/AN FFS beneficiaries or rural API FFS beneficiaries to compare these groups to White beneficiaries on this measure.

Disparities

- Urban AI/AN MA beneficiaries reported experiences with customer service that were similar to the experiences reported by urban White beneficiaries.
- Rural AI/AN MA beneficiaries reported experiences with customer service that were similar to the experiences reported by rural White beneficiaries. Rural AI/AN FFS beneficiaries reported worse experiences with customer service than rural White FFS beneficiaries. The difference between rural AI/AN and rural White FFS beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, urban API beneficiaries reported worse experiences with customer service than urban White beneficiaries. In each case, the difference between urban API and urban White beneficiaries was greater than 3 points on a 0–100 scale.
- Rural API MA beneficiaries reported worse experiences with customer service than rural White MA beneficiaries. The difference between rural API and rural White MA beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, urban Black beneficiaries reported experiences with customer service that were similar to the experiences reported by urban White beneficiaries.
- Rural Black MA beneficiaries reported better experiences with customer service than rural White MA beneficiaries. The difference between rural Black and rural White MA beneficiaries was greater than 3 points on a 0–100 scale. Rural Black FFS beneficiaries reported experiences with customer service that were similar to the experiences reported by rural White FFS beneficiaries.
- In both MA and FFS, urban Hispanic beneficiaries reported experiences with customer service that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural Hispanic beneficiaries reported experiences with customer service that were similar to the experiences reported by rural White beneficiaries.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

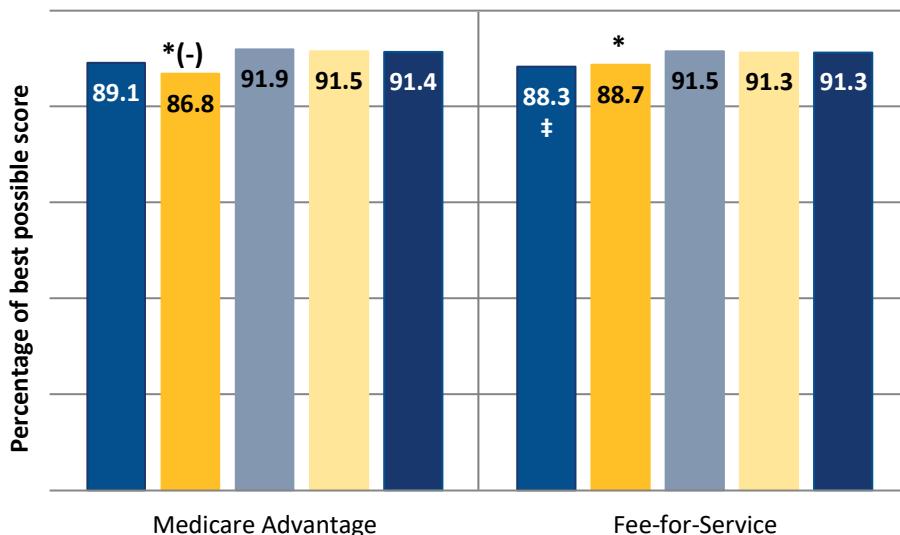
- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

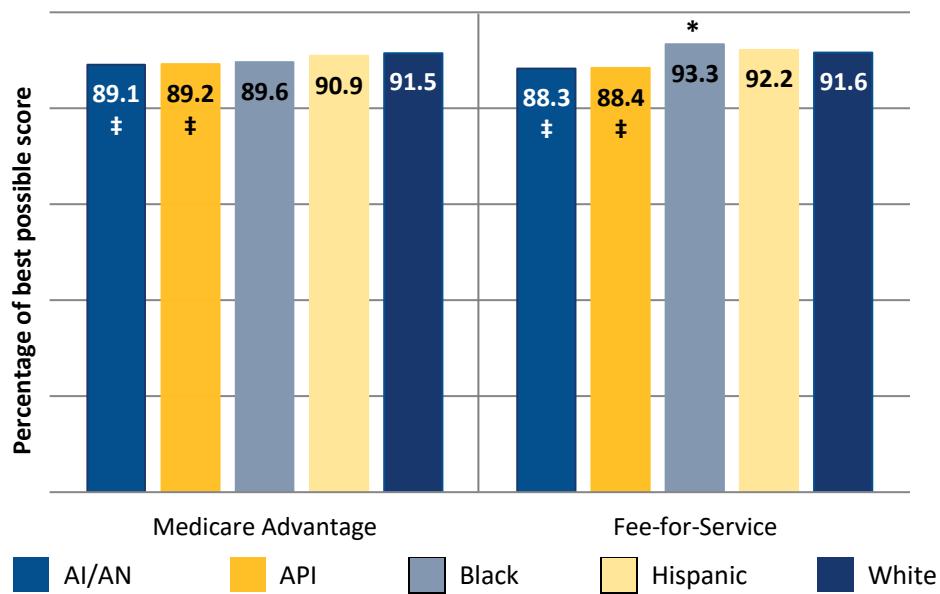
Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by race and ethnicity within urban and rural areas, 2019

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

Disparities

- In both MA and FFS, urban AI/AN beneficiaries reported experiences with doctor communication that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural AI/AN beneficiaries reported experiences with doctor communication that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban API beneficiaries reported worse experiences with doctor communication than urban White beneficiaries. The difference between urban API and urban White MA beneficiaries was greater than 3 points on a 0–100 scale. The difference between urban API and urban White FFS beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, rural API beneficiaries reported experiences with doctor communication that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban Black beneficiaries reported experiences with doctor communication that were similar to the experiences reported by urban White beneficiaries.
- Rural Black MA beneficiaries reported experiences with doctor communication that were similar to the experiences reported by rural White MA beneficiaries. Rural Black FFS beneficiaries reported better experiences with doctor communication than rural White FFS beneficiaries. The difference between rural Black and rural White FFS beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, urban Hispanic beneficiaries reported experiences with doctor communication that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural Hispanic beneficiaries reported experiences with doctor communication that were similar to the experiences reported by rural White beneficiaries.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

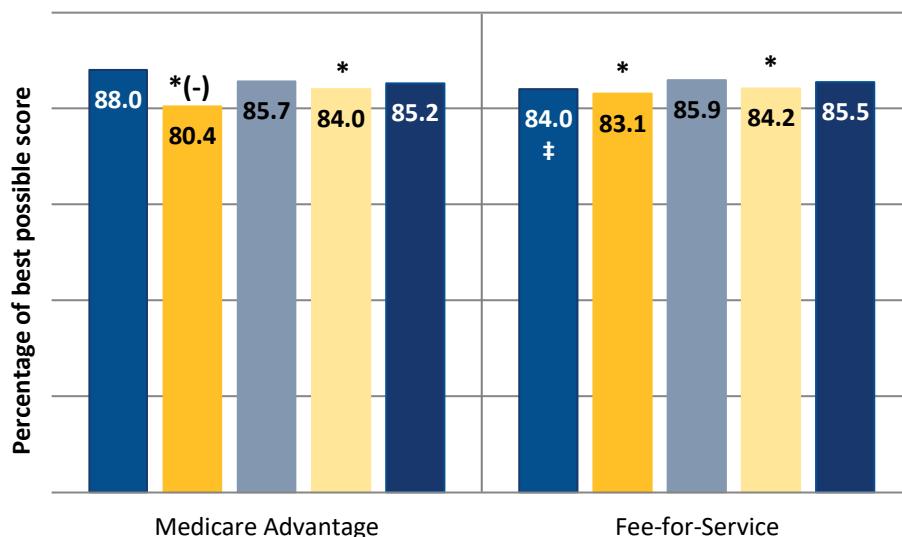
(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] 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.

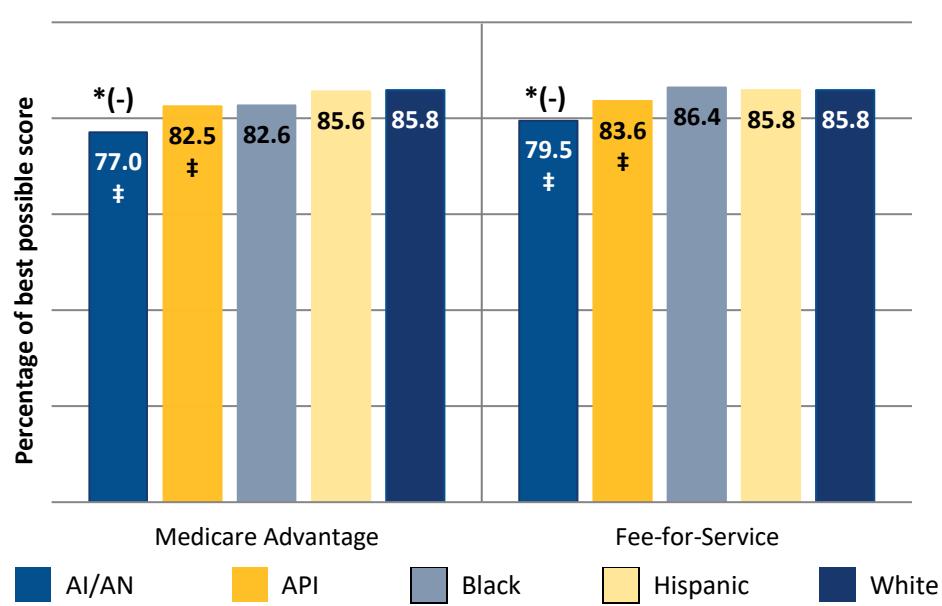
Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patient care is coordinated,[†] by race and ethnicity within urban and rural areas, 2019

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

Disparities

- In both MA and FFS, urban AI/AN beneficiaries reported experiences with care coordination that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural AI/AN MA beneficiaries reported worse experiences with care coordination than rural White MA beneficiaries. In each case, the difference between rural AI/AN and rural White beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, urban API beneficiaries reported worse experiences with care coordination than urban White beneficiaries. The difference between urban API and urban White MA beneficiaries was greater than 3 points on a 0–100 scale. The difference between urban API and urban White FFS beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, rural API beneficiaries reported experiences with care coordination that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban Black beneficiaries reported experiences with care coordination that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural Black beneficiaries reported experiences with care coordination that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban Hispanic beneficiaries reported worse experiences with care coordination than urban White beneficiaries. In each case, the difference between urban Hispanic and urban White beneficiaries was less than 3 points on a 0–100 scale.
- In both MA and FFS, rural Hispanic beneficiaries reported experiences with care coordination that were similar to the experiences reported by rural White beneficiaries.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

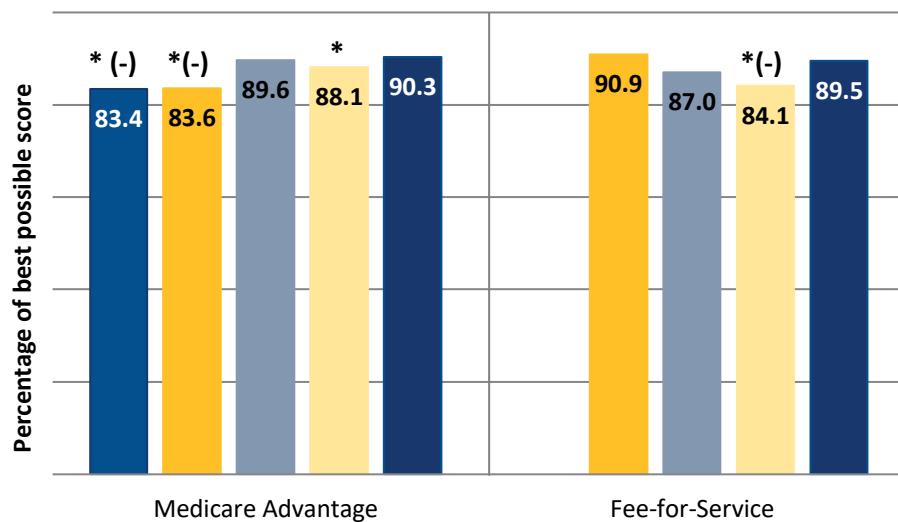
- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] 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.

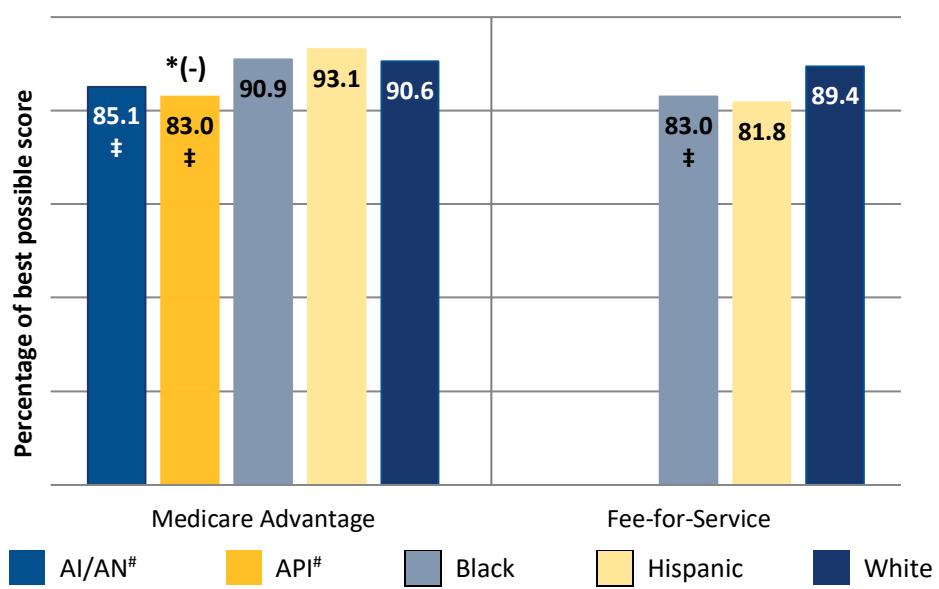
Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for beneficiaries to get the prescription drugs they need using their plans,[†] by race and ethnicity within urban and rural areas, 2019

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

[#] There were not enough data from urban AI/AN FFS beneficiaries, rural AI/AN FFS beneficiaries, or rural API FFS beneficiaries to compare these groups to White beneficiaries on this measure.

Disparities

- Urban AI/AN MA beneficiaries reported worse experiences getting needed prescription drugs than urban White MA beneficiaries. The difference between urban AI/AN and urban White MA beneficiaries was greater than 3 points on a 0–100 scale.
- Rural AI/AN MA beneficiaries reported experiences getting needed prescription drugs that were similar to the experiences reported by rural White MA beneficiaries.
- Urban API MA beneficiaries reported worse experiences getting needed prescription drugs than urban White MA beneficiaries. The difference between urban API and urban White MA beneficiaries was greater than 3 points on a 0–100 scale. Urban API FFS beneficiaries reported experiences getting needed prescription drugs that were similar to the experiences reported by urban White FFS beneficiaries.
- Rural API MA beneficiaries reported worse experiences getting needed prescription drugs than rural White MA beneficiaries. The difference between rural API and rural White MA beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, urban Black beneficiaries reported experiences getting needed prescription drugs that were similar to the experiences reported by urban White beneficiaries.
- In both MA and FFS, rural Black beneficiaries reported experiences getting needed prescription drugs that were similar to the experiences reported by rural White beneficiaries.
- In both MA and FFS, urban Hispanic MA beneficiaries reported worse experiences getting needed prescription drugs than urban White beneficiaries. The difference between urban Hispanic and urban White MA beneficiaries was less than 3 points on a 0–100 scale. The difference between urban Hispanic and urban White FFS beneficiaries was greater than 3 points on a 0–100 scale.
- In both MA and FFS, rural Hispanic beneficiaries reported experiences getting needed prescription drugs that were similar to the experiences reported by rural White beneficiaries.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

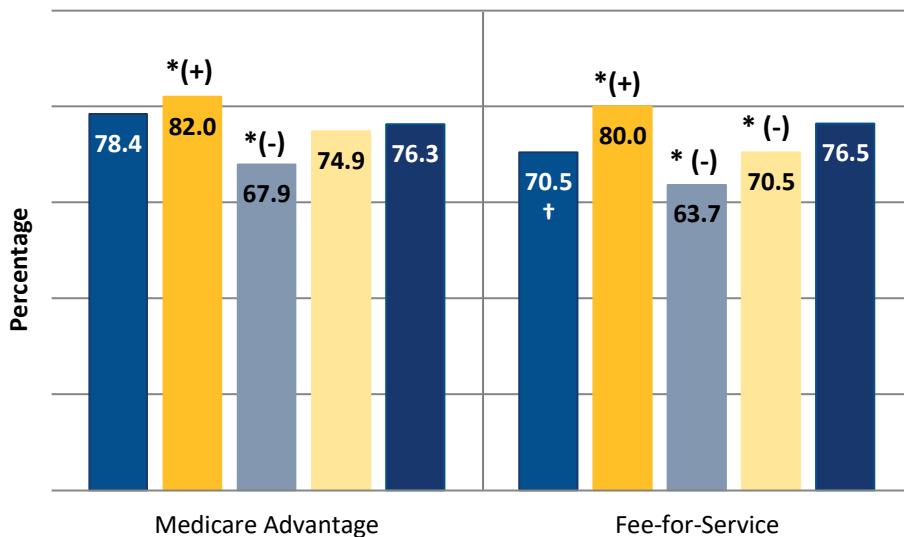
- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] 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.

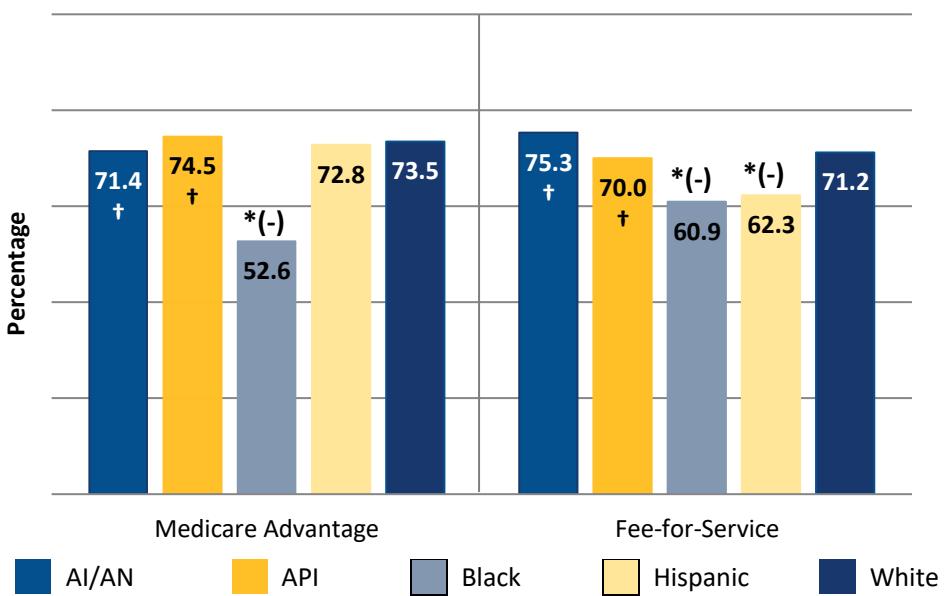
Annual Flu Vaccine

**Percentage of Medicare enrollees who got a vaccine (flu shot),
by race and ethnicity within urban and rural areas, 2019**

Urban



Rural



SOURCE: Data from the 2019 Medicare CAHPS survey.

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

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

Disparities

- In both MA and FFS, urban AI/AN beneficiaries were about as likely as urban White beneficiaries to have received the flu vaccine.
- In both MA and FFS, rural AI/AN beneficiaries were about as likely as rural White beneficiaries to have received the flu vaccine.
- In both MA and FFS, urban API beneficiaries were more likely than urban White beneficiaries to have received the flu vaccine. In each case, the difference between urban API and urban White beneficiaries was greater than 3 percentage points.
- In both MA and FFS, rural API beneficiaries were about as likely as rural White beneficiaries to have received the flu vaccine.
- In both MA and FFS, urban Black beneficiaries were less likely than urban White beneficiaries to have received the flu vaccine. In each case, the difference between urban Black and urban White beneficiaries was greater than 3 percentage points.
- In both MA and FFS, rural Black beneficiaries were less likely than rural White beneficiaries to have received the flu vaccine. In each case, the difference between rural Black and rural White beneficiaries was greater than 3 percentage points.
- Urban Hispanic MA beneficiaries were about as likely as urban White MA beneficiaries to have received the flu vaccine. Urban Hispanic FFS beneficiaries were less likely than urban White FFS beneficiaries to have received the flu vaccine. The difference between urban Hispanic and urban White FFS beneficiaries was greater than 3 percentage points.
- Rural Hispanic MA beneficiaries were about as likely as rural White MA beneficiaries to have received the flu vaccine. Rural Hispanic FFS beneficiaries were less likely than rural White FFS beneficiaries to have received the flu vaccine. The difference between rural Hispanic and rural White FFS beneficiaries was greater than 3 percentage points.

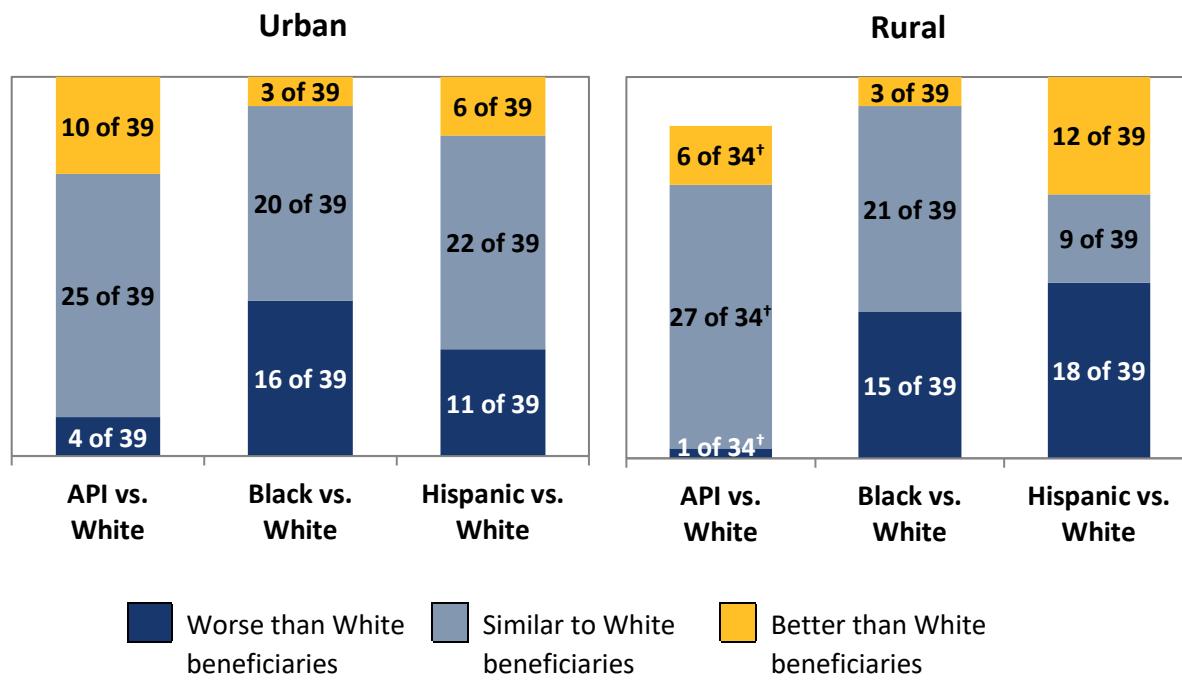
* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Racial and Ethnic Disparities in Care Within Urban and Rural Areas: All Clinical Care Measures

Number of clinical care measures for which urban and rural residents of selected racial and ethnic minority groups had results that were worse than, similar to, or better than results for White urban and rural residents in 2019



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2019 from MA plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

[†] There were only enough data from rural API beneficiaries to make rural-urban comparisons on 34 of the 39 clinical care measures.

Urban API beneficiaries had worse results than urban White beneficiaries

- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol and other drug dependence treatment
- Medication reconciliation after hospital discharge

Urban API beneficiaries had better results than urban White beneficiaries

- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Osteoporosis management in women who had a fracture
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of high-risk medication in the elderly
- Avoiding use of opioids at high dosage

Urban Black beneficiaries had worse results than urban White beneficiaries

- 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 emergency department visit for mental illness (within 30 days of discharge)
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence (within 30 days of discharge)
- Medication reconciliation after hospital discharge
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure

Urban Black beneficiaries had better results than urban White beneficiaries

- Breast cancer screening
- 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

Urban Hispanic beneficiaries had worse results than urban White beneficiaries

- 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 emergency department visit for mental illness (within 30 days of discharge)
- Initiation of alcohol and other drug dependence treatment
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia

Urban Hispanic beneficiaries had better results than urban White beneficiaries

- Breast cancer screening
- Testing to confirm COPD
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Diabetes care—eye exam
- Statin use in patients with diabetes
- Osteoporosis management in women who had a fracture

Rural API beneficiaries had worse results than rural White beneficiaries

- Antidepressant medication management—acute phase treatment

Rural API beneficiaries had better results than rural White beneficiaries

- Diabetes care—kidney disease monitoring
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of high-risk medications in the elderly

Rural Black beneficiaries had worse results than rural White beneficiaries

- Pharmacotherapy management of COPD exacerbation—systemic corticosteroid
- Controlling high blood pressure
- Continuous beta-blocker treatment after a heart attack
- Medication adherence for cardiovascular disease—statins
- Diabetes care—blood pressure 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 emergency department visit for mental illness (within 30 days of discharge)
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence (within 30 days of discharge)
- Initiation of alcohol and other drug dependence treatment
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure

Rural Black beneficiaries had better results than rural White beneficiaries

- Breast cancer screening
- Diabetes care—eye exam
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls

Rural Hispanic beneficiaries had worse results than rural White beneficiaries

- 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 emergency department 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 reconciliation after hospital discharge
- Transitions of care—notification of inpatient admission
- Transitions of care—receipt of discharge information
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Avoiding use of opioids from multiple pharmacies

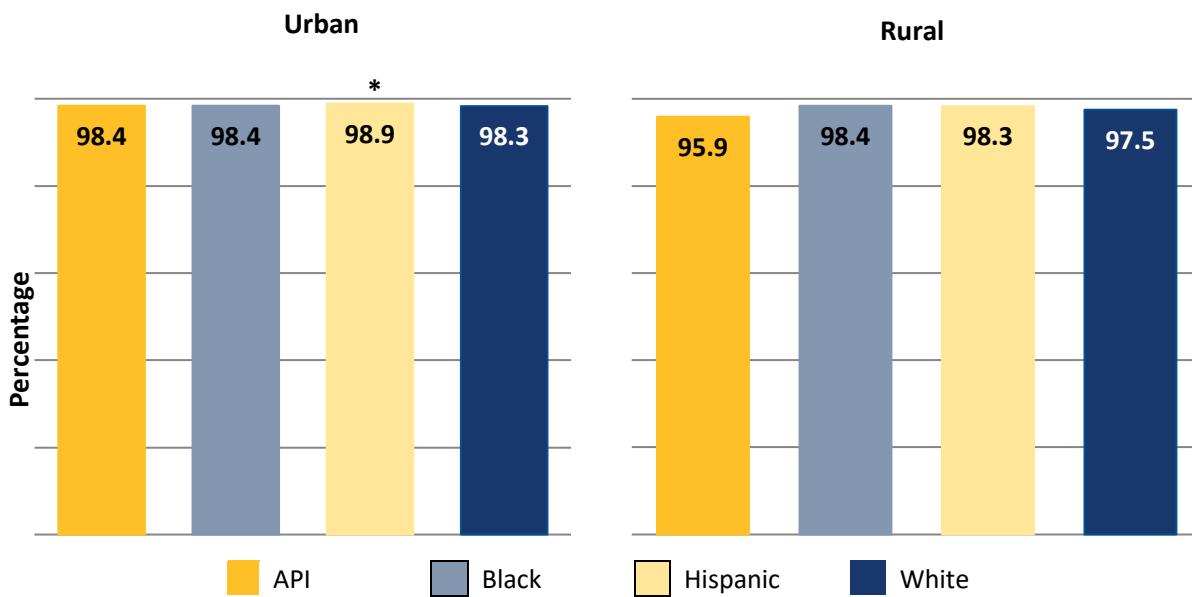
Rural Hispanic beneficiaries had better results than rural White beneficiaries

- Breast cancer screening
- Colorectal cancer screening
- Testing to confirm COPD
- Controlling high blood pressure
- Diabetes care—eye exam
- Diabetes care—kidney disease monitoring
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Osteoporosis management in women who had a fracture
- Follow-up after hospital stay for mental illness (within 30 days of discharge)
- Avoiding use of opioids at high dosage
- Avoiding use of opioids from multiple prescribers

Clinical Care: Prevention and Screening

Adult BMI Assessment

Percentage of MA enrollees aged 18 to 74 years who had an outpatient visit whose body mass index (BMI) was documented in the past two years, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries were about as likely as White beneficiaries to have had their BMIs documented.
- In both urban and rural areas, Black beneficiaries were about as likely as White beneficiaries to have had their BMIs documented.
- Urban Hispanic beneficiaries were more likely than urban White beneficiaries to have had their BMIs documented. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries were about as likely as rural White beneficiaries to have had their BMIs documented.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

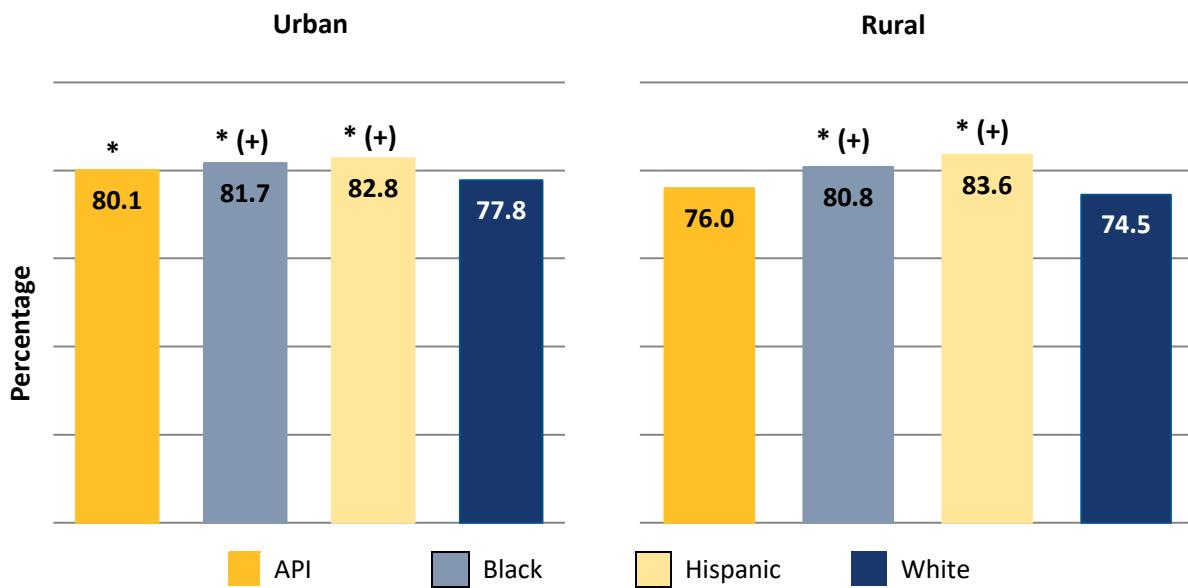
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Breast Cancer Screening

Percentage of MA enrollees (women) aged 50 to 74 years who had appropriate screening for breast cancer, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API women were more likely than urban White women to have been appropriately screened for breast cancer. The difference between urban API and urban White women was less than 3 percentage points. Rural API women were about as likely as rural White women to have been appropriately screened for breast cancer.
- In both urban and rural areas, Black women were more likely than White women to have been appropriately screened for breast cancer. In each case, the difference between Black and White women was greater than 3 percentage points.
- In both urban and rural areas, Hispanic women were more likely than White women to have been appropriately screened for breast cancer. In each case, the difference between Hispanic and White women was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

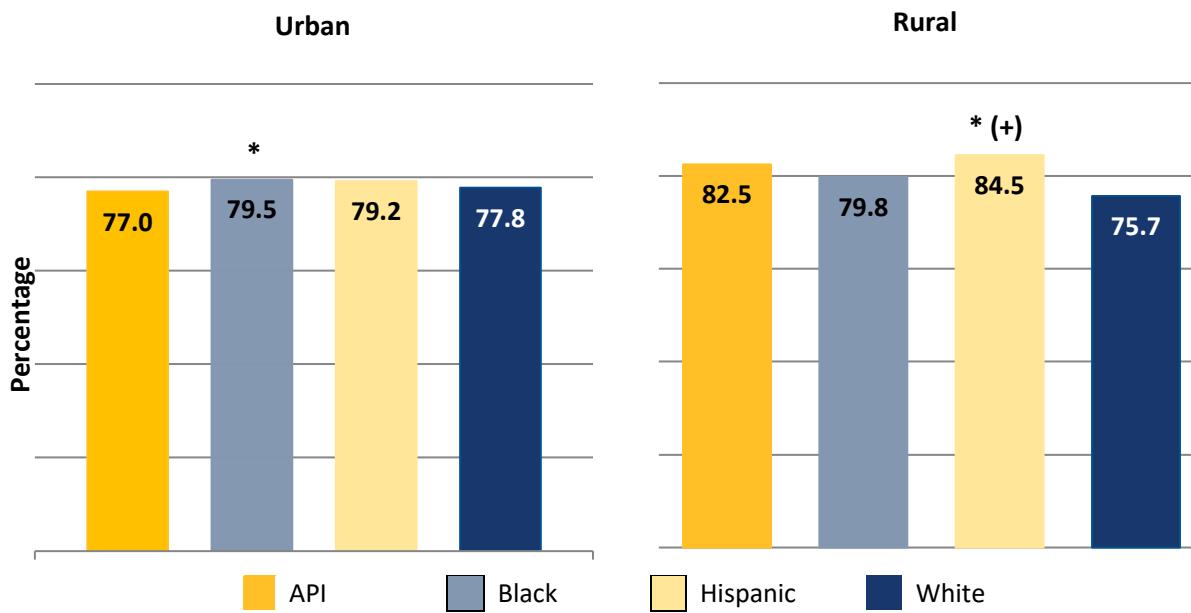
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries were about as likely as White beneficiaries to have been appropriately screened for colorectal cancer.
- Urban Black beneficiaries were more likely than urban White beneficiaries to have been appropriately screened for colorectal cancer. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries were about as likely as rural White beneficiaries to have been appropriately screened for colorectal cancer.
- Urban Hispanic beneficiaries were about as likely as urban White beneficiaries to have been appropriately screened for colorectal cancer. Rural Hispanic beneficiaries were more likely than rural White beneficiaries to have been appropriately screened for colorectal cancer. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality and coverage type ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality and coverage type, the following symbols are also used when applicable:

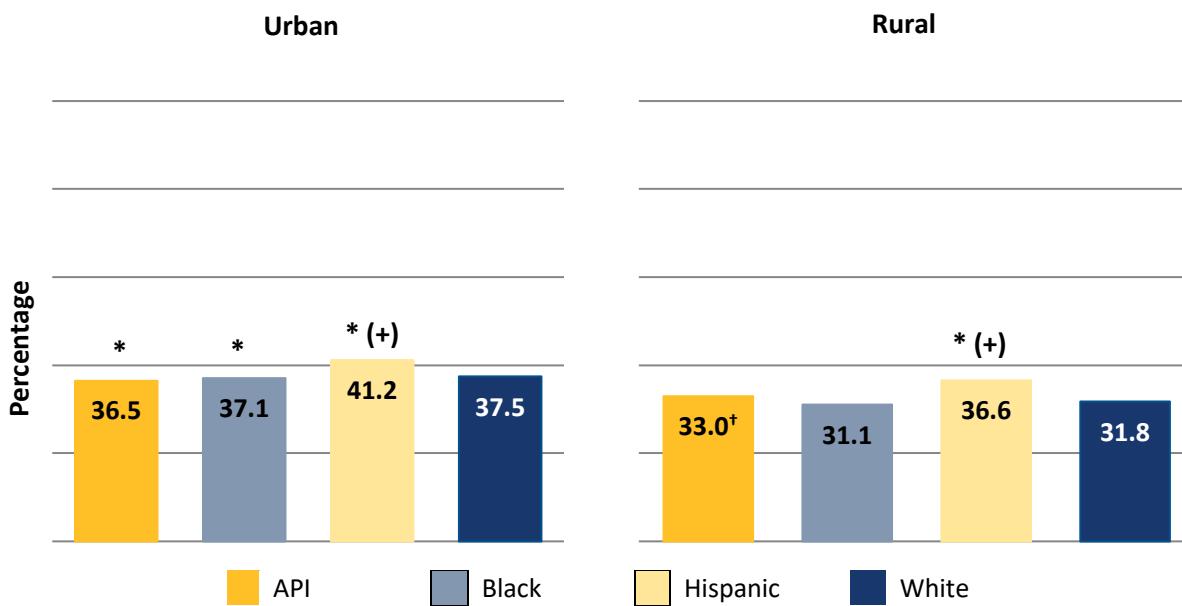
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries with a new diagnosis of COPD or newly active COPD were less likely than urban White beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries with a new diagnosis of COPD or newly active COPD were about as likely as rural White beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis.
- Urban Black beneficiaries with a new diagnosis of COPD or newly active COPD were less likely than urban White beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries with a new diagnosis of COPD or newly active COPD were about as likely as rural White beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis.
- In both urban and rural areas, Hispanic beneficiaries with a new diagnosis of COPD or newly active COPD were more likely than White beneficiaries with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. In each

case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

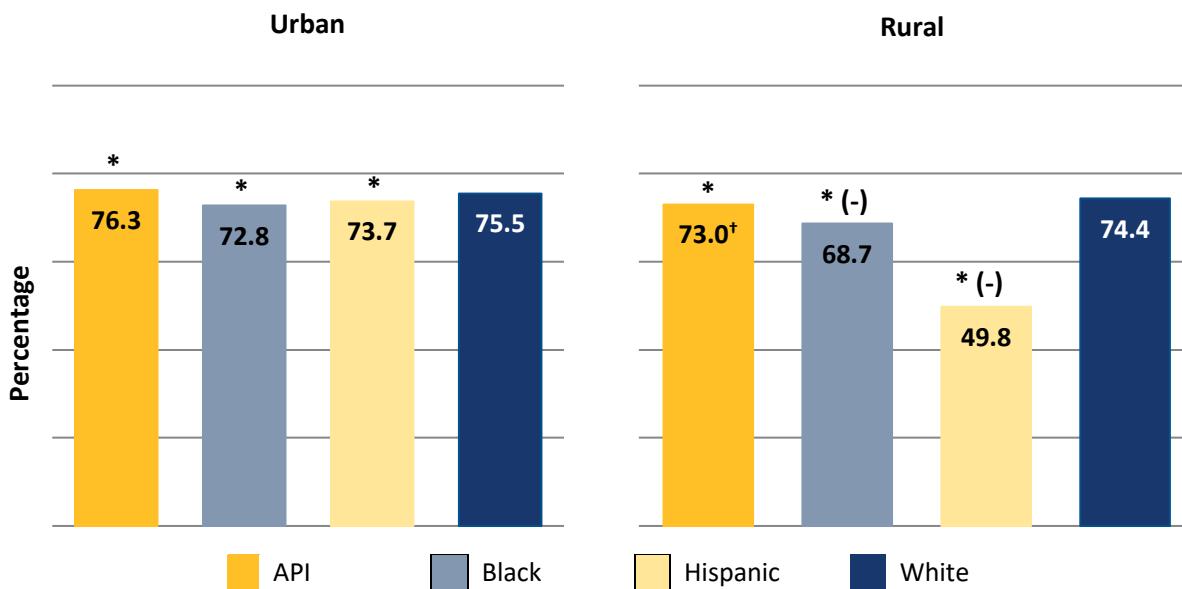
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: 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 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who experienced a COPD exacerbation were more likely than urban White beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries who experienced a COPD exacerbation were less likely than rural White beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between rural API and rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, Black beneficiaries who experienced a COPD exacerbation were less likely than White beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. The difference between rural Black and rural White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who experienced a COPD exacerbation were less likely than White beneficiaries who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference

between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

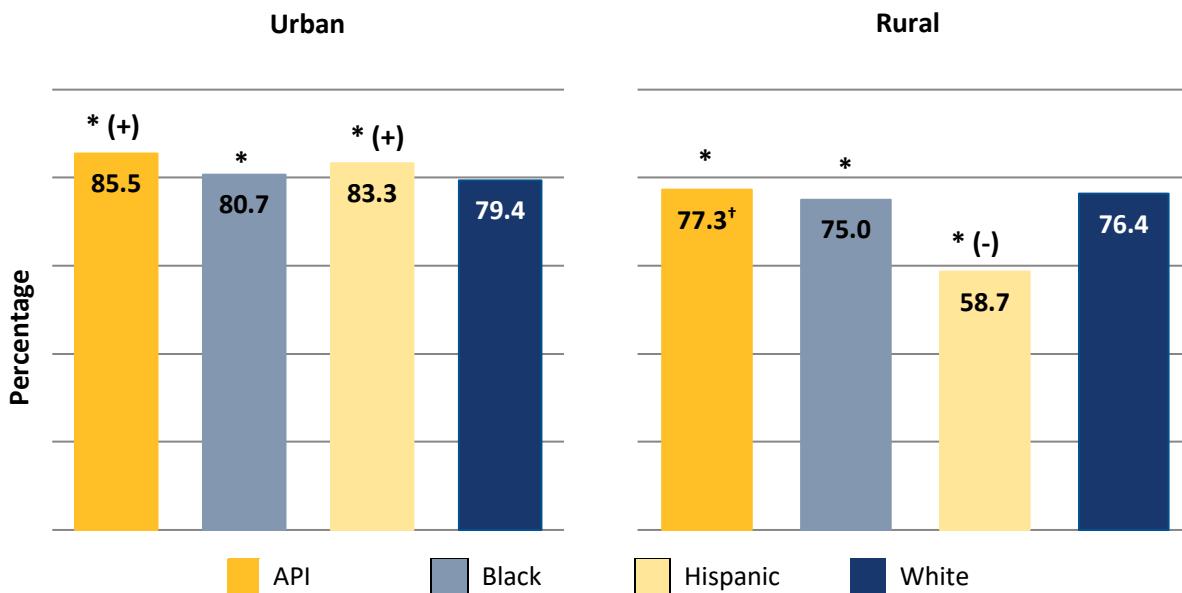
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- In both urban and rural areas, API beneficiaries who experienced a COPD exacerbation were more likely than White beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. The difference between rural API and rural White beneficiaries was less than 3 percentage points.
- Urban Black beneficiaries who experienced a COPD exacerbation were more likely than urban White beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries who experienced a COPD exacerbation were less likely than rural White beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between rural Black and rural White beneficiaries was less than 3 percentage points.
- Urban Hispanic beneficiaries who experienced a COPD exacerbation were more likely than urban White beneficiaries who experienced a COPD exacerbation to have been dispensed a

bronchodilator within 30 days of the event. The difference between urban Hispanic and urban White beneficiaries was greater than 3 percentage points. Rural Hispanic beneficiaries who experienced a COPD exacerbation were less likely than rural White beneficiaries who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

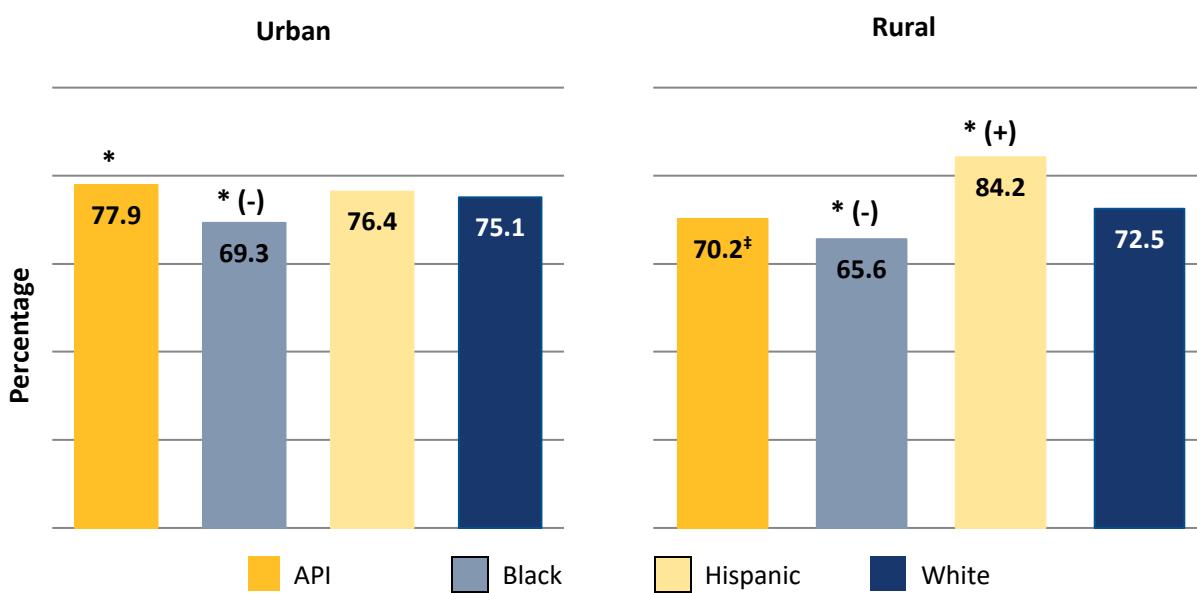
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who had a diagnosis of hypertension were more likely than urban White beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries who had a diagnosis of hypertension were about as likely as rural White beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled.
- In both urban and rural areas, Black beneficiaries who had a diagnosis of hypertension were less likely than White beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- Urban Hispanic beneficiaries who had a diagnosis of hypertension were about as likely as urban White beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. Rural Hispanic beneficiaries who had a diagnosis of hypertension were more likely than rural White beneficiaries who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

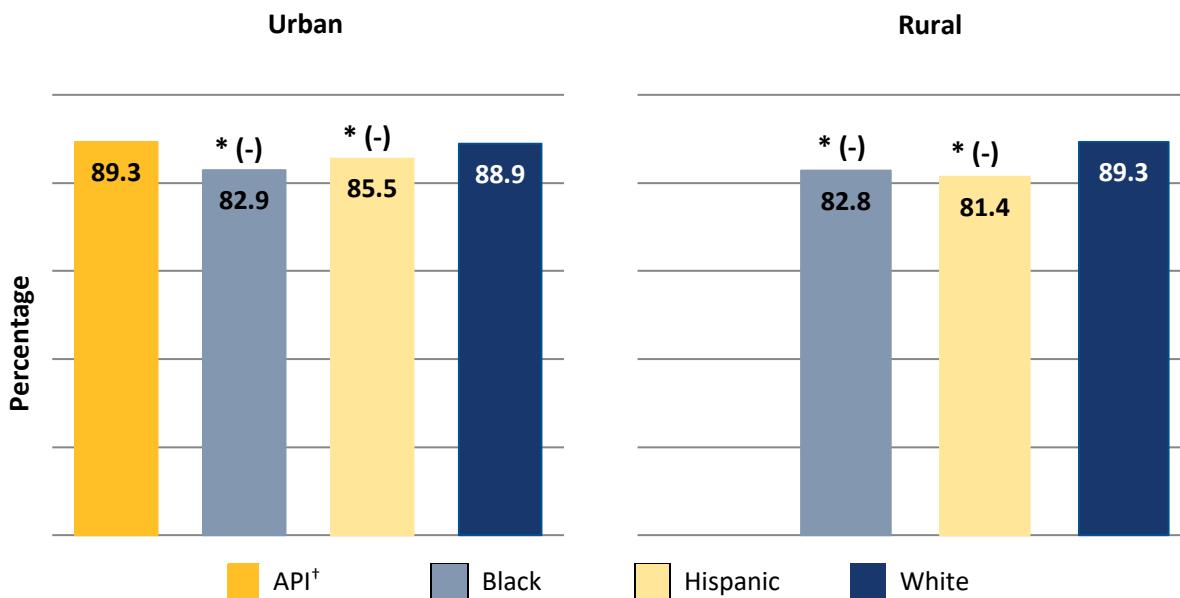
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Continuous Beta-Blocker Treatment

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (AMI) who received persistent beta-blocker treatment for six months after discharge, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

[†] There were not enough data from rural API beneficiaries to compare them to White beneficiaries on this measure.

Disparities

- Urban API beneficiaries who were hospitalized for a heart attack were about as likely as urban White beneficiaries who were hospitalized for a heart attack to have received persistent beta-blocker treatment.
- In both urban and rural areas, Black beneficiaries who were hospitalized for a heart attack were less likely than White beneficiaries who were hospitalized for a heart attack to have received persistent beta-blocker treatment. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who were hospitalized for a heart attack were less likely than White beneficiaries who were hospitalized for a heart attack to have received persistent beta-blocker treatment. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

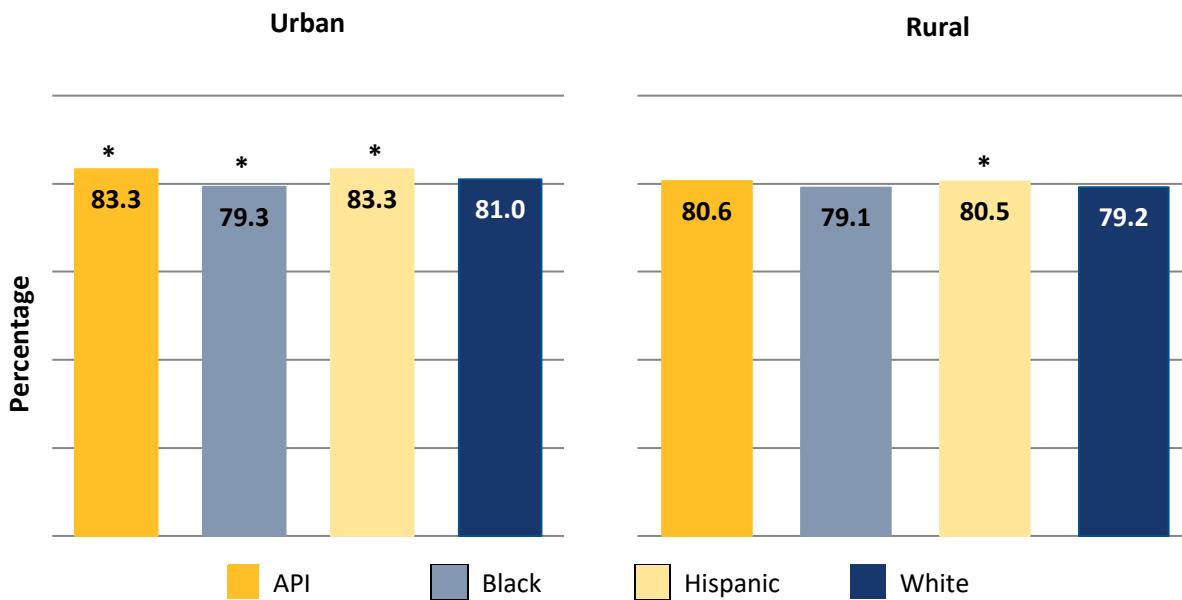
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with ASCVD were more likely than urban White beneficiaries with ASCVD to have received statin therapy. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries with ASCVD were about as likely as rural White beneficiaries with ASCVD to have received statin therapy.
- Urban Black beneficiaries with ASCVD were less likely than urban White beneficiaries with ASCVD to have received statin therapy. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries with ASCVD were about as likely as rural White beneficiaries with ASCVD to have received statin therapy.
- In both urban and rural areas, Hispanic beneficiaries with ASCVD were more likely than White beneficiaries with ASCVD to have received statin therapy. In each case, the difference between Hispanic and White beneficiaries was less than 3 percentage points.

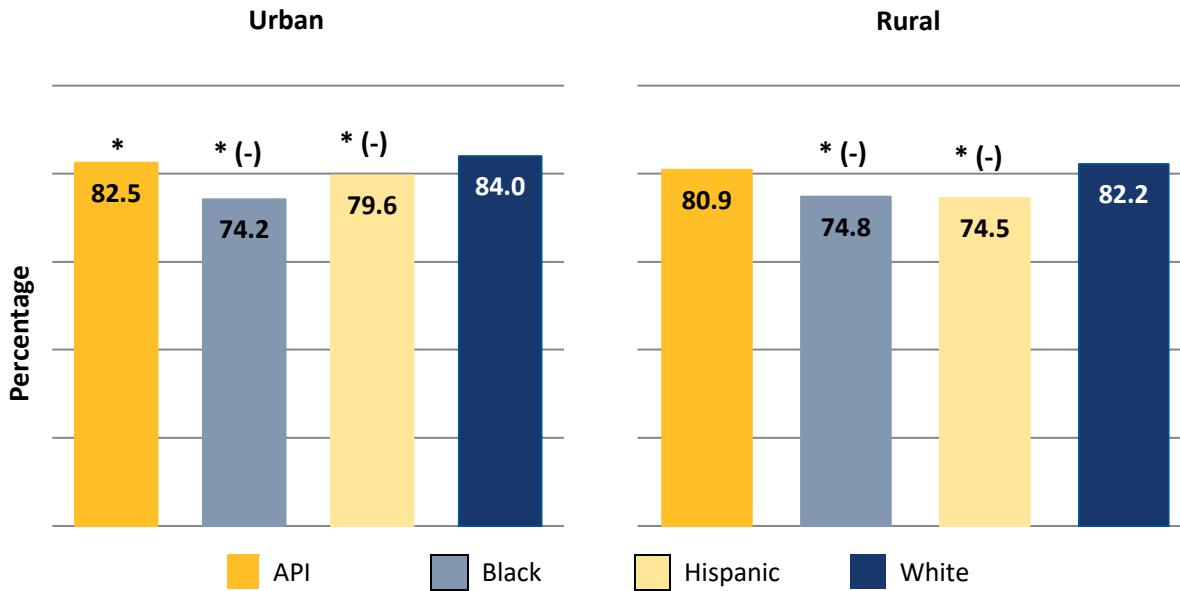
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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 atherosclerotic cardiovascular disease (ASCVD) who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with ASCVD were less likely than urban White beneficiaries with ASCVD to have had proper statin medication adherence. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries with ASCVD were about as likely as rural White beneficiaries with ASCVD to have had proper statin medication adherence.
- In both urban and rural areas, Black beneficiaries with ASCVD were less likely than White beneficiaries with ASCVD to have had proper statin medication adherence. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with ASCVD were less likely than White beneficiaries with ASCVD to have had proper statin medication adherence. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

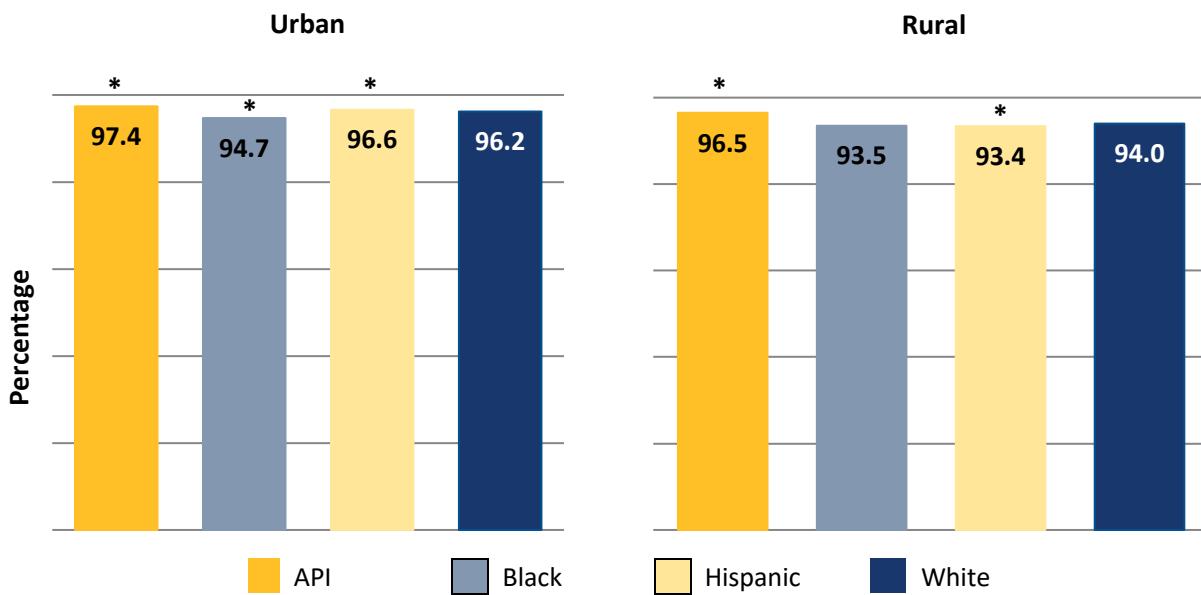
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: Diabetes

Diabetes Care—Blood Sugar Testing

Percentage of Medicare Advantage 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. In each case, the difference between API and White beneficiaries was less than 3 percentage points.
- Urban Black beneficiaries with diabetes were less likely than urban White beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have had their blood sugar tested at least once in the past year.
- Urban Hispanic beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries with diabetes were less likely than rural White beneficiaries with diabetes to have had their blood sugar tested at least once in the past year. The difference between rural Hispanic and rural White beneficiaries was less than 3 percentage points.

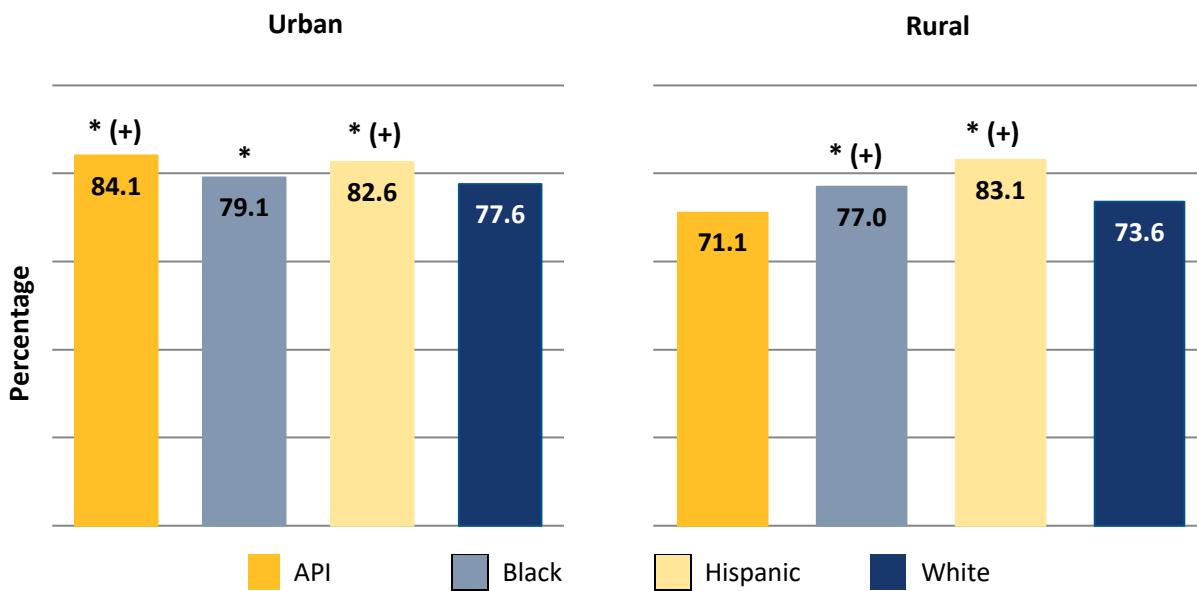
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Diabetes Care—Eye Exam

Percentage of Medicare Advantage 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have had an eye exam in the past year. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. Rural API beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have had an eye exam in the past year.
- In both urban and rural areas, Black beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have had an eye exam in the past year. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. The difference between rural Black and rural White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have had an eye exam in the past year. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

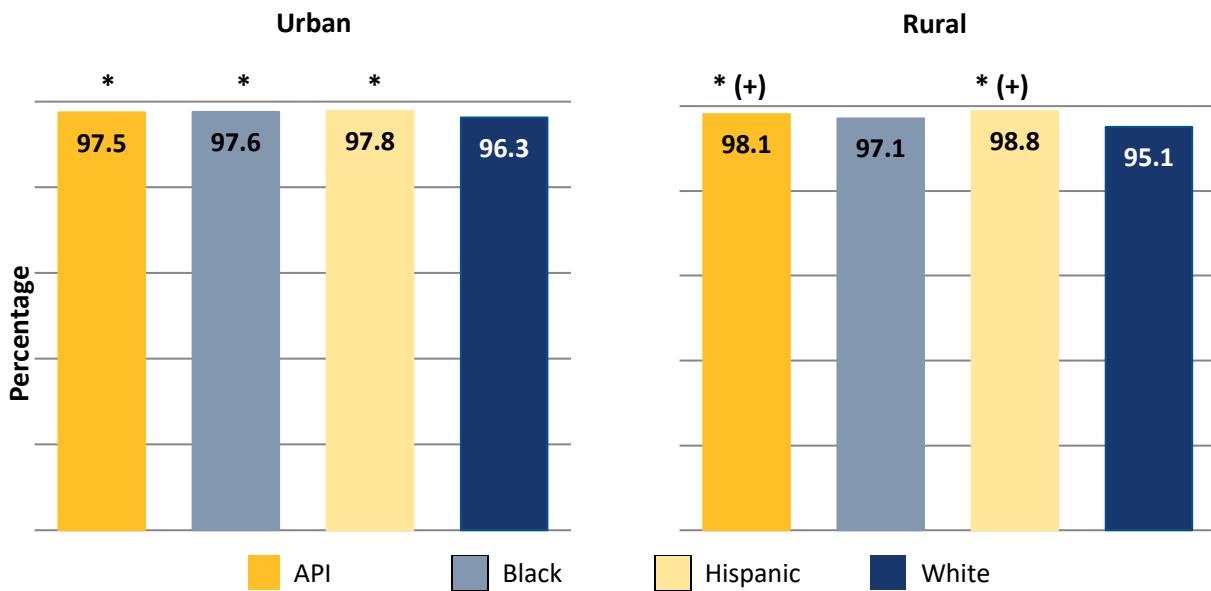
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Diabetes Care—Kidney Disease Monitoring

Percentage of Medicare Advantage 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have had medical attention for nephropathy in the past year. The difference between urban API and urban White beneficiaries was less than 3 percentage points. The difference between rural API and rural White beneficiaries was greater than 3 percentage points.
- Urban Black beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have had medical attention for nephropathy in the past year. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have had medical attention for nephropathy in the past year.
- In both urban and rural areas, Hispanic beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have had medical attention for nephropathy in the past year. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

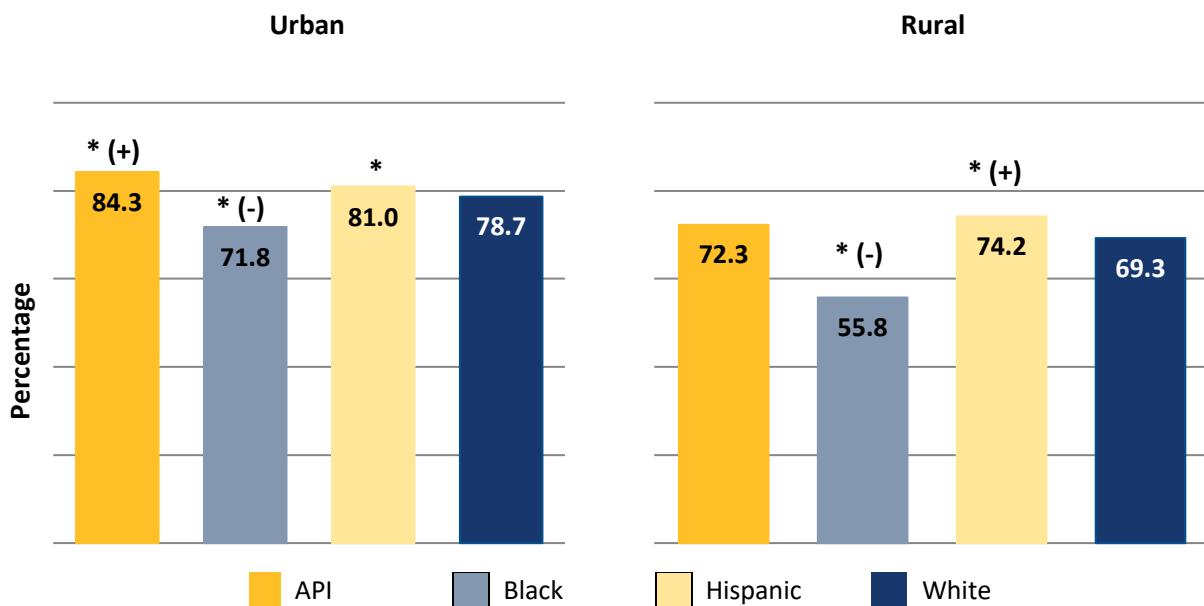
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have their blood pressure under control. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. Rural API beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have their blood pressure under control.
- In both urban and rural areas, Black beneficiaries with diabetes were less likely than White beneficiaries with diabetes to have their blood pressure under control. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have their blood pressure under control. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

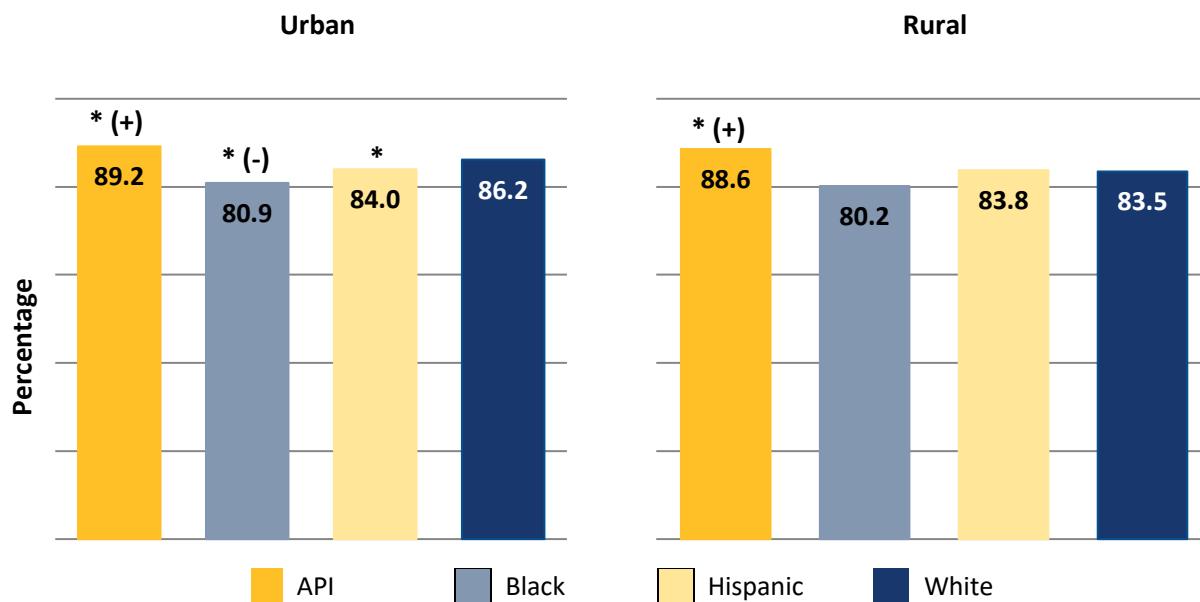
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries with diabetes were more likely than urban White beneficiaries with diabetes to have their blood sugar levels under control. In each case, the difference between API and White beneficiaries was greater than 3 percentage points.
- Urban Black beneficiaries with diabetes were less likely than urban White beneficiaries with diabetes to have their blood sugar levels under control. The difference between urban Black and urban White beneficiaries was greater than 3 percentage points. Rural Black beneficiaries with diabetes about as less likely as rural White beneficiaries with diabetes to have their blood sugar levels under control.
- Urban Hispanic beneficiaries with diabetes were less likely than urban White beneficiaries with diabetes to have their blood sugar levels under control. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have their blood sugar levels under control.

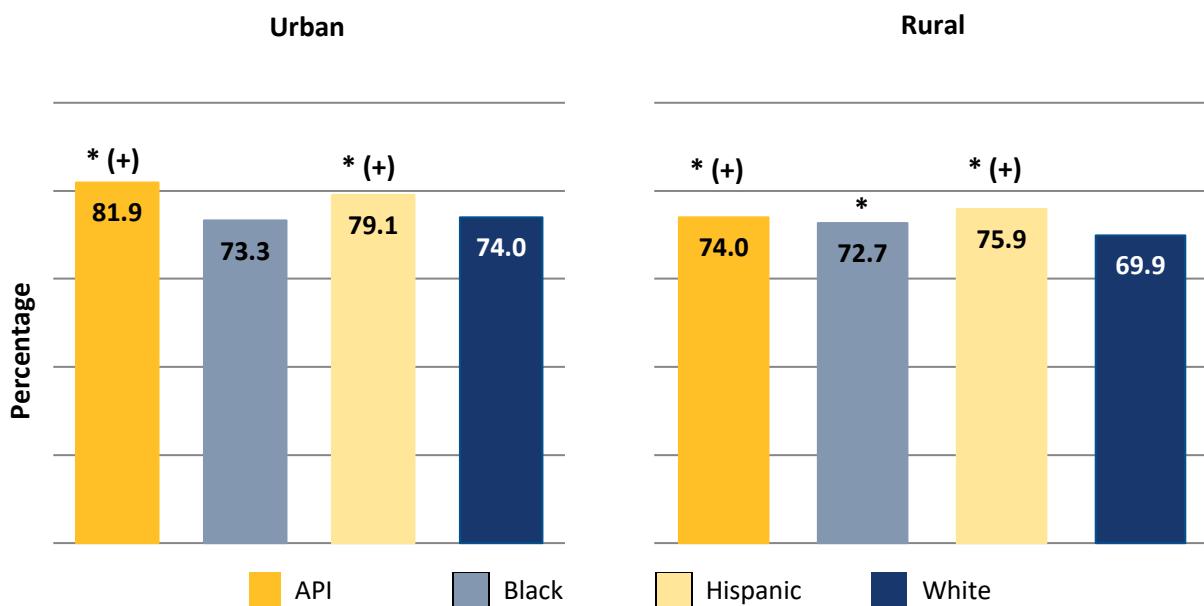
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have received statin therapy. In each case, the difference between API and White beneficiaries was greater than 3 percentage points.
- Urban Black beneficiaries with diabetes were about as likely as urban White beneficiaries with diabetes to have received statin therapy. Rural Black beneficiaries with diabetes were more likely than rural White beneficiaries with diabetes to have received statin therapy. The difference between rural Black and rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with diabetes were more likely than White beneficiaries with diabetes to have received statin therapy. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

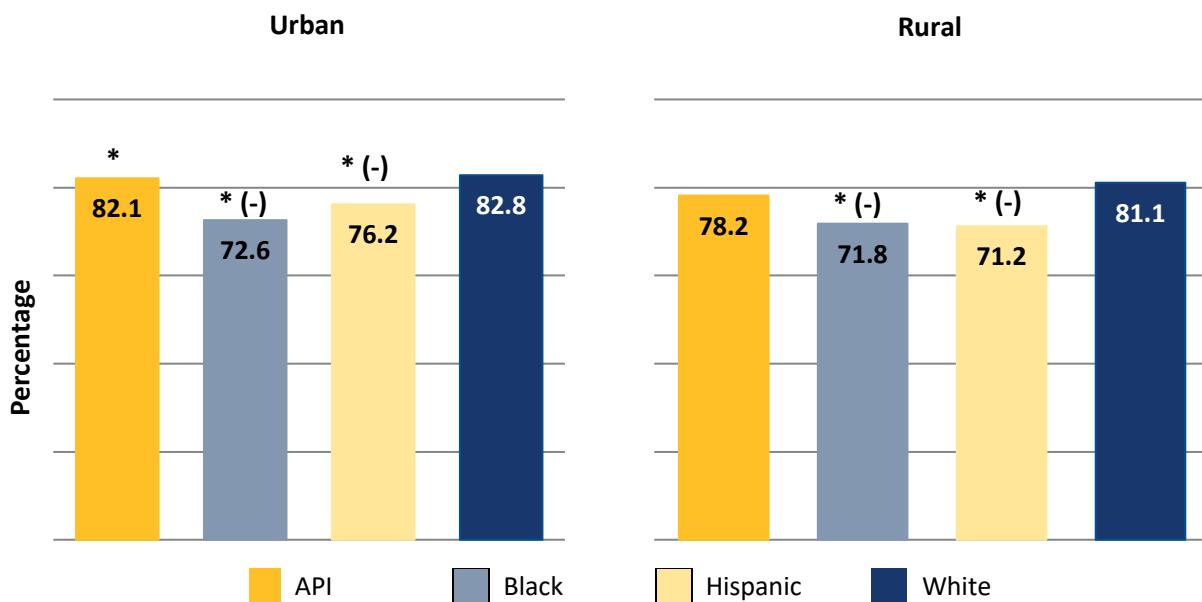
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with diabetes were less likely than urban White beneficiaries with diabetes to have had proper statin medication adherence. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries with diabetes were about as likely as rural White beneficiaries with diabetes to have had proper statin medication adherence.
- In both urban and rural areas, Black beneficiaries with diabetes were less likely than White beneficiaries with diabetes to have had proper statin medication adherence. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with diabetes were less likely than White beneficiaries with diabetes to have had proper statin medication adherence. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

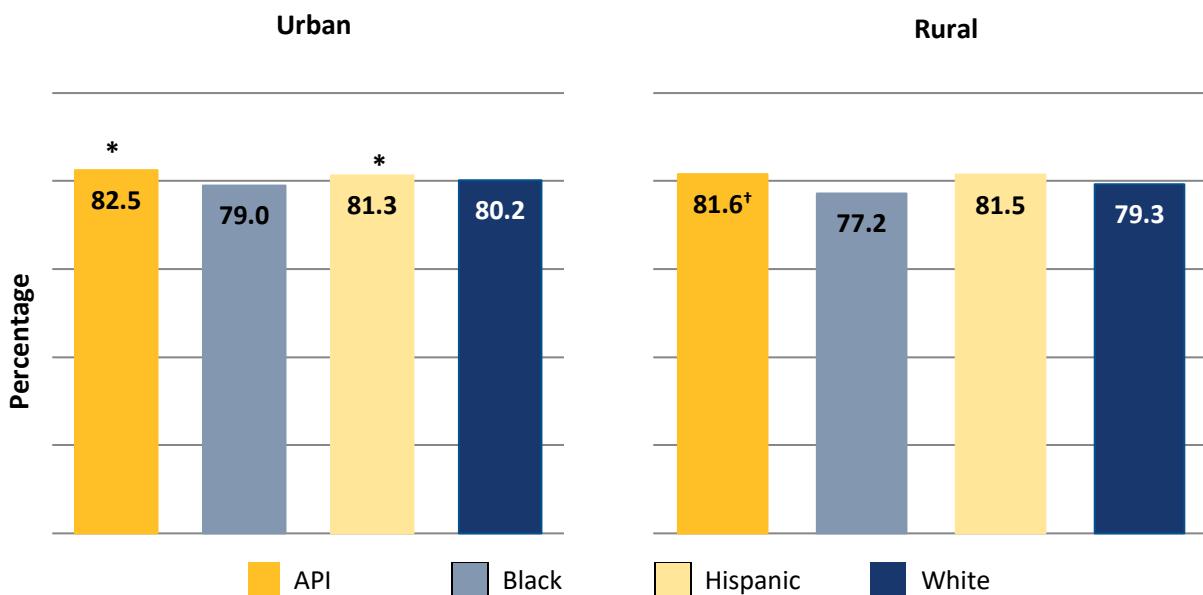
(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] Excludes those who also have clinical atherosclerotic cardiovascular disease.

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 race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who were diagnosed with rheumatoid arthritis were more likely than urban White beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries who were diagnosed with rheumatoid arthritis were about as likely as rural White beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.
- In both urban and rural areas, Black beneficiaries who were diagnosed with rheumatoid arthritis were about as likely as White beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.
- Urban Hispanic beneficiaries who were diagnosed with rheumatoid arthritis were more likely than urban White beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries who were diagnosed with rheumatoid arthritis were about as likely as rural White beneficiaries who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.

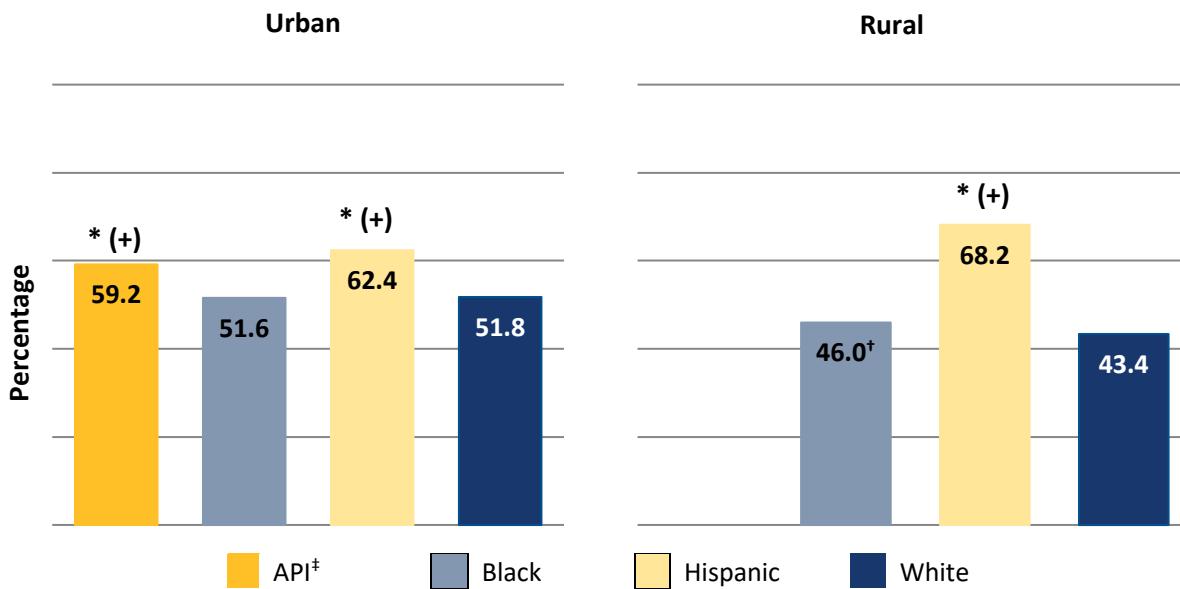
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Osteoporosis Management in Women Who Had a Fracture

Percentage of MA enrollees (women) 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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[‡] There were not enough data from rural API beneficiaries to compare them to White beneficiaries on this measure.

Disparities

- Urban API women who suffered a fracture were more likely than urban White women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between urban API and urban White women was greater than 3 percentage points.
- In both urban and rural areas, Black women who suffered a fracture were about as likely as White women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis.
- In both urban and rural areas, Hispanic women who suffered a fracture were more likely than White women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. In each case, the difference between Hispanic and White women was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

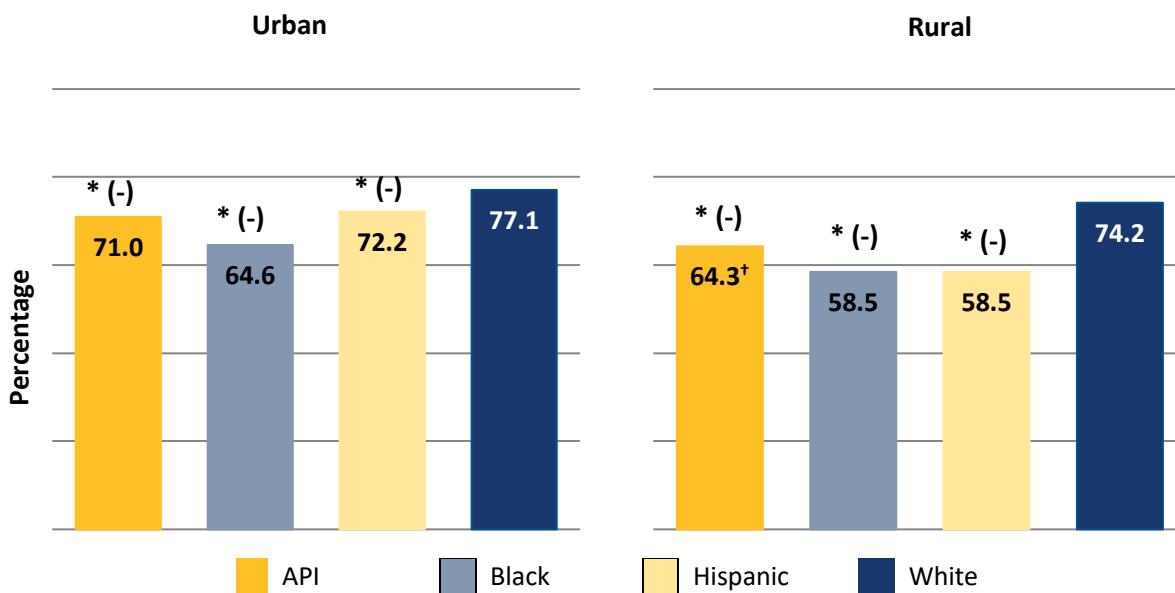
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- In both urban and rural areas, API beneficiaries who were diagnosed with a new episode of major depression were less likely than White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. In each case, the difference between API and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Black beneficiaries who were diagnosed with a new episode of major depression were less likely than White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who were diagnosed with a new episode of major depression were less likely than White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 84 days. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

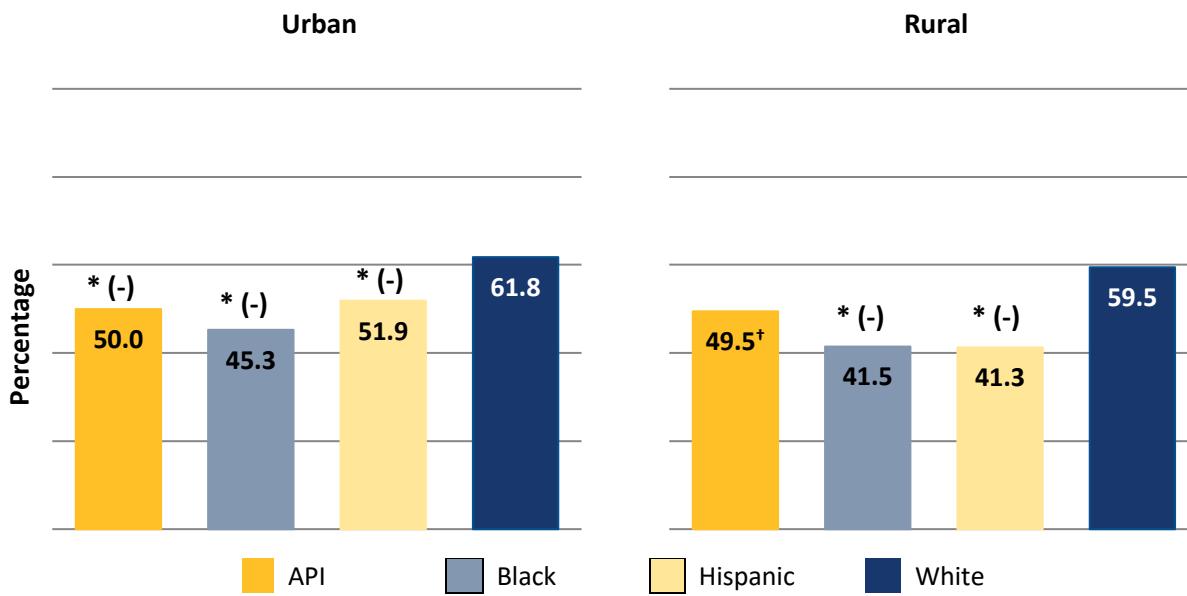
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who were diagnosed with a new episode of major depression were less likely than urban White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. Rural API beneficiaries who were diagnosed with a new episode of major depression were about as likely as rural White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days.
- In both urban and rural areas, Black beneficiaries who were diagnosed with a new episode of major depression were less likely than White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who were diagnosed with a new episode of major depression were less likely than White beneficiaries who were diagnosed with a new episode of major depression to have been newly treated with antidepressant medication and to have remained on the medication for at least 180 days. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

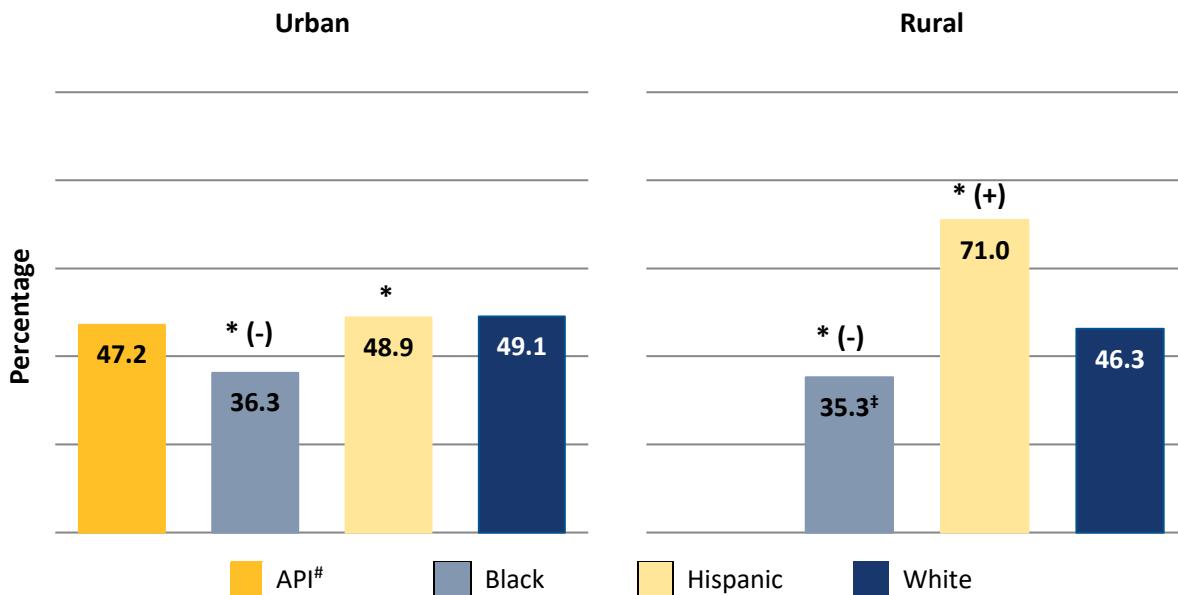
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

[#] There were not enough data from rural API beneficiaries to compare them to White beneficiaries on this measure.

Disparities

- Urban API beneficiaries who were hospitalized for a mental health disorder were about as likely as urban White beneficiaries who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of being discharged.
- In both urban and rural areas, Black beneficiaries who were hospitalized for a mental health disorder were less likely than White beneficiaries who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of being discharged. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- Urban Hispanic beneficiaries who were hospitalized for a mental health disorder were less likely than urban White beneficiaries who were hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of being discharged. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries who were hospitalized for a mental health disorder were more likely than rural White beneficiaries who were hospitalized for a

mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of being discharged. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

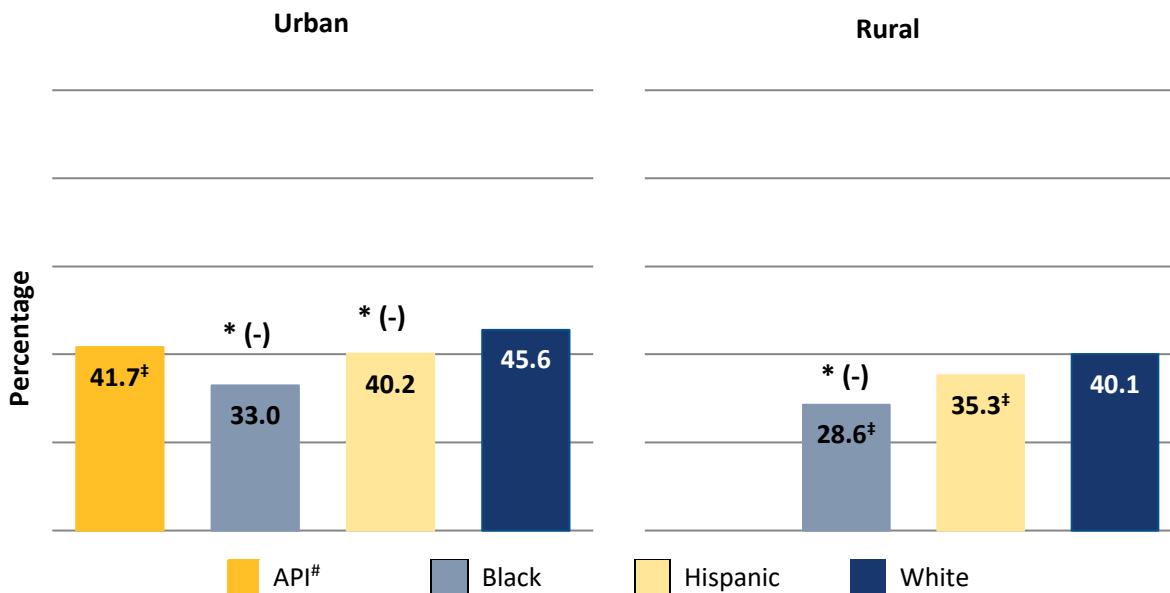
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

There were not enough data from rural API beneficiaries to compare them to White beneficiaries on this measure.

Disparities

- Urban API beneficiaries who had an ED visit for a mental health disorder were about as likely as urban White beneficiaries who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit.
- In both urban and rural areas, Black beneficiaries who had an ED visit for a mental health disorder were less likely than White beneficiaries who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- Urban Hispanic beneficiaries who had an ED visit for a mental health disorder were less likely than urban White beneficiaries who had an ED visit for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit. The difference between urban Hispanic and urban White beneficiaries was greater than 3 percentage points. Rural Hispanic beneficiaries who had an ED visit for a mental health disorder were about as likely as rural White beneficiaries who had an ED visit for a mental

health disorder to have had a follow-up visit with a mental health practitioner within 30 days of the ED visit.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

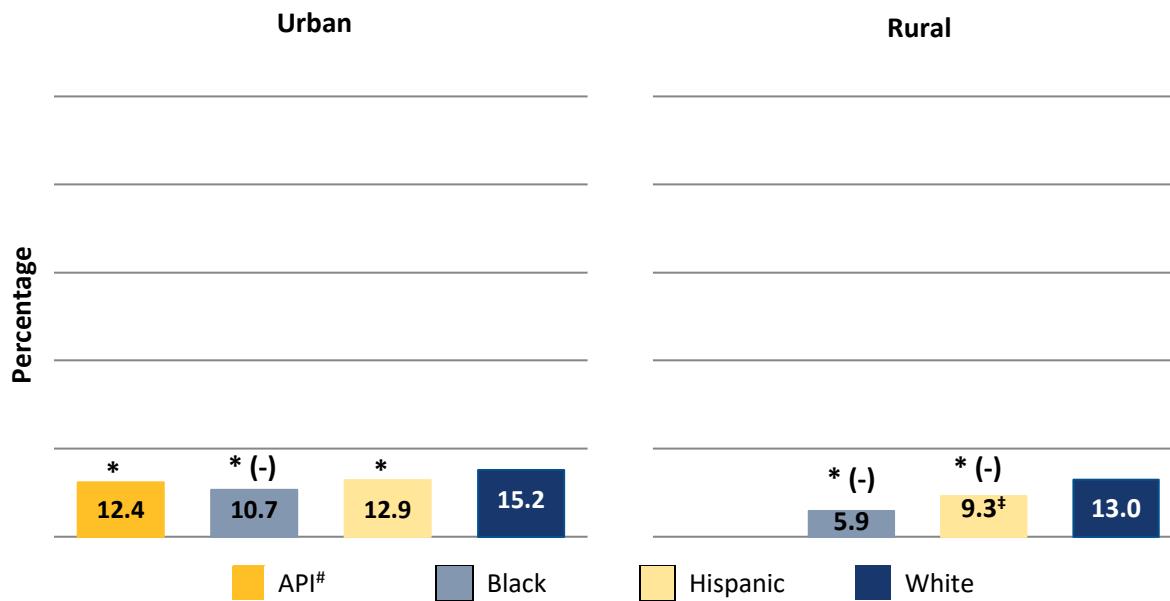
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Follow-up After Emergency Department (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 race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

* There were not enough data from rural API beneficiaries to compare them to White beneficiaries on this measure.

Disparities

- Urban API beneficiaries who had an ED visit for AOD abuse or dependence were less likely than urban White beneficiaries who had an ED visit for AOD abuse or dependence to have had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit. The difference between urban API and urban White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, Black beneficiaries who had an ED visit for AOD abuse or dependence were less likely than White beneficiaries who had an ED visit for AOD abuse or dependence to have had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who had an ED visit for AOD abuse or dependence were less likely than White beneficiaries who had an ED visit for AOD abuse or dependence to have had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit. The difference between urban Hispanic and urban White beneficiaries was less

than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

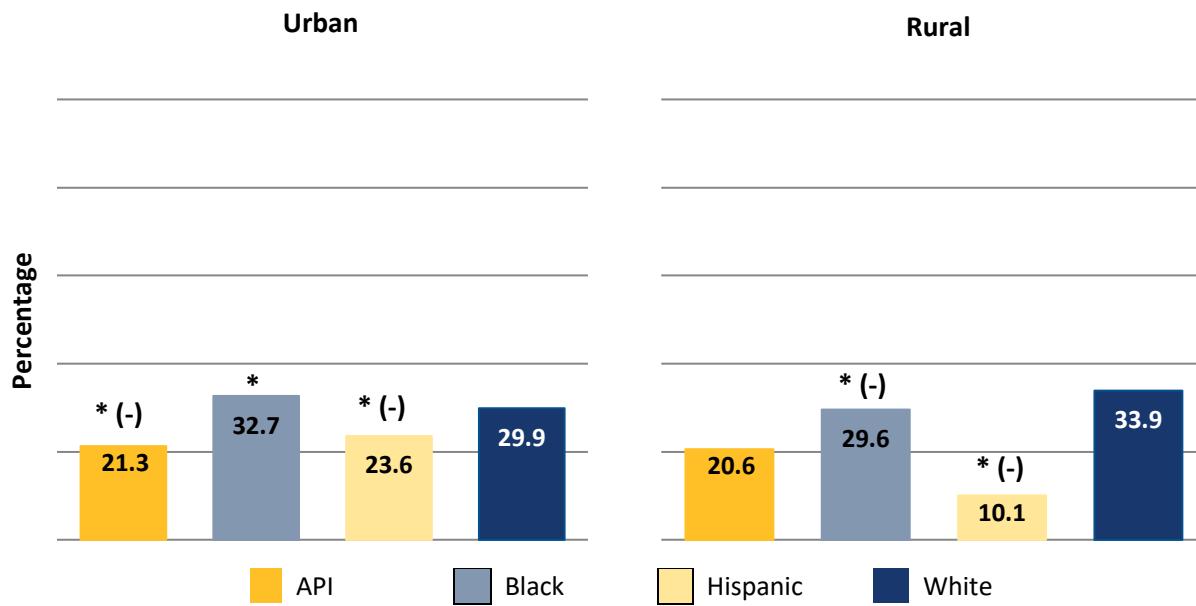
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Initiation of Alcohol and Other Drug Dependence (AOD) Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiate[‡] treatment within 14 days of the diagnosis, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with a new episode of AOD dependence were less likely than urban White beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. Rural API beneficiaries with a new episode of AOD dependence were about as likely as rural White beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis.
- Urban Black beneficiaries with a new episode of AOD dependence were more likely than urban White beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries with a new episode of AOD dependence were less likely than rural White beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between rural Black and rural White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with a new episode of AOD dependence were less likely than White beneficiaries with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

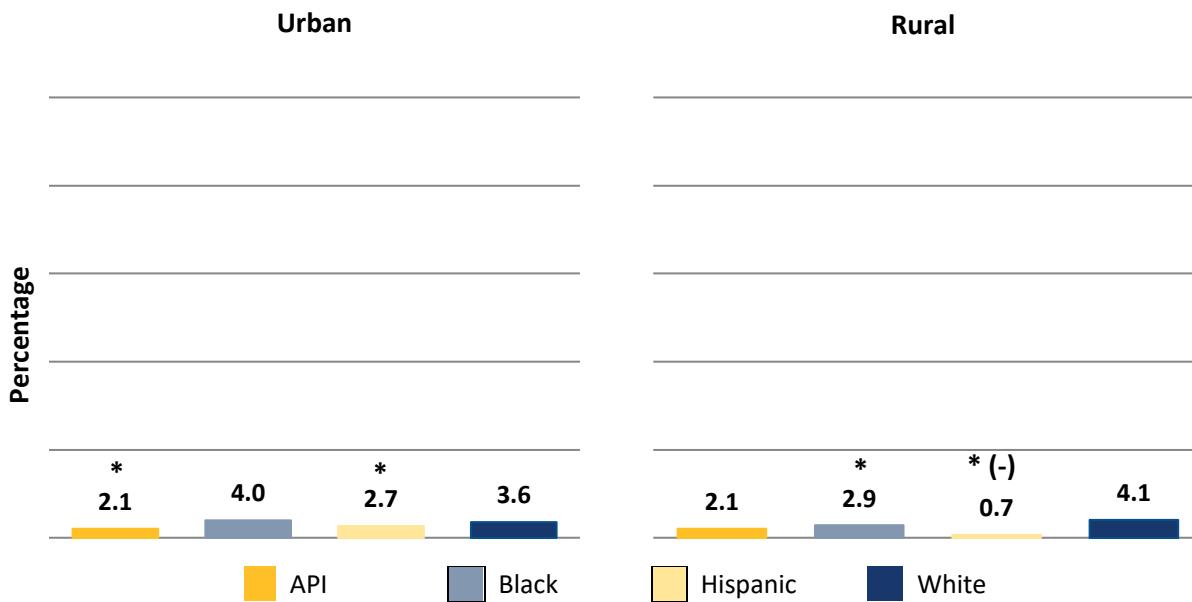
(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

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

Engagement of Alcohol and Other Drug Dependence (AOD) 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 AOD services or medication-assisted treatments within 30 days of the initiation visit, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Urban API beneficiaries with a new episode of AOD dependence who initiated treatment were less likely than urban White beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries with a new episode of AOD dependence who initiated treatment were about as likely as rural White beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment.
- Urban Black beneficiaries with a new episode of AOD dependence who initiated treatment were about as likely as urban White beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. Rural Black beneficiaries with a new episode of AOD dependence who initiated treatment were less likely than rural White beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. The difference between rural Black and rural White beneficiaries was less than 3 percentage points.

- In both urban and rural areas, Hispanic beneficiaries with a new episode of AOD dependence who initiated treatment were less likely than White beneficiaries with a new episode of AOD dependence who initiated treatment to have had two or more AOD services or medication-assisted treatments within 30 days of their initial visit for treatment. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.
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* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

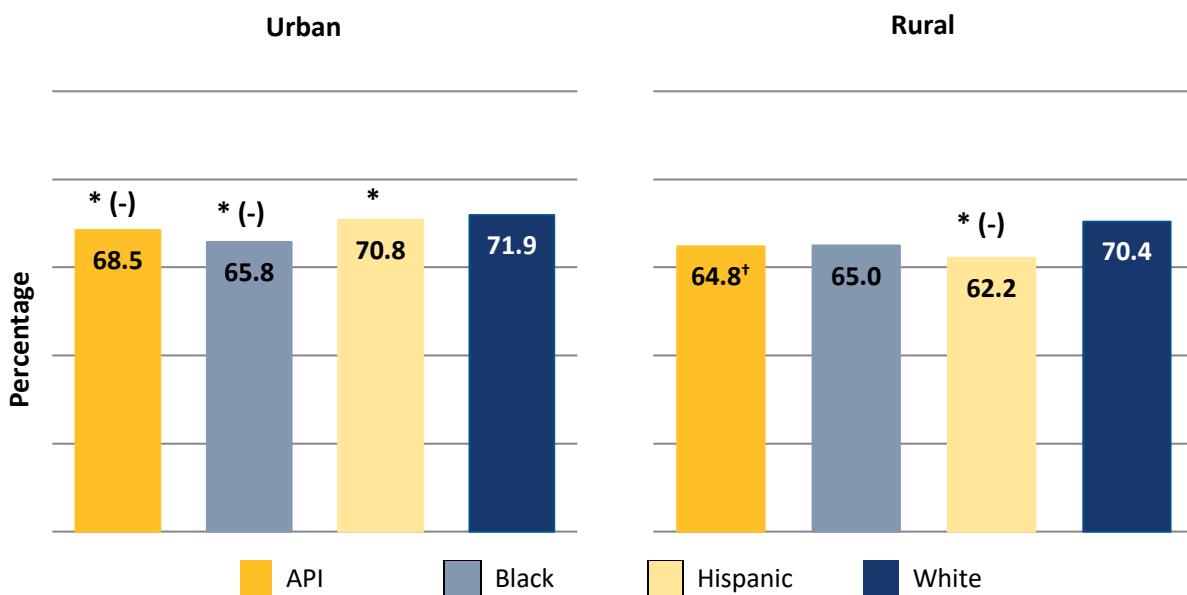
- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Clinical Care: Medication Management and Care Coordination

Medication Reconciliation After Hospital Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility who had their medications reconciled within 30 days, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who were discharged from an inpatient facility were less likely than urban White beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. Rural API beneficiaries who were discharged from an inpatient facility were about as likely as rural White beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days.
- Urban Black beneficiaries who were discharged from an inpatient facility were less likely than urban White beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between urban Black and urban White beneficiaries was greater than 3 percentage points. Rural Black beneficiaries who were discharged from an inpatient facility were about as likely as rural White beneficiaries who were discharged from an inpatient facility to have had their medications reconciled within 30 days.
- In both urban and rural areas, Hispanic beneficiaries who were discharged from an inpatient facility were less likely than White beneficiaries who were discharged from an inpatient

facility to have had their medications reconciled within 30 days. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

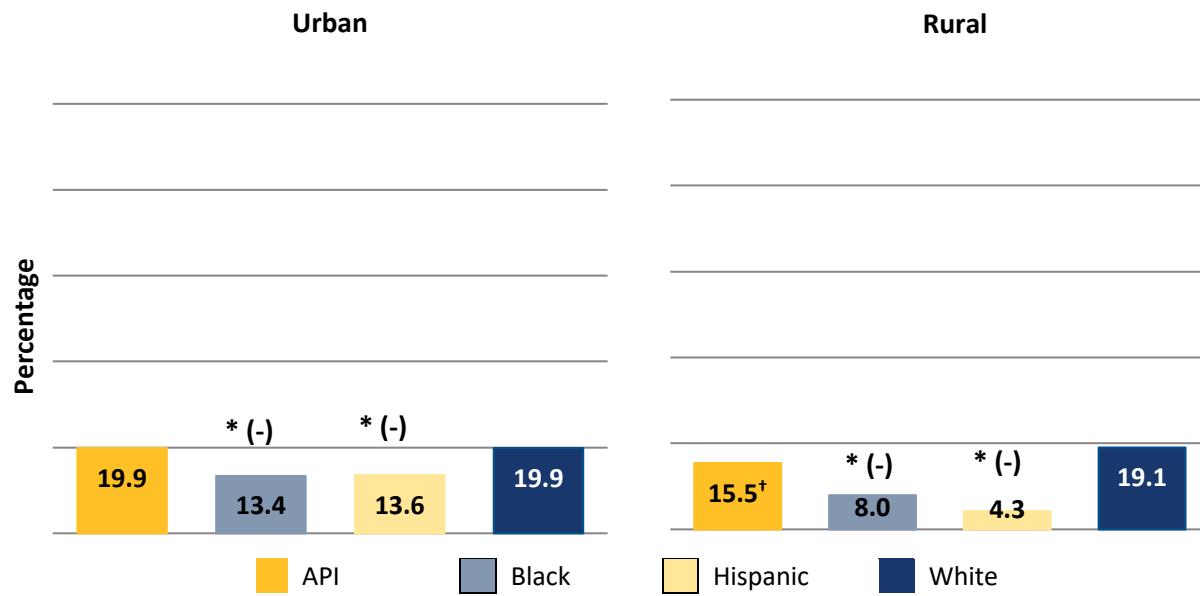
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- In both urban and rural areas, the primary or ongoing care providers of API beneficiaries who were discharged from an inpatient facility were about as likely as the primary or ongoing care providers of White beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission.
- In both urban and rural areas, the primary or ongoing care providers of Black beneficiaries who were discharged from an inpatient facility were less likely than the primary or ongoing care providers of White beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. In each case, the difference between these groups was greater than 3 percentage points.
- In both urban and rural areas, the primary or ongoing care providers of Hispanic beneficiaries who were discharged from an inpatient facility were less likely than the primary or ongoing care providers of White beneficiaries who were discharged from an inpatient facility to have been notified of the inpatient admission on the day of or the day following admission. In each case, the difference between these groups was greater than 3 percentage points.

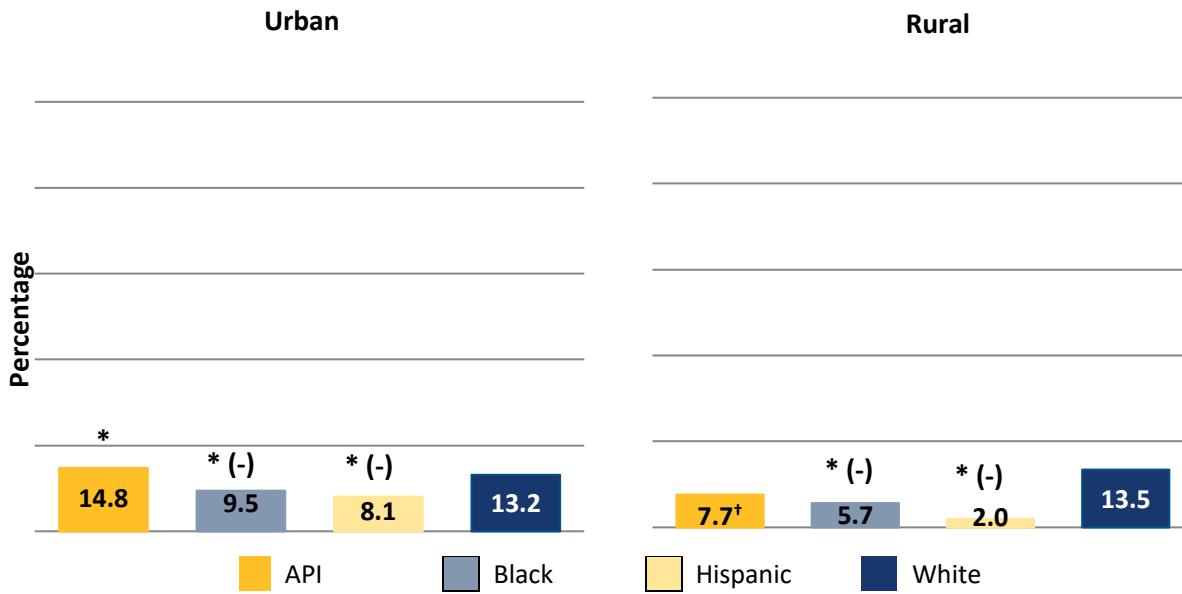
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019**



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who were discharged from an inpatient facility were more likely than urban White beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries who were discharged from an inpatient facility were about as likely as rural White beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge.
- In both urban and rural areas, Black beneficiaries who were discharged from an inpatient facility were less likely than White beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. In each case, the difference between Black and White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries who were discharged from an inpatient facility were less likely than White beneficiaries who were discharged from an inpatient facility to have received discharge information on the day of or the day following discharge. In each case, the difference between Hispanic and White beneficiaries was greater than 3 percentage points.

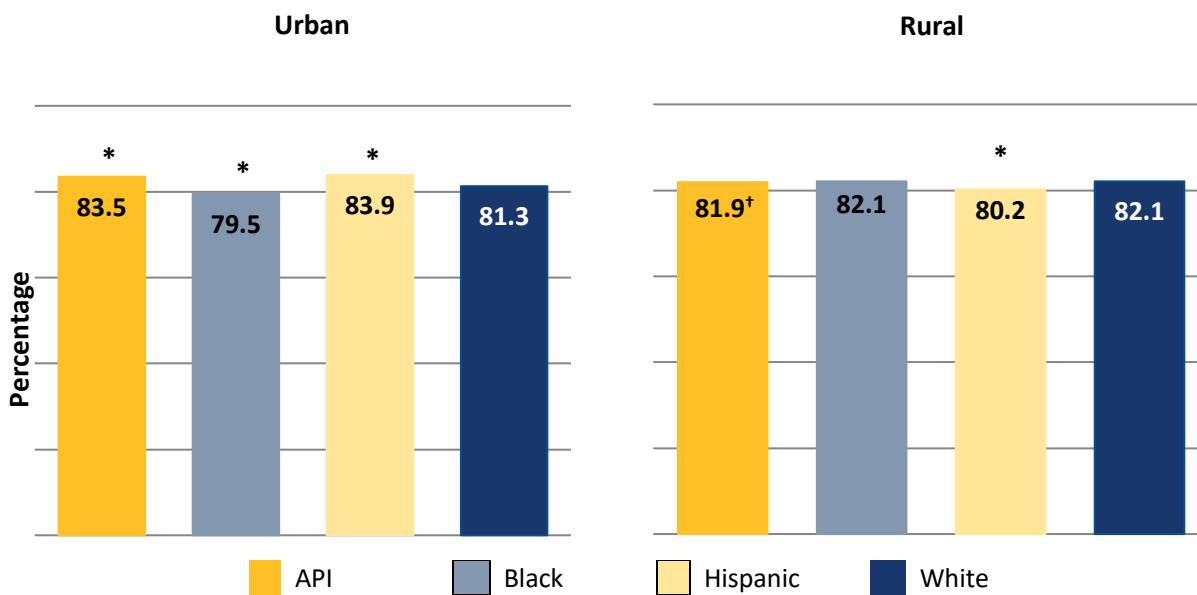
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

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

Disparities

- Urban API beneficiaries who were discharged from an inpatient facility were more likely than urban White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Rural API beneficiaries who were discharged from an inpatient facility were about as likely as rural White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge.
- Urban Black beneficiaries who were discharged from an inpatient facility were less likely than urban White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries who were discharged from an inpatient facility were about as likely as rural White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge.
- Urban Hispanic beneficiaries who were discharged from an inpatient facility were more likely than urban White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge.

discharge. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries who were discharged from an inpatient facility were less likely than rural White beneficiaries who were discharged from an inpatient facility to have had an office visit, to have had a home visit, or to have received telehealth services within 30 days of discharge. The difference between rural Hispanic and rural White beneficiaries was less than 3 percentage points.

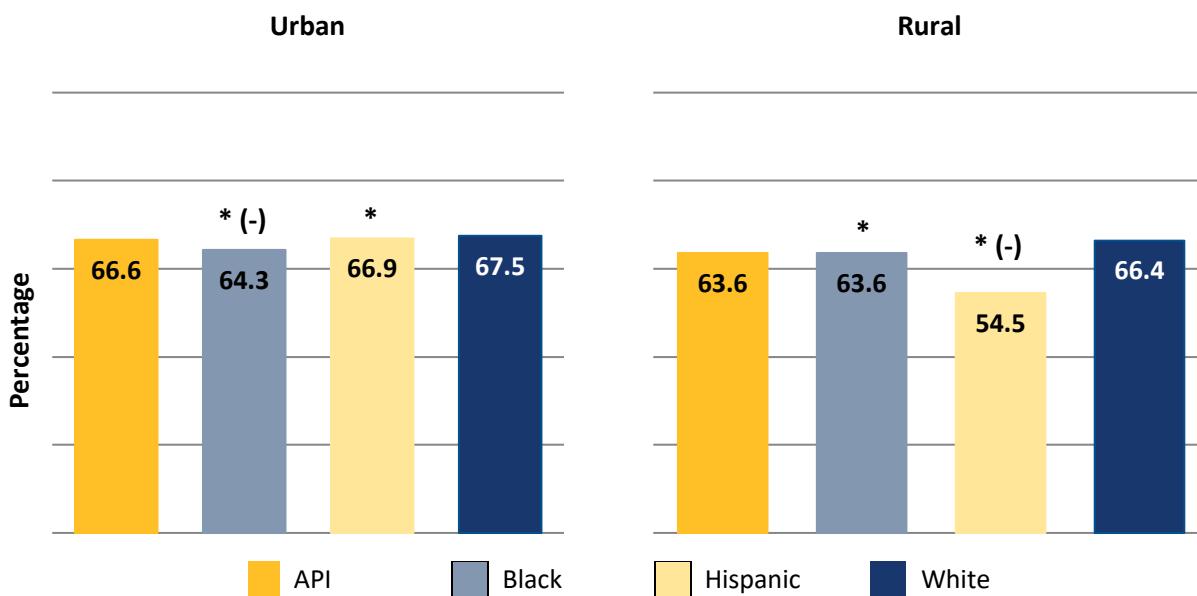
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Follow-up After Emergency Department (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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries with multiple high-risk chronic conditions were about as likely as White beneficiaries with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit.
- In both urban and rural areas, Black beneficiaries with multiple high-risk chronic conditions were less likely than White beneficiaries with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit. The difference between urban Black and urban White beneficiaries was greater than 3 percentage points. The difference between rural Black and rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, Hispanic beneficiaries with multiple high-risk chronic conditions were less likely than White beneficiaries with multiple high-risk chronic conditions to have received follow-up care within seven days of an ED visit. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

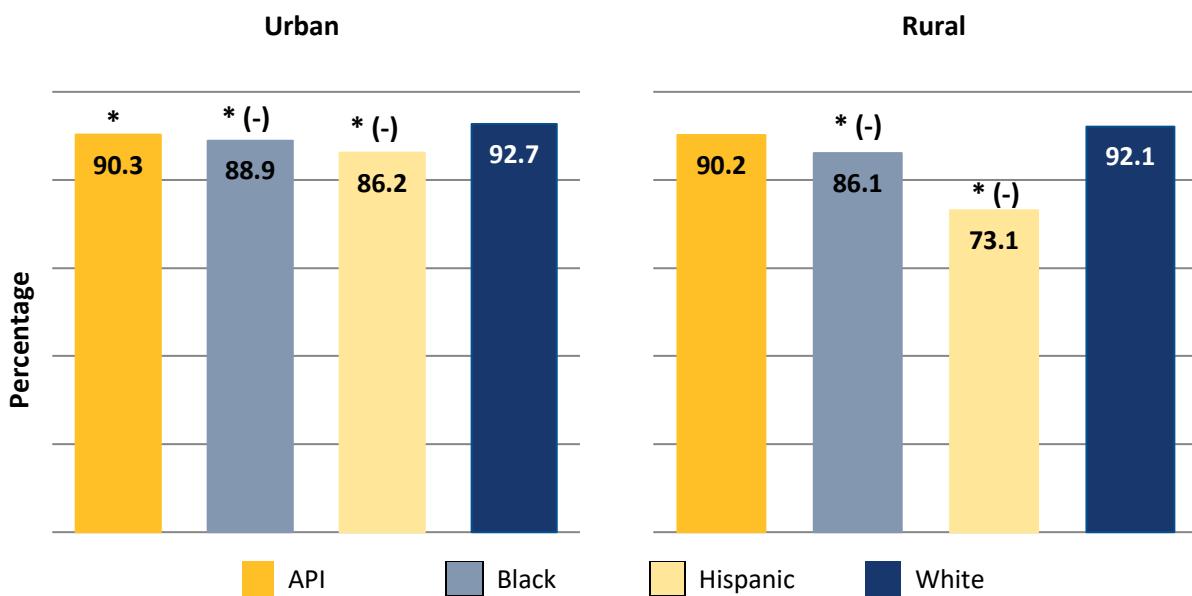
(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Clinical Care: Overuse/Appropriateness

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of potentially harmful medication was avoided less often for elderly urban API beneficiaries with chronic renal failure than for elderly urban White beneficiaries with chronic renal failure. The difference between elderly urban API and elderly urban White beneficiaries was less than 3 percentage points. Use of potentially harmful medication was avoided about as often for elderly rural API beneficiaries with chronic renal failure as for elderly rural White beneficiaries with chronic renal failure.
- In both urban and rural areas, use of potentially harmful medication was avoided less often for elderly Black beneficiaries with chronic renal failure than for elderly White beneficiaries with chronic renal failure. In each case, the difference between elderly Black and elderly White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, use of potentially harmful medication was avoided less often for elderly Hispanic beneficiaries with chronic renal failure than for elderly White beneficiaries with chronic renal failure. In each case, the difference between elderly Hispanic and elderly White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

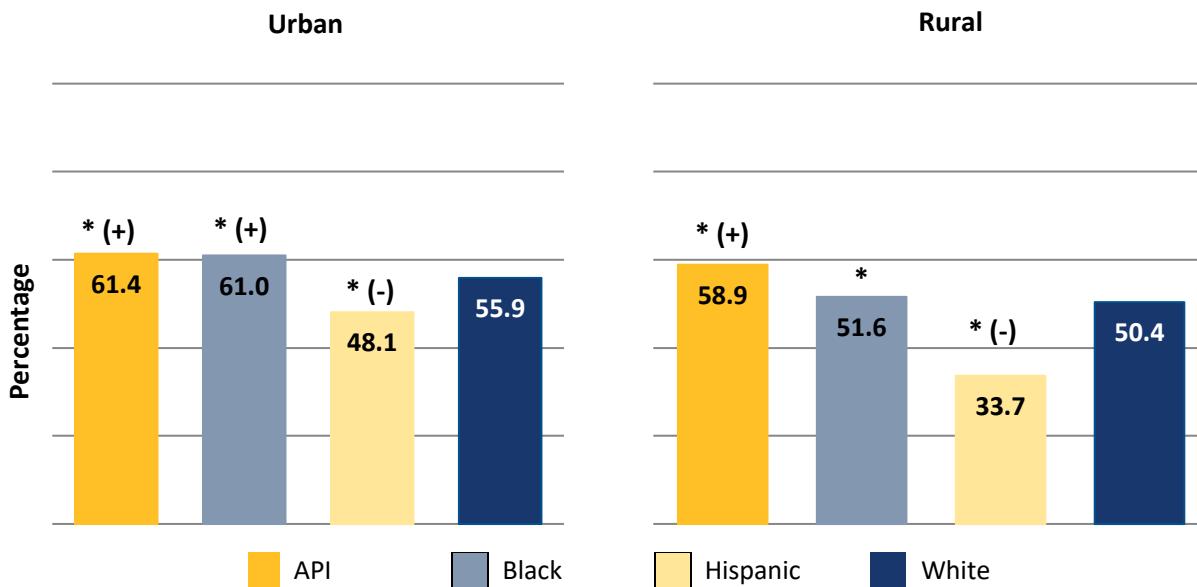
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) and 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 race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, use of potentially harmful medication was avoided more often for elderly API beneficiaries with dementia than for elderly White beneficiaries with dementia. In each case, the difference between elderly API and elderly White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, use of potentially harmful medication was avoided more often for elderly Black beneficiaries with dementia than for elderly White beneficiaries with dementia. The difference between elderly urban Black and elderly urban White beneficiaries was greater than 3 percentage points. The difference between elderly rural Black and elderly rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, use of potentially harmful medication was avoided less often for elderly Hispanic beneficiaries with dementia than for elderly White beneficiaries with dementia. In each case, the difference between elderly Hispanic and elderly White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

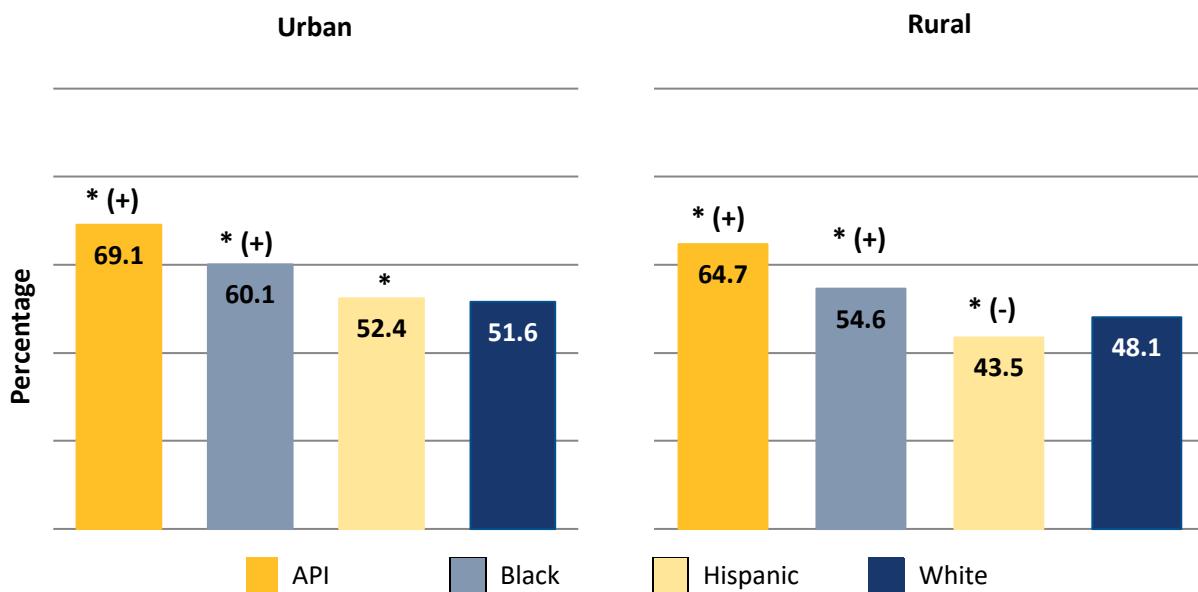
(+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.

(-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] 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 race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, use of potentially harmful medication was avoided more often for elderly API beneficiaries with a history of falls than for elderly White beneficiaries with a history of falls. In each case, the difference between elderly API and elderly White beneficiaries was greater than 3 percentage points.
- In both urban and rural areas, use of potentially harmful medication was avoided more often for elderly Black beneficiaries with a history of falls than for elderly White beneficiaries with a history of falls. In each case, the difference between elderly Black and elderly White beneficiaries was greater than 3 percentage points.
- Use of potentially harmful medication was avoided more often for elderly urban Hispanic beneficiaries with a history of falls than for elderly urban White beneficiaries with a history of falls. The difference between elderly urban Hispanic and elderly urban White beneficiaries was less than 3 percentage points. Use of potentially harmful medication was avoided less often for elderly rural Hispanic beneficiaries with a history of falls than for elderly rural White beneficiaries with a history of falls. The difference between elderly rural Hispanic and elderly rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

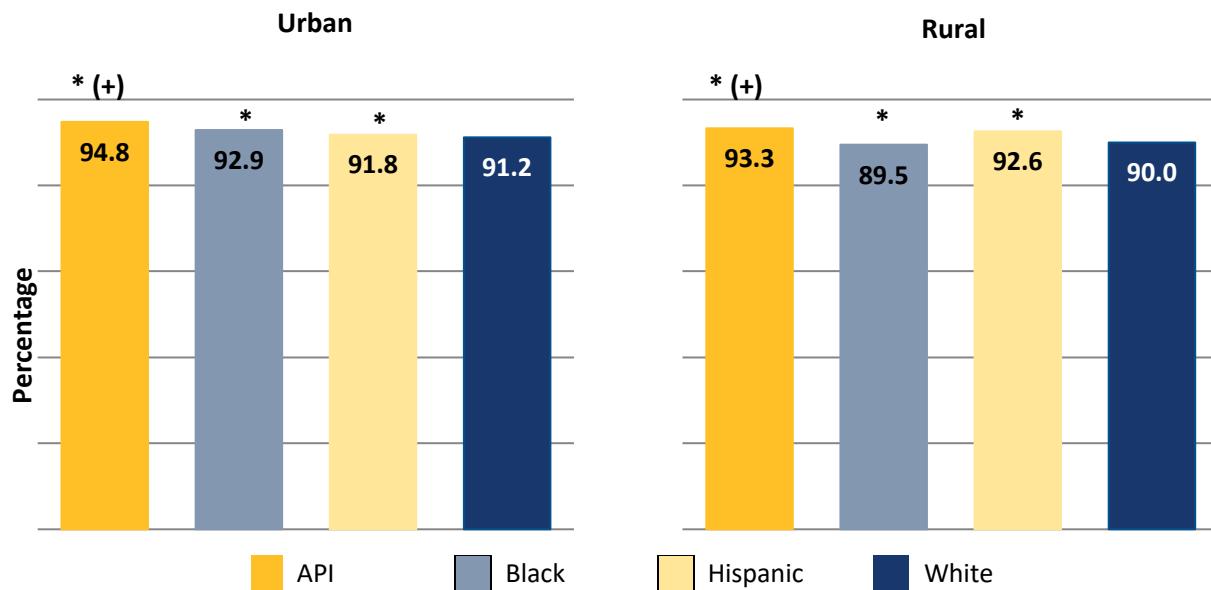
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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

Avoiding Use of High-Risk Medications in the Elderly

Percentage of MA enrollees aged 65 years and older who were not prescribed a high-risk medication, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, use of high-risk medication was avoided more often for elderly API beneficiaries than for elderly White beneficiaries. In each case, the difference between elderly API and elderly White beneficiaries was greater than 3 percentage points.
- Use of high-risk medication was avoided more often for elderly urban Black beneficiaries than for elderly urban White beneficiaries. The difference between elderly urban Black and elderly urban White beneficiaries was less than 3 percentage points. Use of high-risk medication was avoided less often for elderly rural Black beneficiaries than for elderly rural White beneficiaries. The difference between elderly rural Black and elderly rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, use of high-risk medication was avoided more often for elderly Hispanic beneficiaries than for elderly White beneficiaries. In each case, the difference between elderly Hispanic and elderly White beneficiaries was less than 3 percentage points.

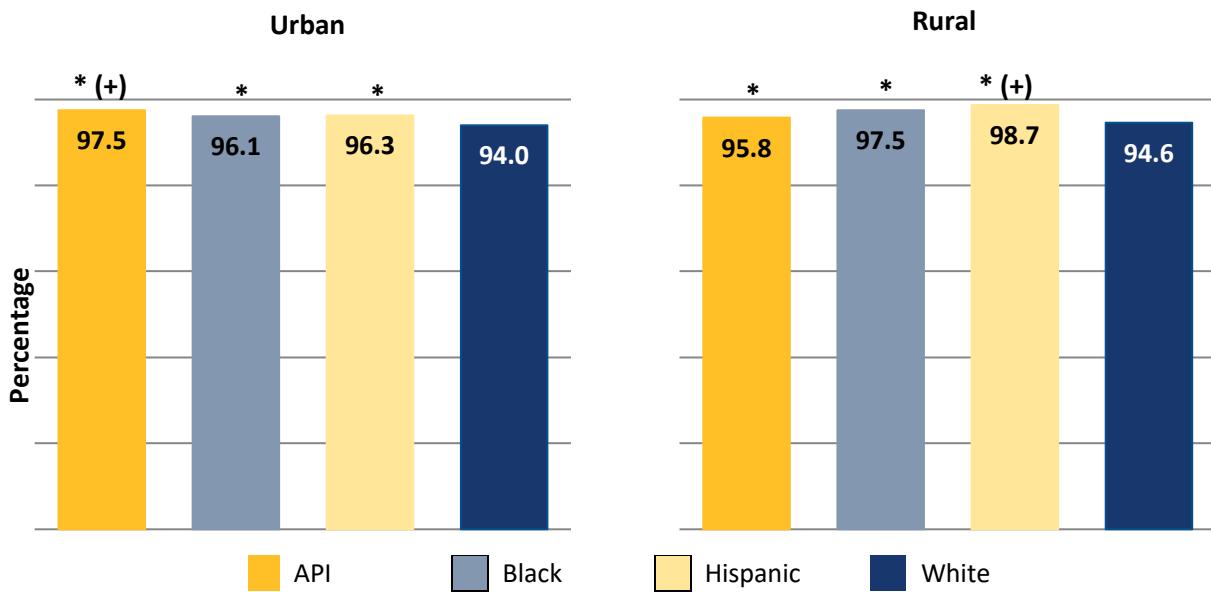
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage[†] for more than 14 days, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, use of opioids at a high dosage for more than 14 days was avoided more often for API beneficiaries than for White beneficiaries. The difference between urban API and urban White beneficiaries was greater than 3 percentage points. The difference between rural API and rural White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, use of opioids at a high dosage for more than 14 days was avoided more often for Black beneficiaries than for White beneficiaries. In each case, the difference between Black and White beneficiaries was less than 3 percentage points.
- In both urban and rural areas, use of opioids at a high dosage for more than 14 days was avoided more often for Hispanic beneficiaries than for White beneficiaries. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

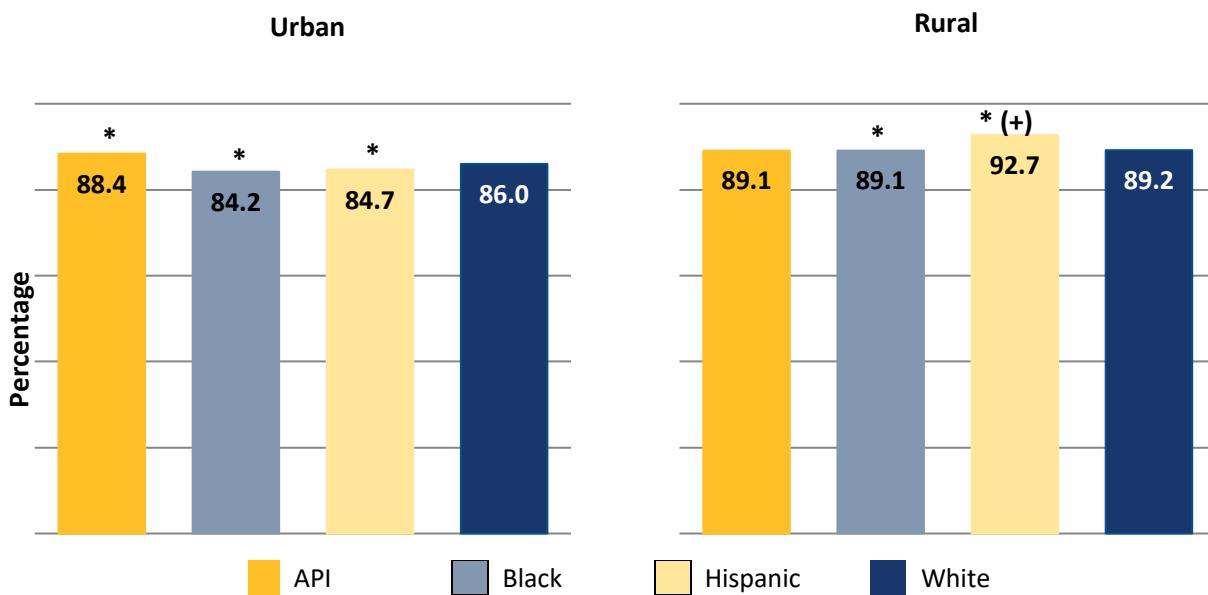
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

[†] Average morphine equivalent dose > 120 mg.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of opioids from multiple prescribers was avoided more often for urban API beneficiaries than for urban White beneficiaries. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Use of opioids from multiple prescribers was avoided about as often for rural API beneficiaries as for rural White beneficiaries.
- In both urban and rural areas, use of opioids from multiple prescribers was avoided less often for Black beneficiaries than for White beneficiaries. In each case, the difference between Black and White beneficiaries was less than 3 percentage points.
- Use of opioids from multiple prescribers was avoided less often for urban Hispanic beneficiaries than for urban White beneficiaries. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Use of opioids from multiple prescribers was avoided more often for rural Hispanic beneficiaries than for rural White beneficiaries. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

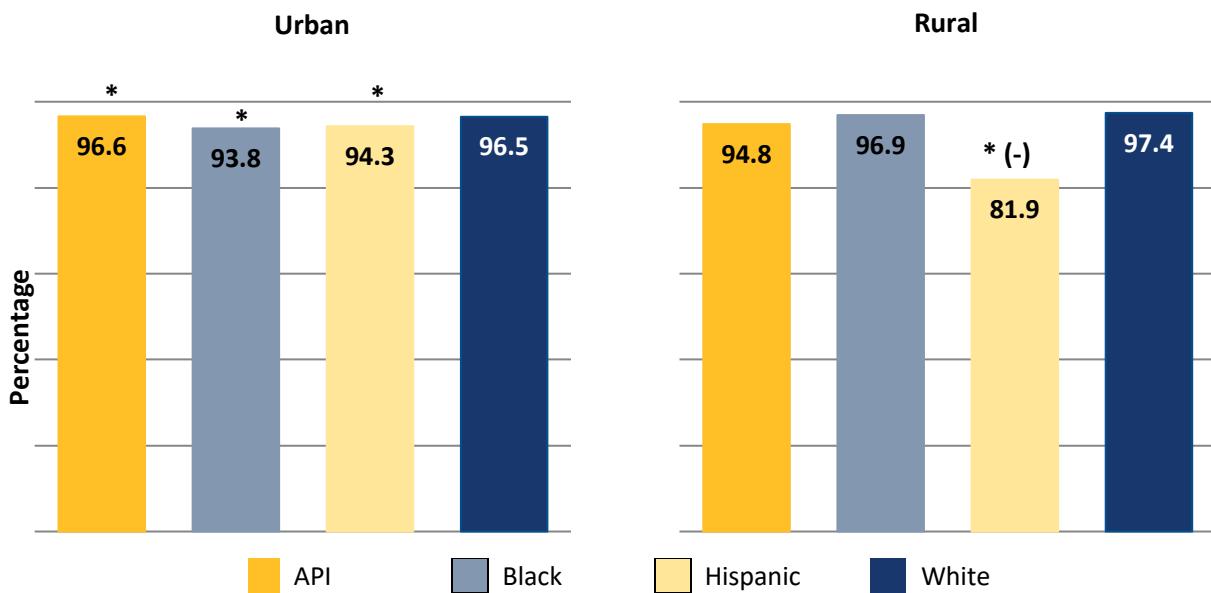
* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- Use of opioids from multiple pharmacies was avoided more often for urban API beneficiaries than for urban White beneficiaries. The difference between urban API and urban White beneficiaries was less than 3 percentage points. Use of opioids from multiple pharmacies was avoided about as often for rural API beneficiaries as for rural White beneficiaries.
- Use of opioids from multiple pharmacies was avoided less often for urban Black beneficiaries than for urban White beneficiaries. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Use of opioids from multiple pharmacies was avoided about as often for rural Black beneficiaries as for rural White beneficiaries.
- In both urban and rural areas, use of opioids from multiple pharmacies was avoided less often for Hispanic beneficiaries than for White beneficiaries. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. The difference between rural Hispanic and rural White beneficiaries was greater than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

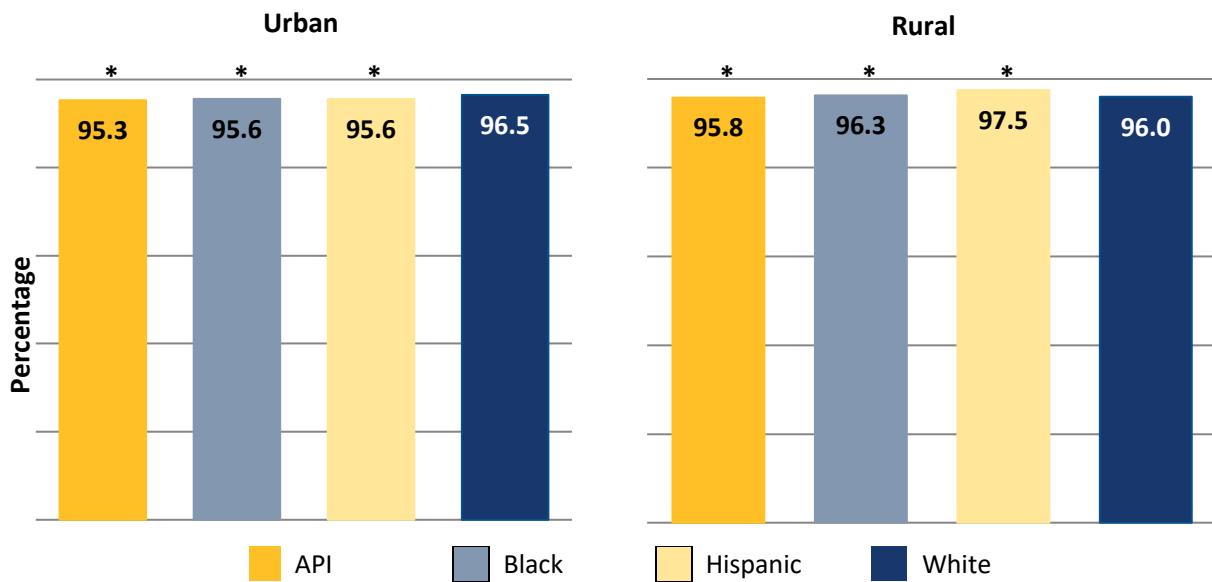
For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Clinical Care: Access/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, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.

NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Disparities

- In both urban and rural areas, API beneficiaries were less likely than White beneficiaries to have had an ambulatory or preventive care visit. In each case, the difference between API and White beneficiaries was less than 3 percentage points.
- Urban Black beneficiaries were less likely than urban White beneficiaries to have had an ambulatory or preventive care visit. The difference between urban Black and urban White beneficiaries was less than 3 percentage points. Rural Black beneficiaries were more likely than rural White beneficiaries to have had an ambulatory or preventive care visit. The difference between rural Black and rural White beneficiaries was less than 3 percentage points.
- Urban Hispanic beneficiaries were less likely than urban White beneficiaries to have had an ambulatory or preventive care visit. The difference between urban Hispanic and urban White beneficiaries was less than 3 percentage points. Rural Hispanic beneficiaries were more likely than rural White beneficiaries to have had an ambulatory or preventive care visit. The difference between rural Hispanic and rural White beneficiaries was less than 3 percentage points.

* Significantly different from the score for White residents of the same locality ($p < 0.05$).

For statistically significant differences between White beneficiaries and racial or ethnic minorities of the same locality, the following symbols are also used when applicable:

- (+) Difference is ≥ 3 points (prior to rounding) and favors the racial or ethnic minority group.
- (-) Difference is ≥ 3 points (prior to rounding) and favors White beneficiaries.

Appendix: Data Sources and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems Surveys

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey consists of a set of mail surveys with telephone follow-ups based on a stratified random sample of Medicare beneficiaries, with contracts serving as strata for Medicare Advantage (MA) beneficiaries and for fee-for-service (FFS) beneficiaries enrolled in prescription drug plans (PDPs) and states serving as strata for FFS beneficiaries not enrolled in a PDP. The 2019 survey attempted to contact 874,398 Medicare beneficiaries and received responses from 318,116, a 36.4 percent response rate. The 2019 survey represents all FFS beneficiaries, MA beneficiaries from 449 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP beneficiaries from 53 PDP contracts with at least 1,500 eligible enrollees.

The Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) consists of more than 90 measures across six domains of care (National Committee for Quality Assurance [NCQA], 2020). These domains include effectiveness of care, access/availability of care, experience of care, utilization and risk-adjusted utilization, relative resource use, and health plan descriptive information. HEDIS measures are developed, tested, and validated under the direction of NCQA. Although CAHPS data are collected only via surveys, HEDIS data are gathered both via surveys and via medical charts and insurance claims 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 the Centers for Medicare & Medicaid Services (CMS), or were deemed unsuitable for this application by CMS experts. HEDIS data are available only for MA beneficiaries.

Information on Geography

Beneficiaries were classified as living in a rural or urban area based on the zip code of their mailing address and the corresponding 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, any beneficiary residing within a metropolitan statistical area was classified as an urban resident; any beneficiary living in a micropolitan statistical area or outside of a CBSA was classified as a rural resident.

Information on Race and Ethnicity

The 2019 CAHPS survey asked beneficiaries, “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.” Following a U.S. Census approach, answers to these two questions were used to classify respondents into one of seven mutually exclusive categories: Hispanic, multiracial, American Indian/Alaska Native (AI/AN), Asian/Pacific Islander (API), Black, 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” but no other race were classified as API.
- Non-Hispanic respondents who selected exactly one race were classified as AI/AN, API, Black, or White, according to their responses.
- Respondents without data regarding race/ethnicity were classified as unknown.
- Unknown cases were dropped from the analysis. The multiracial group was included in the analysis, but estimates for this group are not presented in this report.

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, surname, and residential location (Haas et al., 2019). This methodology is recommended for estimating racial and ethnic disparities for Black, Hispanic, API, and White beneficiaries, but not for AI/AN or multiracial beneficiaries. In 2019, there were 529 MA contracts that supplied the 18,870,141 HEDIS measure records used.

Comparisons of rural-urban differences in patient experience by racial and ethnic group and racial and ethnic differences in patient experience by geography focus on AI/AN, API, Black, Hispanic, and White beneficiaries. Comparisons of rural-urban differences in clinical care by racial and ethnic group and racial and ethnic differences in clinical care by geography focus on API, Black, Hispanic, and White beneficiaries. Estimates of clinical care delivered to AI/AN beneficiaries were excluded for the reason noted above.

Analytic Approach

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

CAHPS estimates for rural and urban residents are from case-mix adjusted linear regression models that contained health contract intercepts, an indicator of rural residence (urban was the reference group), and the following case-mix adjustors: age, education, self-rated health and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. CAHPS estimates for rural and urban residents of different racial and ethnic backgrounds are from case-mix adjusted linear regression models stratified by racial and ethnic group. These models contained health contract intercepts, an indicator of rural residence, and the same set of case-mix adjustors used in the overall rural-urban models.

Predicted probabilities of race and ethnicity were used as weights to develop HEDIS-measure estimates for racial and ethnic subgroups (Elliott et al., 2009). None of the HEDIS measures reported (including the annual flu vaccine measure) is case-mix adjusted.

Cases with missing data on outcome measures were excluded from the analysis. There were no missing data on predictors (race and ethnicity and rural/urban residence) included in the analyses of HEDIS measures. For analyses of CAHPS measures, cases with missing information on race/ethnicity (about 4 percent) were excluded from the analysis, and missing data on case-mix adjustors were imputed using the health contract mean. There were no missing data on rural/urban residence.

Statistical significance tests were used to compare the model-estimated scores for rural residents with the score for urban residents and to compare model-estimated scores for racial and ethnic minority groups with scores for White beneficiaries. A difference in scores is denoted as statistically significant if there is less than a 5-percent chance that the difference could have resulted due to sampling error alone. Differences that are statistically significant and larger than 3 points on a 0–100 scale (CAHPS) or 3

percentage points (HEDIS) are further denoted as practically significant. That is, in the charts that present national data on rural-urban differences in patient experience (CAHPS) and clinical care (HEDIS), differences that are not statistically significant or are statistically significant but less than 3 points in magnitude are distinguished (using symbols and labeling) from differences that are both statistically significant and 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

References

- Caldwell, Julia T., Chandra L. Ford, Steven P. Wallace, May C. Wang, and Lois M. Takahashi, "Intersection of Living in a Rural Versus Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States," *American Journal of Public Health*, Vol. 106, No. 8, 2016, pp. 1463–1469.
- Elliott, Marc N., Peter A. Morrison, Allen M. Fremont, Daniel F. McCaffrey, Philip Pantoja, and Nicole Lurie, "Using the Census Bureau's Surname List to Improve Estimates of Race/Ethnicity and Associated Disparities," *Health Services and Outcomes Research Methodology*, Vol. 9, No. 2, 2009, pp. 69–83.
- Haas, Ann, Marc N. Elliott, Jacob W. Dembosky, John L. Adams, Shondelle M. Wilson-Frederick, Joshua S. Mallett, Sarah Gaillot, Samuel C. Haffer, and Amelia M. Haviland, "Imputation of Race/Ethnicity to Enable Measurement of HEDIS Performance by Race/Ethnicity," *Health Services Research*, Vol. 54, No. 1, 2019, pp. 13–23.
- Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academy Press, 2001.
- James, Cara, Ramal Moonesinghe, Shondelle M. Wilson-Frederick, Jeffrey E. Hall, Ana Penman-Aguilar, and Karen Bouye, "Racial/Ethnic Health Disparities Among Rural Adults—United States, 2012–2015," *MMWR Surveillance Summaries*, Vol. 66, No. 23, 2017, pp. 1–9.
- Meit, Michael, Alana Knudson, Tess Gilberr, Amanda Tzy-Chyi Yu, Erin Tanenbaum, Elizabeth Ormson, Shannon TenBroeck, Alycia Bayne, and Shena Popat, *The 2014 Update of the Rural-Urban Chartbook*, Bethesda, Md.: Rural Health Reform Policy Research Center, 2014.
- National Committee for Quality Assurance, "HEDIS Measures and Technical Resources," webpage, 2020. As of May 1, 2020: <https://www.ncqa.org/hedis/measures/>
- Paddison, Charlotte A., Marc N. Elliott, Amelia M. Haviland, Donna O. Farley, Georgios Lyratzopoulos, Katrin Hambarsoomian, Jacob W. Dembosky, and Martin O. Roland, "Experiences of Care Among Medicare Beneficiaries with ESRD: Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results," *American Journal of Kidney Diseases*, Vol. 61, No. 3, 2013, pp. 440–449.
- Probst, Janice C., Charity G. Moore, Saundra H. Glover, and Michael E. Samuels. "Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health," *American Journal of Public Health*, Vol. 94, No. 10, 2004, pp. 1695–1703.

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