

WHITE PAPER

Trends in Quality Measure Performance Across Public and Private Insurance Types: 2018-2023

Introduction

Achieving the highest level of health for all people is a national priority. Quality measures are a way to incentivize and hold providers and healthcare payers – private commercial insurance companies and Medicare and Medicaid programs – accountable for delivering efficient, evidence-based, high-quality, and cost-effective care.

In 1991, the HMO group, today known as the [Alliance of Community Health Plans](#), released the first draft of a standard set of measurements, the Healthcare Effectiveness Data and Information Set (HEDIS®), in cooperation with its coalition members. HEDIS is a set of performance measures used widely by managed care. The measures have evolved over the past 30 years wherein the National Committee for Quality Assurance (NCQA) coordinates their development, refinement, and maintenance. HEDIS includes more than 95 measures over six (6) domains of care: (1) Effectiveness of Care, (2) Access/Availability of Care, (3) Experience of Care, (4) Health Services Utilization, (5) Health Plan Descriptive Information, and (6) Measures Reported Using Electronic Clinical Data Systems. The measures are designed to compare health plan performance relative to national benchmarks to support quality improvement, pay for reporting, and public reporting initiatives.

This report evaluates and compares how different types of insurance plans perform on a set of five widely used quality measures from 2018 to 2023. The analysis utilized nationally representative administrative claims data from commercial, Medicare (including traditional Fee-for-Service and Medicare Advantage), and managed Medicaid insurance plans. The five measures assess a range of service and outcome-based issues that are important to achieving high-quality and equitable care, including access to care, use of preventive screenings, use of evidence-based treatments, and avoiding hospital readmissions.

Population

The quality measures presented in this report were calculated using data from Inovalon's Medical Outcomes for Research Effectiveness and Economics Registry (MORE² Registry®) dataset as well as data from the 100% Medicare Fee-For-Service (FFS) encounter claims received by Inovalon as a designated national Qualified Entity. The MORE² Registry combines medical and pharmacy encounter claims sourced directly from over 160 commercial, Medicare Advantage (MA), and managed Medicaid health plans operating in all 50 states in the U.S.



Quality Measures

A set of five quality measures have been evaluated each year over the six-year period starting from the first report in 2018 through the current report using 2023 claims data. The measures are stratified and reported by insurance type, including commercial health plans, Medicare (inclusive of Medicare FFS and MA), and managed Medicaid. The measures were selected because of their importance to achieving high quality care.

- Access to care through office visits with primary care physicians is essential to maintaining good health.
- Receipt of preventive screenings and tests have been demonstrated to avoid costly adverse events and slow the progression or worsening burden of illness related to chronic diseases.
- Hospital readmissions following a prior hospital discharge are associated with higher healthcare costs and are a burden on patients. Reducing hospital readmissions is a focus area for the Centers for Medicare & Medicaid Services (CMS) and is included in several value-based purchasing initiatives.
- Alcohol abuse and other drug dependencies present a major public health issue in the U.S. and can lead to poor health outcomes. The opioid crisis continues to present challenges at national and local levels across the nation.

The five quality measures evaluated include:

1. Adult Access to Prevention/Ambulatory Health Services (AAP)
2. Breast Cancer Screening (BCS)
3. Plan All-Cause Readmission (PCR)
4. Initiation of Alcohol/Other Drug Dependence Treatment (Initiation AOD)
5. Engagement of Alcohol/Other Drug Dependence Treatment (Engagement AOD)

To keep the measures consistent and useful for trending across the years, measures were calculated using the 2018 HEDIS technical specifications^[1], which was when the first-year results were reported. Quality measures are reported as rates by insurance type. Details about the specific patient populations included in each measure are specified below.

Adults' Access to Preventative/ Ambulatory Health Service (AAP)

Measure Description: The percentage of patients aged 20 years and older who had at least one office visit with their primary care physician during each measurement year.

Relevance: Physician office visits give individuals an opportunity to receive preventive screenings, tests, and services such as counseling on important health issues such as mental health, obesity, and health behaviors such as smoking and alcohol abuse, diet, and exercise. These visits are also an opportunity to identify and appropriately treat and manage chronic conditions, such as diabetes or heart conditions, and to evaluate social risk factors affecting health outcomes, such as lack of transportation or access to healthy food, loneliness, inadequate housing, and other social drivers of health.

Numerator Eligibility: Medicaid and Medicare plan members were required to have one or more physician office visits in each measurement year and commercial plan members were required to have one or more physician office visits in the current year or anytime in the two years prior to the current measurement year. (Note: emergency room visits, observation stays, and hospital admissions do not count as a physician office visit.)

Denominator Eligibility: Members were required to be 20 years or older as of the end of each measurement year. To be included in the calculation measure, Medicare beneficiaries were required to be enrolled in the same health plan during the year with no more than a 45-day gap in medical insurance coverage and Medicaid enrollees were required to be enrolled in the same plan with no more than a 30-day gap in medical coverage. Commercially insured members were required to be enrolled with medical insurance coverage during the entire measurement year and the two years prior.

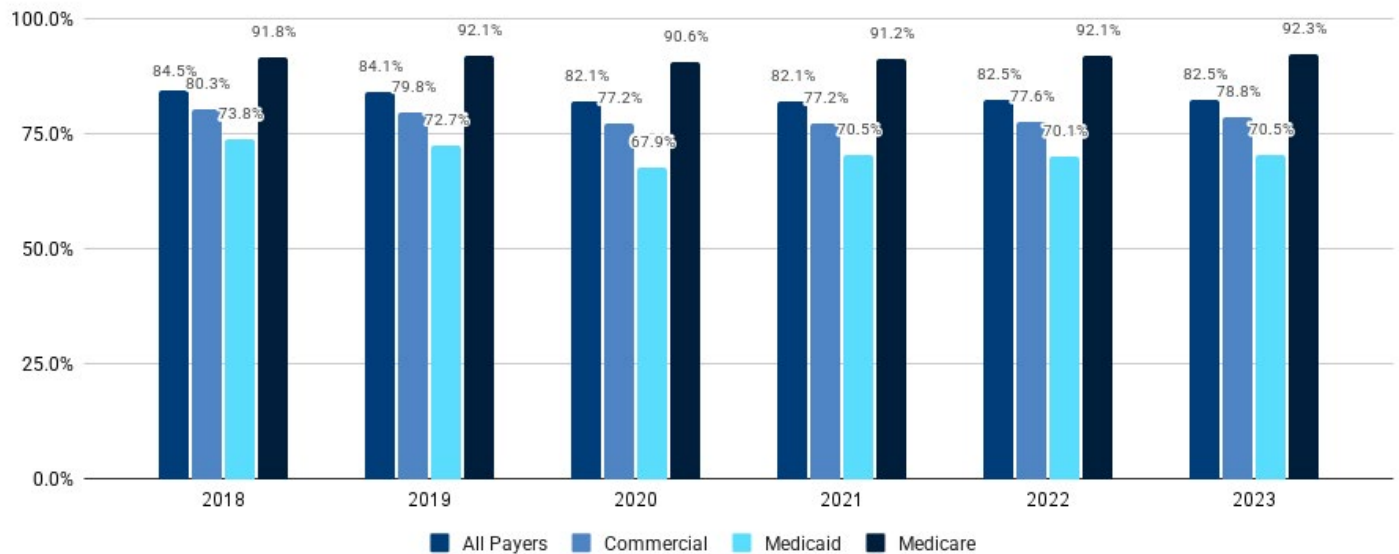
Exclusions: Members in hospice were excluded from the eligible population.

Results

- The percentage of the population with at least one physician office visit remained relatively stable across payer types from 2018 to 2023. Of note was a steep 5% decline in access to care among Medicaid insured people in 2020. The lower access in 2020 likely reflects the disparate impact of the COVID-19 pandemic on the low-income Medicaid population. Rates of physician office visits also declined 2.5% among commercially insured patients in 2020. Access to care rates have not fully recovered and have remained below 2019 levels in 2023 for commercial and Medicaid patients.

- Medicare beneficiaries were most likely to see their primary care doctor compared to patients with commercial or Medicaid coverage. Medicare enrollees experienced a 1.5% drop in 2020, but rates were back to pre-COVID levels of 92% of beneficiaries accessing primary care in 2022-2023.
- Medicaid insured patients were least likely to see their primary care doctor (70.5% in 2023). There was a disparity gap of 31% lower access to care among Medicaid enrollees compared to those insured by Medicare and a 12% disparity gap compared to commercially insured patients.

National Rates of Access to Preventative/Ambulatory Health Services by Insurance Type





Breast Cancer Screening (BCS)

Measure Description: The percentage of women between 50-74 years of age who received a mammogram to screen for breast cancer during each measurement year.

Relevance: Breast cancer is the most common cancer among women in the U.S., except for skin cancers. It accounts for about 30% of new female cancers each year and is the second leading cause of cancer death in women. The median age of diagnosis is 62. While incidence rates have been increasing by 0.6% per year over recent years, death rates have been decreasing since 1989 with an overall decline of 42% through 2021 (American Cancer Society). About one in eight women will develop breast cancer over her lifetime, and it is the leading cause of death for Hispanic women and second leading cause of death for women in other ethnic groups, indicating disparities related to screening and treatment among racial/ethnic minorities. Early screening and detection are critical to reducing mortality and can lead to a greater range of early treatment options, better outcomes, and lower healthcare costs.

Numerator Eligibility: Female plan members were required to have one or more mammograms any time on or between October 1 of the two years prior and December 31 of each measurement year, allowing a 3-month window outside each measurement year to identify screening.

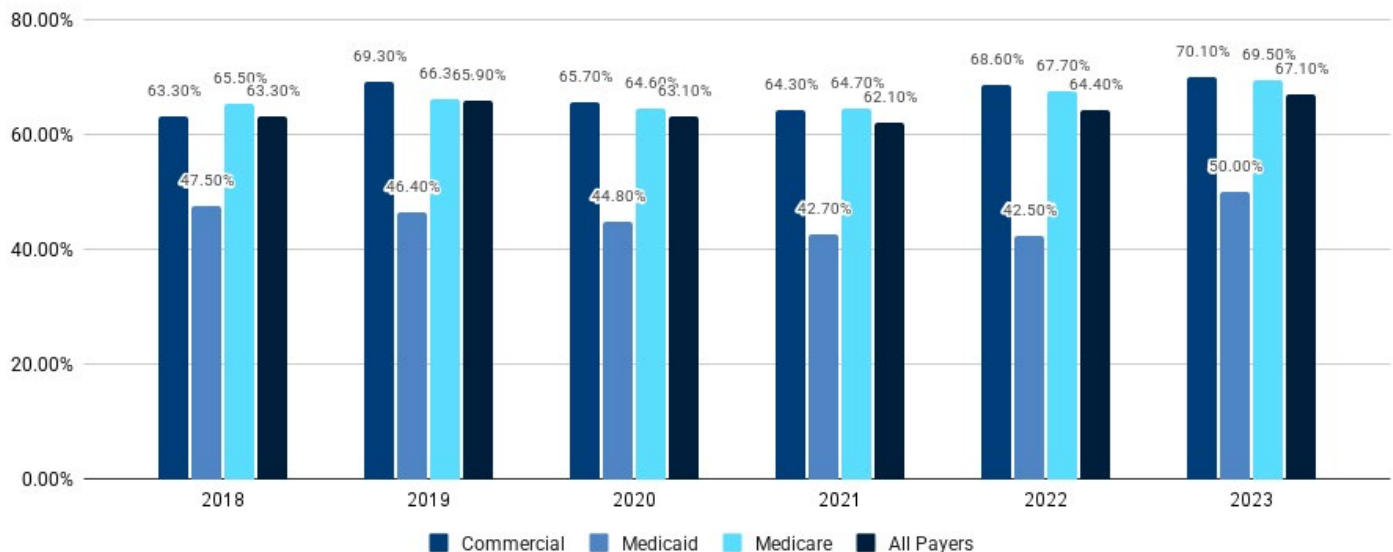
Denominator Eligibility: Plan members were required to be women between the ages 52-74 years, as of the end of each measurement year. To be included in the measure calculation, members were required to be enrolled in the same health plan during the observation period, with no more than a 45-day gap in medical insurance coverage for those covered by commercial and Medicare and no more than a 30-day gap in medical coverage for those covered by Medicaid.

Exclusions: Members in hospice, Medicare members aged 65 and older who were enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year and living in a long-term care institution, and members with a bilateral mastectomy any time during their available medical history were excluded from the eligible population.

Results

- Breast cancer screening rates declined across all payers from 2019 to 2020, and again in 2021 for commercial and Medicaid insured patients. The largest decline was in the Medicaid population, which, despite a recovery to 50% in 2023, still had about 28% lower rates than women enrolled in Medicare or a commercial insurance plan in 2023.
- Breast cancer screening rates were highest in the commercially insured and Medicare populations in 2023 with 70% of women receiving a mammogram and lowest in the Medicaid population with only 50% of enrollees screened, representing a 20% disparity gap.
- Breast cancer screening rates recovered for commercial and Medicare insured women in 2022 and 2023, exceeding rates between 2018-2021. Rates improved for Medicaid-insured women in 2023, but still reflected a stubborn health equity gap for this low income, relatively disadvantaged population.

National Breast Cancer Screening Rates by Insurance Type



Plan All-Cause Readmissions (PCR)

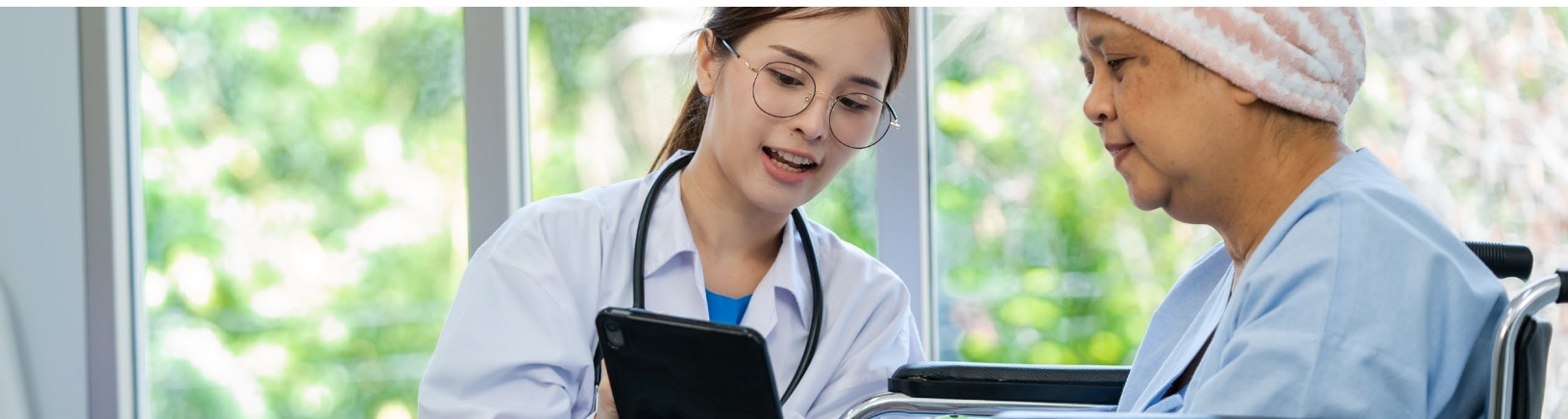
Measure Description: The percentage of patients aged 18 years and older who had at least one short-term hospital stay followed by another hospital admission for any reason within 30 days of the initial hospitalization during the measurement year. The measure is adjusted for age, gender, and the presence of certain chronic conditions (such as cancer) that impact the likelihood of being readmitted to the hospital.

Relevance: Reducing preventable hospital readmissions is a national priority. Readmissions are associated with higher healthcare costs and risk of infections and complications. Readmissions are an indicator of quality of care and providers and hospitals can be penalized for high rates. Readmissions can often be prevented by coordinating care and following evidence-based practice guidelines to improve patient care following hospital discharge.

Numerator Eligibility: Plan members with at least one hospital readmission for any reason within 30 days of being discharged from a prior acute hospital stay.

Denominator Eligibility: Commercial plan members aged 18-64 years as of the first hospital discharge date and Medicare and Medicaid patients aged 18 years and older as of the first hospital discharge date were included in the measure rate calculation. Plan members are required to be enrolled in the same health plan at least 365 days prior to the first hospital discharge date through at least 30 days after the discharge date. Members are also required to have no more than one gap in medical coverage of up to 45 days for Medicare patients and no more than a 30-day gap in medical coverage for those covered by Medicaid during the 365 days prior to the first discharge date. All members were required to have no gap in coverage during the 30 days following the first discharge date.

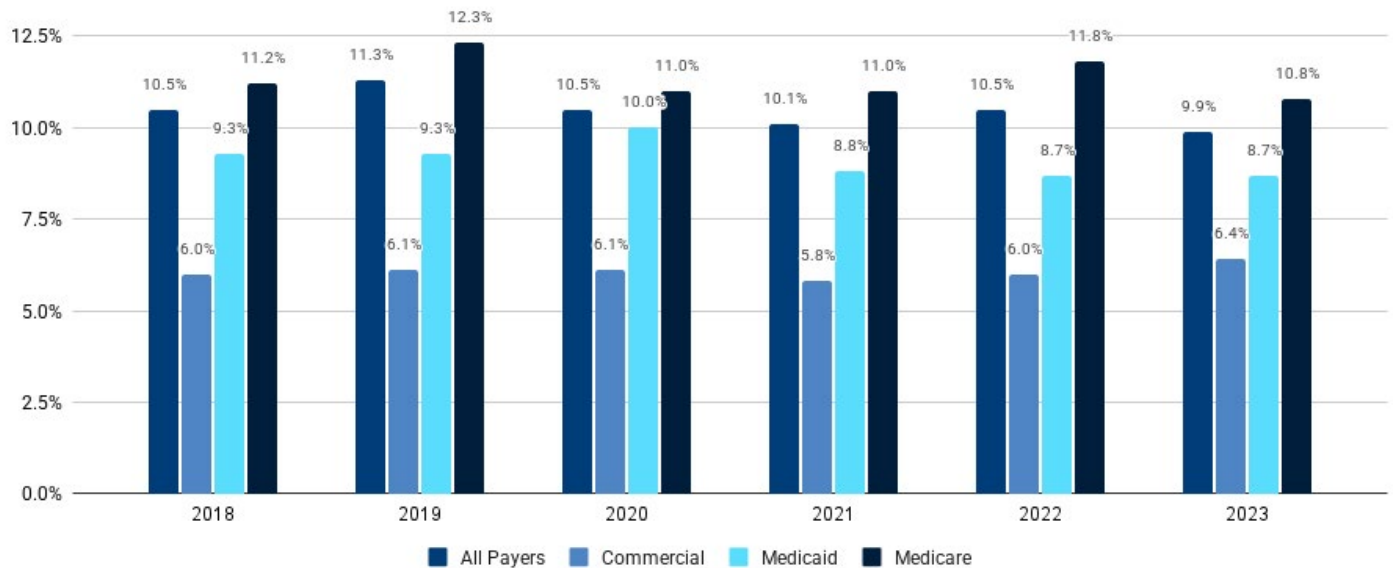
Exclusions: Members in hospice were excluded from the eligible population.



Results

- Readmission rates have remained relatively stable within payer groups but vary significantly across insurance type, with lowest rates among patients with commercial insurance coverage (around 6.5%).
- Medicaid patients were the only cohort showing an increase in 30-day readmissions in 2020, but the cohort had a 1.3% decrease since.
- Medicare beneficiaries had the highest rates of readmission to the hospital within 30 days of a previous hospital discharge, but rates for this population decreased to slightly under 11% following earlier rates near or above 12%. Medicare readmissions are 70% higher compared to those insured by a commercial health plan and 25% higher compared to those insured by Medicaid.

National 30-Day All-Cause Hospital Readmission Rates by Insurance Type



Initiation of Alcohol/Other Drug Dependence Treatment (Initiation AOD)

Measure Description: The percentage of adolescent and adult patients with a diagnosis of alcohol or other drug dependency who initiated treatment within 14 days of the diagnosis.

Relevance: Alcohol and drug addiction can have severe adverse effects on a person's mental and physical health and overall life and can lead to accidents, injury, and death. According to the National Center for Drug Abuse Statistics, [accidental drug overdose is a leading cause of death](#) among persons under the age of 45. Opioid use disorders have become especially problematic in recent years. The U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) annual National Survey on Drug Use and Health reported that 61.2 million people aged 12 and older (21.9% of the U.S. population) used illicit drugs in 2021, including 9.2 million (or 3.3%) who misused opioids. Co-addiction continues to be a significant disorder, with one out of every eight adults struggling with both alcohol and drug use disorders simultaneously.

In 2020, the Recovery Centers of America estimated the cost of substance abuse disorder in the U.S. is approximately \$3.73 trillion annually, including \$500 billion in direct costs. This translates to an astonishing combined GDP of 45 of the 50 states in the U.S.

Effective treatments are available, but very few people get the treatment they need. The Centers for Medicare & Medicaid Services (CMS) finalized expansion of Medicare coverage to include opioid treatment programs delivering medication-assisted-treatment (MAT) effective January 1, 2020. Treatment, in conjunction with counseling or other behavioral therapies, has shown to reduce adverse events associated with alcohol and drug abuse, including mortality, overall health, productivity, social outcomes, and healthcare spending.

Numerator Eligibility: Adolescents and adults who initiated alcohol and other drug dependence treatment through an overnight hospital admission, emergency room visit, or other non-hospital physician visit within 14 days of being diagnosed with alcohol, drug, or substance abuse dependency.

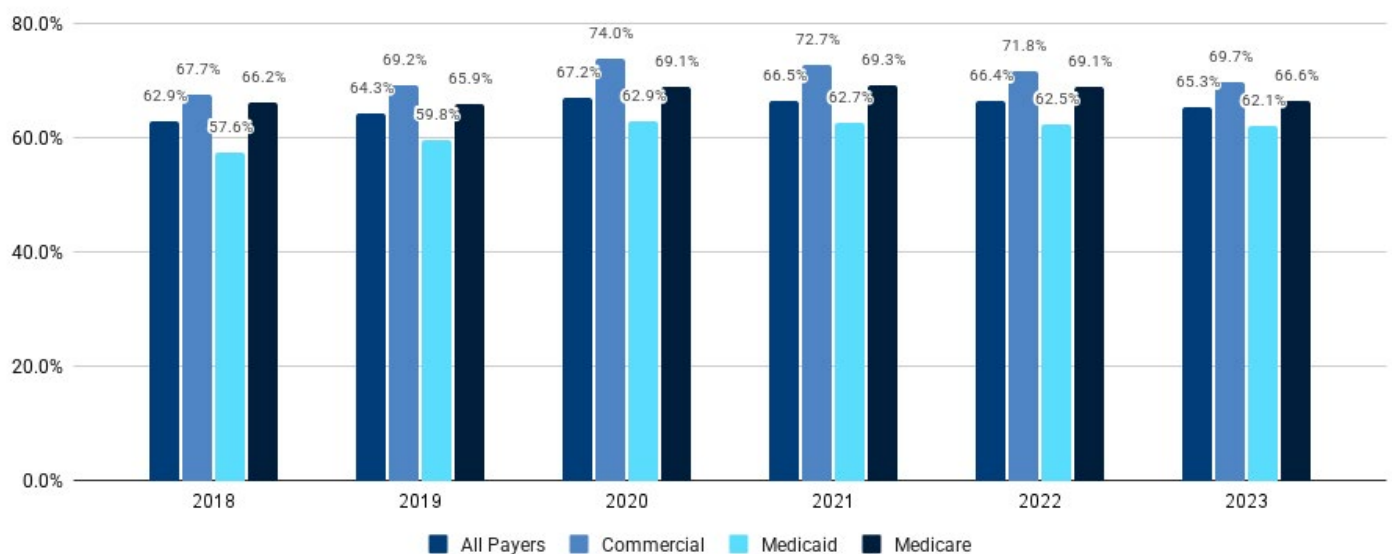
Denominator Eligibility: Plan members who were aged 13 years and older as of the end of each measurement year and who were enrolled in the same health plan with medical coverage for 60 days (2 months) prior to the date of first diagnosis through 44 days after the date of first diagnosis (105 total days).

Exclusions: Members in hospice were excluded from the eligible population.

Results

- Rates of initiation of treatment following a diagnosis of alcohol or other drug abuse steadily increased across all types of payers from 2018 to 2020 when rates peaked. The spike was highest among commercially insured patients with 7% more patients initiating treatment (from 69.2% in 2019 to 74.0% in 2020). Rates declined slightly from 2021 to 2023 for all insurance groups, with the highest decline of close to 4% for those in Medicare and commercial, and close to 1% in Medicaid.
- Treatment rates were lowest in the Medicaid population where about 62% of diagnosed beneficiaries received treatment over the past three years, representing a health disparity gap for this disadvantaged segment of the population. This represents a moderate but consistent improvement compared with the 59% rate in 2018-2019.
- Treatment rates were highest among the commercially insured population, with around 70% initiating treatment in 2023 following diagnosis. This represents more than a 4% drop from 2020.
- Of special note for the Medicare population only, though the rate of treatment initiation following a diagnosis remained stable from 2021 to 2022, the denominator of the measure – which counts Medicare beneficiaries who were diagnosed with alcohol or other drug dependency – increased by 26% from 289,623 in 2021 to 365,006 in 2022 (even though the total number of Medicare beneficiaries included in the analysis decreased by about 3% as shown in Table 1). This indicates a sharp increase in Medicare beneficiaries diagnosed with alcohol or other drug dependency in 2022.

National Rates of Initiation of Treatment for Alcohol, Drug, Substance Abuse by Insurance Type



Engagement of Alcohol/Other Drug Dependence Treatment (Engagement AOD)

Measure Description: The percentage of adolescent and adult patients with a diagnosis of alcohol or other drug dependency who initiated treatment within 14 days of diagnosis and had two or more additional services with a diagnosis of alcohol or other drug dependency documented within 30 days of the first visit.

Relevance: Substance use disorders (SUDs) are a serious public health calamity associated with significant morbidity and mortality worldwide with the highest rates of morbidity or mortality being associated with opioid-related overdoses. Follow-up or continuing care is a critical component of effective treatment for substance use disorders, particularly for those individuals with greater addiction severity.

Effective behavioral interventions and other treatments are available and recommended for primary care but infrequently implemented. Roughly 10% of individuals aged 12 and over reporting a substance abuse disorder receive care. Among those who initiate substance abuse treatment, the completion rate and follow-up at one year was less than half (42%).

Numerator Eligibility: Adolescents and adults who initiated alcohol and other drug dependency treatment through an overnight hospital admission, emergency room visit, or non-hospital physician visit within 14 days of being diagnosed with alcohol, drug, or substance abuse dependency and who had two or more hospital admissions, emergency room visits, or other non-hospital physician visits with a diagnosis of alcohol or other drug dependency within 30 days following the date of the first treatment (engagement in treatment).

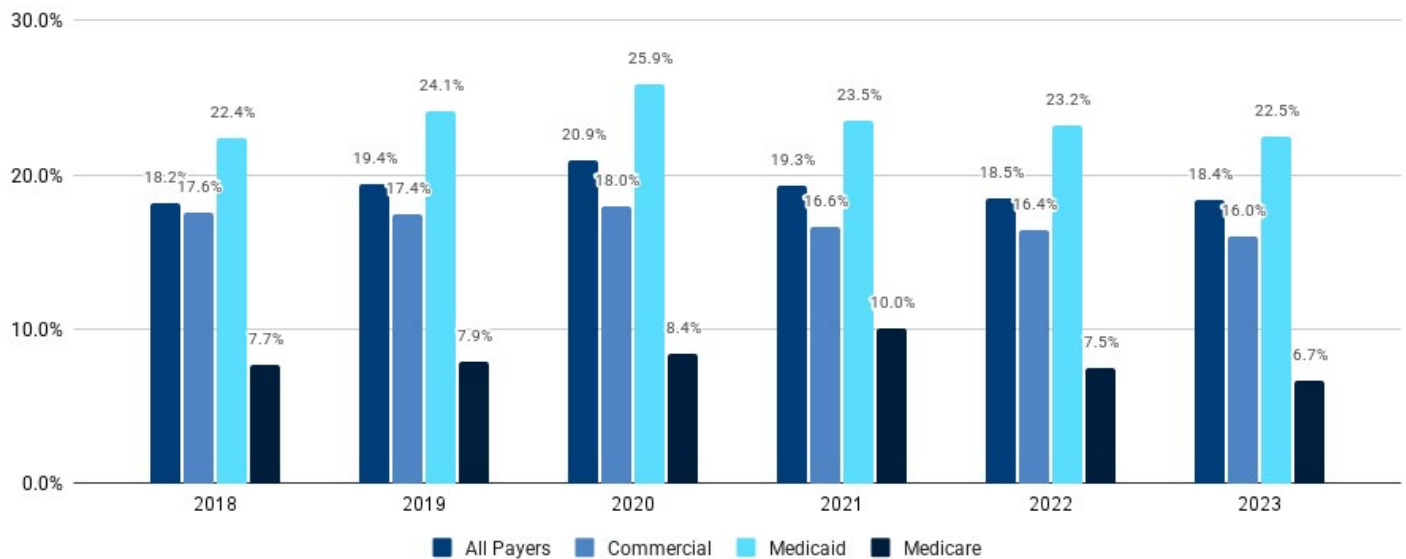
Denominator Eligibility: Plan members who were aged 13 years and older as of the end of each measurement year and who were enrolled in the same health plan with medical coverage for 60 days (two months) prior to the date of first diagnosis of AOD through 44 days after the date of first diagnosis (105 total days).

Exclusions: Members in hospice were excluded from the eligible population.

Results

- Rates of patients who received follow-up services subsequent to initiation of a first treatment following a diagnosis of alcohol or substance abuse remained relatively stable from 2018 to 2020 for patients with commercial health insurance, with a slight increase in 2020 followed by a decline in 2021-2023.
- Medicare beneficiaries were least likely to receive follow-up engagement with a healthcare professional following initiation of treatment, increasing slowly from only 7.7% of enrollees in 2018 to 10% in 2021. The rate then declined in 2023 to 6.7% representing a 32% decline in those who continued with treatment. Follow-up engagement in Medicare enrollees is 58% lower than that for the commercially insured and 70% than in those with Medicaid.
- This is especially concerning given the significant increase in the number of Medicare beneficiaries diagnosed with alcohol/substance abuse in 2022 relative to 2021. This increase was not accompanied by an increase in those who initiated treatment. To compound the problem, this measure shows a significant decline in those continuing treatment after a first session as noted above.
- Medicaid patients were most likely to be engaged in follow-up treatment after initiating treatment (peaking at 26% in 2020 then declining to about 23% in 2021-2023).

National Engagement After Initiation of Treatment for Alcohol, Drug, and Substance Abuse by Insurance Type



Conclusion

We found a wide range of performance across payer types and notable yearly trends on the five HEDIS quality measures. The measures were evaluated over various types of health insurance coverage, including public and private Medicare, managed Medicaid, and commercial health plans. Key findings related to each domain of care are reported below.

Access to Preventative/Ambulatory Health Services

- The percentage of the population with at least one physician office visit remained relatively stable across payer types from 2018 to 2023, with the exception of a **steep 5% decline in access to care among Medicaid insured people in 2020**. Patients covered by Medicaid were least likely to see their primary care doctor during the year, and rates are still below 2019 levels in 2023 for people covered by Medicaid. The lower access in 2020 likely reflects the disparate impact of the COVID-19 pandemic on the low-income Medicaid population.
- Rates of physician office visits also declined 3% among commercially insured patients in 2020 compared to their 2018 high and have not fully recovered to pre-2020 rates of access.
- Medicare beneficiaries were most likely to see their primary care doctor compared to patients with commercial or Medicaid coverage. Medicare enrollees experienced a small decline in 2020, but rates were back to pre-COVID levels of 92% of beneficiaries accessing primary care in 2023.
- In summary, there is a disparity gap of 22% lower access to care among Medicaid enrollees compared to those covered by Medicare in 2023.

Breast Cancer Screening Rates

- Breast cancer screening rates declined slightly across all payers from 2019 to 2020, and yet again in 2021 for commercial and Medicaid insured patients, but have surpassed pre-COVID level as of 2023.
- The largest decline was in the Medicaid population which had about 28% lower rates than women enrolled in Medicare or a commercial insurance plan in 2023.
- Breast cancer screening rates recovered for commercial and Medicare insured women in 2023, with women covered by commercial insurance most likely to receive a mammogram (70%). Medicaid insured women were least likely to receive cancer screening with only 50% of enrollees screened in 2023, a significant improvement over prior years, but still indicating a persistent health equity gap for this low income, disadvantaged population.

Plan 30-Day All-Cause Hospital Readmission Rates

- Medicaid patients were the only cohort showing an increase in 30-day readmissions in 2020.
- Medicare beneficiaries had the highest rates of readmission to the hospital within 30 days of a previous hospital discharge, increasing to nearly 12% in 2022 but dropping to just under 11% in 2023, substantially lower than the 12% peak in 2019. Medicare readmissions are 70% higher compared to those insured by a commercial health plan and 25% higher compared to those insured by Medicaid.

Initiation of Treatment for Alcohol, Drug, Substance Abuse

- Substance abuse continues to be a national health crisis. Access to treatment can result in positive outcomes; yet treatment rates remain low. The rates of initiation of treatment following a diagnosis of alcohol or other drug abuse steadily increased across all types of payers from 2018 to 2020 when rates peaked. The spike was highest among commercially insured patients with 7% more patients initiating treatment (from 69.2% to 74.0% from 2019 to 2020).
- Treatment rates were lowest in the Medicaid population where about 62% of diagnosed beneficiaries received treatment over the past three years, representing a health disparity gap for this disadvantaged segment of the population.

Engagement After Initiation of Treatment for Alcohol, Drug, and Substance Abuse

- Given the nationwide drug epidemic, we found a troubling inference in this research related to remarkably low use of recommended follow-up services for those with alcohol and drug dependencies (or co-dependencies). This is surprising given CMS, HHS, and SAMHSA have dedicated additional funding, improved access, and provided supplementary services to combat this devastating escalation of addiction.
- Medicare beneficiaries were least likely to receive follow-up engagement with a healthcare professional following initiation of treatment, increasing slowly from only 7.7% of enrollees in 2018 to 10% in 2021. The rate then declined in 2023 to 6.7% representing a 32% decline in those who continued with treatment which represented 3.3 times fewer individuals compared to those covered by Medicaid and 2.4 times fewer individuals than those covered by commercial insurance.
- Medicaid patients were most likely to be engaged in follow-up treatment after initiating treatment (peaking at 26% in 2020 then declining to about 23% in 2021-2023).
- Given the continued low rates of follow-up treatment for substance abuse, further outreach and advocacy by state, federal, and industry stakeholders are warranted – especially concerning the low rates of follow-up treatment among the elderly Medicare population.

Summary

These findings reveal several troubling trends in the use of preventive services and access to care. There is considerable opportunity for improvement in health plan performance in attaining high quality care and health equity. Medicare, commercial, and managed Medicaid health plans should implement programs aimed at better care coordination to increase use of preventive services and treatments and reduce hospital readmission rates. Improving performance on these key quality measures is essential to improve overall health outcomes, which can lead to better population health and lower healthcare costs nationwide.

The low rates of performance among low-income individuals covered by Medicaid points to existing health disparities that must be addressed. All plans can utilize these results to find gaps where they could improve access to care and promote greater population health. These include ways to increase preventative screening rates, improve provider-patient engagement, assure faster, more accurate data exchange, and identify and address social drivers of health.

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1. See HEDIS 2018 Volume 2, Technical Specifications for Health Plans.
 2. "Key Statistics for Breast Cancer," American Cancer Society, January 2, 2025, <https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html>

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