

WHITE PAPER

**Trends in Quality
Measure Performance
Across Public and
Private Insurance Types:
2019-2024**

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 (including private commercial insurance companies as well as Medicare and Medicaid programs) accountable for delivering efficient, evidence-based, high-quality, and cost-effective care.

The Healthcare Effectiveness Data and Information Set (HEDIS®)¹ is a set of performance measures used widely by managed care organizations and the Centers for Medicare and Medicaid Services (CMS) to track performance of health plans and providers.² The measures' development, refinement, and maintenance are coordinated by the National Committee for Quality Assurance (NCQA). HEDIS® includes more than 95 measures spanning multiple domains of care, including effectiveness of care, access, patient experience, utilization, and health plan descriptive information, with many measures reportable 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 over a six-year period, 2019-2024. 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 and 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.

1. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2. "Are you up to date on your preventive care," CDC, August 15, 2025, <https://www.cdc.gov/chronic-disease/prevention/preventive-care.html>

Quality Measures

A set of five quality measures have been evaluated each year starting from the first report in 2017 through the current report that incorporates 2024 claims data. The measures are stratified and reported over the most recent six-year period by insurance (payer) 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 and supporting early identification and management of medical conditions. In addition, the receipt of preventive screenings and tests have been shown to avoid costly adverse events and to slow the progression or worsening burden of illness related to chronic diseases.³

Hospital readmissions following a prior hospital discharge are associated with higher healthcare costs and represent a significant burden on patients.⁴ As a result, reducing hospital readmissions had been a focus area for the CMS and is included in several value-based purchasing initiatives.

Finally, alcohol abuse and other drug dependencies represent major public health challenges in the U.S. and are associated with poor health outcomes and increase healthcare costs.^{5,6} In particular, the ongoing opioid crisis continues to pose challenges at both national and local levels, contributing to adverse outcomes and substantial strain on the healthcare system.

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 identifying trends across the years, measures were calculated using the 2017 HEDIS technical specifications, since 2017 was the first year that the results were reported. Details about the specific patient populations included in each measure are specified below.

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3. "Are you up to date on your preventive care," CDC, August 15, 2025, <https://www.cdc.gov/chronic-disease/prevention/preventive-care.html>
 4. "Readmissions and costs among younger and older adults for targeted conditions during the enactment of the hospital readmission reduction program," Lu, C. H., Clark, C. M., Tober, R., Allen, M., Gibson, W., Bednarczyk, E. M., Daly, C. J., & Jacobs, D. M., BMC health services research. 2021; 21(1), 386. <https://doi.org/10.1186/s12913-021-06399-z>
 5. "Global Burden of Alcohol Use Disorders and Alcohol Liver Disease," Rehm, Jürgen, and Kevin D. Shield, Biomedicines. 2019; 7(4):99. <https://doi.org/10.3390/biomedicines7040099>
 6. "Medical Costs of Substance Use Disorders in the US Employer-Sponsored Insurance Population," Li, M., Peterson, C., Xu, L., Mikosz, C. A., & Luo, F. (2023). JAMA network open, 6(1), e2252378. <https://doi.org/10.1001/jamanetworkopen.2022.52378>
 7. See HEDIS 2017 Volume 2, Technical Specifications for Health Plans.

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. 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 measure calculation, Medicare beneficiaries were required to be enrolled in the same health plan during the year with no more than a 30-day gap in medical insurance coverage and Medicaid enrollees were required to be enrolled in the same plan with no more than a 45-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

- Across all years (2019-2024) and all payer types, 82% to 85% of individuals had a primary care visit in each measurement year. Individuals covered by Medicare were most likely to have a primary care visit, while those covered by Medicaid were least likely (e.g., 92.4% versus 72.6%, respectively, in 2024). Among commercially insured individuals, the percentage with a primary care visit in 2024 was 79.4%.
- Primary care visits remained relatively stable from 2019 to 2024 for Medicare beneficiaries, though rates dipped slightly by 1.5 percentage points from 2019 to 2020, potentially reflecting

the impact of the COVID-19 pandemic. The drop in visits from 2019 to 2020 was considerably steeper in the Medicaid population (4.8 percentage points). Commercially insured individuals showed a 2.6 percentage point decrease from 2019 to 2020.

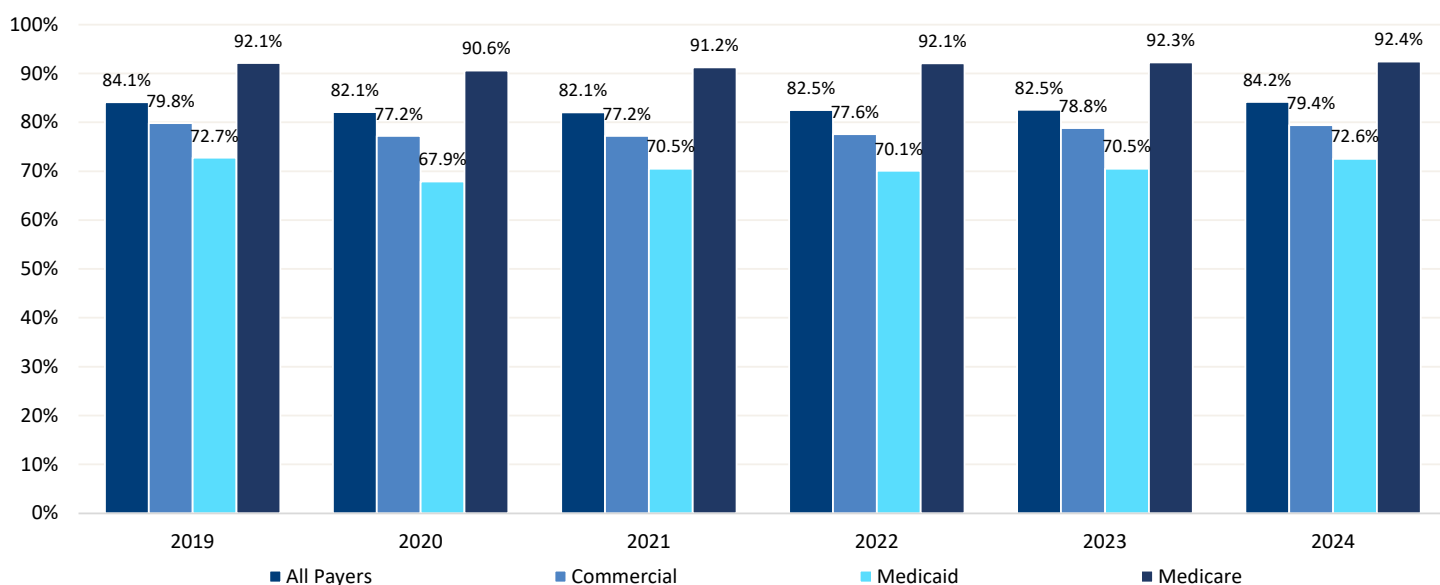
- Across all payer types, primary care visits generally rose from 2021 to 2024. For Medicare beneficiaries, the 2024 visit rate exceeded the 2019 rate by 0.3 percentage points. For Medicaid and commercially insured individuals, 2024 rates nearly reached those of 2019 but did not exceed them.



Key Takeaway

Findings highlight potential gaps in access to care for Medicaid and commercially insured patients as compared to Medicare beneficiaries.

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 United States, except for skin cancers,⁸ accounting for about 30% of new female cancers each year.⁹ About one in eight women will develop breast cancer over her lifetime, at a median age of diagnosis of 62.¹⁰ While incidence rates have been increasing by 1% per year over recent years, death rates have been decreasing since 1989 with an overall decline of 44% through 2022.⁹ Despite decreasing mortality rates, breast cancer is the second leading cause of cancer death in women and it remains the leading cause of cancer death for non-Hispanic Black and Hispanic women.⁷ This indicates disparities related to screening and treatment among racial/ethnic minorities. Early screening and detection are critical to reducing mortality and offering 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 to 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 Medicaid and no more than a 30-day gap in medical coverage for those covered by Medicare.

8. "Breast Cancer Statistics," CDC, June 10, 2025, <https://www.cdc.gov/breast-cancer/statistics/index.html>

9. "Breast Cancer Facts and Statistics," BREASTCANCER.ORG, April 16, 2026, <https://www.breastcancer.org/facts-statistics>

10. "Breast cancer statistics 2024," Giaquinto AN, Sung H, Newman LA, et al., CA Cancer J Clin. 2024;74(6):477-495. doi:10.3322/caac.21863

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

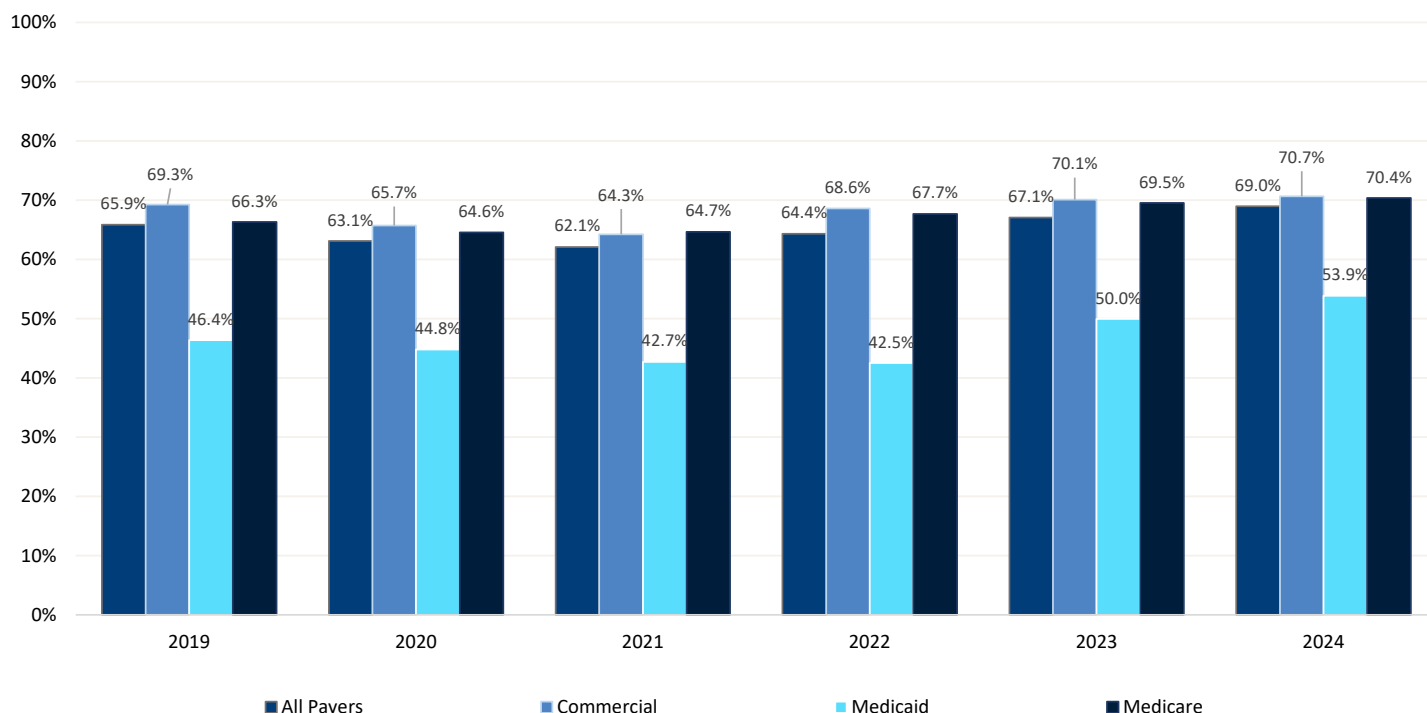
- Across all measurement years 2019 to 2024, breast cancer screening rates were consistently highest for the commercially insured and Medicare populations and lowest for Medicaid. For example, in 2024, the percentage of the Medicaid population who received screening was 53.9%, compared to 70.7% of the commercial and 70.4% of the Medicare populations.
- Screening rates declined for all payers by 3.8 percentage points from 2019 to 2021, likely reflecting the impact of the COVID-19 pandemic. Rates then rebounded, showing a 6.9 percentage point increase from 2022 to 2024, resulting in a net increase in breast cancer screening of 3.1 percentage points across the full study period (65.9% in 2019 to 69.0% in 2024).
- Year-over-year changes differed by payer, with the Medicaid population showing the largest fluctuations, including a notable increase of 7.5 percentage points from 2022 (42.5%) to 2023 (50.0%). Medicare and commercially insured patients showed more modest and steady changes in screening rates throughout the study period.



Key Takeaway

Findings suggest improving access to breast cancer screening in the post-pandemic period, though rates were consistently lower in Medicaid, indicating persistent access barriers for this 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 that impact the likelihood of being readmitted to the hospital (such as cancer).

Relevance: Reducing preventable hospital readmissions is a national priority. Readmissions are associated with higher healthcare costs and risk of infections and complications.³ Readmissions are an indicator of quality of care and providers and hospitals can be penalized for high rates.¹¹ Readmissions can often be prevented by coordinating care and following evidence-based practice guidelines to improve patient care following hospital discharge.¹²

3. "Readmissions and costs among younger and older adults for targeted conditions during the enactment of the hospital readmission reduction program," Lu, C. H., Clark, C. M., Tober, R., Allen, M., Gibson, W., Bednarczyk, E. M., Daly, C. J., & Jacobs, D. M., BMC health services research. 2021; 21(1), 386. <https://doi.org/10.1186/s12913-021-06399-z>

11. "Hospital Readmissions Reduction Program," CMS.gov, March 16, 2026, <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp>

12. "Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis." Tyler, N., Hodkinson, A., Planner, C., Angelakis, I., Keyworth, C., Hall, A., Jones, P. P., Wright, O. G., Keers, R., Blakeman, T., & Panagioti, M. (2023). JAMA network open, 6(11), e2344825. <https://doi.org/10.1001/jamanetworkopen.2023.44825>

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 to 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 Medicaid patients and no more than a 30-day gap in medical coverage for those covered by Medicare during the 365 days prior to the first discharge date, and 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

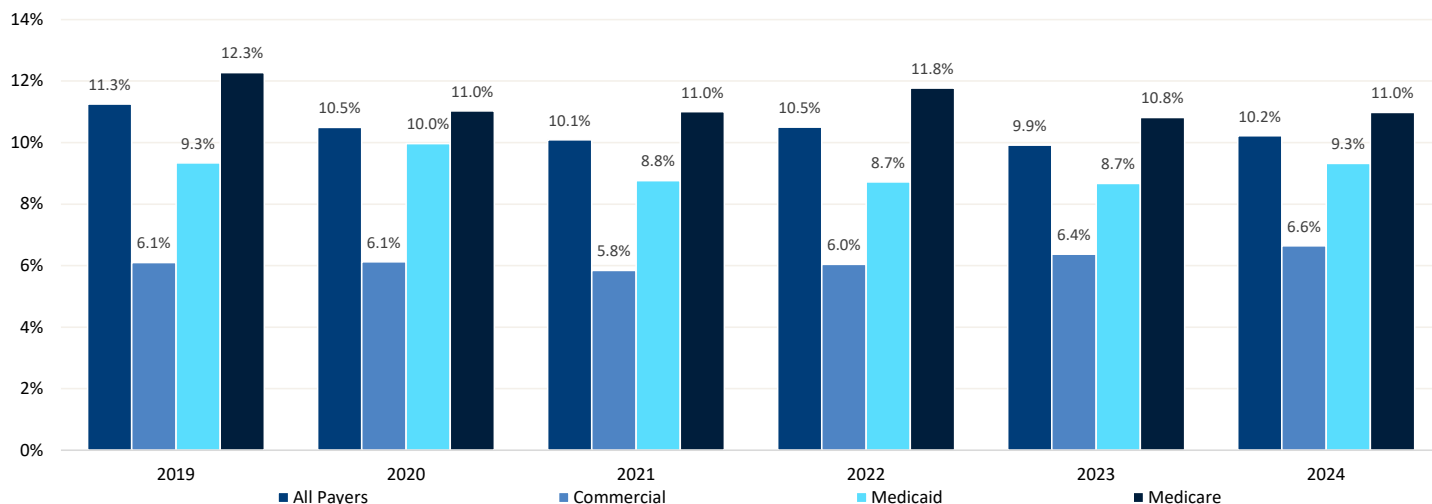
- Across all years (2019-2024), 30-day readmission rates were consistently highest for Medicare beneficiaries (ranging from 10.8% to 12.3%) and lowest for the commercially insured (ranging from 5.8% to 6.6%). Readmission rates for the Medicaid population were between commercial and Medicare, ranging from 8.7% to 10.0%.
- Across all payers, readmission rates slightly declined from 2019 to 2020 (by 0.8 percentage points) and remained relatively consistent from 2021 to 2024. Year-over-year changes were generally within one percentage point, suggesting that 30-day readmission rates were fairly stable during the analytic period.
- The Medicare population showed the largest fluctuations by year, including a decrease of 1.3 percentage points from 2019 to 2020 and an increase of 0.8 percentage points from 2021 to 2022. Medicaid and commercial exhibited smaller changes; over the full period from 2019 to 2024, 30-day readmission rates remained the same in Medicaid (9.3%) and increased by 0.5 percentage points in the commercially insured (6.1% to 6.6%).



Key Takeaway

The higher readmission rates in the Medicare and Medicaid populations likely reflect a combination of complex patient health profiles, socioeconomic barriers, and access to timely post-discharge care.

National Rates of 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 an individual's mental and physical health, as well as overall quality of life, and may result in accidents, injury, and death. Drug overdose, largely driven by opioid-related deaths, is the leading cause of death among U.S. adults aged 18-44, according to data from the Centers for Disease Control and Prevention.^{13,14} Opioid use disorders represent an increasingly serious public health concern. Data from the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health indicate that in 2021, 61.2 million individuals aged 12 and older (21.9% of the US population) reported illicit drug use, including 9.2 million (3.3%) who misused opioids.¹⁵ Co-addiction continues to be a significant disorder, with one out of every six adults struggling with both alcohol and drug use disorders simultaneously.¹⁶

13. "Drug Overdose Deaths," CDC, August 2, 2024, <https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm>

14. "Drug Overdose Death Rate," NCDAS, Accessed April 20, 2026, <https://drugabusestatistics.org/drug-overdose-deaths/>

15. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health," SAMHSA, December 2022, <https://www.cdc.gov/overdose-prevention/media/pdfs/2024/04/SAMHSA-Key-substance-use-and-mental-health-indicators-2021.pdf>

16. "Alcohol and Drug Abuse Statistics (Facts About Addiction)," AmericanAddictionCenters, December 16, 2025, <https://americanaddictioncenters.org/rehab-guide/addiction-statistics-demographics>

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 a combined GDP of 45 of the 50 U.S. States.

Effective treatments are available, but very few people get the treatment they need. CMS finalized expansion of Medicare coverage to include opioid treatment programs delivering medication-assisted-treatment (MAT) effective January 1, 2020. When combined with counseling or other behavioral therapies, treatment has been shown to reduce adverse events associated with alcohol and drug use, including mortality, improve overall health, productivity, and social outcomes, and lower healthcare spending.

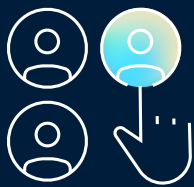
Numerator Eligibility: Adolescents and adults who initiated alcohol and other drug dependence treatment through an overnight hospital admission, emergency room visit, or other non-hospital physician visit within 14 days of being diagnosed with alcohol, drug, or substance abuse dependency.

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 (two months) prior to the date of first diagnosis of alcohol/other drug dependency through 44 days after the date of first diagnosis (105 total days).

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

Results

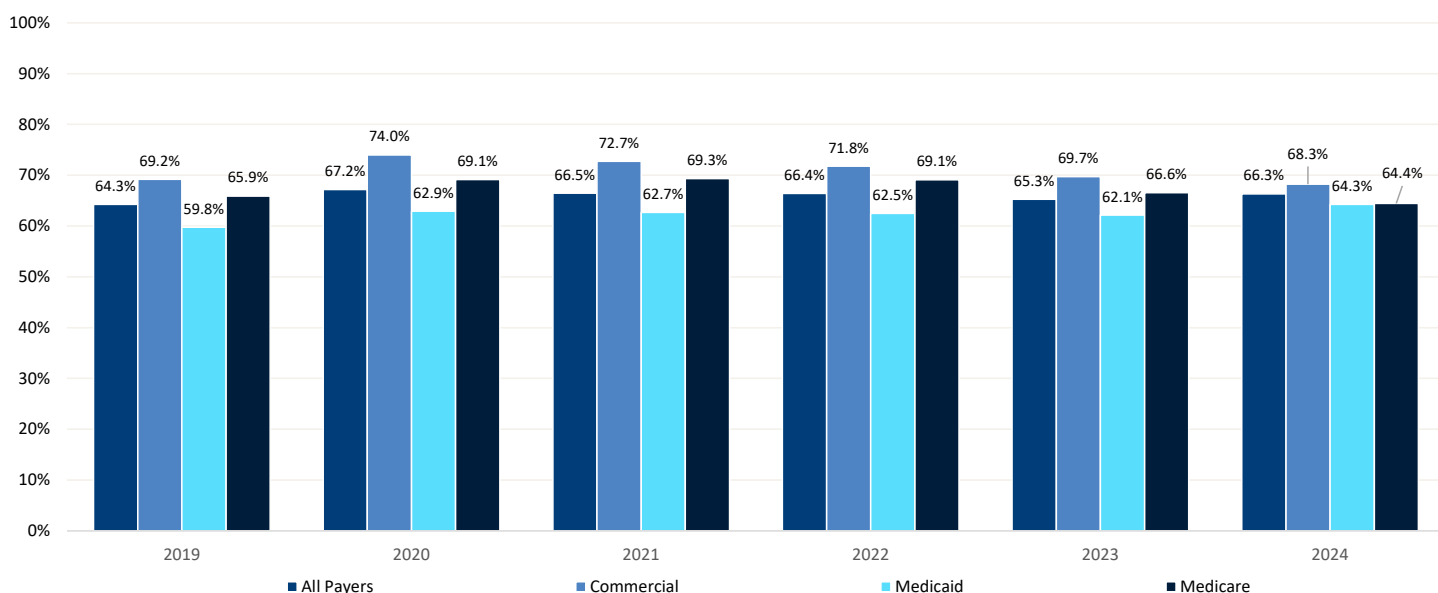
- Rates of initiation of treatment following a diagnosis of alcohol or other drug abuse were highest in the commercially insured, reaching a high of 74.0% in 2020, and lowest in the Medicaid population, where initiation rates reached a high of 62.9% in 2020. Medicare fell in between the other two payers, at 69.1% in 2020.
- Treatment initiation rates remained relatively stable across years, with a net increase of 2.0 percentage points between 2019 and 2024 for all payers. Rates increased by 2.9 percentage points from 2019 to 2020 and subsequently dipped by 0.9 percentage points from 2020 to 2024.
- The year-over-year trends varied by payer, with the commercially insured experiencing the largest early increase in treatment initiation rates, rising 4.8 percentage points from 69.2% in 2019 to 74.0% in 2020. However, this increase was followed by a gradual decline to 68.3% in 2024. Medicare and Medicaid enrollees showed smaller fluctuations in treatment initiation rates over the years. Medicare showed a net decrease of 1.5 percentage points from 2019 (65.9%) to 2024 (64.4%), while Medicaid showed a net increase of 4.5 percentage points (59.8% to 64.3%).



Key Takeaway

Findings suggest ongoing barriers to treatment for alcohol and drug abuse in the Medicaid population. However, the increase in treatment initiation by 4.5 percentage points from 2019 to 2024 in the Medicaid population and narrowing gap with commercial and Medicaid suggests some improvements in access.

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) represent a major public health crisis worldwide and are associated with substantial morbidity and mortality, with the highest rates of morbidity or mortality driven by opioid-related overdoses. Follow-up or continuing care is a critical component of effective treatment for substance use disorders, particularly for individuals with greater addiction severity.

Effective behavioral interventions and other treatments are recommended in primary care but are infrequently implemented. Roughly 20% of individuals 12 and over reporting a substance abuse disorder receive care.^{17,18} Among those who initiate substance abuse treatment, the completion rate varies by clinical approach yet remains under 50% for many treatment settings.¹⁹

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 (2 months) prior to the date of first diagnosis of alcohol/other drug dependency through 44 days after the date of first diagnosis (105 total days).

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

17. "National Survey on Drug Use and Health (NSDUH)," SAMHSA, September 8, 2025, <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024>

18. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health," SAMHSA, July 2025, <https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf>

19. "Addiction Treatment: Statistics on Efficacy," Nicko Estrellado, February 25, 2025, <https://www.addictiongroup.org/resources/treatment-statistics/>

Results

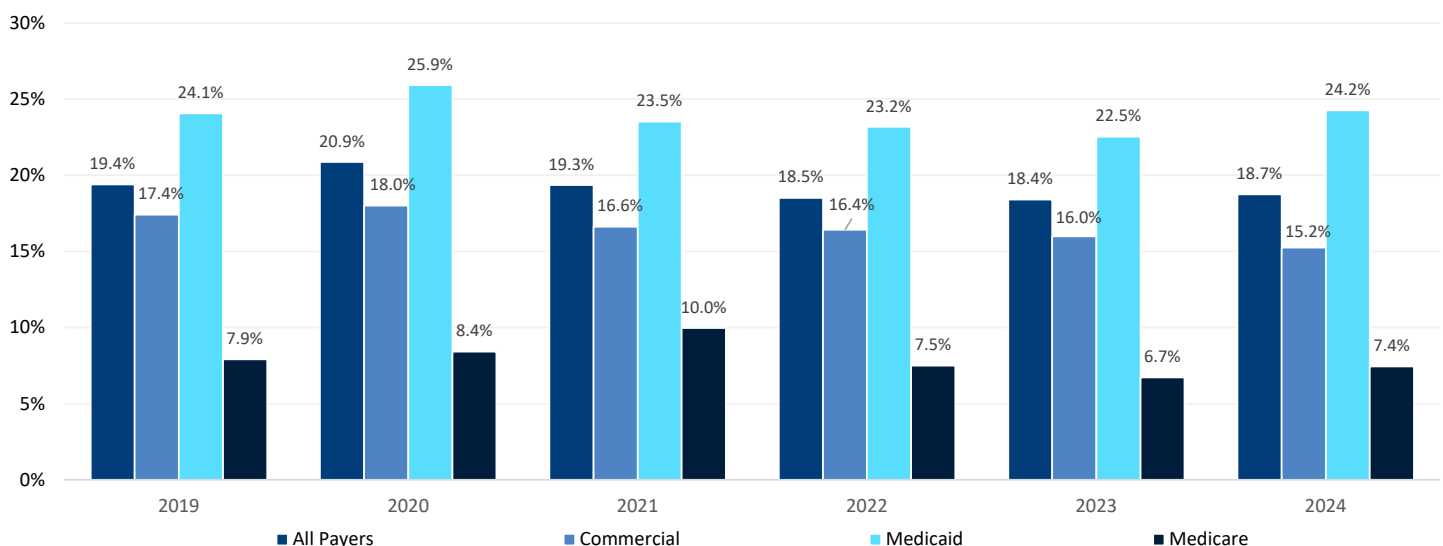
- Rates of engagement in follow-up services after initiation of a first treatment following a diagnosis of alcohol or substance abuse were relatively low for all payer types combined, remaining below 21% for all years 2019 through 2024.
- There were considerable differences by payer, with engagement rates in the Medicaid population exceeding 22% every year and rates in the commercial population ranging from 15% to 18%. Engagement rates in the Medicare population were considerably lower, ranging from 6.7% to 10%.
- For all payer types combined, engagement rates rose by 1.5 percentage points from 2019 to 2020 before decreasing slightly, resulting in a net decrease of 0.7 percentage points from 2019 to 2024.
- Year-over-year trends in engagement rates differed by payer, with rates in the commercially insured rising slightly from 2019 to 2020 before falling, resulting in a net decrease of 2.4 percentage points from 2019 to 2024. The Medicare population showed a 2.1 percentage point increase between 2019 and 2021, after which rates decreased and plateaued, resulting in a net decrease of 0.5 percentage points between 2019 and 2024. The Medicare population also showed an initial increase in engagement rates followed by a decrease and a plateau, resulting in a net decrease of 0.1 percentage points.



Key Takeaway

The considerably lower engagement rates after first treatment initiation in the Medicare population point to potential structural barriers that may require targeted policy attention.

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



Conclusion

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

Access to Preventative / Ambulatory Health Services

- Across all years (2019-2024) and all payer types, 82% to 85% of individuals had a primary care visit in each measurement year. Individuals covered by Medicare were the most likely to have a primary care visit, while those covered by Medicaid were least likely.
- Rates dipped slightly from 2019 to 2020, potentially reflecting the impact of the COVID-19 pandemic. However, visit rates generally rebounded again from 2021 to 2024.
- Findings highlight potential gaps in access to primary care for Medicaid and commercially insured patients as compared to Medicare beneficiaries.

Breast Cancer Screening Rates

- Breast cancer screening rates were consistently higher by about 15 percentage points for the commercially insured and Medicare populations compared to for Medicaid.
- Screening rates declined for all payers from 2019 to 2021, likely reflecting the impact of the COVID-19 pandemic. However, screening rates rebounded from 2021 to 2024, resulting in a net increase in breast cancer screening of 3.1 percentage points across the full study period.
- Findings suggest improving access to breast cancer screening in the post-pandemic period, though rates were consistently lower in Medicaid, which may indicate persistent access barriers for this population.

Plan 30-Day All-Cause Hospital Readmission Rates

- Readmission rates were consistently highest for Medicare beneficiaries and lowest for the commercially insured. Readmission rates for the Medicaid population were between commercial and Medicare, ranging from 8.7% to 10.0%.
- Across all payers, readmission rates slightly declined from 2019 to 2020 and remained relatively consistent from 2021 to 2024.
- The higher readmission rates in the Medicare and Medicaid populations likely reflect a combination of complex patient health profiles, socioeconomic barriers, and access to timely post-discharge care.

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. Rates of initiation of treatment following a diagnosis of alcohol or other drug abuse were highest in the commercially insured and lowest in the Medicaid population.
- Treatment initiation rates remained relatively stable across years for all payers, with commercially insured experiencing the largest early increase in treatment initiation rates followed by a gradual decline.
- Findings suggest ongoing barriers to treatment for alcohol and drug abuse in the Medicaid population. However, the increase in treatment initiation of 4.5 percentage points from 2019 to 2024 and narrowing gap with commercial and Medicaid suggests improvements in access.

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

- Rates of engagement in follow-up services after initiation of a first treatment following a diagnosis of alcohol or substance abuse were relatively low for all payer types combined, remaining below 21% for all years 2019 through 2024. 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.
- There were considerable differences by payer, with engagement rates in the Medicaid population exceeding 22% every year and rates in the commercial population ranging from 15% to 18%. Engagement rates in the Medicare population were much lower (below 10%).
- Given the continued low rates of follow-up treatment for substance abuse, further outreach and advocacy by state, federal, and industry stakeholders is warranted. The considerably lower engagement rates in the Medicare population point to potential structural barriers that may require targeted policy attention.

Summary

Across preventive care metrics (primary care visits and breast cancer screening) and treatment measures (initiation of and engagement with alcohol/drug dependence treatment), Medicaid generally underperforms relative to Medicare and commercial populations, pointing to potential access and care delivery system gaps that warrant targeted policy intervention. Improving performance on these key quality measures is essential to enhancing overall health outcomes, which can lead to better population health and reduce health care costs nationwide.

Additionally, disruption seemingly associated with the COVID-19 pandemic was temporary, but recovery has been uneven. Most measures declined from 2019 to 2020/2021 and rebounded thereafter. However, Medicaid and commercially insured populations have not fully returned to or exceeded pre-pandemic levels in key areas such as primary care and breast cancer screening. Treatment metrics for alcohol and other drug dependence show modest gains and narrowing disparities. Initiation rates have improved slightly over time, particularly among Medicaid populations, suggesting recent access efforts are beginning to have an impact. However, engagement with follow-up treatment remains low across all payers, especially in Medicare.

Health plans can utilize these findings 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, ensure faster and more accurate data exchange, and identify and address social drivers of health (SDOH).

About us

Inovalon is a leading provider of data and solutions empowering data-driven healthcare. We bring together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers, and are informed by the primary source data of more than 99 billion medical events across 1.1 million physicians, 733,000 clinical settings, and 458 million unique lives. For more information, visit www.inovalon.com.

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