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SAMPLE MEDICARE HEALTH OUTCOMES SURVEY
Medicare Advantage Organization
HEDIS® HOS Effectiveness of Care
Report
2025 Round 28



Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



Center for Medicare

July 2026

Medicare Advantage Organizations,

The Centers for Medicare & Medicaid Services (CMS) is pleased to provide you with your Medicare Advantage Organization's (MAO) *Healthcare Effectiveness Data and Information Set (HEDIS®)*^a Health Outcomes Survey (HOS) results for 2025 Round 28 of the Medicare HOS. The *2025 Round 28 HEDIS HOS Effectiveness of Care Report (HEDIS HOS Report)* includes results from the Medicare HOS Version 3.0. CMS encourages MAOs to examine their results for use in quality improvement activities.

The *HEDIS HOS Report* is distributed to help MAOs identify opportunities to improve their HOS results. Information on the HEDIS HOS measures used in the Medicare Star Ratings, as well as additional resources to assist MAOs in their quality improvement efforts, are included in the report. This report also contains an Executive Summary, a Reader's Guide, and trend information over recent years for your individual MAO.

For more program information, contact Health Services Advisory Group (HSAG) through the HOS Information and Technical Support at hos@hsag.com, or (888) 880-0077; you may also visit the [CMS HOS website](#).

Sincerely,

Elizabeth Goldstein, PhD
Director
Division of Consumer Assessment & Plan Performance

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

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Executive Summary

This *Healthcare Effectiveness Data and Information Set (HEDIS®)*^b *Health Outcomes Survey (HOS) Effectiveness of Care Report (HEDIS HOS Report)* presents the HEDIS HOS results for Medicare Advantage Organization (MAO) HXXXXA based on data from the HOS Round 28 surveys (combined Cohort 28 Baseline and Cohort 26 Follow Up data) collected in 2025. The HEDIS HOS measures presented in this report were calculated by the National Committee for Quality Assurance (NCQA).

This report presents the HEDIS HOS results to provide MAOs additional detail about the distribution of their HEDIS HOS scores by contract, state, region, and HOS total, as well as background information about the calculation of HEDIS HOS measures. Additionally, the report presents MAOs with the opportunity to confirm their HEDIS HOS results as displayed on the Health Plan Management System (HPMS). Finally, this report provides MAOs the opportunity to compare their HEDIS HOS results with their other HOS Performance Measurement results and Star Ratings for the purpose of targeting health improvement interventions for their members. If an MAO does not achieve a denominator of at least 100 responses, the rates are reported as *not applicable* (NA) in their tables.

The Cohort 28 Baseline and Cohort 26 Follow Up HOS surveys were fielded from July through November 2025 and were used to collect data for the HEDIS HOS measures. In Round 28, HEDIS HOS results were calculated from 600 MAOs. The overall sample size used for the *HEDIS HOS Report* was 1,024,216.

2025 HEDIS HOS Report

The HEDIS HOS results are intended to inform MAOs of their performance in the following three measures: *Management of Urinary Incontinence in Older Adults* (MUI), *Physical Activity in Older Adults* (PAO), and *Fall Risk Management* (FRM). The HEDIS HOS measures that continue to be used in the Medicare Star Ratings are: *Improving Bladder Control*, *Monitoring Physical Activity*, and *Reducing the Risk of Falling*. The purpose of this report is to provide MAOs the opportunity to review and improve their HEDIS HOS measure results, which are distributed at the same time that MAOs will be receiving their Performance Measurement results.

The state and region statistics in the tables are *not applicable* (NA) for Regional Preferred Provider Organizations (RPPO) and Private Fee-for-Service (PFFS) contracts. For reporting purposes, these types of plans are not included in any specific state or region results; however, they are included in the HOS Total results. For more information about a HEDIS HOS rate of NA, or a rate that was not calculated, see the HEDIS HOS Measures section.

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

HEDIS HOS Measure Trends for MAO HXXXXA

The HEDIS HOS results are from the combined Cohort 28 Baseline and Cohort 26 Follow Up data collected in 2025, (i.e., a round of data).

Measures incorporated into the 2026 Medicare Star Ratings include the MAO 2025 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate). The HEDIS HOS measures will be incorporated into the 2026 Medicare Star Ratings, which will be used as the basis for quality bonus payments in 2027.

Table 1: 2025 HEDIS HOS Rates for MAO HXXXXA, StateXX, CMS Region XX, and HOS Total

	MUI Discuss Rate	MUI Treat Rate	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate	FRM Discuss Rate	FRM Manage Rate
HXXXXA	60.32%	44.44%	13.65%	60.43%	50.54%	28.45%	57.49%
StateXX	60.83%	45.01%	14.85%	59.23%	50.87%	28.86%	58.44%
CMS Region XX	60.48%	44.86%	15.17%	59.20%	51.17%	28.81%	58.44%
HOS Total	60.35%	44.71%	16.05%	57.30%	50.88%	28.28%	59.13%

Consider the trends in Table 2 when implementing preventative health interventions and care management efforts to improve HEDIS HOS results. If the trend is in a negative direction across any of these HEDIS HOS results, your MAO may consider allocating resources to address the causes of the decline and monitor future performance.

Table 2: Trends in HEDIS HOS Rates over Three Rounds of Data for MAO HXXXXA

	MUI Discuss Rate	MUI Treat Rate	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate	FRM Discuss Rate	FRM Manage Rate
2025 Round 28	60.32%	44.44%	13.65%	60.43%	50.54%	28.45%	57.49%
2024 Round 27	61.13%	45.23%	16.25%	56.88%	49.54%	28.21%	59.42%
2023 Round 26	60.94%	45.92%	14.59%	56.95%	49.10%	27.84%	56.41%

How is your MAO doing?

Information in Table 3 allows you to compare the performance of your MAO with others in your state, CMS region, and the HOS total benchmarks for this year.

Table 3: 2025 HEDIS HOS Rates for MAO HXXXXA, All MAOs in StateXX, CMS Region XX, and HOS Total

	MUI Discuss Rate	MUI Treat Rate	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate	FRM Discuss Rate	FRM Manage Rate
HXXXXA	60.32%	44.44%	13.65%	60.43%	50.54%	28.45%	57.49%
HXXXXB	60.38%	45.74%	12.93%	60.72%	51.73%	27.38%	55.95%
HXXXXC	61.34%	45.36%	14.43%	58.76%	49.80%	28.74%	57.89%
HXXXXD	62.56%	44.75%	17.81%	56.37%	50.09%	31.61%	63.31%
HXXXXE	59.54%	44.74%	15.41%	59.84%	52.17%	28.13%	57.56%
StateXX	60.83%	45.01%	14.85%	59.23%	50.87%	28.86%	58.44%
CMS Region XX	60.48%	44.86%	15.17%	59.20%	51.17%	28.81%	58.44%
HOS Total	60.35%	44.71%	16.05%	57.30%	50.88%	28.28%	59.13%

Reader's Guide

The [CMS HOS website](#) provides general information about the program. A full description of the HOS program is available on the HOS website at www.HOSonline.org.

How to Use the Information in this Report

This report was designed to exclusively address the MAO's HEDIS HOS results. It also aims to assist MAOs in identifying opportunities to reduce health differences and explore potential programmatic interventions aimed at maintaining or improving the overall health of their Medicare population.

What information can I find in the HEDIS HOS Report?

A random sample of Medicare members is drawn from each participating MAO and surveyed during the baseline survey fielding (i.e., the HOS questionnaire is administered to a different baseline cohort, or group, each year). MAOs that administered the baseline survey two years prior are also required to administer a follow up survey. The results for the HEDIS HOS measures are calculated by NCQA using data collected for baseline and follow up cohorts in a single survey year (i.e., a round of data). The same survey is administered to both cohorts.

Where can I find additional HOS Program information, such as sampling methodology, and timelines for the reporting and data distribution?

An overview of the HOS Program, the sampling schedule, and program timelines are available on the [Program](#) page of the HOS website. A table of MAO reports and data distribution dates is provided on the [Data](#) page of the website.

Are HOS measures part of the CMS Medicare Star Ratings?

HOS measures are included in the Medicare Star Ratings, which CMS developed to provide consumer information about MAOs and to award quality bonus payments to high-performing health plans. CMS displays MAO information in the [Medicare Plan Finder \(MPF\)](#) tool. More information about the Star Ratings is in The Medicare Star Ratings and HEDIS HOS section of this report.

How are HEDIS HOS Reports distributed?

All reports are distributed electronically to participating MAOs through the CMS HPMS, which requires an HPMS User ID. Downloads of the MAO report include summary-level data in a comma separated values (CSV) file that contains contract-level HEDIS HOS rates. The HEDIS rates reported as *not applicable* (NA) in the MAO report will be blank in the percent column in the CSV file. If all rates are NA, the percent column will be blank for all rates. Once they become available, it is important for MAOs to obtain and review their reports through HPMS.

Technical Assistance

Medicare HOS Information and Technical Support at hos@hsag.com or (888) 880-0077 is available to assist with report questions and interpretation. For questions about the HEDIS HOS measures, contact NCQA at hos@ncqa.org.

Need More Help?

- MAOs are encouraged to direct their questions to the applicable HOS Project Team. If the inquiry is related to program requirements, survey administration, or fielding, please contact the HOS Project Team at NCQA (hos@ncqa.org). For questions related to HOS data and reports or their availability, contact the HOS Project Team at HSAG (hos@hsag.com).
- HOS related peer-reviewed articles, technical reports, and manuals are available on the [Resources](#) page of the HOS website. Consult the [Home](#) page for a listing of new reports and general updates.
- A glossary of definitions relevant to the Medicare HOS may be accessed from the [Glossary](#) link at the bottom of site webpages.
- The HOS protocol followed to administer the survey is specified in the NCQA *HEDIS Measurement Year (MY) 2024, Volume 6: Specifications for the Medicare Health Outcomes Survey* manual.¹ The most recent HEDIS Volume 6 manuals are available at no cost from the [NCQA Store](#). Copies of older HEDIS publications may be obtained by calling NCQA Customer Support at (888) 275-7585.

The Medicare Star Ratings and HEDIS HOS

CMS developed the Medicare Star Ratings to help consumers compare health plans and providers based on quality and performance; to make accurate data more transparent and standardized among plans; and to reward top-performing health plans. Consumers can use the [Medicare Plan Finder \(MPF\)](#) tool to search for health plans in their geographic area and compare cost estimates and coverage information. CMS rates the relative quality of service and care provided by MAOs based upon a five-star rating scale that uses HOS measures combined with other measurement results. Up to 43 unique quality measures were included in the 2026 Medicare Part C and D Star Ratings. These measures include: providing preventive services, managing chronic illness, access to care, HEDIS HOS measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)^c survey, and plan responsiveness.

The Medicare Part C Star Ratings include five contract level HOS measures: two measures of functional health and the three HEDIS HOS measures. Refer to your MAO's annual *HOS Performance Measurement Report* and *Baseline Report* for more information on the functional health measures and how they are incorporated into the Star Ratings. Further details, with the timeline table of the current data collection, report dissemination, and the Medicare Part C Star Ratings can be found in the *Performance Measurement Report* and on the [HOS website](#).

Each of the HEDIS HOS measures incorporate questions about discussions with a doctor or other health care provider about potential health issues and treatment options. CMS uses the following three HEDIS HOS measures for the Medicare Star Ratings:

- *Improving Bladder Control* measure is the Treatment of Urinary Incontinence rate from the *Management of Urinary Incontinence in Older Adults* (MUI) measure
- *Monitoring Physical Activity* measure is the Advising Physical Activity rate from the *Physical Activity in Older Adults* (PAO) measure
- *Reducing the Risk of Falling* measure is the Managing Fall Risk rate from the *Fall Risk Management* (FRM) measure

These rates are calculated from questions about information and care people with Medicare receive from their doctor or other healthcare providers, using data for the baseline and follow up cohorts from the same measurement year (i.e., a round of data). Responses from people age 65 or older as of December 31 of the measurement year are used to derive the HEDIS HOS measure results. Further information on the HEDIS HOS measures and the measure calculations is available in HEDIS HOS Measures section of this report, in the HEDIS Volume 6 manual (www.store.ncqa.org), and on the [HOS website](#).

Information about MAO resources for best practices to improve their HEDIS HOS results specifically and their overall HOS results can be found in the *Performance Measurement Report* and on the [Resources](#) page of the HOS website.

^c CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS HOS Measures

Items for three HEDIS HOS measures were included in the 2025 Medicare HOS questionnaire: *Management of Urinary Incontinence in Older Adults* (MUI), *Physical Activity in Older Adults* (PAO), and *Fall Risk Management* (FRM). The results for the HEDIS HOS measures were calculated by NCQA using data collected for baseline and follow up cohorts in a single survey year (i.e., a round of data). For the 2025 survey year, the round of data (Cohort 28 Baseline and Cohort 26 Follow Up data) are combined, since the same survey is administered to both cohorts. Three rates from the HEDIS HOS measures will be used for the 2027 Medicare Star Ratings: *Improving Bladder Control*, *Monitoring Physical Activity*, and *Reducing the Risk of Falls*.

MAOs must achieve a denominator of at least 100 responses to obtain a reportable result for each HEDIS HOS rate. NCQA assigns a result of *not applicable* (NA) for rates which do not achieve a reportable denominator. For MAO-specific HEDIS HOS rates and trends, please refer to Table 1 and Table 2 in the Executive Summary section of this report.

The remainder of this report presents specific information on the relevance and calculations for each of the measures, as well as the aggregated mean rates for the state, CMS Region, and HOS Total. For a list of the states within each CMS Region, see the listing of CMS regional offices on the [CMS website](#).

HEDIS HOS measures are calculated for respondents age 65 or older as of December 31 of the measurement year. Beginning with the 2018 HEDIS HOS measures, members with evidence from CMS administrative records of a hospice start date or hospice enrollment are excluded from the HEDIS HOS measure calculations. For detailed information about the HEDIS HOS measures, please refer to the *HEDIS MY 2024 Volume 6: Specifications for the Medicare Health Outcomes Survey*.¹

Table 4: 2025 HEDIS HOS Performance Measures for MAO HXXXXA

HEDIS HOS Measure	Numerator	Denominator	Percentage
MUI			
Discussing Urinary Incontinence	190	315	60.32%
Treatment of Urinary Incontinence	140	315	44.44%
Impact of Urinary Incontinence	43	315	13.65%
PAO			
Discussing Physical Activity	501	829	60.43%
Advising Physical Activity	422	835	50.54%
FRM			
Discussing Fall Risk	243	854	28.45%
Managing Fall Risk	215	374	57.49%

Values are provided to the second decimal place for the Star Ratings. HEDIS names are abbreviated in this table. If the denominator for the MAO was less than 100 responses, NCQA assigned a result of *not applicable* (NA).

Management of Urinary Incontinence in Older Adults

The *Management of Urinary Incontinence in Older Adults* (MUI) measure is comprised of four questions that gather data on leakage of urine, also called urinary incontinence (UI), UI interference with daily activities and sleep, patient/provider discussion of UI, patient/provider discussion of UI treatment options, and the impact of UI. Medicare members must be age 65 or older as of December 31 of the measurement year to be eligible for inclusion in this measure. Refer to HEDIS Volume 6 for the full HEDIS measure specification.

The following components of this measure assess different facets of managing urinary incontinence in older adults:

Discussing Urinary Incontinence

The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who discussed their urinary leakage problem with a health care provider.

Denominator The number of members 65 years of age and older who reported having any urinary incontinence in the past six months.

Member response choices must be as follows to be included in the denominator:

Q33= "Yes."

Q35 = "Yes" or "No."

Numerator The number of members in the denominator who indicated they discussed their urinary incontinence with a health care provider.

Member response choices must be as follows to be included in the numerator:

Q35 = "Yes."

Treatment of Urinary Incontinence

The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a health care provider.

Denominator The number of members 65 years of age and older who reported having any urinary incontinence in the past six months.

Member response choices must be as follows to be included in the denominator:

Q33 = "Yes."

Q36 = "Yes" or "No."

Numerator The number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider.

Member response choices must be as follows to be included in the numerator:

Q36 = "Yes."

Impact of Urinary Incontinence

The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

Note: A lower rate indicates better performance for this indicator.

Denominator The number of members 65 years of age and older who reported having any urinary incontinence in the past six months.

Member response choices must be as follows to be included in the denominator:

Q33 = "Yes."

Q34 = "A lot" or "Somewhat" or "Not at all."

Numerator The number of members in the denominator who indicated that urine leakage made them change their daily activities or interfered with their sleep a lot.

Member response choices must be as follows to be included in the numerator:

Q34 = "A lot."

HOS Total Results

In the following tables, if there was only one MAO in the state, the standard deviation (SD) for the state was *not calculated* (NC); and the 10th (P10), the 25th (P25), 50th (Median), 75th (P75), and 90th (P90) percentiles, and minimum and maximum rates will equal the MAO's rate. If the number of responses in the denominator for the MAO rate was less than 100, the HEDIS HOS rate was *not applicable* (NA). If the rates for all MAOs in a state were NA, the HEDIS HOS rate was also NA for the state. Statistics for State and Region were *not applicable* (NA) for Regional Preferred Provider Organizations (RPPO) and Private Fee-for-Service (PFFS) contracts.

Table 5: Discussing Urinary Incontinence Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	60.83	1.16	59.54	60.32	60.38	61.34	62.56	59.54	62.56
CMS Region XX	60.48	1.07	59.17	59.66	60.35	61.09	61.95	58.80	62.56
HOS Total	60.35	5.72	53.77	56.47	60.11	63.06	67.27	45.24	84.87

Table 6: Treatment of Urinary Incontinence Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	45.01	0.53	44.44	44.74	44.75	45.36	45.74	44.44	45.74
CMS Region XX	44.86	0.60	44.09	44.44	44.74	45.36	45.72	43.98	45.74
HOS Total	44.71	4.93	38.39	41.42	44.87	48.02	50.56	30.77	58.08

Table 7: Impact of Urinary Incontinence Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	14.85	1.89	12.93	13.65	14.43	15.41	17.81	12.93	17.81
CMS Region XX	15.17	1.58	13.29	14.43	14.80	15.52	17.79	12.93	17.81
HOS Total	16.05	7.46	8.05	10.53	14.02	20.35	27.40	4.91	40.00

Why Is It Important?

UI is common among older adults and can have significant consequences for those affected as well as for their caregivers. Age-related changes to the genitourinary system can lead to a higher prevalence of the condition. UI may cause a wide range of morbidities, including cellulitis, pressure ulcers, urinary tract infections, falls with fractures, sleep deprivation, social withdrawal, depression, and sexual dysfunction, and increases the risk of institutionalization.^{2, 3} Persons with UI are not often being asked about their UI by a health care professional.⁴ Consequently, UI remains significantly underreported and underdiagnosed.⁵

Risk Factors

Prevalence rates are highest among women, people of advanced age, and those who have cognitive and physical disabilities. Women are most likely to develop incontinence during pregnancy and childbirth, or after the hormonal changes of menopause. Older men may become incontinent as a result of bladder obstruction or prostate surgery. Pelvic trauma, spinal cord damage, decreased mobility, cognitive impairment, and some medications can contribute to episodes of UI.^{2, 6}

Intervention

Evidence in the literature shows that treatment may reduce or eliminate UI in most patients. Effective treatments include behavioral therapies such as bladder training and techniques for pelvic muscle rehabilitation.⁷ Low-intensity behavioral therapies are ideal first-line interventions that are inexpensive, low risk, and can be initiated effectively by primary care providers. Pharmacologic therapies include anticholinergic agents and tricyclic anti-depressants, and surgical therapies include injections with bulking agents, and sling procedures.^{2, 3, 6}

Physical Activity in Older Adults

The *Physical Activity in Older Adults* (PAO) measure is comprised of two questions that gather data on a patient's discussion of physical activity with a doctor or other health provider. Medicare members must be age 65 or older as of December 31 of the measurement year to be eligible for inclusion in this measure.

The following components of this measure assess different facets of promoting physical activity in older adults:

Discussing Physical Activity

The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.

Denominator The number of members 65 and older who responded "Yes" or "No" to the question, "In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."

Member response choices must be as follows to be included in the denominator:

Q37 = "Yes" or "No."

Numerator The number of members in the denominator who responded "Yes" to the question, "In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."

Member response choices must be as follows to be included in the numerator:

Q37 = "Yes."

Advising Physical Activity

The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity.

Note: Members who respond to *Discussing Physical Activity* (Q37), "I had no visits in the past 12 months," are excluded from the results calculation for *Advising Physical Activity* (Q38).

Denominator The number of members 65 and older who responded "Yes" or "No" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity? For example, in order to improve your health, your

doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day, or to maintain your current exercise program.”

Member response choices must be as follows to be included in the denominator:

Q38 = “Yes” or “No.”

Numerator The number of members in the denominator who responded “Yes” to the question, “In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day, or to maintain your current exercise program.”

Member response choices must be as follows to be included in the numerator:

Q38 = “Yes.”

HOS Total Results

Table 8: Discussing Physical Activity Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	59.23	1.76	56.37	58.76	59.84	60.43	60.72	56.37	60.72
CMS Region XX	59.20	1.55	56.49	58.76	59.77	60.38	60.58	56.37	60.72
HOS Total	57.30	7.25	47.77	52.40	57.14	61.64	66.35	36.69	79.85

Table 9: Advising Physical Activity Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	50.87	1.04	49.80	50.09	50.54	51.73	52.17	49.80	52.17
CMS Region XX	51.17	1.14	49.54	50.09	51.58	52.09	52.31	49.27	52.45
HOS Total	50.88	6.33	42.56	46.80	50.95	54.81	58.87	33.91	73.57

Why Is It Important?

Engaging in physical activity helps reduce the risk of the deterioration issues that come with aging.⁸ In community-dwelling older people, exercise reduces the impact of age on mortality and confers the greatest benefits to improvements in the health status of the frail elderly.^{9, 10} Regular physical activity is associated with decreased risk for heart disease, hypertension, diabetes, certain cancers, arthritis, high cholesterol, osteoporosis, and premature mortality.^{11, 12} Physical inactivity and poor diet are the major causes of obesity. Physical activity also improves muscle strength and balance, reducing the risk of falls.

As of 2015, medical costs for fall-related injuries totaled \$50 billion. With the growth of the 65 and older population, an increase in fall-related injuries could also result.¹³ Additionally, the

increase of the 65 and older population draws attention to other common health concerns among older adults such as Alzheimer's disease and other dementias, which may be preventable with physical activity. Costly to treat and maintain, the estimated annual costs of Alzheimer's disease and other dementias is expected to jump to just under \$1 trillion by the year 2050.¹⁴ In general, regular physical activity improves physical functioning, fosters a sense of well-being, reduces fall risk, and reduces risk of depressive symptoms and anxiety.^{15, 16, 17, 18}

Risk Factors

Across three national surveys (NHANES, BRFSS, and NHIS), a decrease in physical activity engagement has been related to increasing age, various demographic variables, and functional limitations.¹⁹ As of 2020, of those age 65-74 years, the approximate prevalence of no leisure-time physical activity was lower than for those age 75-84 years. Adjusted for age, sex, and race/ethnicity, the prevalence of no leisure-time physical activity was between 32.2% and 55.4% across surveys for those age 65-74 compared to 41.4% to 68.5% for those age 74-85 years.¹⁹ Sex and racial differences have also played a role in participation in regular physical activity: men reported having greater levels of physical activity compared to women, and Non-Hispanic Whites were reported to have increased levels of physical activity compared to Non-Hispanic Blacks or Hispanics.¹⁹

The objectives of Healthy People 2030 include reducing the proportion of adults who engage in no leisure-time physical activity and increasing the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.²⁰

Intervention

Older adults should consult their health care provider to determine what level of physical activity is safe and appropriate. Sedentary older adults should begin physical activity with short intervals of moderate activity (5 to 10 minutes).²¹ It is recommended to aim for at least 150 minutes of moderate-intensity physical activity a week, or 75 minutes of vigorous-intensity activity a week. When older adults cannot meet these goals because of chronic conditions, they should be as physically active as their abilities allow. Aerobic activities such as jogging, walking, rolling a wheelchair, or swimming should be engaged in at least 3 days per week. Strength training involving multiple muscle groups, such as calisthenics, weight lifting, carrying laundry or groceries, chair exercises, or working in the yard, should be done at least 2 days per week.⁸

Fall Risk Management

The *Fall Risk Management* (FRM) measure consists of four questions to ascertain whether people with Medicare had a history of falls or problems with balance or walking, whether they discussed falls with a medical provider, and their provider's management of fall risk. Medicare members must be age 65 or older as of December 31 of the measurement year to be eligible for inclusion in this measure. The following components of this measure assess different facets of fall risk management:

Discussing Fall Risk

The percentage of Medicare members 65 years older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

Denominator The number of members 65 years of age and older who had a practitioner visit in the past 12 months.

Member response choices must be as follows to be included in the denominator:

Q39 = "Yes" or "No."

Numerator The number of members in the denominator who indicated they discussed falls or problems with balance or walking with their current provider.

Member response choices must be as follows to be included in the numerator:

Q39 = "Yes."

Managing Fall Risk

The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

Denominator The number of members 65 years of age and older who had a visit in the past 12 months and who responded to the Survey indicating they had a fall or problems with balance or walking in the past 12 months.

Member response choices must be as follows to be included in the denominator:

Q39 = "Yes" or "No."

Q40 = "Yes" **or** Q41 = "Yes."

Q42 = "Yes" or "No."

Numerator The number of members in the denominator who indicated their provider provided fall risk management.

Member response choices must be as follows to be included in the numerator:

Q42 = "Yes."

HOS Total Results

Table 10: Discussing Fall Risk Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	28.86	1.62	27.38	28.13	28.45	28.74	31.61	27.38	31.61
CMS Region XX	28.81	1.19	27.72	28.13	28.56	29.05	30.74	27.38	31.61
HOS Total	28.28	5.73	22.03	24.73	27.46	31.13	36.12	15.05	53.33

Table 11: Managing Fall Risk Rate for StateXX, CMS Region XX, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	58.44	2.82	55.95	57.49	57.56	57.89	63.31	55.95	63.31
CMS Region XX	58.44	2.19	55.81	57.49	58.17	59.03	61.78	55.67	63.31
HOS Total	59.13	9.11	49.12	52.33	57.32	64.82	71.98	38.36	91.24

Why Is It Important?

More than one out of four adults age 65 or older fall each year and falls are the most common cause of injuries and fatalities among the elderly.^{22, 23} Falls are also a common cause of nursing home admissions among older adults.²⁴ Fall related injuries, such as hip fractures, are associated with significant functional decline, limited mobility, loss of ability to live independently, and decreased quality of life.²³ In 2018 among adults age 65 and older, 32,000 fatal fall related injuries and 8.4 million non-fatal fall related injuries were medically treated.^{22, 25} In 2015, medical expenses for falls reached a total of \$50 billion. Medicare and Medicaid were subject to 75% of those costs.²³ Between 2007 and 2016, death rates caused by falls increased by 30%, and seven deaths per hour resulting from falls can be expected, if the rate continues to increase.²³

Risk Factors

The risk of fall related injuries increases with age. Adults 85 and older were four to five times more likely to have fall related injuries than adults 65-74 years of age.^{26, 27} Females are more likely than males to have non-fatal fall injuries, whereas males are more likely than females to have fatal fall injuries. Other risk factors for falls historically include: lack of physical activity, misuse of alcohol, taking specific prescription drugs (e.g., psychotropic or narcotic medications), hearing or visual impairments, and unsafe home environments.^{26, 28}

Intervention

Regular exercise and exercise programs; e.g., strength training, may increase strength and improve balance among older adults. Regular medication reviews by physicians or pharmacists can help reduce side effects and drug interactions. Annual eye checkups are important for maintaining eye health. Home assessment and modifications may reduce hazards in the home, such as improper lighting, that can lead to falls.²³ Fall prevention programs may need to provide and install safety devices to effectively reduce environmental hazards.^{28, 29}

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