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2021 ROUND 24
MEDICARE ADVANTAGE ORGANIZATION

HEDIS® HOS EFFECTIVENESS OF CARE REPORT

Medicare Health Outcomes Survey

HSAG HEALTH SERVICES ADVISORY GROUP

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

NCQA Measuring quality. Improving health care.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

July 2022

Medicare Advantage Organizations,

The Centers for Medicare & Medicaid Services (CMS) is pleased to provide you with your Medicare Advantage Organization's (MAO) HEDIS HOS results for *2021 Round 24* of the Medicare Health Outcomes Survey (HOS). The *2021 Round 24* 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. The Report also includes an Executive Summary, a Reader's Guide, as well as trend information over recent years for your individual MAO.

For more program information, you may submit inquiries to hos@hsag.com, or contact Health Services Advisory Group (HSAG) through the HOS Information and Technical Support Telephone Line at (888) 880-0077, and you may visit the CMS HOS website at www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS.

Sincerely

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

Medicare Health Outcomes Survey
Sample MAO Report

The following is a **sample** version of the *Round 24 HEDIS® HOS* Report made available to all Medicare Advantage Organizations (MAOs) participating in the *2021 Round 24* Medicare Health Outcomes Survey.

The figures, tables, and text in this document contain example MAO and state level data; however, all references to the *HOS Total* reflect **actual** data.

The Medicare HOS Information and Technical Support Telephone Line (1-888-880-0077), and Email Address (*hos@hsag.com*), are available to provide assistance with report questions and interpretation. A full description of the HOS program may be found at *www.HOSonline.org*.

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Executive Summary

This Healthcare Effectiveness Data and Information Set (HEDIS®)[a] Health Outcomes Survey (HOS) Effectiveness of Care Report (HEDIS HOS Report) presents the HEDIS HOS results for Medicare Advantage Organization (MAO) HXXXA based on data from the HOS Round 24 surveys (combined *Cohort 24 Baseline* and *Cohort 22 Follow Up* data) collected in 2021. 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 did not have a sufficient number of seniors ($N \geq 100$) or was not required to report HEDIS HOS measures, the rates are reported as *not applicable* (NA) in their tables.

The *Cohort 24 Baseline* and *Cohort 22 Follow Up* HOS surveys were fielded from August through November 2021 and were used to collect data for the HEDIS HOS measures. In Round 24, HEDIS HOS results were calculated from 561 MAOs. The overall sample size used for the HEDIS HOS Report was 813,582.

2021 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*. Between 2012 and 2020, the Osteoporosis Testing in Older Women (OTO) measure was part of the Medicare Part C display measures on the CMS website. As of the 2021 HOS survey administration year, the OTO measure has been retired by the measure steward, NCQA. OTO data are no longer available, and all references to the measure have been removed. 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.

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

HEDIS HOS Measure Trends for MAO HXXXA

The three HEDIS HOS measures will be incorporated into the 2023 Medicare Star Ratings, which will be used as the basis for quality bonus payments in 2024.

Table 1 depicts the HEDIS HOS results for your MAO, and the mean rates for your state, CMS Region, and HOS Total. These results are from the combined *Cohort 24 Baseline* and *Cohort 22 Follow Up* data collected in 2021, i.e., a round of data.

Table 1: 2021 HEDIS HOS Rates for MAO HXXXA, 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*
HXXXA	57.73%	44.09%	15.00%	58.30%	51.19%	25.37%	54.22%
StateXX	59.26%	45.54%	14.52%	57.75%	50.19%	25.04%	54.46%
CMS Region XX	59.10%	45.49%	14.58%	57.44%	50.08%	25.19%	54.40%
HOS Total	59.30%	45.19%	15.76%	55.28%	49.92%	26.11%	55.63%

†See Table 3 results for all MAOs in the state.
* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

The results in Table 2 show the trends in HEDIS HOS results for your MAO over the current and previous two rounds, where available. Consider the direction of these trends 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 HXXXA

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*
2021 Round 24	57.73%	44.09%	15.00%	58.30%	51.19%	25.37%	54.22%
2020 Round 23	63.64%	47.18%	20.28%	54.86%	50.63%	28.29%	61.54%
2019 Round 22	57.98%	44.92%	13.90%	59.30%	52.82%	25.81%	57.34%

* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

How is your MAO doing?

Table 3 presents the HEDIS HOS results for all MAOs in your state, CMS Region, and the HOS Total. These results depict how your MAO is performing on each of the HEDIS HOS measures relative to each contract in your state, as well as the regional and national averages.

Table 3: 2021 HEDIS HOS Rates for MAO HXXXA, 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
HXXXA	57.73%	44.09%	15.00%	58.30%	51.19%	25.37%	54.22%
HXXXB	59.83%	46.15%	14.96%	58.52%	51.24%	25.08%	54.91%
HXXXC	60.55%	45.62%	14.22%	57.70%	49.04%	25.38%	55.47%
HXXXD	58.18%	45.66%	13.64%	57.29%	49.49%	24.08%	54.18%
HXXXE	60.00%	46.19%	14.76%	56.94%	50.00%	25.30%	53.53%
StateXX	59.26%	45.54%	14.52%	57.75%	50.19%	25.04%	54.46%
CMS Region XX	59.10%	45.49%	14.58%	57.44%	50.08%	25.19%	54.40%
HOS Total	59.30%	45.19%	15.76%	55.28%	49.92%	26.11%	55.63%

Reader's Guide

The Reader's Guide is provided to assist MAOs using the Medicare HEDIS HOS Report. This section includes information on CMS Medicare Star Ratings, and answers general questions about the reports and data. For further assistance, please refer to the Technical Assistance information below.

Technical Assistance

The Medicare HOS Information and Technical Support Telephone Line (1-888-880-0077) and Email Address (hos@hsag.com) are available to assist with report questions and interpretation. For questions about the HEDIS HOS measures, contact NCQA at hos@ncqa.org. The CMS HOS website provides general information about the program (www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS). A full description of the HOS program is available at www.HOSonline.org.

How to Use the Information in this HEDIS HOS Report

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

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 at www.HOSonline.org. A table of MAO reports and data distribution 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 reward high-performing health plans. CMS displays MAO information in the Medicare Plan Finder (MPF) tool on the www.medicare.gov/plan-compare website and awards quality bonus payments to high-performing health plans. For information about the Star Ratings, refer to The Medicare Star Ratings and HEDIS HOS section in 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 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, and if all rates are NA then the "percent" column will be blank for all rates.

Need More Help?

- MAOs are encouraged to contact the HOS Technical Support Team at Health Services Advisory Group at hos@hsag.com with questions.
- Additional information about peer-reviewed articles, technical reports, and manuals related to the HOS is available on the Resources page of the HOS website (www.HOSonline.org). Consult the Home page for a listing of new reports and general updates.
- A glossary consisting of definitions relevant to the Medicare HOS may be accessed from the Glossary link at the bottom of site webpages.
- Participating MAOs contracted with a CMS approved survey vendor to administer the surveys following the protocol specified in the NCQA HEDIS Measurement Year (MY) 2020, Volume 6: Specifications for the Medicare Health Outcomes Survey manual.[1] The most recent manuals (HEDIS 2016 Volume 6 – HEDIS MY 2020) are available at no cost from the NCQA Store (https://store.ncqa.org/hedis-quality-measurement/hedis-specifications-for-the-medicare-health-outcomes-survey.html). Copies of older HEDIS® Volume 6 may be obtained from NCQA by calling NCQA Customer Support at 1-888-275-7585.

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 (www.medicare.gov/plan-compare) 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 38 unique quality measures were included in the 2022 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®) 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. Please 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 at www.HOSonline.org.

Each of the HEDIS HOS measures are divided into components. 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 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 with Medicare are used to derive the HEDIS HOS measures: Management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, and Fall Risk Management. Further information is available in the HEDIS HOS Measures section, and on the HOS website at www.HOSonline.org.

Information about MAO resources for best practices to improve their HEDIS HOS results specifically and their overall HOS results including the Star Ratings can be found in the Performance Measurement report and are made available on the HOS website.

2021 HEDIS HOS Measures

All three HEDIS HOS measures were included in the 2021 Medicare HOS: *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 2021 survey year, the round of data (*Cohort 24 Baseline* and *Cohort 22 Follow Up* data) are combined.

MAOs must achieve a denominator of at least 100 responses in order 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 additional HEDIS HOS measure results, please refer to the HEDIS HOS Measures Tables in the Executive Summary section.

The summary table below presents the results for numerators, denominators, and percentages for the HEDIS HOS measures for your MAO. The subsequent pages present 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, visit www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices.

For the HEDIS HOS measures, age is calculated as 65 and 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 2020 Volume 6: Specifications for the Medicare Health Outcomes Survey.[1]

Table 4: 2021 HEDIS HOS Performance Measures for MAO HXXXA

HEDIS HOS Measure	Numerator	Denominator	Percentage
MUI			
Discussing Urinary Incontinence	127	220	57.73%
Treatment of Urinary Incontinence*	97	220	44.09%
Impact of Urinary Incontinence	33	220	15.00%
PAO			
Discussing Physical Activity	337	578	58.30%
Advising Physical Activity*	301	588	51.19%
FRM			
Discussing Fall Risk	153	603	25.37%
Managing Fall Risk*	135	249	54.22%

* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate) and *Reducing the Risk of Falling* (FRM Manage Rate).
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

Measure Description

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.

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 Medicare 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:
Q42 = "Yes."
Q44 = "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:
Q44 = "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 Medicare 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:
Q42 = "Yes."
Q45 = "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:

Q45 = "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 Medicare 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:

Q42 = "Yes."
Q43 = "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:

Q43 = "A lot"

HOS Total Results

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

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	59.26	1.23	57.73	58.18	59.83	60.00	60.55	57.73	60.55
CMS Region XX	59.10	1.00	57.72	58.18	59.38	59.83	60.28	57.71	60.55
HOS Total	59.30	5.93	52.63	55.17	58.71	62.60	66.36	42.65	87.07

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

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	45.54	0.85	44.09	45.62	45.66	46.15	46.19	44.09	46.19
CMS Region XX	45.49	0.85	43.95	45.53	45.71	46.15	46.22	43.81	46.24
HOS Total	45.19	4.88	39.30	42.06	44.97	48.58	51.28	29.46	59.13

Please see the note accompanying HEDIS Table 5 above for the meaning of NC and NA.

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	14.52	0.58	13.64	14.22	14.76	14.96	15.00	13.64	15.00
CMS Region XX	14.58	0.44	13.89	14.22	14.75	14.94	14.98	13.64	15.00
HOS Total	15.76	7.17	8.41	10.64	13.52	19.12	26.32	4.79	47.53

Please see the note accompanying HEDIS Table 5 above for the meaning of NC and NA.

Why Is It Important?

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.[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

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

Measure Description

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.

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 as of December 31 of the measurement year 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 activity."

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

Q46 = "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 activity."

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

Q46 = "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* (Q46), "I had no visits in the past 12 months," are excluded from the results calculation for *Advising Physical Activity* (Q47).

Denominator The number of members 65 and older as of December 31 of the measurement year 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:

Q47 = "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:

Q47 = "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	57.75	0.67	56.94	57.29	57.70	58.30	58.52	56.94	58.52
CMS Region XX	57.44	1.75	55.16	56.63	57.50	58.30	59.67	54.02	60.83
HOS Total	55.28	6.91	46.39	50.69	55.24	60.16	64.00	34.36	78.24

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

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

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	50.19	0.99	49.04	49.49	50.00	51.19	51.24	49.04	51.24
CMS Region XX	50.08	1.41	48.27	49.45	49.92	51.19	51.94	47.50	52.65
HOS Total	49.92	5.81	42.52	46.00	50.13	53.54	57.08	32.87	67.15

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

Why Is It Important?

Engaging in physical activity is more influential than genetic factors in avoiding 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, gender, 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] Gender 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] In 2018, the US Department of Health and Human Services issued new physical activity guidelines for Americans, which summarized the benefits of physical activity in disease prevention across various demographics in the United States.[21]

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).[22] 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.[21, 23]

Fall Risk Management

Measure Description

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.

The following components of this measure assess different facets of fall risk management:

Discussing Fall Risk
The percentage of Medicare members 65 years of age and 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:
Q48 = "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:
Q48 = "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:
Q48 = "Yes" or "No."
Q49 = "Yes" or Q50 = "Yes."
Q51 = "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:
Q51 = "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	25.04	0.55	24.08	25.08	25.30	25.37	25.38	24.08	25.38
CMS Region XX	25.19	0.52	24.40	25.08	25.27	25.38	25.84	24.08	25.93
HOS Total	26.11	5.91	20.20	22.10	24.86	28.43	34.39	12.40	56.69

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

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

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
StateXX	54.46	0.74	53.53	54.18	54.22	54.91	55.47	53.53	55.47
CMS Region XX	54.40	0.70	53.29	54.18	54.53	54.91	55.21	53.05	55.47
HOS Total	55.63	9.09	45.63	49.38	54.11	60.00	69.35	30.97	87.35

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

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.[24, 25] Falls are also a common cause of nursing home admissions among older adults.[26] 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.[25] 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.[27] In 2015, medical expenses for falls reached a total of $50 billion. Medicare and Medicaid were subject to 75% of those costs.[25] 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.[25]

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.[28, 29] 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.[28, 30]

Intervention

Regular exercise and exercise programs; e.g., tai chi, may increase strength and improve balance among older adults.[24] 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.[25] Fall prevention programs may need to provide and install safety devices to effectively reduce environmental hazards.[30, 31]

References

[1] National Committee for Quality Assurance. *HEDIS® Measurement Year (MY) 2020, Volume 6: Specifications for the Medicare Health Outcomes Survey.* Washington, DC: NCQA Publication, 2021. Available at: www.ncqa.org/hedis/measures/hos. Accessed on: Mar 17, 2022.

[2] Davis NJ, Wyman JF, Gubitosa S, et al. Urinary Incontinence in Older Adults. *American Journal of Nursing*. 2020 Jan;120(1):57-62. Available at: https://journals.lww.com/ajnonline/Fulltext/2020/01000/Urinary_Incontinence_in_Older_Adults. Accessed on: Mar 17, 2022.

[3] Pizzol D, Demurtas J, Celotto S, et al. Urinary incontinence and quality of life: a systematic review and meta-analysis. *Aging Clinical and Experimental Research*. 2021 Jan;33(1):25-35. Available at: https://link.springer.com/article/10.1007/s40520-020-01712-y. Accessed on: Mar 17, 2022.

[4] Lane GI, Hagan K, Erekson E. Patient-Provider Discussions About Urinary Incontinence Among Older Women. *Journal of Gerontology Series A*. 2021 Feb 25;76(3):463-469. Available at: https://academic.oup.com/biomedgerontology/article/76/3/463/5827477. Accessed on: Mar 17, 2022.

[5] Mardon RE, Halim S, Pawlson G, et al. Management of urinary incontinence in Medicare managed care beneficiaries. *Archives of Internal Medicine*. 2006; 166:1128-1133. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410364. Accessed on: Mar 17, 2022.

[6] Burgio KL, Kraus SR, Johnson TM. Effectiveness of Combined Behavioral and Drug Therapy for Overactive Bladder Symptoms in Men: A Randomized Clinical Trial. *JAMA Internal Medicine*. 2020 Mar 1;180(3):411-419. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2758797. Accessed on: Mar 17, 2022.

[7] Sung VW, Borello-France D, Newman DK, et al. Effect of Behavioral and Pelvic Floor Muscle Therapy Combined With Surgery vs Surgery Alone on Incontinence Symptoms Among Women With Mixed Urinary Incontinence: The ESTEEM Randomized Clinical Trial. *Journal of the American Medical Association.* 2019 Sep 17;322(11):1066-1076. Available at: https://jamanetwork.com/journals/jama/fullarticle/2749872. Accessed on: Mar 17, 2022.

[8] Centers for Disease Control and Prevention. *Healthy Aging: Improving and Extending Quality of Life Among Older Americans At a Glance, 2015*. Available at: https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2015/healthy-aging-aag.pdf. Accessed on: Mar 17, 2022.

[9] Groessl EJ, Kaplan RM, Rejeski WJ, Katula JA, et al. Physical Activity and Performance Impact Long-term Quality of Life in Older Adults at Risk for Major Mobility Disability. *American Journal of Preventive Medicine*. 2019 Jan;56(1):141-146. Available at: https://www.ajpmonline.org/article/S0749-3797(18)32268-2/fulltext. Accessed on: Mar 17, 2022.

[10] Piercy KL, Troiano RP, Ballard RM, et al. The Physical Activity Guidelines for Americans. *Journal of the American Medical Association*. 2018 Nov 20;320(19):2020-2028. Available at: https://jamanetwork.com/journals/jama/fullarticle/2712935. Accessed on: Mar 17, 2022.

[11] Centers for Disease Control and Prevention. *National Association of Chronic Disease Directors (NACDD) State of Aging and Health in America: Data Brief Series* 2020. Available at: https://www.cdc.gov/aging/publications/briefs.htm. Accessed on: Mar 17, 2022.

[12] Newsom JT, Denning EC, Elman MR, et al. Physical Activity as a Mediator between Race/Ethnicity and Changes in Multimorbidity. *Journals of Gerontology Series B.* 2021 Aug 10:gbab148. Available at: https://academic.oup.com/psychsocgerontology/advance-article-abstract/doi/10.1093/geronb/gbab148/6347407?redirectedFrom=fulltext&login=false. Accessed on: Mar 17, 2022.

[13] Florence CS, Bergen G, Atherly A, et al. Medical Costs of Fatal and Nonfatal Falls in Older Adults. *Journal of the American Geriatrics Society.* 2018; 66: 693-698. Available at: https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15304. Accessed on: Mar 17, 2022.

[14] Alzheimer's Association. *2022 Alzheimer's disease facts and figures*. Available at: https://www.alz.org/media/documents/alzheimers-facts-and-figures.pdf. Accessed on: Mar 17, 2022.

[15] Wang D, Wang P, Lan K, et al. Effectiveness of Tai chi exercise on overall quality of life and its physical and psychological components among older adults: a systematic review and meta-analysis. *Braz J Med Biol Res*. 2020;53(10):e10196. Available at: https://www.scielo.br/j/bjmbr/a/ZtZZz3NYFtWZ8ZkkTgJwmQd/?lang=en. Accessed on: Mar 17, 2022.

[16] Karssemeijer EGA, Aaronson JA, Bossers WJ, et al. Positive effects of combined cognitive and physical exercise training on cognitive function in older adults with mild cognitive impairment or dementia: A meta-analysis. *Ageing Research Reviews*. 2017 Nov;40:75-83. Available at: https://www.sciencedirect.com/science/article/pii/S1568163717301149?via%3Dihub. Accessed on: Mar 17, 2022.

[17] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. *A Report of the Surgeon General. Physical Activity and Health: Older Adults*. Available at: https://www.cdc.gov/nccdphp/sgr/pdf/olderad.pdf. Accessed on: Mar 17, 2022.

[18] Khoo I, Close JCT, Lord SR, et al. Relationship between Depressive Symptoms and Cognitive, Psychological, and Physical Performance in Community-Dwelling Older People with Cognitive Impairment. *Dement Geriatr Cogn Disord*. 2021;50(5):482-490. Available at: https://www.karger.com/Article/Abstract/520853. Accessed on: Mar 17, 2022.

[19] Keadle SK., McKinnon R, Graubard BI., et al. Prevalence and trends in physical activity among older adults in the United States: a comparison across three national surveys. *Preventive Medicine.* 2016; 89:37-43. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0091743516300871?via%3Dihub. Accessed on: Mar 17, 2022.

[20] US Department of Health & Human Services. Healthy People 2030: Physical Activity Objectives. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/physical-activity Accessed on: Mar 17, 2022.

[21] U.S. Department of Health & Human Services (HHS). Office of Disease Prevention and Health Promotion. 2018 Physical Activity Guidelines for Americans. Washington: HHS; 2018. Available at: https://health.gov/paguidelines/second-edition/report/. Accessed on: Mar 17, 2022.

[22] World Health Organization (2020). *WHO Guidelines on Physical Activity and Sedentary Behaviour*. Available at: https://bjsm.bmj.com/content/54/24/1451. Accessed on: Mar 17, 2022.

[23] Centers for Disease Control and Prevention. *Adults 50 and older Need More Physical Activity*. 2019. Available at: https://www.cdc.gov/physicalactivity/inactivity-among-adults-50plus/index.html. Accessed on: Mar 17, 2022.

[24] Moreland B, Kakara R, Henry A. Trends in Nonfatal Falls and Fall-Related Injuries Among Adults Aged ≥65 Years — United States, 2012–2018. MMWR Morb Mortal Wkly Rep 2020;69:875–881. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6927a5.htm?s_cid=mm6927a5_w. Accessed on: Mar 17, 2022.

[25] Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Older Adult Falls. Available at: https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html. Accessed on: Mar 17, 2022.

[26] Tinetti ME, Williams CS. Falls, injuries due to falls, and the risk of admission to a nursing home. *New England Journal of Medicine*. 1997; 337:1279-1284. Available at: https://www.nejm.org/doi/full/10.1056/NEJM199710303371806. Accessed on: Mar 17, 2022.

[27] Burns ER, Stevens JA, Lee R. The direct costs of fatal and non-fatal falls among older aduts-United States. *Journal of Safety Research*. 2016; 58:99-103. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0022437516300172?via%3Dihub. Accessed on: Mar 17, 2022.

[28] National Safety Council. *Injury Facts: Older Adult Falls Data Details* 2020. Available at https://injuryfacts.nsc.org/home-and-community/safety-topics/older-adult-falls/data-details/. Accessed on: Mar 17, 2022.

[29] Patton S, Vincenzo J, Lefler L. Gender Differences in Older Adults' Perceptions of Falls and Fall Prevention. *Health Promotion Practice*. 2021. Available at: https://journals.sagepub.com/doi/10.1177/15248399211009783. Accessed on: Mar 17, 2022.

[30] Gill TM, Bhasin S, Reuben DB, et al. Effect of a Multifactorial Fall Injury Prevention Intervention on Patient Well-Being: The STRIDE Study. *Journal of the American Geriatrics Society.* 2021;69(1):173-179. Available at: https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16854. Accessed on: Mar 17, 2022.

[31] Ng BP, Lu J, Tiu GF, et al. Bathroom modifications among community-dwelling older adults who experience falls in the United States: A cross-sectional study. Health Soc Care Community. 2022 Jan;30(1):253-263. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/hsc.13398. Accessed on: Mar 17, 2022.