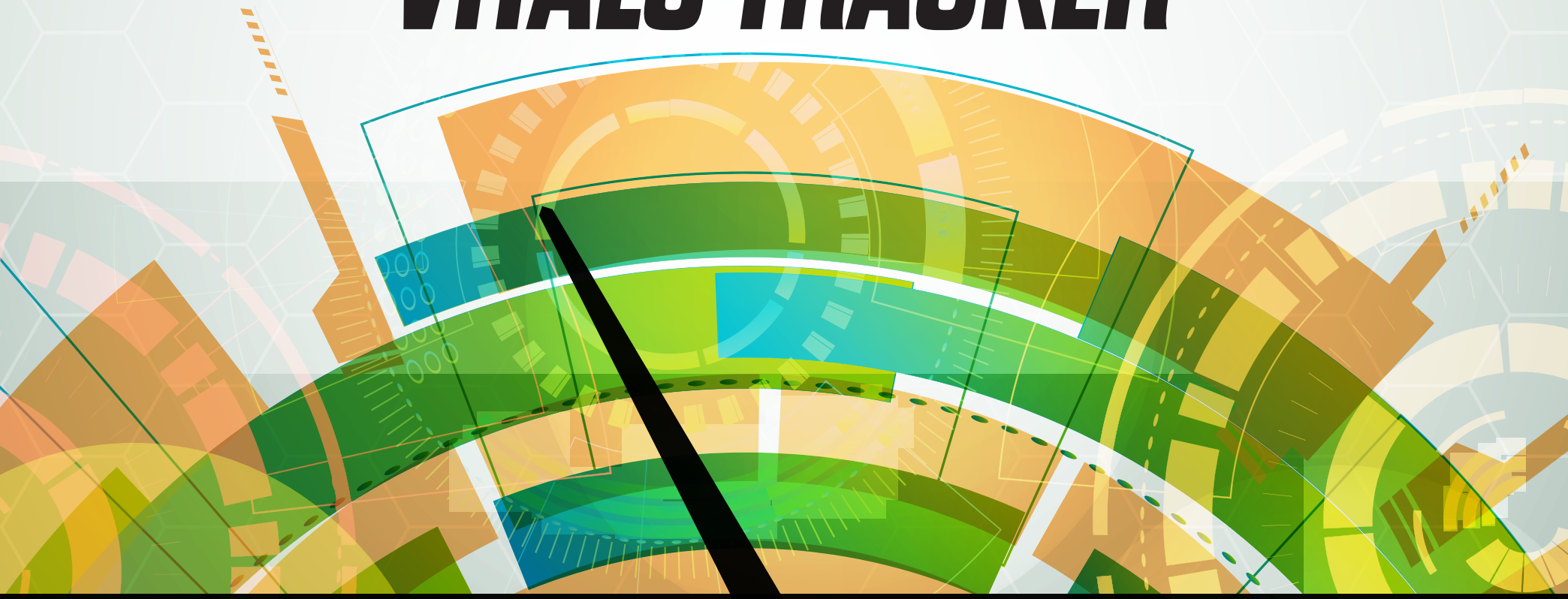
U.S. HEALTHCARE VITALS TRACKER



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Vitalic Health

The pursuit of financial sustainability and better health outcomes in healthcare.

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We lead the financial management of healthcare.

Introducing the U.S. Healthcare Vitals Tracker

The sentiment among American consumers is clear: They are being let down by a healthcare ecosystem that delivers world-class medical care but is not responding to their concerns about affordability and long-term health.

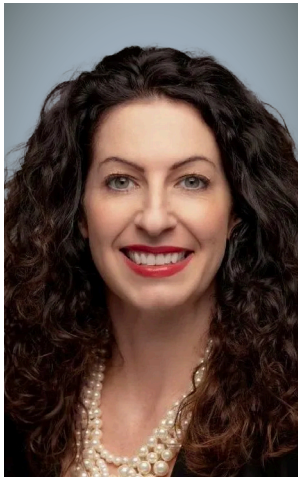
Healthcare quality and insurance coverage ratings have plummeted to historic lows, according to Gallup. Workers are being squeezed harder than ever as four out of five employers are increasing employee contributions to health insurance. And in a recent international study, the Commonwealth Fund concluded the U.S. is "in a class by itself in the underperformance of its healthcare sector."

This sentiment comes as no surprise to the Healthcare Financial Management Association (HFMA), the leading organization for healthcare finance. In our own recent survey of industry experts, 94% agreed the current healthcare system is not financially sustainable, with more than half of respondents expecting a tipping point within three years. Healthcare spending is outpacing inflation and economic growth, Medicare trust fund insolvency is looming and demands to improve affordability are escalating. **These realities are driving public and political pressure to fix healthcare now.**

Despite that growing sense of urgency, nearly 90% of thought leaders HFMA surveyed said policymakers and healthcare stakeholders are not effectively leading the way to sustainability at a macro level.

"There is an undeniable leadership vacuum when it comes to identifying and solving the real problems that can make a difference in affordability and industry sustainability," said Mayo Clinic CFO and past HFMA Chair Dennis Dahlen. "We firmly believe HFMA has a responsibility to do all it can to advance financial sustainability, affordability and better health."

Added Ceci Connelly, president and CEO of the Alliance of Community Health Plans: "There's simply no way around the need to develop a cohesive approach to assessing and addressing the state of health and healthcare. That requires a credible convener."



"Through Vitalic Health, plans are underway for bold, unified actions that will bring renewed vitality to our communities."

▶ **C. Ann Jordan, JD**
HFMA President and CEO

94% agree the current healthcare system is **not financially sustainable.**

90% of thought leaders said policymakers and healthcare **stakeholders are not effectively leading the way to sustainability at a macro level.**

54% expect a **tipping point** in healthcare system sustainability **within three years.**

Source: HFMA survey of healthcare industry thought leaders

In the absence of strong leadership and industry alignment, HFMA views stepping into this void as in line with both its mission to lead the financial management of healthcare and its status as a nonprofit, nonpartisan, nonlobbying organization.

In a first step toward convening healthcare stakeholders and moving toward solutions, HFMA has developed the U.S. Healthcare Vitals Tracker.

"In short, the Vitals Tracker is a direct reflection of financial sustainability, affordability and health, and will serve as context for conversations and projects to come," said HFMA President and CEO C. Ann Jordan, JD. "Through Vitalic Health, plans are underway for bold, unified actions that will bring renewed vitality to our communities."

What to know about the U.S. Healthcare Vitals Tracker

The Tracker is designed to facilitate rapid assessment of the health of our nation's healthcare system. Additional information about the Tracker and its development are provided in this section and the methodology section that follows.

Who is the Tracker for?

The U.S. Healthcare Vitals Tracker is accessible and relevant to all, including patients, providers, payers, policymakers, employers, investors, media and academia. By focusing on collective challenges and opportunities, the Tracker aims to facilitate the development of solutions that benefit all stakeholders. Interested parties from different sectors of healthcare can focus on the areas where they can effect change.

What is the frequency of Tracker updates?

The tool will be updated every two years and assess the financial health and long-term viability of the national healthcare ecosystem. Additionally, inputs can be changed in real time to model the impacts of proposed regulatory, policy or payment changes for the purpose of collaboration and dialogue.

What is the geographic scope?

This year, the Tracker is presented on a national scale. Going forward, it will be computed both nationally and on a regional basis.

What aspects of the U.S. healthcare system are tracked?

The Tracker relates national healthcare system affordability and performance by tracking metrics related to affordability and health span.

What specific metrics are included?

The Tracker comprises 25 well-known and universally accepted metrics in six categories — affordability, economics, purchaser satisfaction, social well-being, public health and environmental factors — under the twin umbrellas of Healthcare Affordability and Health Span, which roll up into the Tracker result. (Health span refers to the length and quality of healthy life based on physical, mental and social factors.)

In addition, the Tracker can be useful when, say, new public policies are proposed or enacted. By inputting assumptions from these new variables, the Tracker can demonstrate likely implications on the overall healthcare system.

CONCLUSION: Meaningful action, lower costs, healthier lives

Vitalic Health's Vitals Tracker isn't just an empty call for change — it's a catalyst for convening, discussion and action that can truly move the needle. In fact, stakeholders from all corners of healthcare are already mobilizing and preparing to contribute to the Vitalic Health mission of lower costs and healthier lives.

Future projects of Vitalic Health will revolve around identifying issues with academic partners, health systems, entrepreneurs and other stakeholders to build knowledge and practical, effective solutions. Our successes and failures will all result in learnings that will be publicly shared.

THE GOALS:

- Macro-level system improvement
- Payment model transformation
- Convening to benefit all

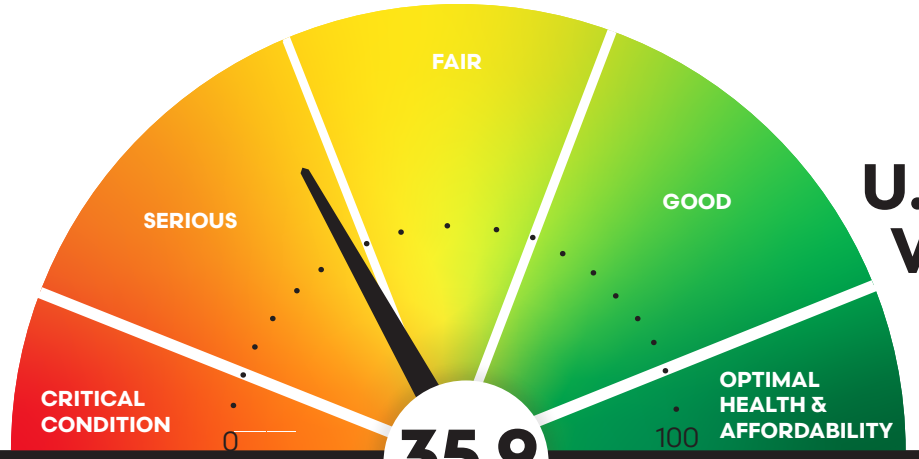
U.S. HEALTHCARE VITALS TRACKER

► **HFMA President and CEO C. Ann Jordan, JD, announces the launch of the U.S. Healthcare Vitals Tracker at the HFMA Annual Conference in Denver on June 22, 2025.** Photo by Marshall Clarke

THE TRACKER IS NOT:

- It's **NOT** political.
- It's **NOT** an assignment of blame.
- It's **NOT** a perfect measurement.
- It's **NOT** the solution in and of itself.

Healthcare system condition: Serious



U.S. Healthcare Vitals Tracker

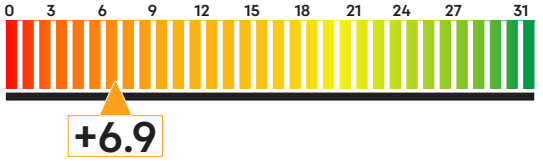
Second lowest score since 1997

Healthcare Affordability

The economic accessibility and sustainability of healthcare for individuals, families, providers and payers.

▶ **15 out of 50 possible points**

Affordability



Economics

Purchaser Satisfaction

The Tracker calculates healthcare ecosystem performance using universally accepted measures that are weighted by importance.

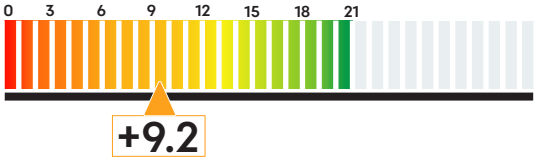
Condition definitions, page 12 | Measure definitions, page 13

Health Span

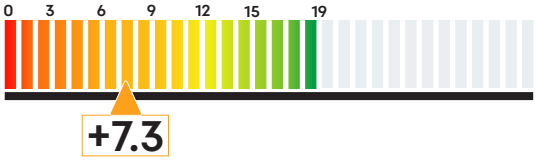
The length and quality of healthy life based on physical, mental and social factors. Inclusive of living well with chronic disease or disability.

▶ **20.9 out of 50 possible points**

Social Well-Being



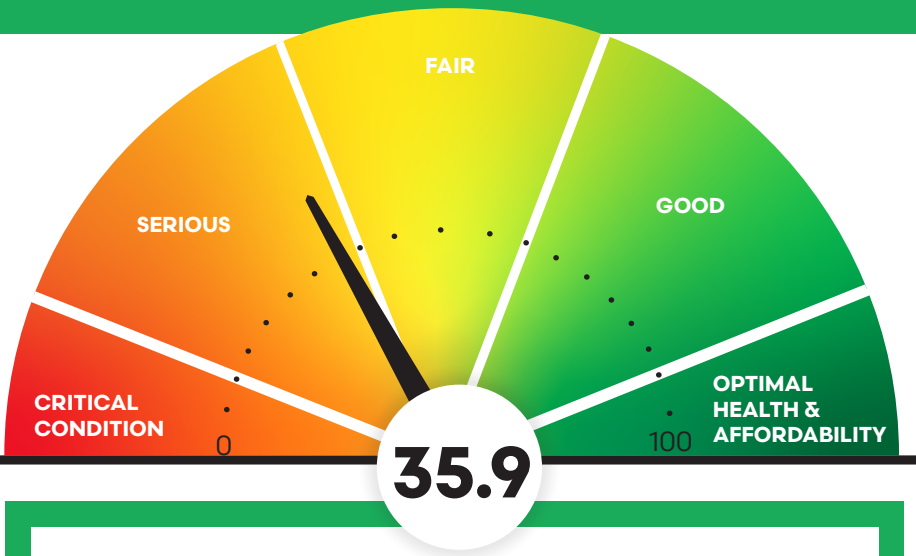
Public Health



Environmental Factors

Serious Condition:

How did our healthcare system get here?



Our nation's healthcare system is in serious condition and heading toward critical condition, according to the newly released U.S. Healthcare Vitals Tracker.

What's more, with a Tracker result of 35.9 on a 100-point scale, it's clear the healthcare system is not making progress toward improving affordability and health span, the two high-level goals the Tracker measures. If healthcare stakeholders are unable to change the current trajectory, the entire system will slip further into crisis mode.

The Vitals Tracker provides a comprehensive and transparent assessment framework that measures and monitors the U.S. healthcare system's affordability and capability to meet present and future service demands. Tracker scores have been plotted back to 1997, when the Balanced Budget Act was enacted, marking the last time the U.S. federal budget ran a surplus. That year represented the high-water mark for the Vitals Tracker, which then stood at 90.8.

A steep downward trend began soon afterward as healthcare affordability measures began to decline. Several subsequent events did little to slow the rate of decline, including the introduction of prescription drug coverage for seniors (Medicare Part D) in 2004 and significant legislation, including the American Recovery and Reinvestment Act of 2009. The Affordable Care Act, signed into law in 2010, brought some stabilization as health insurance access improved for more of the population.

But the Tracker score is still precipitously below its 1997 baseline: When it comes to affordability and health span, our healthcare system is performing at a lower level than it did nearly 30 years ago. The underperformance is not for lack of efforts to improve.

WHAT IT MEANS

When it comes to affordability and health span, our healthcare system is performing at a lower level than it did nearly 30 years ago.

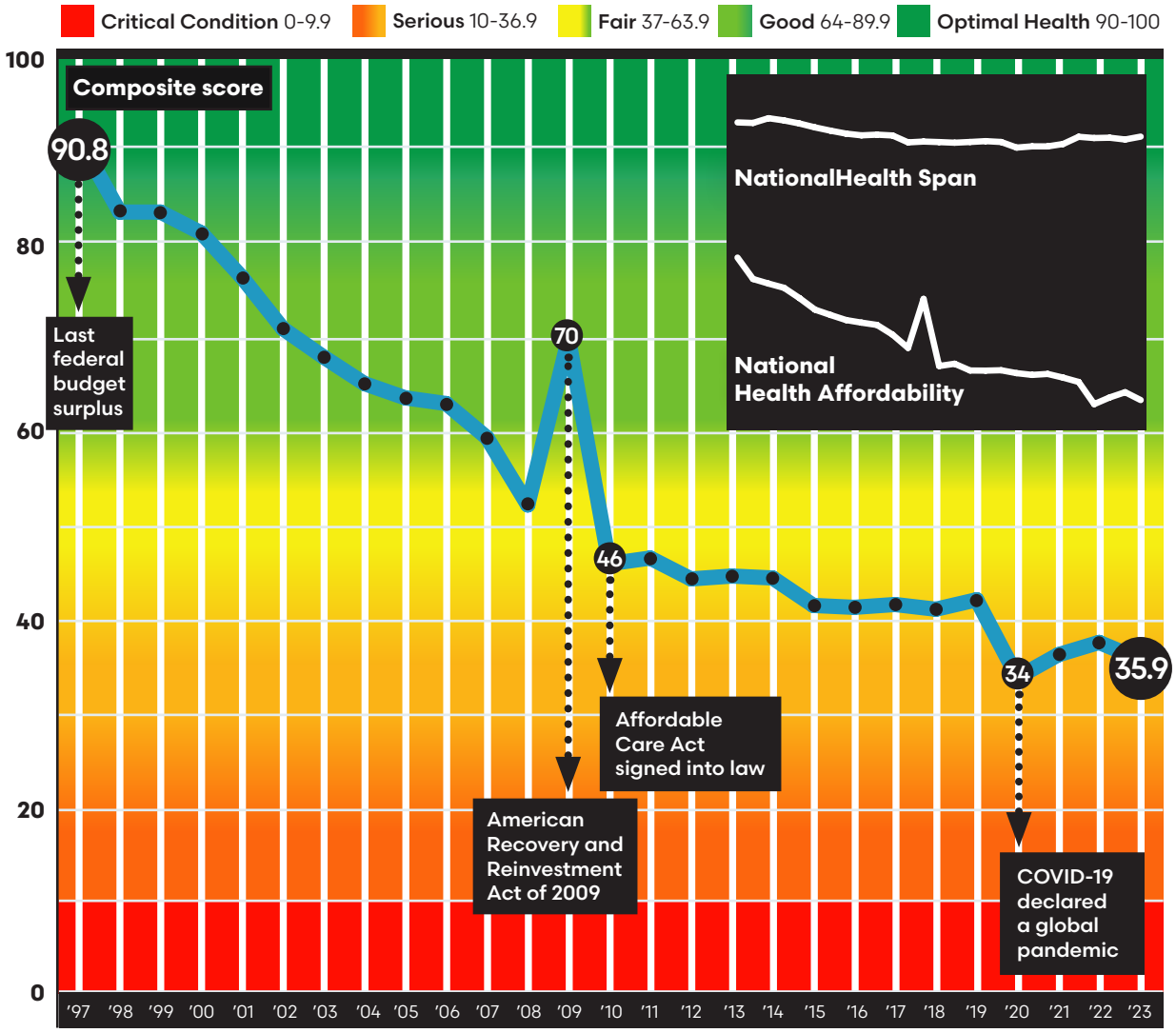
The pace of medical discoveries and technological breakthroughs have accelerated, adding cost to the system that is not proportional to improvements in health outcomes.

A wide array of interventions aimed at bending the affordability curve, such as the Affordable Care Act, have been deployed over the years with minimal impact. Meanwhile, the pace of medical discoveries and technological breakthroughs has accelerated, adding cost to the system that is not always commensurate with the improvement in health outcomes.

What's missing amid the ceaseless swirl of activity in the healthcare sphere is a unified effort toward achieving shared goals, such as improving healthcare value and population health. Our nation's complex, diverse healthcare system does not facilitate collaboration among stakeholders. Traditional fault lines, such as those between payers and providers, often impede joint efforts to assess the viability of prospective solutions or the impacts of initiatives in progress.

The Healthcare Affordability Paradox

Over nearly 30 years, despite medical discoveries, technological breakthroughs and even legislative action, health span has not improved while affordability continues to decline.



Modern U.S. Healthcare in four acts

1997-2008: 1997 was the last year the federal government recorded a budget surplus. Healthcare became less affordable as medical inflation outpaced general inflation while the introduction of Medicare Part D increased access but didn't control prices. Health insurance premiums surged 100% as wages stagnated, leading to the early rise of high-deductible plans.

2009-10: Healthcare affordability briefly improved during The Great Recession as programs like Medicaid and the Children's Health Insurance Program (CHIP) saw increased enrollment. The American Recovery and Reinvestment Act (ARRA) of 2009 provided subsidies for COBRA coverage and issued extra Medicaid funding to the states, and also provided $19.2 billion for the Health Information Technology for Economic and Clinical Health (HITECH) Act to support the adoption of electronic health records. The Affordable Care Act (ACA) was passed in 2010.

2011-19: The ACA contained mandates to reduce long-term costs through initiatives such as preventive care mandates, value-based care payment models and accountable care organizations. Systemwide costs slowed, but affordability flattened as premiums increased by 55%, deductibles doubled and there was further shift to high-deductible health plans.

2020-23: During the COVID-19 pandemic, affordability improved slightly as $2.2 trillion in stimulus flowed from the Coronavirus Aid, Relief and Economic Security Act (CARES) Act in late 2020, but this was offset by other trends. Deferred care eventually spiked demand in 2021-22. Providers increased care delivery costs to compensate for pandemic-related expenses even as inflation drove up the cost of supplies, labor and facility operations. Prescription drug prices continued to rise. Increased costs were largely transferred to consumers' out-of-pocket costs.

The data behind the Tracker

The goal of the U.S. Healthcare Vitals Tracker is to establish a comprehensive and transparent framework that enables healthcare organizations and other stakeholders to collaborate on reinventing the delivery of high-quality care, improving quality of life and maintaining access to affordable healthcare. The Tracker was developed following extensive stakeholder interviews and expert feedback, and it was essential to use internationally recognized indices to facilitate dialogue with stakeholders. Each of the indices chosen included multiple metrics to provide a well-rounded statistical representation of the affordability and quality of life years lived of the U.S. population (e.g., obesity and disease prevalence rates, and provider financial resilience).

Major factors in healthcare affordability

The decline in healthcare affordability for the consumer since 1997 can be explained by a combination of factors that have compounded over time. Here are the primary drivers:

Aging population: As the population ages, particularly with the baby boomer generation almost fully above retirement age, there's greater demand for medical care, especially for age-related illnesses and long-term care.

Chronic disease prevalence: The rise of chronic conditions such as diabetes, heart disease and obesity requires ongoing care, medications and frequent monitoring.

Administrative costs: Administrative expenses (billing, insurance processing, etc.) account for a significant portion of total healthcare spending — more than in most other countries.

Insurance design: The structure of private health insurance has shifted more costs to consumers (e.g., through high-deductible plans).

Prescription drug prices: The cost of prescription medications, especially biologics and other specialty drugs, has increased sharply.

Medical technology advancements: New diagnostic tools, treatments and procedures have improved outcomes but are often expensive. Hospitals and providers must invest in costly equipment, which raises operational costs.

Provider consolidation: Providers, pharmaceutical companies, retailers and payers continue to merge into larger organizations with a range of benefits and challenges.

Fee-for-service model: Many providers are still paid per service rather than for outcomes. This can encourage more tests and procedures, some of which may be unnecessary and increase costs.

Key questions the Tracker is designed to address

- Are interventions to slow the rate of growth in healthcare expenditures having the desired impacts and avoiding unintended consequences?
- How effective are strategies to prevent or delay the onset of chronic conditions, the leading cause of death in America?
- What impacts would Medicaid funding cuts have?
- How are cyclical economic downturns affecting healthcare spending and hospital financial stability?
- Are efforts to rebuild consumer trust in healthcare working?

Who we are and why now: HFMA and Vitalic Health

HFMA is a nonprofit, nonpartisan, non-lobbying organization that advances healthcare by convening other key stakeholders to address industry challenges. Extensive discussions and research conducted with a diverse task force of industry experts and thought leaders led to the creation of Vitalic Health, a new business initiative operating alongside and powered by HFMA. Vitalic Health strives to advance financial sustainability and better health outcomes by facilitating solve-based convening among industry stakeholders.

Vitalic Health will lead stakeholders toward revolutionary payment models and business practices that rein in healthcare expenditure growth while increasing health and lifespan. It coexists with — and seeks to expand on — HFMA's longstanding mission of leading the financial management of healthcare. The goal: a more financially sustainable and affordable system that drives healthier lives.

The U.S. Healthcare Vitals Tracker, the first tool developed for Vitalic Health's toolbox, shows us the limitations of what our nation has achieved in the absence of optimized collaboration among key stakeholders. Going forward, the Tracker will be instrumental in bringing people together to solve problems, and in spotlighting collaboration gaps and successes alike.

"Vitalic Health is entering the national dialog on healthcare at the right time," said Henry Ford Health CFO Robin Damschroder. "There is a growing appetite for true collaboration as people from all corners of healthcare realize the urgency of the affordability issue. We needed both a trusted convener and a conversation starter like the Vitals Tracker."

> **"There is a growing appetite for true collaboration as people from all corners of healthcare realize the urgency of the affordability issue."**
>
> ▶ **Robin Damschroder**
> CFO, Henry Ford Health

What's next for Vitalic Health™

Think of the U.S. Healthcare Vitals Tracker as context for a national dialogue while Vitalic Health facilitates multi-stakeholder projects that can move the needle in the right direction.

IMPACT MEASUREMENT INSTITUTE

The first output will be the U.S. Healthcare Vitals Tracker, a first-of-its-kind tool, designed to monitor and measure the U.S. healthcare ecosystem's vitality. Comprised of 25 well-known and universally accepted metrics, the Vitals Tracker scores the system based on factors of affordability and health span.

SWARM STUDIES

These studies will identify key healthcare industry problems that are perceived as difficult to solve due to their complex and interconnected nature. From there, Vitalic Health will partner with stakeholders, academic partners and business groups to explore new solutions for driving meaningful change.

SOLUTIONS STUDIO

This initiative bridges the innovation gap by partnering with health systems, startups and technology companies to develop, test and scale practical solutions for financial sustainability challenges. Rapid implementation and measurable impact will be key.

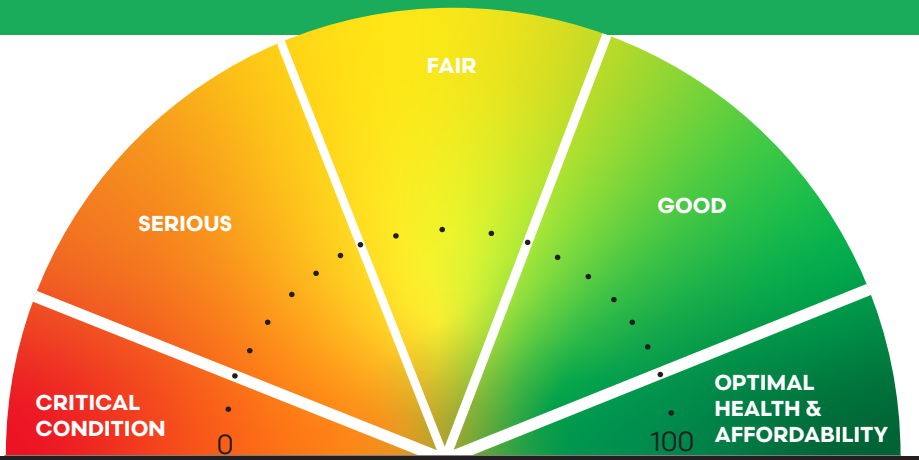
PAYMENT MODEL CONSORTIUM

This will bring together health systems, payers, employers, technology, retail health and policymakers to collaboratively design, test and scale sustainable payment models. This will be the only national forum specifically focused on payment model innovation with a financial sustainability lens that begins with a focus on value-based care.

Core to the Vitalic Health vision is the belief that opportunities to advance health and healthcare are limitless but no stakeholder can reach their full mission potential by acting alone.

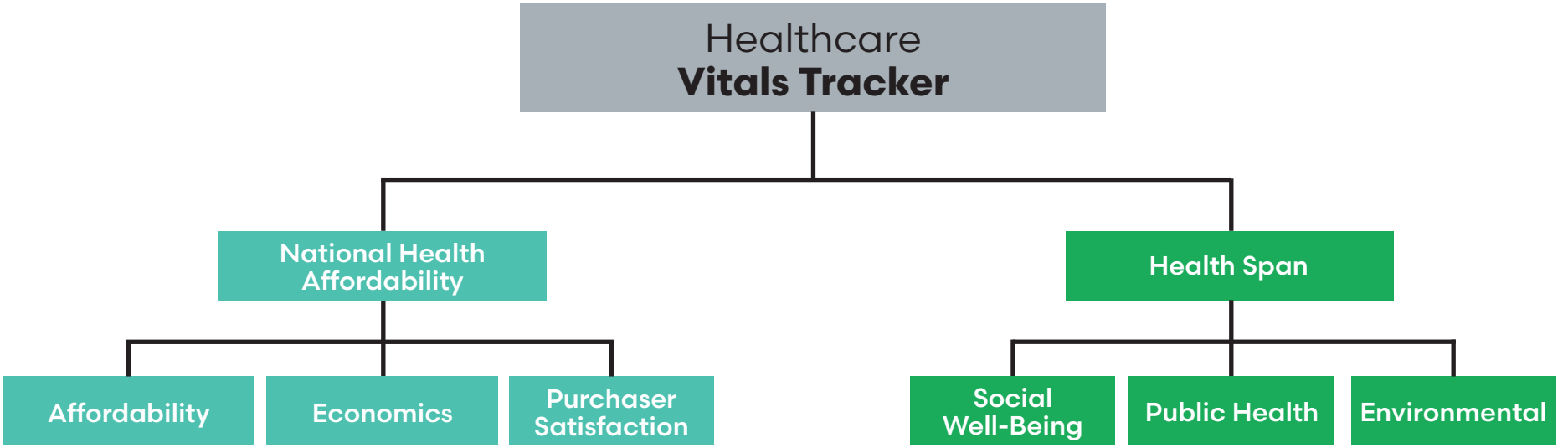
APPENDIX

Condition definitions: U.S. Healthcare Vitals Tracker



Critical Condition 0-9.9	Serious 10-36.9	Fair 37-63.9	Good 64-89.9	Optimal Health 90-100
Recognize the crisis: Patients face growing barriers to preventive, elective and critical care. **Address access issues:** Hospital closures and long emergency department wait times are rising. **Tackle workforce shortages:** Provider burnout and exits are worsening staffing gaps. **Act urgently:** The healthcare system is nearing systemic failure — immediate intervention is critical. **Confront affordability:** Today, more than 50 million people are now uninsured or underinsured.	**Acknowledge public frustration:** Dissatisfaction with the healthcare system is rising nationwide. **Prioritize affordability:** Costs are outpacing inflation, leaving more people uninsured or underinsured. **Expand access:** Financial barriers are worsening health disparities and limiting care. **Act now:** Without intervention, the system faces deeper decline and instability. **Strengthen public health:** Underfunding is fueling preventable disease outbreaks and chronic illness.	**Address access issues:** Preventive care and outcomes vary widely by zip code, income and demographics. **Improve affordability:** Many patients still delay care because of cost, despite broader insurance access. **Fix inefficiencies:** System strain persists and innovations are not reaching all populations equally. **Monitor system health:** The system is functioning, but widening gaps signal potential decline.	**Ensure timely, effective care:** Most patients are receiving the services they need, including preventive care. **Maintain affordability and access:** Care is broadly accessible, affordable and trusted by the public. **Leverage data and technology:** Strong digital infrastructure supports better outcomes and coordination. **Stay vigilant:** Positive trends are emerging, but continued focus is needed to solidify progress. **Support workforce and infrastructure:** A sustainable system is in place, with improving care coordination and reduced uninsured rates.	**Prepare for the future:** A thriving, resilient system is well-equipped to adapt to emerging challenges. **Deliver high-performing care:** Affordable, equitable, tech-enabled services are driving strong patient satisfaction and health outcomes. **Ensure universal access:** Essential services are reliably available across all populations. **Advance integrated care:** Widespread adoption of coordinated care models supports better management and continuity. **Lead in chronic disease management:** Strong public health infrastructure positions the U.S. as a global leader.

Healthcare **Vitals Tracker**



- Inflation
- Healthcare cost to GDP ratio
- Average employer per capita cost of health benefits
- Average insurance premiums for families
- Medicare spend per beneficiary
- Medical loss ratio
- Provider financial resilience

- Gross domestic product (GDP)
- Unemployment rate
- Income Inequality Index

- Government purchaser
- Employer purchaser
- Patient/ consumer

- Human development index
- Poverty rate
- Educational attainment
- Social progress index
- Community well-being

- Life expectancy
- Infant mortality
- Healthcare access and quality
- Disease prevalence rates

- Air quality index
- Water quality and access
- Food quality and safety

The Vitals Tracker comprises 25 well-known and universally accepted metrics across six categories organized under National Health Affordability and Health Span, which roll up into the overall result. The Tracker was designed to provide a nationally representative view of healthcare performance by focusing on large, general indices that capture systemic trends. Rather than highlighting isolated points — such as opioid deaths or Medicaid data — or region-specific measures, the selected indices integrate these granular metrics within their frameworks to deliver a comprehensive score for our healthcare system.

Data Dictionary

AFFORDABILITY

Measure	Sub-Measures	Notes
Inflation	**Consumer Price Index (CPI):** Average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. **Personal Consumption Expenditures (PCE) Price Index:** Reflects changes in the price of goods and services consumed by households. Used by the Federal Reserve to set monetary policy. **Producer Price Index (PPI):** Average change over time in the selling prices received by domestic producers for their output.	Inflation measures the rate at which the prices of goods and services increase over time.
Healthcare Cost to GDP Ratio	**Total Health Expenditure:** Encompasses all spending on healthcare services, including hospital care, physician services, pharmaceuticals and public health activities. **Per Capita Health Spending:** Average healthcare spending per person, providing insights into the overall cost burden on individuals. **Growth Rate of Health Spending:** Annual increase in healthcare expenditures, helping to track trends over time.	The Healthcare Cost to GDP Ratio measures the proportion of a country's gross domestic product (GDP) spent on healthcare.
Average Employer per Capita Cost of Health Benefits	**Annual Premiums:** The total cost of health insurance premiums paid by employers for employee coverage. **Employee Contributions:** The portion of health insurance premiums that employees are required to pay. **Deductibles:** The amount employees must pay out-of-pocket before their health insurance begins to cover expenses. **Cost-Sharing Provisions:** These include copayments, coinsurance and other out-of-pocket costs that employees incur when accessing healthcare services.	These metrics provide a comprehensive view of the financial burden of health benefits on both employers and employees.

Data Dictionary

AFFORDABILITY

Measure	Sub-Measures	Notes
Average Insurance Premiums for Families	**Costs for different types of health plans:** Refers to the typical monthly or annual cost of health insurance plans that cover a family unit, including the primary policyholder, their spouse and dependent children. Includes employer-sponsored plans as well as non-subsidized health insurance plans purchased through the marketplace.	The average annual premium for family health insurance in 2024 was approximately $25,572 for employer-sponsored plans. This represents a 7% increase from the previous year. Premiums can vary based on factors such as the type of health plan, the size of the firm and the region. For plans purchased through the marketplace, the average monthly premium for a family of four was $1,437 in 2022. These costs can fluctuate based on the specific plan chosen and the number of family members covered.
Medicare Spend per Beneficiary	**Price-Standardized Payments:** Adjustments are made to remove geographic payment differences and additional payments for indirect medical education and disproportionate share hospitals. **Risk Adjustment:** Accounts for variations due to patient age and health status. **Episode Spending Breakdown:** Spending is divided into three periods — before admission, during the hospital stay and after discharge — and further categorized by claim types such as inpatient and outpatient services.	The Medicare Spend per Beneficiary (MSPB) Index measures the efficiency of hospitals in managing Medicare costs for patient care. It includes all Medicare Part A and Part B payments made during an episode of care, which spans from three days before a hospital admission to 30 days after discharge.
Medical Loss Ratio	**80/20 Rule:** Insurers in the individual and small group markets must spend at least 80% of premium income on medical care and quality improvement activities. For large group markets, the requirement is 85%. **Refunds:** If insurers fail to meet these thresholds, they must provide rebates to policyholders. This ensures that consumers receive value for their premiums.	The Medical Loss Ratio (MLR) is a measure used to ensure that health insurance companies spend a significant portion of premium dollars on medical care and quality improvement rather than administrative costs and profits. Insurers must report their MLR data annually to regulatory bodies, ensuring transparency and accountability.
Provider Financial Resilience	**S&P 500 Health:** Comprises companies included in the S&P 500 that are classified as members of the geographic information systems healthcare sector. This sector encompasses a diverse range of industries, including pharmaceuticals, biotechnology, healthcare equipment and providers.	

Data Dictionary

ECONOMICS

Measure	Sub-Measures	Notes
GDP	**Consumer Spending:** The total value of all goods and services purchased by households. **Business Investment**: Spending by businesses on capital goods like machinery, buildings and technology. **Government Spending:** Expenditures by the government on goods and services, including public services and infrastructure. **Net Exports:** The value of a country's exports minus its imports.	Gross Domestic Product (GDP) is a measure of the total economic output of a country.
Unemployment Rate	**Labor Force Participation Rate:** This is the percentage of the working-age population that is either employed or actively seeking work. **Employment-Population Ratio:** This ratio measures the proportion of the working-age population that is employed. **Duration of Unemployment:** This metric tracks how long individuals have been unemployed, providing insights into the persistence of unemployment. **Demographic Breakdown:** Unemployment rates are often analyzed by age, gender, race and ethnicity to identify disparities within different groups.	The unemployment rate measures the percentage of the labor force that is without work but actively seeking employment.
Income Inequality Index	**Gini Coefficient:** This is the most commonly used measure of income inequality. It ranges from 0 (perfect equality) to 1 (perfect inequality), indicating how evenly income is distributed across a population. **Income Quintile Shares:** This metric divides the population into five equal groups (quintiles) based on income levels and measures the share of total income received by each quintile. **Theil Index:** This measure captures income inequality by considering the distribution of income across individuals, with higher values indicating greater inequality. **Mean Logarithmic Deviation (MLD):** This metric assesses inequality by measuring the average deviation of income from the mean, with higher values indicating more inequality. **Atkinson Index:** This measure allows for sensitivity to different parts of the income distribution, emphasizing inequality among the lower-income groups.	The Income Inequality Index measures the distribution of income within a population, highlighting disparities between different income groups.

Data Dictionary

PURCHASER SATISFACTION

Measure	Sub-Measures	Notes
Government Purchaser Satisfaction	**HCAHPS:** The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measures patients' perspectives on hospital care. It includes 29 questions covering key aspects of the hospital experience.	**Communication with Nurses and Doctors:** Evaluates how well healthcare providers communicate with patients. **Responsiveness of Hospital Staff:** Assesses the timeliness and attentiveness of hospital staff. **Cleanliness and Quietness of the Hospital Environment:** Measures the cleanliness and noise levels within the hospital. **Communication about Medicines:** Looks at how effectively hospital staff explain medications to patients. **Discharge Information:** Evaluates the quality of information provided to patients upon discharge. **Overall Rating of the Hospital:** Patients rate their overall experience at the hospital. **Recommendation of the Hospital:** Measures whether patients would recommend the hospital to others.
Employer Purchaser Satisfaction	**CAHPS:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys include several submeasures that assess employer purchaser satisfaction. These submeasures are designed to capture various aspects of the healthcare experience from the perspective of employers who purchase health plans for their employees.	**Access to Care:** Evaluates how easily employees can access necessary medical care, including the availability of appointments and the ease of getting referrals to specialists. **Communication with Providers:** Assesses the quality of communication between healthcare providers and employees, including how well providers explain medical conditions and treatments. **Customer Service:** Measures the quality of customer service provided by the health plan, including the helpfulness and responsiveness of customer service representatives. **Claims Processing:** Evaluates the efficiency and accuracy of the health plan's claims processing, including the timeliness of payments and the clarity of explanations of benefits. **Plan Administration:** Assesses the overall administration of the health plan, including the ease of enrollment and the clarity of plan information provided to employees. **Health Promotion and Education:** Measures the effectiveness of health promotion and education programs offered by the health plan, including wellness programs and preventive care initiatives.

Data Dictionary

PURCHASER SATISFACTION

Measure	Sub-Measures	Notes
Patient/Consumer Satisfaction	**Clinician and Group Survey Satisfaction:** The Clinician & Group Survey Database Survey (CG CAHPS) Database is a central repository of survey data from practice sites, medical groups and regional health collaboratives that have administered the CG CAHPS survey and choose to submit their data to the database. **Home and Community Based Services:** The CAHPS Home and Community-Based Services (HCBS) Survey Database is a central repository of survey data from State Medicaid agencies and the managed care entities with which they contract that have administered the HCBS CAHPS survey and chose to submit their data to the database. Its purpose is to help evaluate, compare and improve the quality of services provided by both fee-for-service HCBS and managed long-term services and supports programs. **Child Hospital Services:** The CAHPS Child Hospital Survey (Child HCAHPS) Database is a central repository of survey data from hospitals that have administered the Child HCAHPS survey and chose to submit their data to the database.	

Vitalic Health

About Vitalic Health

Powered by the Healthcare Financial Management Association, Vitalic Health strives to advance financial sustainability and better health outcomes. It facilitates solve-based convening among diverse industry stakeholders to address the complexities of lowering health expenditures and increasing health and lifespan to improve the vitality of communities across the United States. Vitalic Health seeks to expand HFMA's longstanding mission of leading the financial management of healthcare by revolutionizing business practices and payment models.

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healthcare financial management association

The Healthcare Financial Management Association (HFMA) equips its more than 140,000 members nationwide to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare.

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