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VALUE-BASED PURCHASING-CHANGES IN 2014
OPTIMIZING HEALTHCARE

FEBRUARY 26, 2014

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Goals and Objectives

- Describe the legal and risk management implications of the value-based care program
- To identify those practices that will most likely result in medical/professional liability claims and litigation
- Identify risk mitigation efforts and discuss value-base care's integration in the enterprise risk management sector
- ***Overall goals and objectives for ACO and value-based care:***
  - "Instead of payment that asks, How much did you do?, the Affordable Care Act clearly moves us toward payment that asks, How well did you do?, and more importantly, How well did the patient do?"

Source: Don Berwick, CMS

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What is Value-Based Purchasing (VBP)?

- The VBP program design includes:
  - **Measuring Quality Performance** – Creating a Total Performance Score (TPS) for each participating hospital. The TPS is based on 20 performance measures for FY 2013. There will be 24 performance measures for FY 2014.
  - **Reimbursement based on Quality Outcomes** – The VBP program is funded by withholding 1% of the CMS reimbursement (diagnosis-related group (DRG) payments) from participating hospitals. Reimbursement is based on the performance scores.

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What facilities do participate in VBP?
Eligible Hospitals

More than 3,000 hospitals across the country are eligible to participate in the CMS hospital VBP initiative

- The program applies to hospitals that receive reimbursement from CMS
- It includes hospitals located in the 50 states and the District of Columbia and acute-care hospitals in Maryland
- Hospitals must meet the minimum required VBP performance measures
  - The Patient Experience of Care domain requires at least 100 HCAPHS surveys in the performance period
  - The Clinical Process of Care domain requires hospitals to report on at least four measures during the performance period, with a minimum of 10 cases per measure

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What facilities do not participate in VBP?
Ineligible Hospitals

- Hospitals and hospital units excluded from the Inpatient Prospective Payment System (IPPS), including psychiatric hospitals, rehab facilities, long-term care facilities, children's hospitals, cancer centers, critical access hospitals, and hospitals in US territories
- Hospitals that have received an exemption from Secretary of the Department of Health and Human Services
- Hospitals subject to payment reductions under the Hospital Inpatient Quality Reporting (IQR) program
- Hospitals cited for deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients

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Overall Financial Impact
Withholding CMS Reimbursement

- The VBP initiative is funded by withholding reimbursement from participating hospitals' Diagnosis Related Group (DRG) payments
  - 1.0 percent for Fiscal Year (FY) 2013
  - 1.25 percent for FY 2014
  - 1.5 percent for FY 2015
  - 1.75 percent for FY 2016
  - 2 percent for FY 2017
- CMS estimates that in FY 2013, 50% of participating hospitals will receive a net increase in payments and 50% will receive a net decrease in payments
- The one percent of DRG payments withheld from eligible hospitals is estimated at $850 million

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VBP Measures
FY 2013 measures

12 Clinical process of care measures

1. AMI-7a Fibrinolytic Therapy received within 30 minutes of hospital arrival
2. AMI-8 primary PCI received with 90 minutes of hospital arrival
3. HF-1 discharge instructions
4. PN-3b blood cultures performed in the ED prior to initial antibiotic received in hospital
5. PN-6 initial antibiotic selection for CAP in immunocompetent patient
6. SCIP-Inf-1 prophylactic antibiotic received within one hour prior to surgical incision
7. SCIP-Inf-2 prophylactic antibiotic selection for surgical patients
8. SCIP-Inf-3 prophylactic antibiotics discontinued within 24 hours after surgery
9. SCIP-Inf-4 cardiac surgery patients with controlled 6AM postoperative serum glucose
10. SCIP-Card-2 surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period
11. SCIP-VTE-1 surgery patients with recommended venous thromboembolism prophylaxis ordered
12. SCIP-VTE-2 surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours

70%

8 Patient experience of care dimensions

1. Nurse communication
2. Doctor communication
3. Hospital staff responsiveness
4. Pain management
5. Medicine communication
6. Hospital cleanliness and quietness
7. Discharge information
8. Overall hospital rating

30%

Source: CMS official VBP web site

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Healthcheck – 2014 and beyond
FY 2014 measures

13 Clinical process of care measures

1. AMI-7a Fibrinolytic Therapy received within 30 minutes of hospital arrival
2. AMI-8 primary PCI received with 90 minutes of hospital arrival
3. HF-1 discharge instructions
4. PN-3b blood cultures performed in the ED prior to initial antibiotic received in hospital
5. PN-6 initial antibiotic selection for CAP in immunocompetent patient
6. SCIP-Inf-1 prophylactic antibiotic received within one hour prior to surgical incision
7. SCIP-Inf-2 prophylactic antibiotic selection for surgical patients
8. SCIP-Inf-3 prophylactic antibiotics discontinued within 24 hours after surgery
9. SCIP-Inf-4 cardiac surgery patients with controlled 6AM postoperative serum glucose
10. ★ SCIP-Inf-9 postoperative urinary catheter removal on postoperative day 1 or 2
11. SCIP-Card-2 surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period
12. SCIP-VTE-1 surgery patients with recommended venous thromboembolism prophylaxis ordered
13. SCIP-VTE-2 surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours

45%

3 Mortality measures ★

1. MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN Pneumonia (PN) 30-day mortality rate

25%

8 Patient experience of care dimensions

1. Nurse communication
2. Doctor communication
3. Hospital staff responsiveness
4. Pain management
5. Medicine communication
6. Hospital cleanliness and quietness
7. Discharge information
8. Overall hospital rating

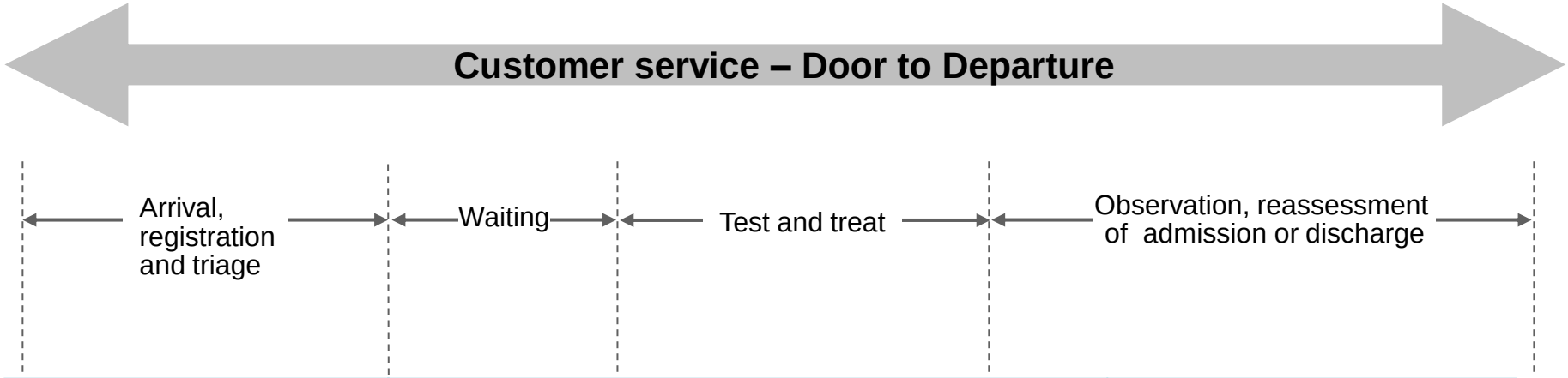
30%

★ Represents a new measure for the FY 2014 program not in the FY 2013 program

Source: CMS official VBP web site

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Value Based Purchasing – Connecting Care
Emergency Department --Clinical, Operational and Regulatory Risks



ED Intake	ED throughput	ED output
• Quick registration • Triage – Bypass – Protocols – Med reconciliation – Trauma – BH crisis • Medical screening • Door to drug (stroke) • Waiting room – Visualization of patients – Time sensitive workflow – Door to departure	• Medical Screening Exam (MSE) • Testing – radiology/laboratory • Care management and social worker needs • Direct admits • Boarded patients/behavioral health • Telemedicine/telestroke	• Barriers to admission • Discharge barriers • Transfer delays • Hospitalists availability • Specialty consultants • Follow up of test results • Follow up MD visit • Follow up procedures • Long-term boarders • Diversions/capacity

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Additional Financial Risks
Readmission Management and Reduction

Readmissions reduction and management

The last readmission group is considered as preventable – or avoidable – readmission. There is a great potential to reduce the number of this type of readmission by identifying causes and developing preventable strategies in hospitals and community settings.

DRG penalty calculations	HF	AMI	PNE
Number of patients treated with MS-DRGs	500	200	800
Number of readmissions (Risk adjusted)	140	44	162
Risk-adjusted readmit rate	28.5%	22.5%	20.8%
US 30-day readmission rate	**24.5%**	**19.9%**	**18.2%**
Predicted/expected ratio	1.1632	1.1306	1.1428
P/E ratio – 1	.1632	.1306	.1428
Total Medicare payments	$1,500,000	$775,000	$2,150,000
Excess payment amount	$245,000	$101,000	$307,000
Total penalty payment			**$653,000**

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Section 1

Healthcare Reform Risk Impacts Efficiencies, Value and Outcomes

New reform risks

ACO model 1	ACO model 2	ACO model 3
Specialty group	Community hospital	Multi-specialty group practice
PCP group	Specialty group	
Hospital	Home health services	
	Mental health facility	
	PCP group	

Specialty physicians | **Tertiary care facility** | **Specialty hospital**

Providers outside of the ACO may be utilized by ACOs for certain services

- For an organization to be considered as an ACO, its structure must facilitate the following capabilities:
  - Formal legal structure for receipt and distribution of bonus payments
  - Management and leadership structure for decision making
  - Include PCPs and a core group of specialists
- As providers develop ACOs, they will need to consider a number of other laws and regulations, including:
  - Stark Law and Anti-Kickback Statute
  - Civil Monetary Penalties Law
  - Corporate Practice of Medicine Doctrine
  - HIPAA
  - Antitrust regulations
  - State insurance regulations
  - Tax exemption laws

Sources: Brookings-Dartmouth May 2009 Issue Brief on Accountable Care Organizations; Patient Protection and Affordable Care Act

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Current Delivery System
Highly fragmented and uncoordinated care delivery experience

Most of US healthcare today

Primary Care Physician
Gastroenterologist
Cardiologist
Ophthalmologist
Urologist
Nephrologist
Oncologist
Dermatologist
Gerontologist
Pulmonologist



- Limited care coordination
- No care quarterback
- Overlapping and redundant services
- Too many medications
- Confusing and unpleasant consumer experience (Not patient centric)

- **Risk concerns of uncoordinated care**
- **Unnecessary costs**
- **Sub-optimal quality and outcomes**
- **Hard to evaluate the “value of care provided”**

Uncoordinated fragmented care leads to higher cost with sub-optimal outcomes

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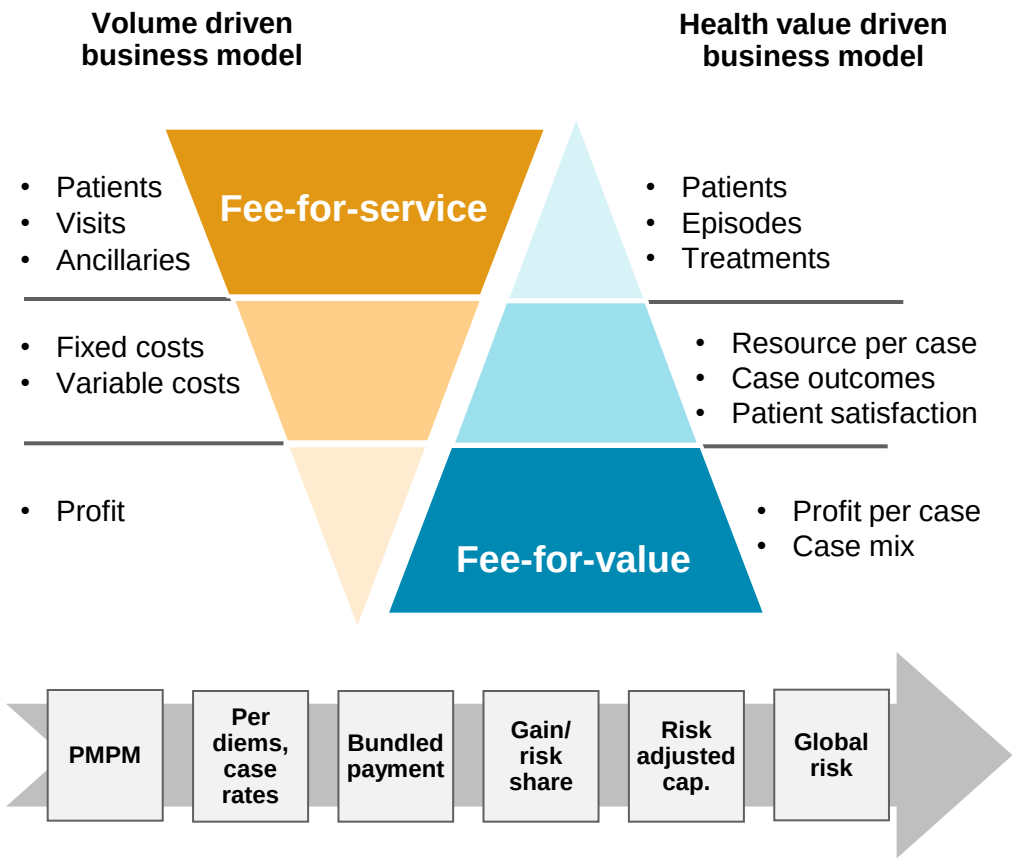
Healthcare Reform Impact Drivers

- Increased access to care
- Care Coordination
- Clinical Integration of care across the continuum
- Reduce overall healthcare costs
- Reduce healthcare dollars, reduce waste and improve service line efficiencies
- Deployment of health information exchange and improve access to health information technology
- Identify and eliminate fraud and abuse
- Collateral Healthcare Reform Impacts
  - Physician acquisition and clinical integration
  - New payment methodologies to spur care coordination
  - Increased healthcare mergers and acquisitions
  - Increased fraud and abuse enforcement
  - Closer review and scrutiny of non-profits
  - Healthcare reimbursement overhaul/shared savings
  - Increased regulatory, state and federal regulations

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In response to the aggressive goals of Healthcare Reform, the market has begun to migrate from traditional fee-for-service models to new fee-for-value arrangements

Market drivers

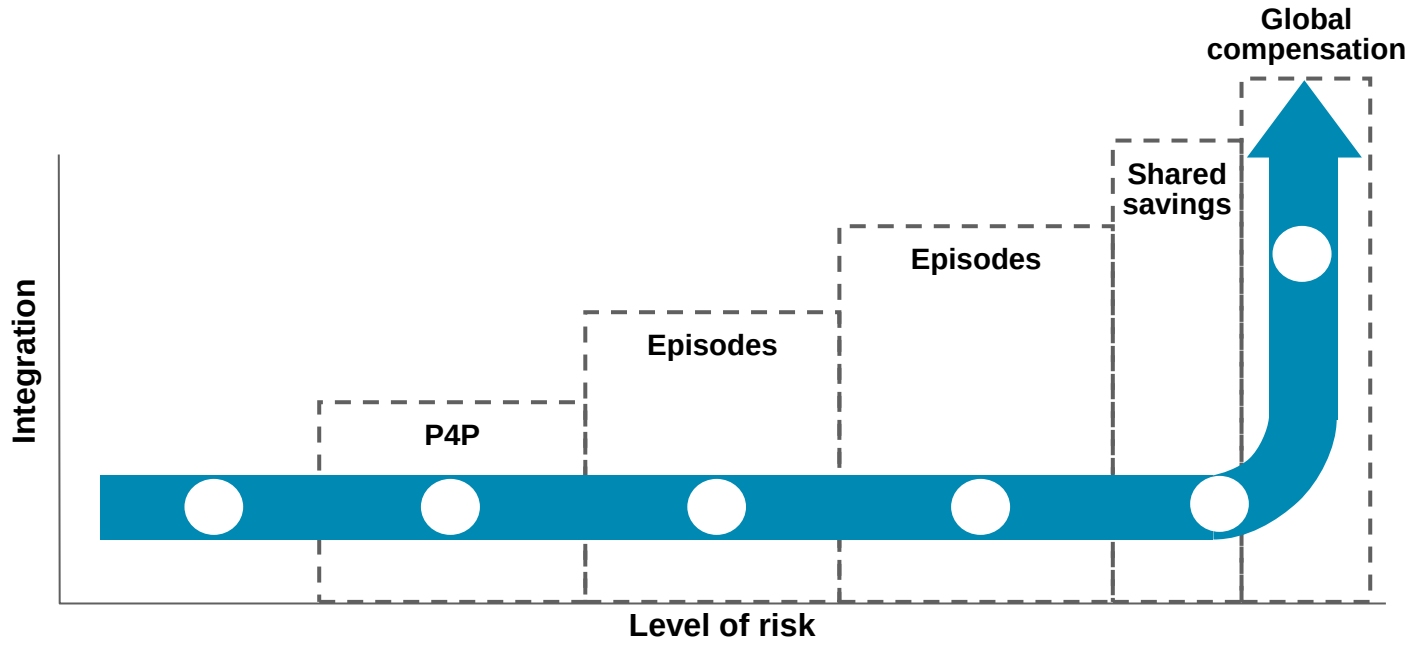


Key implications

- Our business models will change
  - Delivery system will get paid on value and not volume
  - Value is delivering high quality outcomes and patient experience while managing total cost of care
- Significant upside opportunity but high fixed costs can be inhibitive to innovation
- Innovation requires significant transformation of care delivery and reimbursement, including:
  - 24/7 Access to care when needed
  - Clinical transformation of the delivery system
  - Aligned reimbursement among all providers
  - Information Technology/Telehealth
  - Patient engagement and empowerment

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Reshaping the Healthcare System



- P4P measures target focused quality and process improvement outcomes (Highest healthcare dollar consumption)
- Bundled care realigns surgical and procedural care
- Condition-based reimbursement moves delivery systems to population management
- Shared savings makes the delivery system responsible for budgets
- Global compensation transforms total care (Value-Based Care)

Source: Oliver Wyman

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New Transitional Care Integration Models
New Risks

	Transactional efficiency (FFS)	**Episodic care models** (Payment model driven)	**Condition based care models** (Care model driven)	**Population based care models** (Integrated whole person)
Definition	Simple service based models that can continue to deliver highly efficient care in a FFS environment	Complex service based models that can deliver efficient care through high levels of specialization and low operational variability	Specialized care delivery model that is organized along specific condition and/or disease etiologies	High value-based delivery model that manages the clinical risk of targeted or whole patient populations
				
Example model types	• Stand-alone ERs • Urgent care facilities • Dermatologists • Ophthalmologists • Dentists • Walk-in-clinics	• Orthopedics (Hips and knees) • CV surgery • General/ specialty surgery	• Cardiology • Cancer • Diabetes • Pulmonary • Kidney	• Partial Pop. Managers • Frail elder • High risk • Poly-chronic • Full Pop Managers • ACOs • Globally capitated models

Source: Oliver Wyman

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Section 2

Value-Based Care

Measuring Efficiencies, Value and Outcomes

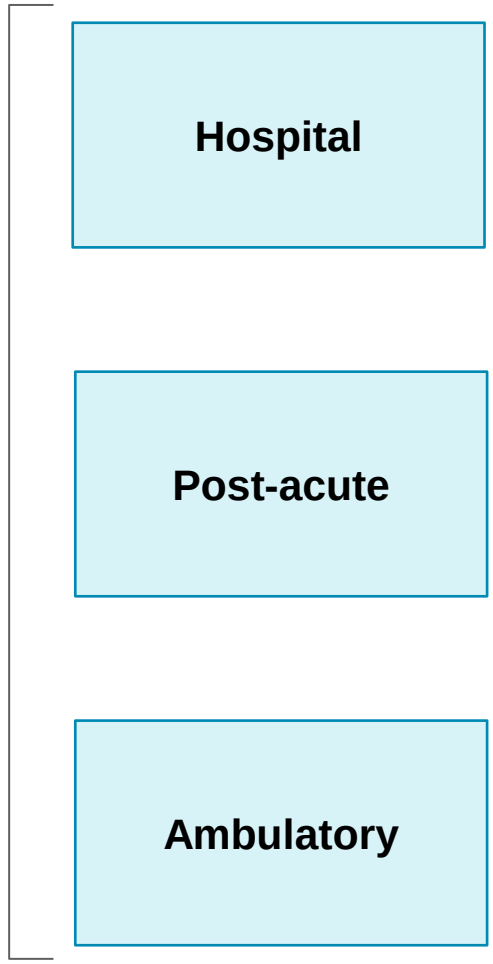
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Sample Global Measures in each Care Setting

Care Coordination



- CPOE utilization rate
- Hospital utilization rate
- Mortality rates

- Transitions of care: Medication reconciliation
- Risk of readmission

- Chronic diseases
- Prevention and wellness
- Patient access
- Patient satisfaction

Source: ARHQ

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Sample Clinical Performance Initiatives

Year 1

- Diabetic care outcomes
- Asthma care outcomes
- 30-day readmission rate
- Hospitalist effectiveness
- Coronary artery disease
- Congestive heart failure outcomes
- Depression screening
- Smoking cessation
- Flu vaccinations
- Community-acquired pneumonia
- Child immunizations
- Patient satisfaction
- Generic prescribing

Year 2

- COPE
- Hospitalist effectiveness
- Cardiac surgery outcomes
- Orthopedic surgery outcomes
- Obstetrics: Post partum care
- Obstetrics: Post partum depression
- Ophthalmology: Diabetic retinopathy
- Peer satisfaction
- System-wide cost index
- Specialty care referral rate

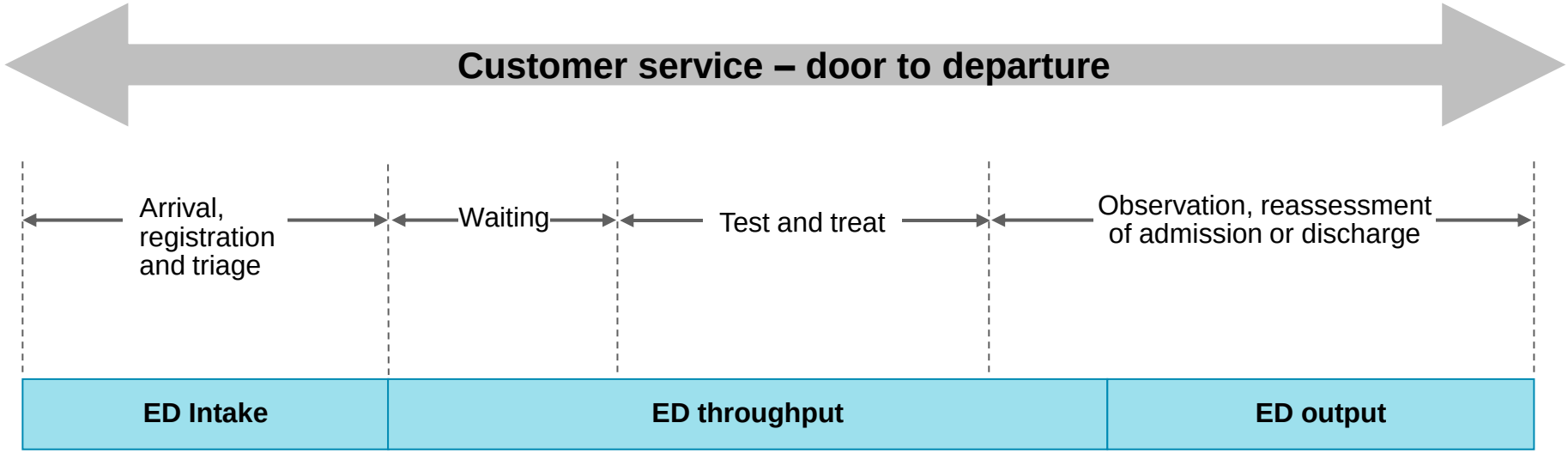
Year 3

- Cancer care outcomes
- MRI utilization rates
- Surgical care improvement: Inpatient
- Surgical care improvement: Outpatient

Note: Clinical initiatives established in year 1 would be expanded in year 2 and 3
Source: AHRQ and CMS.gov

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Value-Based Purchasing
ED Throughput and Turn-around-Time (TAT) Risks



- Quick registration
- Triage
  - Bypass
  - Protocols
  - Med reconciliation
  - Trauma
  - BH crisis
- Medical screening
- Door to drug (stroke)
- Waiting room
  - Visualization of patients
  - Time sensitive workflow
  - Door to departure

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Additional Financial Risks
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Readmissions Reduction and Management

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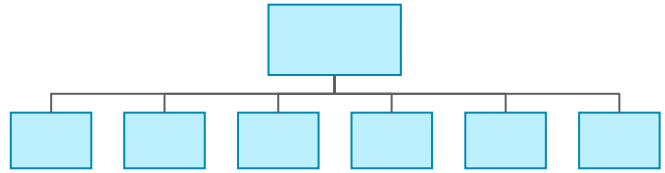
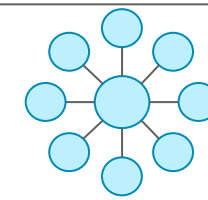
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Section 3

Enterprise Risk Domains

The risk, quality and finance connection

Healthcare Reform –Transitioning from FFS to FFV

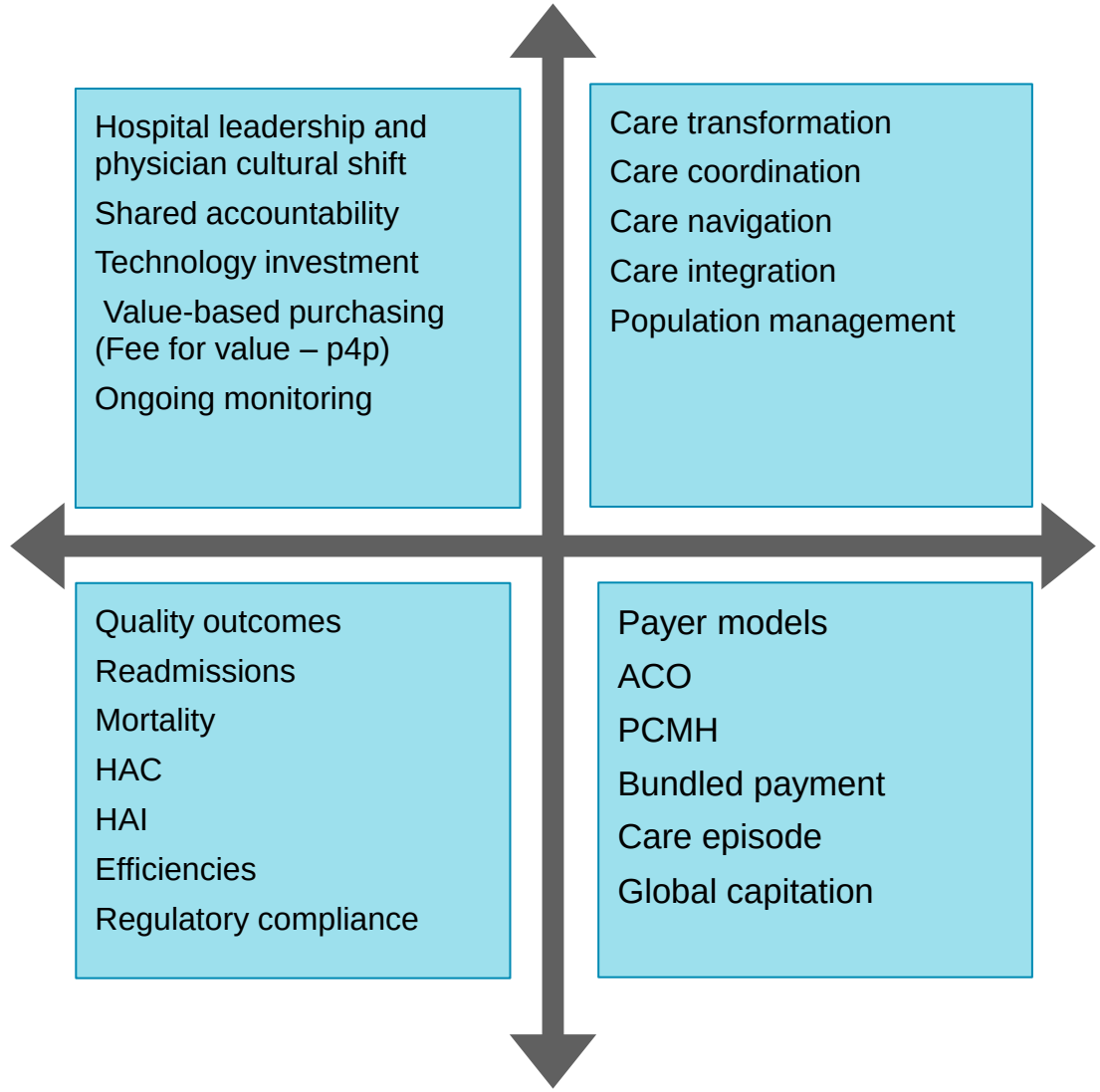
	Fee-for-service	Fee-for-value
Organizational structure		
Efficiency	Focus on operating expenses (labor rates, supply chain, vendor contracting, etc.)	Focus on overall cost of care (duplicative efforts, shifting service to lower cost sites, etc.)
Quality	Measured through adherence to process	Measured through clinical outcomes
Risk management	Managed at the unit of service level – cost for a service must be lower than reimbursement	Managed at the population level – cost to treat population must be lower than reimbursement
Care management	Managed when and where care is delivered (complex care, admissions, etc.)	Managed across the entire service delivery system (chronic care, episodes, etc.)
Health enablement	Point-of-care controls needed (EMR, order entry systems, etc.)	Care synchronizing tools needed (data analytics, health information exchange, etc.)
Physician alignment	Integrated to provide referrals and volume	Integrated to provide coordinated delivery of care
Reimbursement/ compensation	Productivity-based compensation	Quality and outcomes based compensation

Many players may not be able to make the jump to FFV and will be forced out of business

Source: Oliver Wyman

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ACO and Care Coordination
Legal and Risk Domains



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Value-based care
Legal and Risk Domains

Patient Care and Medical Treatment

- Value-based purchasing initiatives
- Patient safety and risk prevention focus
- Hospital acquired conditions/infection control
- Readmissions
- ER and OR throughput/efficiencies
- Care transformation/integration (Inpatient)
- Ambulatory centers and physician offices
  - Ambulatory clinical integration
- LTC, HH, medical homes, ALF, SNF
  - Post acute clinical integration

Operations Management

- Key departments (ER, trauma, surgery, orthopedic, outpatient) value stream mapping
- Medical staff credentialing (All Providers)
- Throughput and efficiency
- Staff, patient and environmental safety
- Leadership training and support
- Disaster planning/storm/catastrophe continuity
- Human resources management (Staffing)
- Overall governance and leadership team

Process and technology

- Health information management
- Clinical documentation
- Policy and procedures
- Transparency (Public website)
- Physician compare
- Hospital compare
- Regulatory reform and compliance
- HIPAA/privacy and security (IT)
- Cyber risks
- IT security and privacy risk assessment

Finance and compliance

- Revenue cycle and denial management
- Audit function/RACS/ZPICS
- Licensing
- Federal and state requirements
- Compliance/fraud/abuse
- Government relations and requirements
- VBP/fee-for-value/value-based care
- Readmissions/HACs
- Sentinel events – cost $$
- Meaningful use attestation

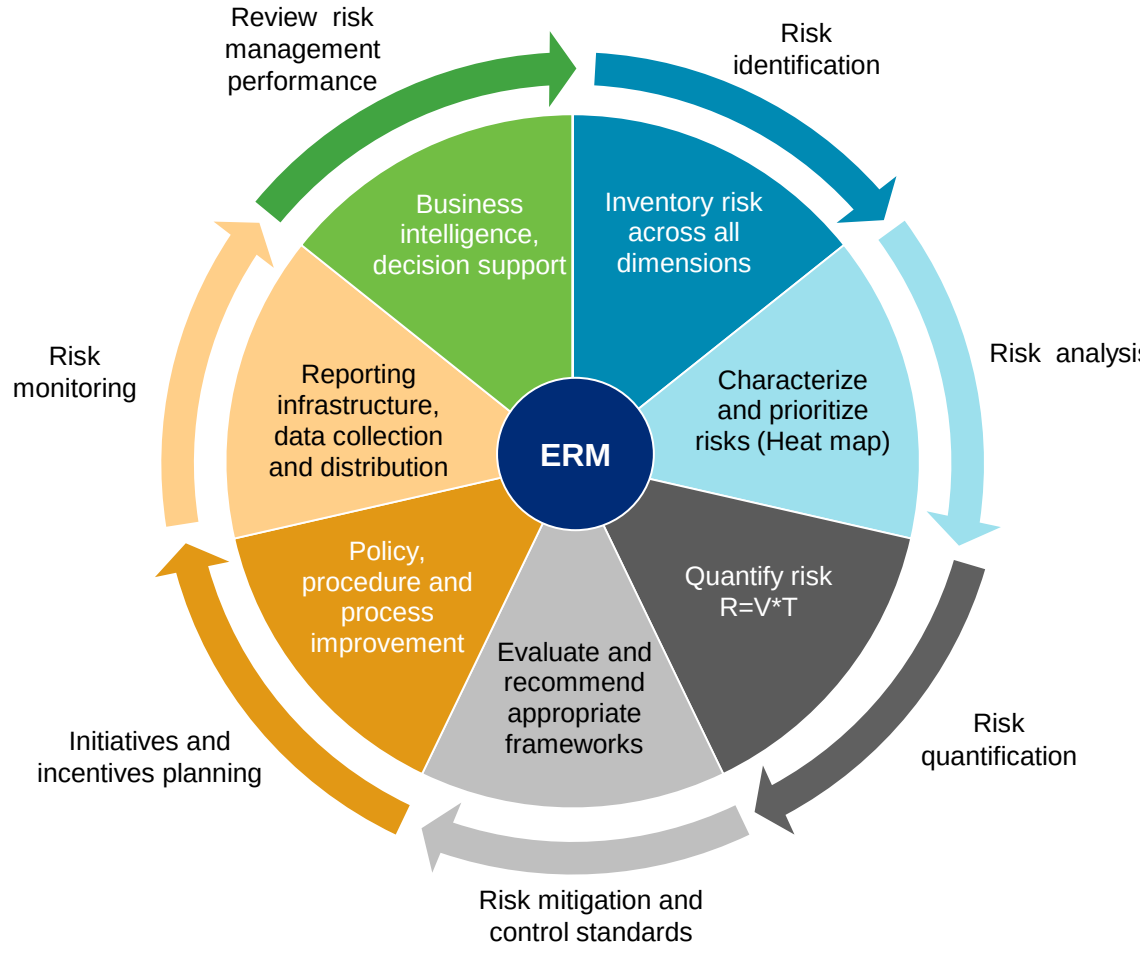
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Enterprise Risk Management
Reducing Risks with Collaboration and Transformation

A successful risk program creates the structure and foundation for a comprehensive approach to evaluate all the risk issues across an organization

ERM consulting projects include:

1. Strategic
2. Operational
3. Financial
4. Regulatory and accreditation
5. Human capital
6. Technology



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Value-Based Purchasing
Enterprise Risk Management Summary

Operational risk	Consolidation of business operations, bundling of services, ACOs, acquisitions, etc.
Strategic risk	Changes in managed care contracts and new business partners. Publically available data
Financial risk	Changes in coding, reimbursement, value-based purchasing, “never events”/potential preventable conditions”, “present on admission”, hospital acquired infections, readmissions, etc.
Regulatory risk	OIG plan, New CMS CoPs, HIPAA, Increase in regulatory citations, violations and penalties
Technology risk	Electronic medical records, telemedicine, social media, increase in new technology
Human capital risk	Employing physicians and other allied health practitioners, changes in benefits, staffing changes, etc.

It is crucial for risk managers to understand healthcare reform and create the appropriate changes in their programs and insurance structure

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Other Risk Exposures

- **When care delivery is not optimal** …
  - Patient complaints
  - Patient safety risks
  - Clinical documentation risks
  - Professional liability claims
- **Reputational risks**
  - Transparency of information for physician and healthcare providers
- **Plaintiff's malpractice risks**
  - Using quality data to attempt to establish standard of care, trends, and patterns
  - Utilizing public information to target patients in advertisements for representation
- **Underwriters/carriers**
  - Using data to calculate risk exposures and impact premiums

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Value-Based Purchasing
Risk Reduction Strategies

- Build a strong “safety net” among all hospital stakeholders
  - Communication
  - Technology and Real-time Data Analysis
  - Team approach-quality, risk and care management (The Glue)
- Engage physicians in the improvement process (Inform the physicians)
- Provide financial impact reports to all appropriate committees
  - VBP scorecards/action plans
- Governance, medical staff, c-suite and managers education and communication
  - Accountability and commitment
- Transparency and communication
- Technology (Single platform for EMR)
- Real time data analytics and workstream mapping
- **Care coordination using transitional care innovations and redesign**

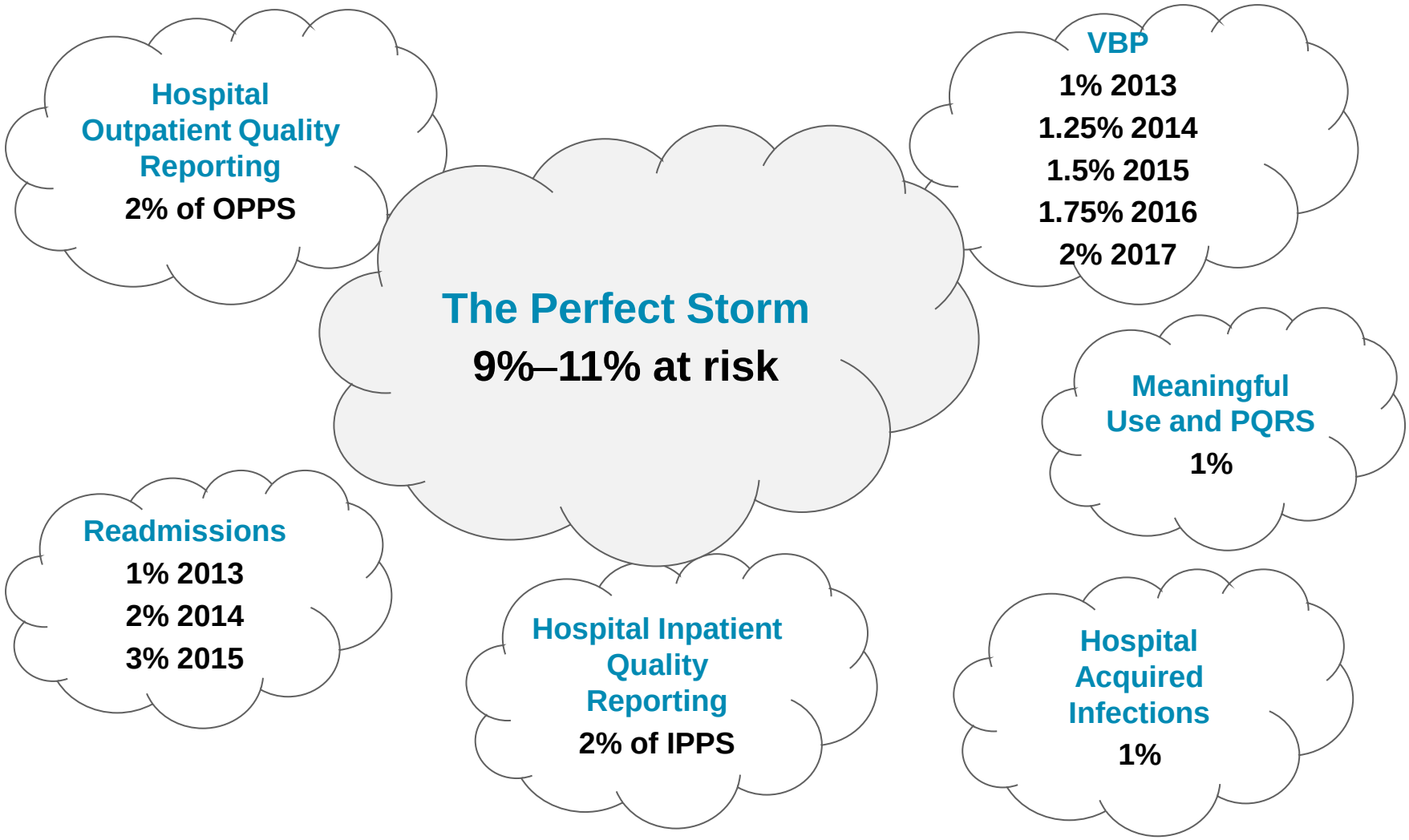
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VBP
Care Coordination and Integration Benefits

- Reduction in:
  - Financial risks producing improved operational viability
  - Operational and reputational risks
  - Medical malpractice/litigation claims
  - Premiums for underwriter/carrier issues
  - Regulatory and accreditation issues
  - Adverse events/mandatory reportable events
- Improvement in:
  - Public consumer opinions
  - Employees, physicians, residents and patient satisfaction scores
- Positive impact on:
  - Managed Care contracting, hospital rating and business partner relationships

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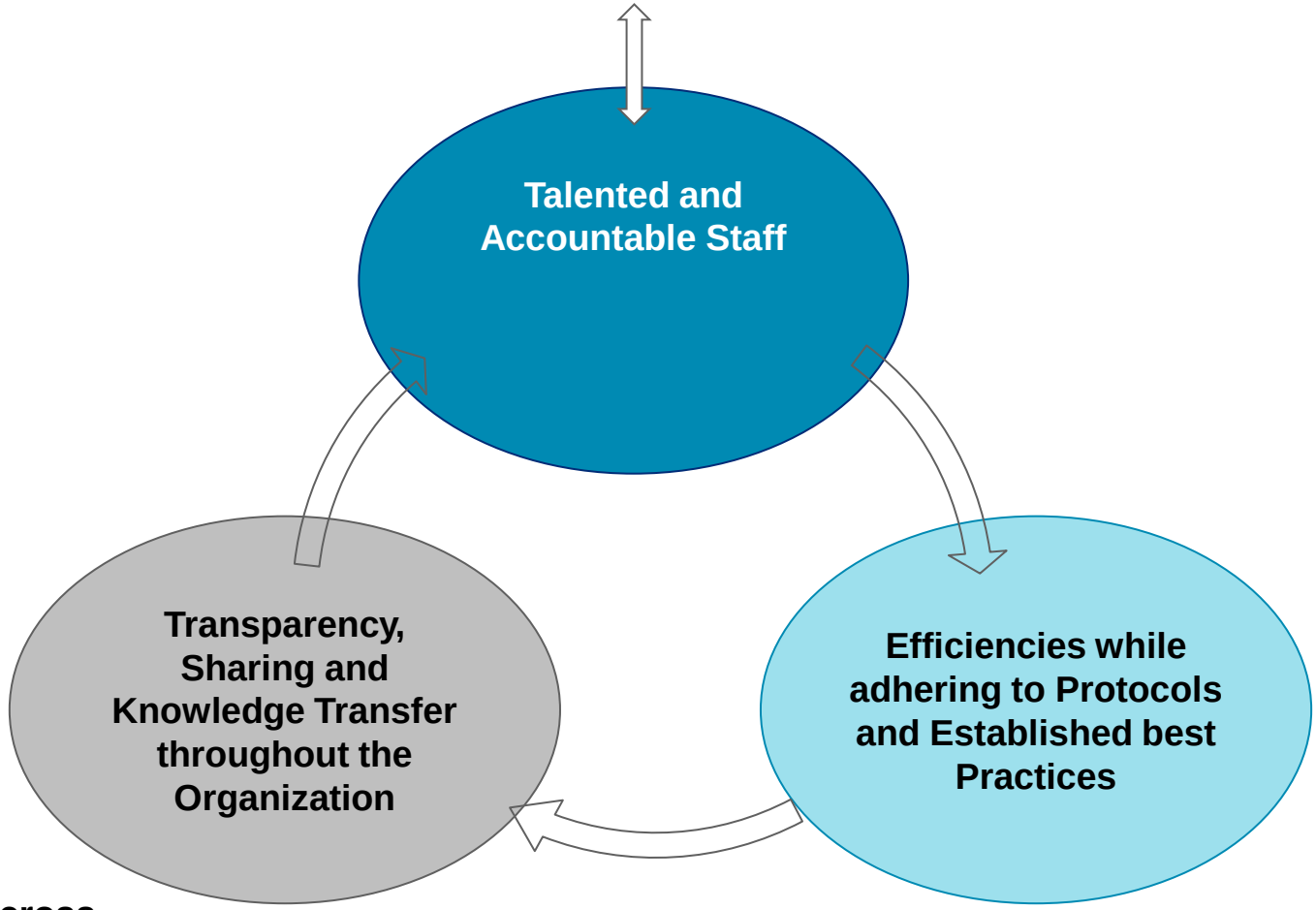
VBP Financial Risk Summary
Staying Strong in the Midst of Reform



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Reduce Risks and Claims

Skilled project leaders who can think "outside the box"



Willingness to cross boundaries posed by information silos

Effective process to identify and manage risks

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Questions



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VBP Resources

- CMS official VBP web site: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html
- CMS VBP fact sheet: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/FY-2013-Program-Frequently-Asked-Questions-about-Hospital-VBP-3-9-12.pdf
- Refer to the hospital VBP final rule for more information on the hospital VBP quality measures: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf.
- For detailed information on the Hospital VBP program, refer to: http://www.cms.gov/Hospital-Value-Based-Purchasing.
- For further details about scoring for the FY 2013 hospital VBP program, refer to the July 2011 Open door forum: http://www.cms.gov/Hospital-Value-Based-Purchasing/Downloads/HospVBP_ODF_072711.pdf.

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Value-Based Care and Physician Practice Reporting Resources

VBP

- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/%5d.

Data.gov

- https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3

VBP federal register December 2013

- http://www.bricker.com/documents/resources/reform/fr121013hvb.pdf

HCAHPS

- http://www.hcahpsonline.org/executive_insight/
- http://www.hcahpsonline.org/Facts.aspx

HCAPHS fact sheet

- http://www.hcahpsonline.org/files/August%202013%20HCAHPS%20Fact%20Sheet2.pdf

PQRS

- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

New PQRS measurement option qualified clinical data registry reporting

- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html

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