CG CAHPS FREQUENTLY ASKED QUESTIONS

The CAHPS Clinician & Group Survey (CG CAHPS) assesses patient experience with health care providers and staff in doctors' offices. Survey results can be used to improve care delivered by individual providers, sites of care, medical groups, or provider networks. In addition, the results equip consumers with information they can use to choose physicians and other health care providers, physician practices, or medical groups. The survey includes standardized instruments for adults and children that can be used in both primary care and specialty care settings.

Background & History

The Agency for Healthcare Research and Quality (AHRQ) first released the Clinician & Group Survey for adults and children in 2007, building on prior work conducted by the CAHPS Consortium and other physician-level surveys of patient experience. Since that time, the survey has been updated and refined to better meet the changing circumstances of its users. At each stage of the process, the Consortium benefited from a significant amount of input from key stakeholders, including providers, health plans, purchaser communities, and patients.

Q Why should I participate in CG CAHPS data collection?

A The CG CAHPS survey provides an excellent source of information related to the patient's experience at your medical practice while also allowing for apples to apples comparisons of medical practices across the country.

Secondly, as we have seen with other CAHPS instruments, measurement mandates in this care setting are forthcoming.

Lastly, we have observed with HCAHPS that early adopters of CAHPS survey measurement perform better when required administration and public reporting begins. These organizations have had time to become familiar with the instrument and aspects of care measured by the survey. This also gives an organization the ability to identify and implement best practices to ensure improvement.

Q Can you explain the history and evolution of the survey?

A It all started with a hospital patient experience survey, HCAHPS. In 2002, the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (ARHQ) and CAHPS Consortium began a partnership which led to the creation of the first national standardized survey in healthcare. It was specific to the inpatient environment and called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

The aim was threefold:

- Produce comparable data on the patient's experience to allow objective and meaningful comparisons between hospitals
- Leverage the patient-reported quality metrics of HCAHPS as part of value-based payment
- Increase transparency of the quality of hospital care via public reporting

In October 2012, HCAHPS was included in Hospital Value-Based Purchasing (VBP) calculation. Inpatient hospital care was the first care setting to experience a financial impact based on patient survey results. Organizations will continue to be held accountable for a portion of reimbursement based on the patient's experience.

The CG CAHPS Survey was developed by AHRQ in 2006 and endorsed in 2007 by the National Quality Forum. Since its development, CG CAHPS has evolved into three different survey instruments being used by different entities:

- The Patient-Centered Medical Home (PCMH) CAHPS was implemented in 2011 and is utilized by the National Committee for Quality Assurance (NCQA) as part of its PCMH certification process.
- Accountable Care Organization (ACO) CAHPS was implemented in 2012 and is used by CMS and pioneer ACOs as part of the shared savings program. The ACO CAHPS scores specifically are part of the ACO-34 data set.
- The Physician Quality Reporting System (PQRS) CAHPS was implemented in 2011. In 2015, the program began

applying negative payment adjustments to PQRS group practices with over 100 Eligible Providers (EPs) who did not report satisfactory data on quality measures for Medicare Part B Physician Fee Schedule (MPFS) covered professional services in 2013.

Each instrument contains core CG CAHPS composites and supplemental questions based on the program for which they were modified.

Regulatory Requirements and Expectations

Physician Compare and Publicly Reported Information

CMS created the Physician Compare website in December 2010 as required by the Affordable Care Act (ACA) of 2010. The purpose of the site is to provide easy access to the most useful information to help the patient find clinicians to meet their health care needs. Performance scores on Physician Compare help patients make informed decisions and encourage clinicians to provide the best care.

Q Will CG CAHPS information be publicly reported in 2017?

A Yes. In December 2016, the Centers for Medicare & Medicaid Services (CMS) began publicly reporting performance scores on the Physician Compare website for a sub-set of individual clinician and group practice PQRS measures and non-PQRS measures submitted through a Qualified Clinical Data Registry (QCDR). Included in these measures are the 2015 CAHPS for PQRS summary survey scores submitted via certified survey vendors. CAHPS measures for individual health care professionals are not under consideration for public reporting on Physician Compare at this time because CMS is not collecting this data.

Q What CAHPS information will be publicly reported and how will measures be displayed?

A The CAHPS for PQRS Survey includes the core questions contained in the CAHPS Clinician & Group Survey (Version 2.0), plus additional questions to measure, Summary Survey Measures (SSMs). 11 of the 12 CAHPS for PQRS SSMs may be reported on Physician Compare for groups of 100 or more EPs who participate in PQRS Group Practice Reporting Option (GPRO) and for groups of 2 to 99 EPs reporting via a certified CAHPS vendor. These include:

- Getting Timely Care, Appointments & Information (Core questions)
- How Well Your Providers Communicate (Core questions)
- Patient's Rating of Provider (Core questions)
- Access to Specialists
- Health Promotion and Education
- Shared Decision-making
- Health Status & Functional Status
- Courteous & Helpful Office Staff (Core questions)
- Care Coordination (Core questions)
- Between Visit Communication
- Helping You Take Medications as Directed
- Stewardship of Patient Resources

A How are measures displayed on Physician Compare?

The title of each measure has an expand/collapse bar with an associated graphical representation of the percent in a series of five stars and the actual percent listed to the right. All the measures will be collapsed when a user first sees the page. A user can then expand each measure to see additional information.

All measures are collapsed upon first view of a profile, but can be expanded to see additional information for each measure. Each measure has an expand/collapse bar that shows the measure ranking on a scale of one to five stars and the percent. At this time, the stars are simply graphical representations of the percent. Each star represents 20%. Thus, 100% is 5 stars, 80% is 4 stars, etc. CAHPS for PQRS, which are patient experience measures, will be added

and the summary survey scores displayed. We anticipate this will be shown as both stars indicating a graphical representation of the percent and the percent performance score (top box score).

Q Is there an expected sample size (n size) for public reporting?

A Yes. For the 2016 survey, CMS will draw a target sample of 860 beneficiaries from patients who have had at least two (2) primary care visits.

Medicare Access & CHIP Reauthorization Act (MACRA)

As part of the Medicare Access & CHIP Reauthorization Act (MACRA), the Merit-based Incentive Payment System (MIPS) will begin January 1, 2017. MIPS CAHPS will replace the current PQRS CAHPS survey and groups can voluntarily collect MIPS CAHPS beginning with the 2017 performance year. The first data collection is expected to begin in November 2017 using a MIPS CAHPS survey that aligns with the PQRS CAHPS survey in design and administration.

The MIPS CAHPS survey is a voluntary measure for year one and counts as one of the six required measures for a positive reimbursement adjustment. The survey counts as one measure within the Quality Performance category and earns 20 points as a High Point measure under the Clinical Practice Improvement category. Administration of MIPS CAHPS will occur from November 2017 through February 2018 and use a mail followed by telephone methodology (similar to the approach for PQRS CAHPS administration).

Registered groups of two or more MIPS eligible clinicians may elect to voluntarily participate in the MIPS CAHPS survey.

- The MIPS CAHPS survey would count as one cross-cutting and/or patient experience measure.
  - Group may report any 5 measures within MIPS plus the MIPS CAHPS survey to achieve the 6 measure threshold.
- Group must have the MIPS CAHPS survey reported on its behalf by a CMS-approved survey vendor.
- Group will need to use another submission mechanism (e.g., qualified registry, QCDR, EHR) to complete the quality data submission.
- Data completeness criterion: Sampling requirements for Medicare Part B patients

The CAHPS for Clinician and Groups (CG CAHPS) Survey

Q Which survey should I use? How can I administer the survey?

A Step 1: Which Survey?

- The answer depends on why you are surveying. Do you need to meet CMS, NCQA or state requirements as part of your surveying today?
  - If yes, then the instrument you use is determined by the need:
    - CMS's PQRS program → PQRS CAHPS
    - CMS's ACO programs → ACO CAHPS
    - NCQA's PCMH → PCMH CAHPS
    - State → varies by state, but many are leveraging a longitudinal CG CAHPS version 3 survey.
  - If no, then you have flexibility today to administer a version of CG CAHPS that meets your needs. Many vendors offer versions of CG CAHPS surveys or you can self-administer, as the survey is in the public domain.
- Note: some organizations may need to administer more than one version of the survey for different types of clinics or practices.

A Step 2: How should I administer the survey?

- CG CAHPS surveys were designed to be collected via mail, phone or email.
- In general strengths and weaknesses of these three collection models are:

MODE	PROs	CONs
Mail	Administrative Ease Low Cost	Lower response rate May be biased towards older patients
Phone	Highest Response Rate	Most expensive Tends to show positive bias in answers
Email	Administrative Ease Least Expensive	Lowest response rate May be biased towards younger patients

- Consider your contact fill rate in your decision. If you only have email addresses for 10% of your patients, email is likely not a good mode to use in collecting data.
- Some have also found a multi-model collection model of value; for example, start with mail and then call only those who don't respond to the mailed survey.
- Consider mode adjustments to data. Does your vendor adjust CG CAHPS data based on the mode of administration? CMS requires mode adjustment to data collected for its purposes. And mode adjustment is important if you want to compare your results to others.
- If you are using the survey to meet a regulatory need, it is important to talk with your vendor to ensure you select a collection process that meets the regulatory need.

Q Do I look at data by survey received date or visit date?

A The answer to this question will be determined based on who you are reporting the data to. Not all regulatory bodies use the same methodology on what data to report in what time-period so it is important to research this based on the reporting entity (i.e. CMS, state, NCQA, etc.). Your vendor can help you better understand which methodology is required.

For improvement purposes, we recommend you look at data based on visit dates. It is very easy to identify the date that you implemented a tactic or behavior to improve the patient experience. You can see the impact of that tactic by looking at surveys from patients who had a visit on that date or thereafter. And remember that with longitudinal surveys, it can take a while for the changes you make to show in the survey responses.

Q Do I use the adjusted or raw score for phone surveys?

A Always use the mode-adjusted data when possible. This allows for the cleanest comparison amongst organizations.

CG CAHPS is relatively new and CMS has only mandated collection for large groups and ACOs. Ask your vendor if they have adjusted CG CAHPS data in their database.

Q What survey version should our organization use? What is the impact of the different versions?

A As we indicated above, first figure out if you are required to use a specific survey version to meet regulatory needs.

In some cases, you may find that you have to use different versions of the survey for different patient populations based on payer mix. For example, you may need to use ACO CAHPS for your Medicare Shared Savings Program and CG CAHPS 3.0 for your state's Medicaid program.

- If you are just beginning to survey your medical practices for the first time, Studer Group recommends CG CAHPS version 3 because we know that this is the version of the survey that will be used widely in the future. The version 3 survey is a longitudinal survey based on a 6-month period. The questions generally follow the form, "In the last six (6) months when you visited this provider how often did they…?" And the answer choices are: Always, Usually, Sometimes or Never. The version 3 survey is also in synch with the CMS versions of the CG CAHPS survey known as PQRS CAHPS and ACO CAHPS.

- If you are currently using the 2.0 version and have improvement plans and/or incentive plans in place based on that survey instrument version, do not switch in the middle of a performance period. Wait until your performance period ends before changing.
- Generally, we do not recommend using a vendor's customized version(s) of CG CAHPS surveys. They can lead your organization to focus on items that will change or be measured differently as the industry moves into standardized data collection. No one likes to find out they are low performing on standardized national survey after being told by their vendor they are high performing on based on the vendor's benchmarks.

Q Will switching from a 12-month survey to a 6-month survey impact the survey results?

A It will shrink the sample population, as a shorter sampling period decreases the number of patients eligible to receive a survey. A shorter recall period for questions may influence respondents' perceptions of events and therefore, you cannot accurately compare performance from different versions, even if the question is the same on both surveys.

CMS conducted a study to look at the difference in performance and response rates between the CG CAHPS 12-month version and 6-month version. CMS found that there was no difference in performance between the two survey version in the following domains:

- Time with provider
- Phone for routine/urgent care
- Medical questions
- Specialist visits
- Taking prescription medications

CMS found some difference performance in the following areas:

- Ability to schedule visits
- Test results

CMS concluded that users of CG CAHPS surveys switching to a 6-month recall may obtain *slightly* higher scores in some domains.

Q What is the difference in survey questions based on the version of CG CAHPS (i.e. PCMH, ACO, PQRS, etc.)?

A All CG CAHPS questions include the same core questions. This is why Studer Group always recommends that organizations start by focusing on the core questions.

- The attached appendix includes additional information about the core & supplemental questions by survey.

Q What are the core questions versus the added supplemental questions? What does Studer Group recommend to survey?

A Studer Group recommends that you start by focusing on the core questions. Since these are common to all surveys, improving them will help you with all your CG CAHPS related surveys. Core questions are those included in the following domains:

- Getting Timely Appointments, Care, and Information
- How Well Providers Communicate With Patients
- Providers' Use of Information to Coordinate Patient Care *(New to the 3.0 version)*
- Helpful, Courteous, and Respectful Office Staff
- Patients' Rating of the Provider

Q Should I survey Advanced Practice Providers (APPs)?

A Yes. CG CAHPS was specifically designed to survey patients regardless of what kind of clinician delivered the care. This is why the surveys refer to the provider who delivered care vs the physician or doctor. If you are performing CAHPS surveys to meet CMS program requirements, then the Eligible Providers are defined as: Doctors (MD, DO, DC, DPM, DMD, OD), Practitioners (NP, PA, CNS, CRNA, CNM, CCSW, PsyD, CCC-A, RDN) and Therapists (PT, OT, Speech).

Q Should I survey patients in my Urgent Care using the CG CAHPS survey?

A No. The CG CAHPS survey asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory settings and so is not the best fit for the Urgent Care setting. It is also for this reason that we would consider Infusion Suites or Endoscopy settings as unsuitable for the CG CAHPS survey.

Recommendations for Transparency when Sharing the Data

When displaying data within the medical practice setting, there are steps in the journey to full transparency of data.

Studer Group recommends that the journey to transparency of patient experience data contain the following sequenced steps:

1. Provide training for all staff and providers around the survey instrument, survey questions, administration, and scoring methodologies.
2. Once training is complete, begin reporting data at the clinic level.
    a. Report clinic performance on composite measures first.
    b. Then, report clinic performance in comparison to the national benchmark via national percentiles.
    c. Finally, compare clinic performance to the targeted goal. The measures reported should directly reflect those goals that are in place for the organization.
3. The next step to transparency is to provide data broken out by provider utilizing masked names. (e.g. Dr. A; or Provider 1) for those measures that reflect provider performance (i.e. Physician Communication).
4. The final step is to display results attributed to individual provider names (i.e. full transparency).

A critical component to the process is to provide sufficient communication about the timeline for each phase in the journey to transparency. Providing this information allows physicians enough time to prepare for each transition.

Goals and Performance

Q Explain the difference in top box & percentile ranking. Do I look at top box or percentile ranking?

A The percent top box is the percent of the survey / patient population that choose the best possible answer. Most often with CAHPS instruments, this is the percent of Always responses or the percent of 9's and 10's for the rating question.

A percentile score tells us what percent of other organization's scores are higher or lower than our score. Or how many are performing better or worse than you are. Thus, you don't want to be in the 1st percentile because 99% of other organizations are performing better than you. You want to be in the 99th percentile!

Studer Group recommends that organizations focus on the top box score until such point that CG CAHPS is widely adopted and standardized national benchmarks are available.

We strongly recommend organizations not set goals based on a specific vendor's proprietary benchmarks / percentile rankings. This is because as organizations join and change vendors, these benchmarks can change. Nothing will demotivate your team more than to work hard, improve their top-box scores and then be penalized because the vendor's benchmark changes.