



PRIMER/BRIEF

Forces Driving Implementation of the CAHPS Clinician & Group Survey

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For many years, physician practices and affiliated organizations have fielded various surveys to find out whether their patients are satisfied with the care they receive. The past five years, however, have seen a slow but steady shift toward the CAHPS Clinician & Group (CG-CAHPS) Survey, which asks patients about their experiences with care rather than their satisfaction (see box at right). This survey also is different because it is standardized; in contrast to many homegrown surveys, the CG-CAHPS Survey asks patients in multiple physician practices to answer the same questions. This allows purchasers, payers, and consumers to assess and compare patients' experiences with health care providers and physician practices, not just across a community but also across the country. It also enables those providers to identify their strengths and weaknesses and measure their progress.

Various organizations at the community, regional, and state level—including many of the Robert Wood Johnson Foundation's 16 Aligning Forces for Quality communities—are currently exploring ways to make this kind of health care quality information publicly available. One important consideration for these organizations as well as the physician practices is the fact that several national programs also are using or planning to use the CG-CAHPS Survey to assess patient experience and drive improvements in care. To minimize confusion in the marketplace, use resources efficiently, and support physician practices in meeting their requirements, survey sponsors must understand the various market and regulatory forces driving the collection and reporting of standardized survey results across the country, determine how local efforts can fit with those activities, and assess whether and how to harness the larger forces to motivate action at the community level.

This brief updates a document produced for the Aligning Forces for Quality communities in April 2012. It outlines the emerging national consensus that is driving interest in and use of the CG-CAHPS Survey across the country, describes various initiatives that will require use of the survey, and discusses the implications for Alliance communities and other survey sponsors. This information is expected to inform and support the decisions of the multi-stakeholder teams that Alliances and other survey sponsors convene to plan for and implement the CG-CAHPS Survey in their communities.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/quality-equality.

About the Author

The Shaller Consulting Group provides technical assistance to Aligning Forces for Quality by helping regional Alliances support patient experience measurement and improvement.

A National Consensus

There is a growing consensus that measures of patient experience are a critical component of comparative health care quality information for consumers, providers, payers, and policymakers. This consensus is reflected in the priorities of organizations charged with setting the direction for quality measurement and reporting at a national level:

- The **National Priorities Partnership (NPP)**, convened by the National Quality Forum, was responsible for supporting the U.S. Department of Health and Human Services (HHS) in setting priorities and goals for its National Quality Strategy. Among the recommended goals was measuring and using patient experience in all care settings. The NPP Work Group on Patient and Family Engagement specifically identified widespread implementation of CAHPS surveys in ambulatory settings as its top priority. For more information, see <http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=596>.
- More recently, the **Measure Applications Partnership (MAP)**, a public-private group also convened by the National Quality Forum, has made recommendations to HHS regarding the performance measures to be used for both public reporting and performance-based payment programs. In a report to HHS, the MAP recommended the use of measures from the CG-CAHPS Survey across all clinician performance measurement programs. For more information see “[MAP Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking](#)” and related information at http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx.

One of the biggest audiences for these recommendations is the Centers for Medicare & Medicaid Services (CMS), which is responsible for multiple national programs—including the Medicare Shared Savings Program and the Physician Quality Reporting System—that incorporate information from CAHPS surveys (see below).

Program-Related Requirements

In the coming years, physician practices will have to meet numerous requirements imposed by various public and private programs, including those of national and local payers, accrediting bodies, medical societies, and states. These requirements will strongly influence whether, when, and how health care organizations implement the CG-CAHPS Survey and which version they prefer to use. Some of these programs are already well defined and affecting a large number of providers; some are on the immediate horizon and likely to affect many providers but are still evolving; and some affect only some providers and some communities. While Alliances and other survey sponsors can leverage these various requirements to motivate organizations to collect and report patient experience information, they also will have to work with their stakeholders to determine how best to align their survey activities with the external requirements so as to minimize the data collection and reporting burden on health care organizations. Learn more in [Leveraging Existing Surveying Efforts: A Decision Guide](#).

Programs of the Centers for Medicare & Medicaid Services (CMS)

Key Facts About the CAHPS Clinician & Group (CG-CAHPS) Survey

- The CG-CAHPS Survey is part of a larger family of standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys that assess patients’ and enrollees’ experiences with health care in various settings.
- CAHPS surveys are developed and maintained by a federally sponsored research consortium funded by the U.S. Agency for Healthcare Research and Quality (AHRQ).
- All CAHPS surveys go through a rigorous development and testing process to ensure the reliability and validity of the measures.
- All CAHPS surveys can be customized to the users’ information needs.
- The National Quality Forum has endorsed the CG-CAHPS Survey as a measure of patient experience.
- The CG-CAHPS Survey currently has three versions: the 12-Month version, the Visit version, and the Patient-Centered Medical Home (PCMH) version.
- To maintain comparability, a set of “core questions” is included in all versions of the CG-CAHPS Survey.

As a result of the Affordable Care Act, CMS is now funding several programs that include the use of a CG-CAHPS Survey to assess and report on the quality of ambulatory care. This section provides a brief description of those programs and how they use the survey.

The survey-related decisions made by CMS are particularly important because of the number of practices that are affected as well as the likelihood that other payers will follow CMS’s lead. In the case of the CAHPS Hospital Survey (HCAHPS), for example, CMS started with voluntary reporting, introduced pay-for-reporting, and then implemented a pay-for-performance program. Within just a few years, HCAHPS became the standard measure for data collection, reporting, and value-based purchasing programs for all hospitals across the country.

Overview of CMS Programs and Associated Versions of the CG-CAHPS Survey

As of January 2013

CMS Program	Anticipated Version of the CG-CAHPS Survey
Medicare Shared Savings Program	New version released for Accountable Care Organizations (ACO)
Physician Quality Reporting System (PQRS)	Likely to be similar to the ACO version of CG-CAHPS
Public Reporting on PhysicianCompare.gov	Likely to be similar to the version adopted for PQRS
Comprehensive Primary Care (CPC) Initiative	Patient-Centered Medical Home (plus additional items]
Multi-payer Advanced Primary Care Practice (MAPCP)	Patient-Centered Medical Home (plus additional items)

Medicare Shared Savings Program

Clinician & Group Survey version: New version for Accountable Care Organizations

CMS has introduced new programs to encourage health care providers to function as accountable care organizations (ACOs) in order to improve the quality of care and reduce the costs of care for Medicare beneficiaries. Under the Medicare Shared Savings Program, the ACOs approved by CMS will be required to submit data for 33 quality measures in four domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations.

To assess patient experience, ACOs will be fielding a version based on the CG-CAHPS Survey that uses a six-month reference period and combines the core questions with various supplemental items addressing additional topics, such as access to specialists, health promotion and education, team care, functional status, and shared decision-making. The survey will ask Medicare beneficiaries only about their experiences with the provider who delivered a plurality of their primary care, which could be a primary care provider or a specialist. Because scores will be reported at the level of the ACO, CMS will require at least 300 completed surveys for each ACO. Survey results are expected to be reported to CMS by July 2013. More information about the ACO quality standards, including the CG-CAHPS Survey for ACOs, is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html.

Implications: Because the survey will be administered to Medicare beneficiaries only and the survey results will be reported at the level of the ACO, this program’s use of a new version of the CG-CAHPS Survey will not satisfy an Alliance’s need to collect and report survey results for patients with various sources of coverage at the level of physician practices. However, if there are ACOs in the community, it is important for the Alliance and its stakeholders to be aware of this survey activity and look for opportunities to coordinate if possible.

Physician Quality Reporting System (PQRS)

Clinician & Group Survey version: Likely to be very similar to the ACO version of CG-CAHPS

Administered by CMS, the Physician Quality Reporting System (PQRS) gives eligible health care professionals a financial incentive to report data for more than 200 quality measures. CMS is planning to add group-level patient experience measures to this list in 2013. The measures are likely to include the composite and rating measures from the

core questions in the CG-CAHPS Survey as well as a few measures based on supplemental items. As with the survey for ACOs, the surveyed population will include Medicare beneficiaries only.

The survey results collected through this program also are expected to be used on the PhysicianCompare site (see below).

Implications: Once this survey is rolled out, medical groups participating in the PQRS will be motivated to gather sufficient information to report to CMS. Survey sponsors and their stakeholders would benefit from determining the extent to which local groups will be affected by this program and aligning their survey activities as needed so the groups can use the same data for both purposes.

Public Reporting on PhysicianCompare.gov

Clinician & Group Survey version: Likely to be very similar to version adopted for PQRS

In accordance with the Affordable Care Act, CMS launched a public site called PhysicianCompare in early 2011 to support consumers in identifying, comparing, and selecting physicians: <http://www.medicare.gov/find-a-doctor/provider-search.aspx>. Under the law, CMS also is required to have a plan in place by 2013 for incorporating information on clinical quality and patient experience in PhysicianCompare. Reporting of group-level clinical data from the PQRS as well as some ACO-level data from the Medicare Shared Saving Program is expected to begin in 2014.

Patient experience data from the CG-CAHPS Survey likely will be added soon afterwards. While CMS has not yet announced which survey version it will use for public reporting purposes, the version developed for the PQRS is the best-positioned candidate.

Implications: For those physician groups participating in PQRS, most of which are relatively large, the fact that the survey results will be reported in PhysicianCompare creates yet one more reason to ensure the community's survey is aligned with the one required by CMS so the results can be used for both purposes. For smaller groups and unaffiliated physicians, the impact of CMS reporting patient experience scores in PhysicianCompare is uncertain. However, having survey results that meet CMS's requirements would give those practices the option of participating in public reporting without having to take on additional survey activities.

Comprehensive Primary Care (CPC) Initiative

Clinician & Group Survey version: Patient-Centered Medical Home

In the fall of 2012, the CMS Innovation Center kicked off a partnership with state and private payers to test a model for enhanced primary care delivery that is supported by a new shared savings model. Current participants in this program include 500 primary care practices in seven markets: Arkansas, Colorado, Oregon, New Jersey, the Capital District-Hudson Valley region of New York, the Cincinnati-Dayton region of Ohio and Kentucky, and the Greater Tulsa region in Oklahoma. These practices represent more than 2,100 providers. For more information about this program, visit <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html>.

As part of the CPC initiative, the participating practices must achieve nine milestones, one of which involves assessing and improving patient experience. Practices will have a choice between focusing attention on a survey domain of their choice by gathering additional data or soliciting and acting on guidance from a patient advisory council. Starting in 2013, as part of the shared savings component of the program, CMS will sponsor the annual administration of the patient-centered medical home (PCMH) version of the CG-CAHPS Survey at the practice site level for four years, drawing from the full patient population of each practice (i.e., not just Medicare beneficiaries). Using the baseline data as a starting point, practices will be able to earn shared savings based on a number of measures, including those derived from the survey results.

Implications: This multi-payer initiative moves the measurement of patient experience with primary care and the use of that data beyond the Medicare population to reflect the general population that is the focus of community-based survey sponsors, including Alliances, and their stakeholders. Coordination with this initiative will be critical in the two test markets that overlap with the Alliance communities—Cincinnati and Oregon—but all Alliances will want to keep an eye on this test of primary care redesign and its use of the survey.

Multi-Payer Advanced Primary Care Practice (MAPCP)

Clinician & Group Survey version: Patient-Centered Medical Home

Medicare is also participating in a multi-payer demonstration that includes Medicaid and private health plans in seven states: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. The demonstration started with three of the states in July 2011 and will last three years in each state. Its purpose is to make advanced primary care practices (also known as medical homes) more broadly available and assess their impact on quality, utilization, and costs. More information is available at http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf.

As part of the evaluation plan for this project, CMS is funding the administration in 2013 of the PCMH version of the CG-CAHPS Survey in each state, except for those already fielding this survey in the same time period. The current plan is to draw separate samples for Medicare, Medicaid, and dual-eligible populations, with a goal of 512 completed surveys for each payer group. The samples will be drawn across all practices for each of the payer groups to enable comparisons at the payer level.

Implications: Like the Comprehensive Primary Care Initiative, this demonstration will shed light on the impact of delivery system reform on patient experience as well as other aspects of quality, which is relevant to all Alliances. In particular, since five of the seven states participating in this demonstration are home to Aligning Forces communities, this demonstration offers an opportunity to compare data that Alliances might collect at the practice site level to state payer level benchmarks.

Recognition of Medical Homes, National Committee for Quality Assurance

Clinician & Group Survey version: Patient-Centered Medical Home (Adult and Child)

In addition to CMS, another influential body is the National Committee for Quality Assurance (NCQA). Under its patient-centered medical home (PCMH) recognition program, medical practices must meet a specified set of criteria to be recognized as medical homes. Launched in January 2008, this program has to date recognized approximately 2,000 practices representing 20,000 physicians.

Since the summer of 2011, the recognition program has included an optional distinction in patient experience reporting for those recognized practices that use the PCMH version of the CG-CAHPS Survey to assess their patients' experiences with care. To maintain this distinction, the practices must continue to submit the data on an annual basis. For more information, visit <http://www.ncqa.org/tabid/1429/Default.aspx>.

While not all medical practices that function as medical homes are pursuing NCQA recognition, many participate in local, state, and regional demonstrations that use NCQA's criteria—including use of the PCMH version of the CG-CAHPS Survey—to determine whether the practices qualify as medical homes.

Implication for Alliances: Any medical practices in the community seeking or maintaining recognition as medical homes from NCQA will be motivated to use the PCMH version of the survey and follow NCQA's guidance on administering it. Those practices participating in demonstration projects using the same criteria also may have an interest in this version.

Maintenance of Certification, American Board of Medical Specialties

Clinician & Group Survey version: Core communication items only from the Visit Survey (Adult and Child)

The American Board of Medical Specialties (ABMS) oversees the Maintenance of Certification® (MOC) process that 24 medical specialties use to confirm physicians' qualifications every five years. Since 2009, the MOC program has required that medical boards use part of the CG-CAHPS Survey to assess the communication skills and professionalism

Use of CAHPS Survey in Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration

The Centers for Medicare & Medicaid Services is collaborating with the Health Resources and Services Administration (HRSA) to administer the FQHC Advanced Primary Care Practice Demonstration. This project is designed to support the FQHCs in becoming NCQA-recognized medical homes.

As part of an evaluation of this demonstration's impact on accessibility, quality, and costs of care for patients, CMS is funding a survey to assess how receiving care in these medical homes affects patient experience. The survey, which will expand on the PCMH version of the CG-CAHPS Survey, will be administered to Medicare beneficiaries only. Because the survey is limited to this population, the results are not expected to be useful for the NCQA distinction in patient experience or reporting for other purposes.

of physicians with direct patient care responsibilities. The boards are fulfilling this requirement with a subset of survey questions that focus on physician-patient communication. Each physician going through the MOC process submits the results for those questions to his or her specialty board, which submits the information to ABMS.

Every board determines how its physicians will meet the requirements within the MOC process. Physicians certified by the American Board of Radiology, for example, are using survey questions about communication at the last visit. The American Board of Internal Medicine, on the other hand, requires that primary care providers conduct a self-evaluation of their practice's performance as part of a Practice Improvement Module; as part of that evaluation, the physicians may administer the full 12-month version of the CG-CAHPS Survey.

For more information, contact Sigita Wolfe, manager, MOC/CPD Developmental Programs, American Board of Medical Specialties, at swolfe@ABMS.org.

Implication for Alliances: Individual physicians going through the Maintenance of Certification process—both primary care providers and specialists—will be interested in reporting the results of at least the CAHPS communication items to their specialty boards. In particular, they will want to use the item wording and distribution methods specified by their respective boards. Some specialties, including primary care providers, may be interested in the full survey to satisfy board-specific requirements.

Private Health Plans' Pay-for-Performance Programs and Medical Home Demonstrations

Clinician & Group Survey version: Varies

Across the country, major health plans (such as Blue Cross Blue Shield of Massachusetts and HealthPlus of Michigan) and multi-stakeholder organizations (such as California's Integrated Healthcare Association) have incorporated patient experience scores into pay-for-performance programs that give providers a financial incentive to meet specified performance standards. The Integrated Healthcare Association, for example, included nine patient experience measures derived from the CG-CAHPS Survey among the 82 measures it collected and reported for physician organizations in 2011; the aggregated results are used by health plans for incentive payments, by IHA to recognize top performers publicly, and by the practices themselves to improve performance. For some health plans, the incentive is part of a medical home demonstration project, which supports use of the PCMH version of the CG-CAHPS Survey.

Use of CG-CAHPS PCMH Survey for Medicaid-Sponsored Medical Home Demonstrations

In accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, federal agencies have identified a core set of quality measures for children's health care and developed programs to encourage the use of those measures to assess and improve care provided under Medicaid and CHIP programs. Several states have received multi-year demonstration grants that encourage the development of patient-centered medical homes; a few are using the PCMH version of the CG-CAHPS Survey to assess the children's experiences with care in those medical homes.

Implication: To ensure that CAHPS Survey implementation is consistent with the requirements of any pay-for-performance programs for primary care and other providers, Alliances and other survey sponsors should make an effort to consult with payer organizations and, when possible, include them among the stakeholders involved in the community-level survey effort.

State Programs

Clinician & Group Survey version: Varies

Several states are requiring or promoting implementation of the CG-CAHPS Survey by medical practices. For example:

- The Minnesota Department of Health has mandated use of the CG-CAHPS Visit Survey for all physician clinics with a sufficient number of adult patients. The survey was fielded in the fall of 2012 and likely will be repeated in 2014.
- The Oregon Health Authority paid for a one-time implementation of the CG-CAHPS PCMH Survey as part of a demonstration project for the Medicaid program.

- The Vermont Blueprint for Health, which is a statewide initiative to change both the delivery and payment systems, includes use of the CG-CAHPS PCMH Survey to assess Vermonters’ experiences in physician practices as they transform into Advanced Primary Care Practices.
- Maine’s Dirigo Health Agency is subsidizing the cost of fielding the CG-CAHPS PCMH Survey for all practices in the state that agree to participate and follow the state’s guidelines.

In all but Vermont, Alliances are collaborating with the state agencies to support collecting and reporting survey results.

Implication: The activities of these four states demonstrate the variety of approaches that states may take in driving the use of a CG-CAHPS Survey and the important role that Alliances and other community organizations can play in the process. Alliances can benefit from inviting state agencies to the table and taking steps to ensure they are aware of and included in any survey activities the state may be envisioning.

Key Takeaways for *Aligning Forces* Communities and Other Survey Sponsors

Alliances and other organizations can leverage survey activities at the state, regional, and national levels to motivate CG-CAHPS Survey use in their communities. By educating local health care organizations about survey requirements on the horizon, Alliances can help them understand how participating in community-wide surveys will prepare them for what’s coming and enable them to assess and improve their performance in advance of national programs.

The regulatory and market forces that are driving the implementation of the CG-CAHPS Survey are evolving rapidly. In addition to CMS’s various programs, state agencies, health plans, and other payers and purchasers are exploring ways to use patient experience scores from the CG-CAHPS Survey to assess the impact of delivery system reforms and identify and reward strong performers. Alliances need to establish relationships with local payers and purchasers so they can keep track of whether and how they are using the CG-CAHPS Survey and identify opportunities for aligning requirements in order to reduce the data collection burden on health care providers as well as patients.



The various survey requirements create a significant burden for health care organizations. To help picture the potential array of forces on medical practices, consider the case of Allina, a health system in Minnesota. Allina functions as an accountable care organization under CMS’s programs, offers care through patient-centered medical homes, and must abide by state requirements regarding use of the Visit version of the CG-CAHPS Survey and certification as a “health care home.” As a result, Allina will be dealing with surveys for three versions of the Clinician & Group Survey: Visit, PCMH, and a new version designed for accountable care organizations.

Alliances can play a critical role in reducing that burden on health care organizations. Alliances and other survey sponsors are well positioned to help address this dilemma by exploring opportunities to align measurement

requirements through a “leveraged approach” to implementing the CG-CAHPS Survey, as discussed in [Leveraging Existing Surveying Efforts: A Decision Guide](#). This approach enables multiple organizations to get what they need from the same survey, reducing the burden on both providers and respondents.

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