



National Consensus Development and Strategic Planning
for Health Care Quality Measurement

Fall 2025 Cycle Endorsement and Maintenance (E&M) Technical Report


INITIAL RECOGNITION AND MANAGEMENT

April 2026

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Executive Summary

For over 2 decades, the United States (U.S.) has focused on improving health care quality for Americans. One of the ways this has been done is by developing and implementing clinical quality measures to quantify the quality of care provided by health care providers and organizations. These clinical quality measures are based on standards related to the effectiveness, safety, efficiency, person-centeredness, and timeliness of care.¹

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Health care professionals use quality measures to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and gaps in care delivery and outcomes.^{1,2}

Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. Battelle's Partnership for Quality Measurement (PQM) members support consensus-based processes by serving on committees, ensuring informed and thoughtful reviews of quality measures across a range of focus areas aligned with a person's journey through the health care system. Battelle engages PQM members to carry out the consensus-based E&M process, which relies on robust and focused discourse, efficient information exchange, effective engagement, and inclusion of a multitude of voices that represent the health care community (Figure 1).

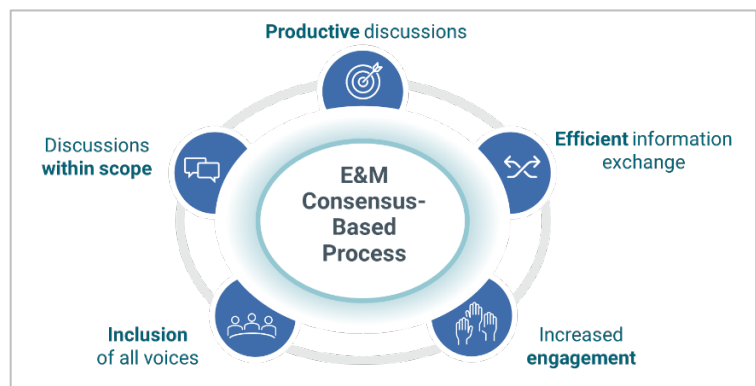


Figure 1. E&M Consensus-Based Process

One of those focus areas is Initial Recognition and Management, which includes measures that focus on patient-centered care and patient satisfaction with care. Patient-centered care allows for maximum patient involvement in health care decisions and contributes to informed decision-making and patient/provider trust.³ When patients are satisfied with their care, clinical outcomes improve, adherence to care instructions increases, and utilization of health care decreases.⁴ The Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys increase provider accountability, and providers and facilities use the results to improve patient care, which in turn increases patient outcomes and reduces health care costs.⁵

For this measure review cycle, developers submitted 26 measures to the Initial Recognition and Management committee for endorsement consideration. Of the 26 measures reviewed by the committee (Figure 2), the committee endorsed 21 measures and endorsed five measures with conditions (Table 1) based on the PQM Measure Evaluation Rubric within version 2.1 of the [E&M Guidebook](#).



Figure 2. Fall 2025 Measures for Committee Review

Table 1. Measures Reviewed by the Initial Recognition and Management Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0005-1 (Adult) 0005-6 (Child)	Clinician and Group (CG)-CAHPS Survey – Getting Timely Appointments, Care, and Information (Access)	Maintenance	Westat/AHRQ	Endorse Endorse with Conditions
0005-2 (Adult) 0005-7 (Child)	CG-CAHPS Survey – How Well Providers Communicate with Patients (Provider Communication)	Maintenance	Westat/AHRQ	Endorse Endorse with Conditions
0005-3 (Adult) 0005-8 (Child)	CG-CAHPS Survey – Helpful, Courteous, and Respectful Office Staff (Office Staff)	Maintenance	Westat/AHRQ	Endorse Endorse with Conditions
0005-4 (Adult) 0005-9 (Child)	CG-CAHPS Survey – Providers’ Use of Information to Coordinate Patient Care (Care Coordination)	Maintenance	Westat/AHRQ	Endorse Endorse with Conditions
0005-5 (Adult) 0005-10 (Child)	CG-CAHPS Survey – Rating of the Provider	Maintenance	Westat/AHRQ	Endorse Endorse with Conditions
0006-1 (Adult)	Health Plan (HP) CAHPS Survey – Getting Needed Care	Maintenance	Westat/AHRQ	Endorse

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CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0006-9 (Child)				Endorse
0006-2 (Adult)	HP CAHPS Survey – Getting Care Quickly	Maintenance	Westat/AHRQ	Endorse
0006-10 (Child)				Endorse
0006-3 (Adult)	HP CAHPS Survey – How Well Doctors Communicate	Maintenance	Westat/AHRQ	Endorse
0006-11 (Child)				Endorse
0006-4 (Adult)	HP CAHPS Survey – Health Plan Customer Service	Maintenance	Westat/AHRQ	Endorse
0006-12 (Child)				Endorse
0006-5 (Adult)	HP CAHPS Survey – Rating of All Health Care	Maintenance	Westat/AHRQ	Endorse
0006-13 (Child)				Endorse
0006-6 (Adult)	HP CAHPS Survey – Rating of Personal Doctor	Maintenance	Westat/AHRQ	Endorse
0006-14 (Child)				Endorse
0006-7 (Adult)	HP CAHPS Survey – Rating of Specialist	Maintenance	Westat/AHRQ	Endorse
0006-15 (Child)				Endorse
0006-8 (Adult)	HP CAHPS Survey – Rating of Health Plan	Maintenance	Westat/AHRQ	Endorse
0006-16 (Child)				Endorse

Endorsement and Maintenance (E&M) Overview

Battelle’s E&M process ensures that measures submitted for endorsement are evidence based, scientifically sound, and both safe and effective. This means that the use of the measure will increase the likelihood of desired health outcomes, will not increase the likelihood of unintended adverse health outcomes, and is consistent with current professional knowledge.

We organize measures for E&M by five project areas. Each project topical area has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. PQM members representing all facets of the health care system make up these committees. Each E&M committee has an Advisory Group and a Recommendation Group (Figure 3).

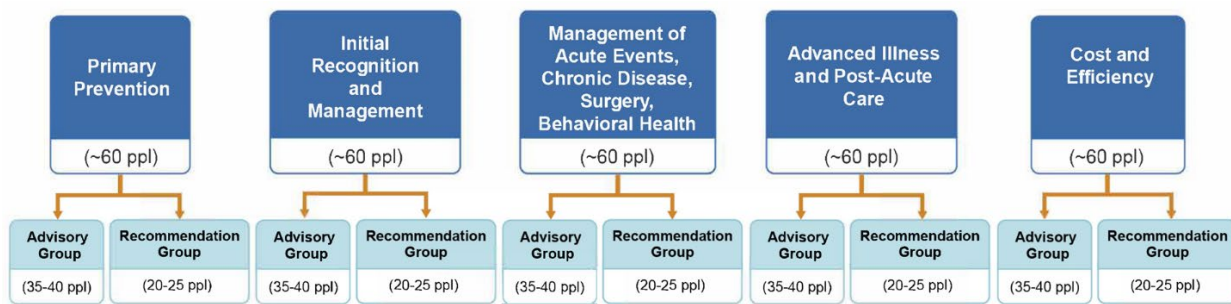


Figure 2. E&M Committee Structure

The goal is to create inclusive committees, made up of interested parties, that balance experience, expertise, and perspectives. The interested parties include those who are impacted or affected by quality and cost/resource use. Figure 4 gives an overview of the perspectives that members represent on E&M committees.



Figure 4. E&M Interested Parties

For the Fall 2025 cycle, the Management of Acute Events and Chronic Conditions committee had 11 patient partners (i.e., patients, caregivers, advocates) and 15 clinicians, with specialties in nephrology, surgery, nursing, and other areas of practice (Figure 5). The committee also included eight population health experts.

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[Appendix A](#) provides a list of committee members, and the [PQM website](#) has the full committee rosters and bios on the respective project pages.

At the beginning of each E&M cycle, committee members complete a measure-specific disclosure of interest (MS-DOI) form identifying potential conflicts with the measures under endorsement review for the respective E&M

cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's [COI policy](#).

Each E&M cycle (i.e., Fall or Spring) has a designated Intent to Submit (ITS) deadline, when measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the ITS deadline (Table 2), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

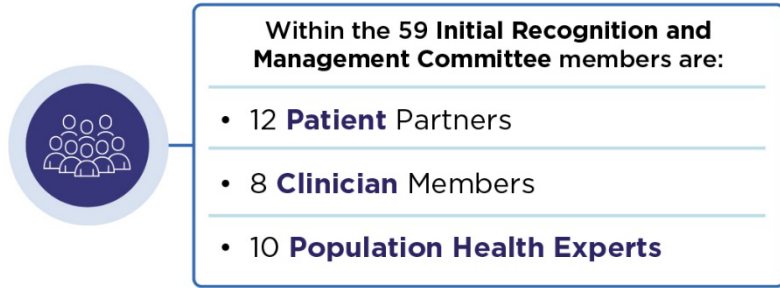


Figure 5. Initial Recognition and Management Committee Members

Table 2. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit*	Full Measure Submission*
Fall	October 1	November 1
Spring	April 1	May 1

*Deadlines are set at 11:59 PM (ET) of the day indicated. If the deadline falls on a weekend or holiday, the deadline will be the next immediate business day.

We then publish measures to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting and concurrently with the development of the staff preliminary assessments (PAs). For this evaluation cycle, the public comment period opened on November 17, 2025, and closed on December 16, 2025. The public comment period solicits both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (i.e., Fall or Spring). Developers/stewards can provide written responses to any public comments received directly on the measure's webpage. These responses are under the "Comments" tab of each [measure page](#) on the PQM website.

Prior to the close of the public comment period, we host a Public Comment Listening Session to gather additional public comments on the measures; these virtual sessions are organized by project with measures grouped by topic/condition. Any interested party may attend to give a brief spoken statement on one or more of the measures. This cycle's session was on December 10, 2025.

We post all public comments received during this 30-day period, including those shared during the Public Comment Listening Session, to the respective measure page on the [PQM website](#).

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We received five public comments for the measures this cycle. If a measure received any comments, the [measure’s evaluation summary](#) includes a summary of these comments.

Following the Public Comment Listening Session, we convene the Advisory Group of each E&M project during a public virtual meeting. The purpose of these meetings is to gather initial feedback and questions about the measures under endorsement review. Developers/stewards can share written responses to Advisory Group feedback after these meetings. They can also provide written responses to any public comments received directly on the measure’s webpage. This process ensures comprehensive input and engagement from all stakeholders involved. For the Management of Acute events and Chronic Conditions committee, the Advisory Group convened on [December 8, 2025](#), and we published a summary of the member feedback and developer/steward responses on the [PQM website](#).

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details, including all attachments, the PQM Measure Evaluation Rubric, the staff PAs, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group for review. The Management of Acute Events and Chronic Conditions Recommendation Group convened on [February 4](#) and [February 5](#), 2026. The [Measure Evaluation Summaries](#) section of this report includes brief summaries of the Recommendation Group deliberations and voting results, and the [PQM website](#) has a detailed meeting summary.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the staff PAs. Measure developers/stewards attend endorsement meetings to provide a measure overview and answer questions from the Recommendation Group.

The Recommendation Group then considers the various inputs and renders a final endorsement decision via a vote. If the Recommendation Group has 20 or more members, consensus is 75% or greater agreement among all active, non-recused Recommendation Group members (Table 3). If the group has fewer than 20 members, the threshold for agreement is 70%. Maintenance measures that fail to reach the 75% consensus threshold but receive between 60% and 74% of votes to retain endorsement (i.e., endorse and/or endorse with conditions) are reconsidered at the end of the endorsement meeting. If the consensus threshold is 70%, maintenance measures are reconsidered if they receive between 60% and 69% of votes to retain endorsement. If the Recommendation Group does not reach consensus via vote after the reconsideration discussion, then the measure loses endorsement.

Table 3. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	<p>Applies to new and maintenance measures.</p> <p>The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to endorse the measure.</p>	<p>Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (see Evaluations for Endorsement Maintenance for more details).[±] Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has</p>

Decision Outcome	Description	Maintenance Expectations
		been more than 6 years since the measure’s date of last endorsement.
Endorsed with Conditions*	<p>Applies to new and maintenance measures.</p> <p>The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) that the measure can be endorsed as it meets the criteria, but committee reviewers have conditions they would like addressed when the measure comes back for maintenance. If the developer/steward has not addressed these recommendations, they should provide a rationale for the E&M committee to consider.</p>	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (see Evaluations for Endorsement Maintenance for more details). [±] Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure’s date of last endorsement.
Not Endorsed [°]	<p>Applies to new measures only. The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to not endorse the measure.</p>	None.
Endorsement Removed [°]	<p>Applies to maintenance measures only.</p> <p>Either:</p> <ul style="list-style-type: none"> • The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time). 	None.

[±] Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed (see [Emergency/Off-Cycle Reviews](#) for more details).

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** The E&M committee determines the conditions, with the consideration of what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

°Measures that fail to reach the consensus threshold are not endorsed.

The “Endorsed with Conditions” category serves as a means of endorsing a measure but with conditions set by the Recommendation Group. These conditions take into consideration what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, Battelle posts committee endorsement decisions and associated rationales to the PQM website for 3 weeks for the appeals period. During this time, any interested party may request an appeal regarding any E&M committee endorsement decision.

In the case of a measure being endorsed or endorsed with conditions, the appeal must:

- Cite evidence of the appellant’s interests that are directly and materially affected by the measure, and provide evidence that the CBE’s endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or show that the E&M committee did not consider information that was available by the cycle’s Intent to Submit deadline and that information is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The committee did not apply the CBE measure evaluation criteria appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The committee did not follow the CBE E&M process. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If Battelle determines that an appeal is eligible, we convene the Appeals Committee, consisting of the co-chairs from all five E&M project committees (n=10), to review and discuss the appeal. The Appeals Committee concludes its review by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is 75% or greater agreement via a vote among members.

For the Fall 2025 cycle, the appeals period opened on February 25 and closed on March 17, 2025. The measures reviewed by Management of Acute Events and Chronic Conditions committee did not receive any appeals.

Initial Recognition and Management Measure Evaluation

For this measure review cycle, the Initial Recognition and Management committee evaluated 26 measures undergoing maintenance review against standard [measure evaluation criteria](#). During the Recommendation Group endorsement meeting, the committee voted to endorse 21 measures and to endorse five measures with conditions (Table 4).

Table 4. Number of Fall 2025 Initial Recognition and Management Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	26	0	0
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	26	0	26
Number of measures endorsed	21	0	21
Number of measures endorsed with conditions	5	0	5
Number of measures not endorsed/ endorsement removed	0	0	0

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting.*

Summary of Potential High-Priority Gaps

During the committee’s evaluation of the measures, committee members identified gap areas that are summarized below for future development and endorsement considerations.

Pediatric Measurement

Across CG-CAHPS child composites, committee members called for stronger pediatric measurement. The Advisory Group also asked for clearer attention to age distinctions (younger children vs. adolescents) and noted that parents often expect faster access for pediatric care; members encouraged stratification options and additional pediatric stakeholder input to ensure items reflect real-world pediatric expectations and workflows.

Care Settings & Modalities

Committee members urged a more complete capture of where care occurs and how it is delivered. They emphasized the importance of ensuring proportional inclusion of telehealth in sampling and reporting, identifying the site of care (urgent care, emergency department [ED], primary care) to sharpen actionability for access composites, and recognizing portal-based “follow-up” as acceptable when it includes meaningful interpretation. For HP-CAHPS, committee

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members highlighted under-measured digital front-door experiences (e.g., pre-contact wait time, phone-tree/interactive voice response [IVR] burden, chatbots, website/billing navigation) and asked for optional supplemental items and clearer case-mix guidance so plans can diagnose bottlenecks and compare fairly across diverse enrollee populations.

Summary of Major Concerns

The following summary of the measure evaluation highlights the major concerns the committee considered.

Child-Specific Accountable-Entity Testing

Across the CG-CAHPS set, the committee's central concern was that child measures must be supported by pediatric-specific, accountable-entity reliability and validity testing rather than extrapolated from adult evidence. Members emphasized that children are not "little adults" and called out gaps in entity-level testing for every child composite (Access, Provider Communication, Office Staff, Care Coordination) and the single-item Rating of Provider. Of note, a public comment from the American Medical Association (AMA) echoed these concerns, flagging reliance on adult data and missing measure-score testing for the child versions.

As a result, the Recommendation Group endorsed all five child CG-CAHPS measures with conditions, requiring developers to return at 3-year maintenance with pediatric, entity-level empirical evidence (reliability and validity) to substantiate the child constructs and support fair comparisons. Committee discussion suggested methods such as factor analysis and clearer documentation of pediatric stakeholder input, and several members asked for age-sensitive interpretation (e.g., younger children vs. adolescents) to ensure the measures reflect real-world pediatric care. Together, these actions and conditions signal that closing the pediatric evidence gap is a high-priority prerequisite for continued endorsement of the child CG-CAHPS portfolio.

Summary of Methodological Issues

The following brief summaries of the measure evaluation highlight the methodological issues the committee considered.

Case-Mix Adjustment

For CG-CAHPS and HP CAHPS, the staff assessments rated Reliability "Not Met but Addressable" due to reliance on unadjusted data. Committee members repeatedly asked when and how to apply case-mix adjustment. The developer stated that, based on prior analyses, adjusted and unadjusted rates are generally similar; however, they recommend applying case-mix adjustment whenever comparing sites/entities, and they noted they can provide adjusted reliability results in a future maintenance submission.

Small Denominators

For CG-CAHPS, committee members flagged reliability analyses with very small minimum site samples (≈ 10 completes). They encouraged the developer to provide strengthened entity-level testing where prior samples were small (practice level).

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For HP CAHPS, the committee considered potential denominator constraints (e.g., the Customer Service composite only included beneficiaries who contacted a customer service representative or for the Rating of Specialist composite, that fewer members see specialists). To mitigate reliability loss, the developer advised plans to oversample eligible members (e.g., those who contacted customer service or saw a specialist) when using results for accountability. They also noted that electronic interactions, not just phone calls, count as customer-service contacts, which adds more eligible encounters. In addition, they pointed out that while the Agency for Healthcare Research and Quality (AHRQ) database accepts submissions without a formal minimum, plans should target ≥ 300 respondents for stable plan-level estimates (with low counts otherwise depressing reliability).

Measure Evaluation Summaries

CBE #0005 (Instrument Only) – Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS), Version 3.1 [Westat/Agency for Healthcare Research and Quality (AHRQ)] – Maintenance

[Specifications](#) | [Comment Summary Guide](#)

Description: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey 3.1 (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 6 months. CG-CAHPS Survey Version 1.0 was endorsed by NQF³ in July 2007 (NQF #0005) and version 2.0 received maintenance endorsement in early 2015. Version 3.0 was released in July 2015 and was last endorsed in 2019. The 3.1 version of the survey updates the 3.0 version to prompt respondents to consider in-person, phone, and video visits when they answer the questions and to report which type(s) of visits they had. The survey is part of the CAHPS family of patient experience surveys and is available at <https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html>

- The Adult CG-CAHPS Survey 3.1 is administered to patients aged 18 and over who had at least one visit to a selected provider during the past 6 months. The survey has 32 questions including one overall rating of the provider and 12 questions used to create four (4) composite measures.
- The Child CG-CAHPS Survey 3.1 is administered to the parents or guardians of pediatric patients under the age of 18. The survey has 40 questions including one overall rating of the provider and 11 questions used to create four (4) composite measures.
- The composite measures are:
 - Getting Timely Appointments, Care, and Information (Access)
 - How Well Providers Communicate With Patients (Provider Communication)
 - Helpful, Courteous, and Respectful Office Staff (Office Staff)
 - Providers' Use of Information to Coordinate Patient Care (Care Coordination)
- The survey also has a single-item rating measure:
 - Rating of Provider
- A guidance document is available on the AHRQ CAHPS website (<https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance...>) which explains how to administer the survey, including how to choose the sample, maintain confidentiality, collect the data, track returned questionnaires, and calculate the response rate.

Summary of Public Comments: There were no public comments.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure in the Spring 2019 cycle. CMS's Public Reporting and Regulatory and Accreditation Programs currently use the measure.

Discussion Topic/Theme	Committee Discussion Summary
Survey Administration	<ul style="list-style-type: none"> • Advisory and Recommendation Group members raised concern about survey length and asked about various survey administration modes (such as email/text/web). • The developer explained that the survey now allows web/email distribution, but mail must remain an available option for patients without digital access.
Data Security	<ul style="list-style-type: none"> • The Advisory Group requested details on data-security standards. • The developer shared that surveys are independently administered through health plans, state agencies, medical groups, or health systems.
Design and Methodology	<ul style="list-style-type: none"> • A patient representative suggested the developer consider a 5-point Likert scale, believing it would more meaningfully reflect the nuance of patient experience. • The developer said they have conducted extensive research to ensure patients do not feel they are being “forced” into a response, which is also why they do not use binary response options. (Of note, most of the questions in the CG-CAHPS have four response options: always, usually, sometimes, and never.) • Another committee member and the patient co-chair added that they had not found evidence that shows CAHPS patients prefer a 5-point scale and that the current scale is well validated. • The committee raised concerns about possible manipulation of sampling. • The developer shared that vendors conduct sampling from full patient lists from the provider, and if those patient lists look small relative to the provider’s patient population, this would raise concerns for the vendor.

Appeals: None

CBE #0005-1 (Adult) and 0005-6 (Child) – CG-CAHPS Survey – Getting Timely Appointments, Care, and Information (Access) [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0005-1 (Adult) Description: The Adult CG-CAHPS Survey Getting Timely Appointments, Care, and Information (Access) composite measure assesses patients’ experiences with how often they got appointments for care as soon as needed and got timely answers to questions when they called the office.

0005-6 (Child) Description: The Child CG-CAHPS Survey Getting Timely Appointments, Care, and Information (Access) composite measure assesses experiences with how often they got

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appointments for care as soon as the child needed and got timely answers to questions when they called the office.

0005-1 (Adult) Committee Vote: Endorse

0005-1 (Adult) Vote Count: Endorse (15 votes; 79%), Remove Endorsement (4 votes; 21%), Recusals (0).

0005-6 (Child) Committee Vote: Endorse with Conditions

0005-6 (Child) Vote Count: Endorse (2 votes; 11%), Endorse with Conditions (13 votes, 72%), Remove Endorsement (3 votes; 17%), Recusals (0).

0005-6 (Child) Conditions: When this measure comes back for maintenance (3 years), the developer should:

- Provide entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Summary of Public Comments: These measures received two comments. The AMA stated that the child survey and corresponding measures lack performance data and reliability/validity testing, rely on extrapolated adult data, and omit required measure score-level testing. They concluded the measures do not meet the minimum endorsement criteria and that endorsement should be reconsidered until these issues are addressed. Another commenter stated that patients are confused by the term “provider,” often thinking it refers only to medical doctors. They recommended updating the terminology to reduce confusion.

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> • The Advisory Group highlighted the subjectivity of “as soon as needed” and same-day response expectations (e.g., messages sent late in the day), and the differences between primary vs. specialty care access; they suggested clearer phrasing and differentiation of urgent vs. routine scenarios. • The developer pointed to cognitive testing (including readability) and emphasized the 6-month recall and frequency scale (“always/usually/sometimes/never”) are designed to capture overall patterns rather than single encounters.
Provider Actionability	<ul style="list-style-type: none"> • Advisory Group members expressed concern that the measure results could penalize individual clinicians for system-level constraints (e.g., scheduling capacity, policies). • The Recommendation Group echoed concerns about system controllability but emphasized the value of elevating the patient voice on access to inform leadership action. • The developer agreed the results are intended to surface system-level access issues organizations can address (e.g., capacity, workflows).

Discussion Topic/Theme	Committee Discussion Summary
	<ul style="list-style-type: none"> Recommendation Group members suggested adding more recent evidence of improvement strategies tied to survey findings, as providing demonstrated relevance may influence practices when they decide which strategies to use.
<p>Child vs. Adult Data</p>	<ul style="list-style-type: none"> Advisory Group members asked if parents hold higher standards for childcare and want faster access. The developer noted earlier development work suggested parents do set higher standards and that 2016 data showed higher child scores than adult scores. A public comment asserted the child composite lacks accountable-entity (measure-score) reliability/validity testing, relies on extrapolated adult data, and therefore does not meet minimum endorsement criteria. Recommendation Group members urged the developer to provide child-specific empirical testing and recommended working with child advocacy groups to either establish face validity or collect data. Based on the discussions and feedback, the Recommendation Group voted to impose the following condition on measure 0005-6: when the measure returns for maintenance endorsement (3 years), the developer would have provided entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Appeals: None

Additional Recommendations for the Developer/Steward: A Recommendation Group member stated that the survey’s actionability could be improved by the developer providing better user information.

CBE #0005-2 (Adult) and 0005-7 (Child) – CG-CAHPS Survey – How Well Providers Communicate with Patients (Provider Communication) [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0005-2 (Adult) Description: The Adult CG-CAHPS Survey How Well Providers Communicate with Patients (Provider Communication) composite measure assesses patients’ experiences with how often their providers explained things clearly, listened carefully, showed respect, and spent enough time with the patient.

0005-7 (Child) Description: The Child CG-CAHPS Survey How Well Providers Communicate with Patients (Provider Communication) composite measure assesses experiences with how often their child’s providers explained things clearly, listened carefully, showed respect, and spent enough time with the child.

0005-2 (Adult) Committee Vote: Endorse

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0005-2 (Adult) Vote Count: Endorse (16 votes; 89%), Remove Endorsement (2 votes; 11%), Recusals (0).

0005-7 (Child) Committee Vote: Endorse with Conditions

0005-7 (Child) Vote Count: Endorse (4 votes; 22%), Endorse with Conditions (13 votes, 72%), Remove Endorsement (1 vote; 6%), Recusals (0).

0005-7 (Child) Conditions: When this measure comes back for maintenance (3 years), the developer should:

- Provide entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Summary of Public Comments: [See #0005-1 and #0005-6.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Respondent Perceptions	<ul style="list-style-type: none"> • The Advisory Group discussed how patients often struggle to absorb complex information in a single provider visit and suggested considering post-diagnosis check-ins, plainer language, examples, and explicitly referencing the provider’s team to align with modern care models. • The Recommendation Group echoed the Advisory Group’s concerns, noting that one visit often is not sufficient to reach a point of resolution or clarity. They suggested incorporating more recommendations for how providers can efficiently communicate with patients. • The developer clarified the composite captures experiences over 6 months (not a single encounter), that the survey anchors items to the provider named in Question 1, and that practices can add Patient-Centered Medical Home supplemental items to explicitly reflect team-based care.
Provider Actionability	<ul style="list-style-type: none"> • The Advisory Group felt that this survey item was more actionable for clinicians than the Access composites (0005-1 and 0005-6) because clinicians can control communication. • A few Recommendation Group members agreed with the Advisory Group; yet others cautioned that interpretability can vary and asked the developer to supply clearer, evidence-based improvement tactics and explanations for limited improvement trends. • The developer emphasized that they designed the measures to be actionable and added that a health system has already used these measures to improve provider communication.
Child vs. Adult Data	<ul style="list-style-type: none"> • See CBE #0005-1/CBE# 0005-6.

Discussion Topic/Theme	Committee Discussion Summary
	<ul style="list-style-type: none"> The Advisory and Recommendation Group discussed how distinctions between small children and teenagers may affect communication experiences. They asked whether the measure collects and reports age. Based on this discussion, the Recommendation Group voted to impose the following condition on measure 0005-7: when the measure returns for maintenance endorsement (3 years), the developer would have provided entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Appeals: None

CBE #0005-3 (Adult) and 0005-8 (Child) – CG-CAHPS Survey – Helpful, Courteous, and Respectful Office Staff (Office Staff) [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0005-3 (Adult) Description: The Adult CG-CAHPS Survey Helpful, Courteous, and Respectful Office Staff (Office Staff) composite measure assesses patients' experiences with how often office staff were helpful and treated them with courtesy and respect.

0005-8 (Child) Description: The Child CG-CAHPS Survey Helpful, Courteous, and Respectful Office Staff (Office Staff) composite measure assesses experiences with how often office staff were helpful and treated them with courtesy and respect.

0005-3 (Adult) Committee Vote: Endorse

0005-3 (Adult) Vote Count: Endorse (13 votes; 81%), Remove Endorsement (3 votes; 19%), Recusals (0).

0005-8 (Child) Committee Vote: Endorse with Conditions

0005-8 (Child) Vote Count: Endorse (3 votes; 19%), Endorse with Conditions (11 votes, 69%), Remove Endorsement (2 votes; 13%), Recusals (0).

0005-8 (Child) Conditions: When this measure comes back for maintenance (3 years), the developer should:

- Provide entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Summary of Public Comments: [See #0005-1 and #0005-6.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS's Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
<p>Clarity and Survey Administration</p>	<ul style="list-style-type: none"> • The Advisory Group discussed the impact of digital check-ins and suggested using clearer phrasing to better associate survey responses to in-office staff and first impressions. One Advisory Group member also inquired whether these surveys refer to one visit or multiple visits within a certain time period. • A few Recommendation Group members, including a patient representative, agreed that terminology clarity is important for interpretability and comparability across practices. • The developer shared that not all practices use digital check-ins, and the surveys capture patients' experiences with clerks and receptionists in person in the office. The developer added that they have conducted cognitive testing on the survey wording and monitor the terminology for refinement, as needed.
<p>Meaningfulness to Patients</p>	<ul style="list-style-type: none"> • Several Recommendation Group members debated the meaningfulness of these measures to patients. A few patient representatives said that if the developer and CMS want to remove items to reduce burden and cost, that is fine, because these measures are likely not as meaningful to patients as others. However, other patient representatives, including the patient co-chair, disagreed, saying that even if a patient likes their provider, if they cannot interact positively with the front-office staff, they are likely to leave the practice; they highlighted that studies support the importance of this concept. • The developer noted they are constantly evaluating whether all items are necessary while considering how to shorten the survey. While these measures may not reflect "core" clinical concepts, they are important to providers and patients. • An Advisory Group member shared that these questions are well-received by providers and health systems and resonate strongly with Medicare members because check-in/check-out book end the visit experience.
<p>Provider Actionability</p>	<ul style="list-style-type: none"> • While the Advisory Group said they felt these measures were actionable, a Recommendation Group member expressed concern that the measures may not be actionable in all settings. They highlighted that providers in a larger health care setting may have less influence on how front-office staff are trained. • The developer stated they designed the measures to be actionable and that larger health care systems still receive feedback, but that their approach to implementing changes would simply be different than a smaller organization. They also noted the CAHPS improvement resources and shared examples of systems that used results to train front-office staff and adjust workflows.
<p>Child vs. Adult Data</p>	<ul style="list-style-type: none"> • See CBE #0005-1/CBE# 0005-6. • The Advisory Group and Recommendation Group emphasized that what is important to children may differ from what is important to adults. • Based on this discussion, the Recommendation Group voted to impose the following condition on measure 0005-8: when the measure returns for maintenance endorsement (3 years), the developer would have provided

Discussion Topic/Theme	Committee Discussion Summary
	entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Appeals: None

CBE #0005-4 (Adult) and 0005-9 (Child) – CG-CAHPS Survey – Providers’ Use of Information to Coordinate Patient Care (Care Coordination) [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0005-4 (Adult) Description: The Adult CG-CAHPS Survey Providers’ Use of Information to Coordinate Patient Care (Care Coordination) composite measure assesses patients’ experiences with how often their providers knew their medical history, followed up to give results of tests, and asked about prescription medications being taken.

0005-9 (Child) Description: The Child CG-CAHPS Survey Provider’s Use of Information to Coordinate Patient Care (Care Coordination) composite measure assesses experiences with how often providers knew the child’s medical history and followed up to give results of tests.

0005-4 (Adult) Committee Vote: Endorse

0005-4 (Adult) Vote Count: Endorse (13 votes; 81%), Remove Endorsement (3 votes; 19%), Recusals (0).

0005-9 (Child) Committee Vote: Endorse with Conditions

0005-9 (Child) Vote Count: Endorse (3 votes; 19%), Endorse with Conditions (10 votes, 63%), Remove Endorsement (3 votes; 19%), Recusals (0).

0005-9 (Child) Conditions: When this measure comes back for maintenance (3 years), the developer should:

- Provide entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Summary of Public Comments: [See #0005-1 and #0005-6.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> • The Advisory Group discussed how larger practices rely on patient portals for test results and messaging and asked what counts as “follow-up.” The developer clarified that a phone call is not required; portal communication is acceptable as long as it includes meaningful interpretation of results. • The Advisory Group also commented that “important information about your medical history” can be interpreted differently by patients, making it hard for providers to know what to improve. The developer acknowledged the phrase can feel vague and stated they would bring the feedback to the CAHPS Consortium for potential refinement. • The Advisory Group further asked whether other composites could incorporate the care coordination concepts to reduce burden. The developer explained the composite was designed as a low-burden, three-item measure; including the items elsewhere would not shorten the survey and could introduce scale inconsistencies. • The Recommendation Group highlighted medication safety as a coordination priority, noting that medication errors contribute to many emergency admissions, particularly among Medicare beneficiaries with polypharmacy. The Advisory Group and Recommendation Group recommended that coordination discussions explicitly include all medications—prescriptions, over-the-counter (OTC) medications, and supplements. The developer said the item captures discussions around what medications the patient is taking to avoid interactions.
Small Practice Feasibility	<ul style="list-style-type: none"> • A few Recommendation Group members expressed concern that these measures may not be feasible for small practices, because of the time, cost, and potential EHR requirements necessary to gather needed data. • The developer highlighted that the measures focus on the patient perception of their experience rather than system interoperability; improvement can focus on visit preparedness, results communication with interpretation, and medication-review workflows even without advanced EHR tools.
Provider Actionability	<ul style="list-style-type: none"> • The Advisory Group asked how practice-level composites relate to the overall provider rating and whether practice-level reporting risks misattribution to individual clinicians. The developer explained they report correlations at the practice and individual-respondent levels (not individual clinician due to lack of identifiers), showing how composites relate to provider ratings for individuals.
Redundancy	<ul style="list-style-type: none"> • The Recommendation Group asked if the concepts covered under these measures could be incorporated into other measures. • The developer said they developed the most low-burden measurement of what would reflect care coordination for patients. They noted that these measures are only three questions and that incorporating them into other measures would not reduce the overall length of the survey and could potentially be confusing, as some of the measures have different scales.
Child vs. Adult Data	<ul style="list-style-type: none"> • See CBE #0005-1/CBE# 0005-6.

Discussion Topic/Theme	Committee Discussion Summary
	<ul style="list-style-type: none"> Based on this discussion, the Recommendation Group voted to impose the following condition on measure 0005-9: when the measure returns for maintenance endorsement (3 years), the developer would have provided entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Appeals: None

CBE #0005-5 (Adult) and 0005-10 (Child) – CG-CAHPS Survey – Rating of the Provider [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0005-5 (Adult) Description: The Adult CG-CAHPS Survey Rating of the Provider measure assesses the patient’s overall rating of their provider on a scale of 0 to 10, with 0 being the worst and 10 being the best.

0005-10 (Child) Description: The Child CG-CAHPS Survey Rating of the Provider measure assesses the overall rating of the child’s provider on a scale of 0 to 10, with 0 being the worst and 10 being the best.

0005-5 (Adult) Committee Vote: Endorse

0005-5 (Adult) Vote Count: Endorse (12 votes; 75%), Remove Endorsement (4 votes; 25%), Recusals (0).

0005-10 (Child) Committee Vote: Endorse with Conditions

0005-10 (Child) Vote Count: Endorse (2 votes; 13%), Endorse with Conditions (13 votes, 81%), Remove Endorsement (1 vote; 6%), Recusals (0).

0005-10 (Child) Conditions: When this measure comes back for maintenance (3 years), the developer should:

- Provide entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Summary of Public Comments: [See #0005-1 and #0005-6.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
<p>Future Survey Considerations</p>	<ul style="list-style-type: none"> • The Advisory Group observed that respondents—especially seniors—may forget the named provider by the time they reach the overall rating and recommended auto-inserting the provider’s name again to keep responses anchored. • The developer acknowledged the recall/anchoring feedback, noted that Question 1 names “this provider” and instructs respondents to consider that provider throughout, and committed to explore ways to reinforce the anchor in future iterations. • The Recommendation Group discussed the most appropriate scale for these measures. A Recommendation Group patient partner advocated for a 5-point Likert scale. Several other committee members, including the patient co-chair, expressed support for the current 10-point scale. • The developer said they tested several scales across many different populations and modes. They found that the selected scale works well and patients indicate it captures their experiences; however, they noted they will continue to revisit and explore the scales.
<p>Provider Actionability</p>	<ul style="list-style-type: none"> • The Recommendation Group referenced the staff assessment that rated Use & Usability as “Not Met but Addressable,” citing limited improvement in scores (2015-2023) and asked for clearer, evidence-based improvement tactics tied to score changes. • The developer and committee co-chairs pointed out that while national/top-box movement may appear modest across ~2,500 sites, organizations use results for site-level interventions (e.g., coaching, feedback), and there is no better alternative single-item global rating to replace this signal today. • The developer further indicated the measure continues to be used across programs and settings and pointed to the broader CAHPS improvement resources that compile published studies and practical guidance for using results to improve care.
<p>Child vs. Adult Data</p>	<ul style="list-style-type: none"> • See CBE #0005-1/CBE# 0005-6. • Based on this discussion, the Recommendation Group voted to impose the following condition on measure 0005-9: when the measure returns for maintenance endorsement (3 years), the developer would have provided entity-level empirical testing of reliability and validity using child survey data to support the extrapolation argument.

Appeals: None

CBE #0006 (Instrument Only) – Consumer Assessment of Healthcare Providers and Systems Health Plan Survey (HP CAHPS), Version 5.1 [Westat/AHRQ] – Maintenance

[Specifications](#) | [Comment Summary Guide](#)

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Description: The CAHPS Health Plan (HP CAHPS) Survey is a survey that asks health plan enrollees to report about their care and health plan experiences as well as the quality of care received from physicians. HP CAHPS Version 4.0 was endorsed by NQF in July 2007, and Version 5.0 received maintenance endorsement in January 2015 and was last endorsed in Spring 2019 (CBE #0006). The 5.1 version of the CAHPS Health Plan Survey, released in the fall of 2020, explicitly asks about respondents' experiences with care received in person, by phone, and by video to account for changes in care due to the pandemic. The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at <https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html>.

The Adult CAHPS Health Plan Survey is designed to be administered to includes individuals 18 years and older who have been enrolled in a health plan and have received care for a specified period (6 months or longer for Medicaid version, 12 months or longer for Commercial version) with no more than one 30-day break in enrollment. The CAHPS Adult Health Plan Survey has 39 items. Ten (10) of the survey items are used to form 4 composite measures. The survey also has 4 single-item rating measures.

The Child CAHPS Health Plan Survey is designed to be administered to parents or guardians of children aged 0-17 who have been enrolled in a health plan and have received care for a specified period (6 months or longer for Medicaid version, 12 months or longer for Commercial version) with no more than one 30-day break in enrollment. The CAHPS Child Health Plan Survey has 41 items. Eleven (11) of the survey items are used to form 4 composite measures. The survey also has 4 single-item rating measures.

The composite measures are:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Customer Service

The survey also has 4 single-item rating measures:

- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Care
- Rating of Health Plan

The only difference between the Medicaid and commercial versions of the CAHPS Health Plan Survey is the reference period: 6 months for Medicaid enrollees and 12 months for commercial enrollees.

A guidance document is available on the AHRQ CAHPS website (<https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html>) which explains how to field the CAHPS Health Plan Survey and gather the data needed for analysis and reporting. It provides instructions and advice related to the following topics: constructing the sampling frame, choosing the sample, maintaining confidentiality, collecting the data, tracking returned questionnaires, and calculating the response rate.

Summary of Public Comments: There were no public comments.

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Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Spring 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Recall Period Difference	<ul style="list-style-type: none"> • Advisory Group members asked why the recall period is different for the Medicaid and commercial versions of the survey. Another member inquired about the 6-month interval for health plans, as many enrollees may only interact with care once a year. • The developer explained that they updated the Medicaid version of the survey to change the recall period and that CAHPS surveys commonly use a 6-month recall period because respondents have difficulty remembering a full year.
Patient Meaningfulness	<ul style="list-style-type: none"> • The Recommendation Group debated whether plan-level CAHPS results are meaningful to patients. Some members questioned the importance of global ratings; others emphasized that HP CAHPS is one of the few standardized, patient-voice signals for plans used in reporting and accountability. The patient co-chair further said they found this survey to be a powerful reflection of the voice of patients. • The developer underscored ongoing use of HP CAHPS in public reporting and programs and noted that v5.1 reflects current care patterns, helping ensure the measure set continues to capture patient experience across modalities.
Scale and Response Options	<ul style="list-style-type: none"> • The Advisory Group voiced concern that the questions with a 0-10 response scale may feel subjective and less actionable and could be perceived as unfair across contexts; members asked whether clearer anchors might improve inconsistent interpretability. • The developer responded that prior CAHPS testing shows respondents do not have difficulty using the 0-10 scale and that retaining it preserves benchmarking consistency across CAHPS applications and programs.
Accountability and Actionability	<ul style="list-style-type: none"> • The Advisory Group and the Recommendation Group questioned how much health plans can directly influence aspects that often occur in provider offices, such as access or clinician communication. Several members nonetheless noted plans act on results by addressing network adequacy and contracting decisions. • The developer explained they designed the instrument for plan-level accountability. It intentionally captures experiences tied to plans’ networks and member services; plans can add supplemental items or integrate claims to pinpoint where to intervene. • The Recommendation Group asked for clearer, plan-actionable strategies and more specificity in the instrument logic model linking inputs to outcomes; members suggested that greater specificity could sharpen improvement guidance. • The developer responded that core items are intentionally generic to apply across programs and populations. Plans commonly use supplemental item

Discussion Topic/Theme	Committee Discussion Summary
	<p>sets (or locally developed questions) to target problem areas identified by the core instrument.</p> <ul style="list-style-type: none"> The Recommendation Group encouraged the developer to strengthen the logic model by specifying pathways from plan actions (e.g., network design, member services) to patient experience outcomes and to provide more up-to-date evidence to support continued use. The developer acknowledged the request and pointed to ongoing instrument review through the CAHPS Consortium.
Case Mix Adjustment	<ul style="list-style-type: none"> A Recommendation Group member asked why the corresponding measures do not adjust based on case mix. The developer noted that while case-mix adjustment is not inherent to the instrument, they do provide analytic results and computational tools for entities to case mix adjust, as needed. As such, CMS does adjust for several characteristics, including entities that serve disadvantaged populations.

Appeals: None

CBE #0006-1 (Adult) and 0006-9 (Child) – HP CAHPS Survey – Getting Needed Care [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-1 (Adult) Description: The Adult HP CAHPS Survey Getting Needed Care composite measure assesses enrollees’ experiences with how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan.

0006-9 (Child) Description: The Child HP CAHPS Survey Getting Needed Care composite measure assesses how often it was easy for enrollees to get appointments for their child with specialists and get the care, tests, or treatment the child needed through their health plan.

0006-1 (Adult) Committee Vote: Endorse

0006-1 (Adult) Vote Count: Endorse (16 votes; 89%), Remove Endorsement (2 votes; 11%), Recusals (0).

0006-9 (Child) Committee Vote: Endorse

0006-9 (Child) Vote Count: Endorse (17 votes; 94%), Remove Endorsement (1 vote; 6%), Recusals (0).

Public Comments: The 0006 measures received one public comment from the AMA. The AMA expressed concern that the developer did not provide measure score-level testing for composite

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measures and that several adult and child composites show Cronbach's α below 0.7, which is less than desirable. They conclude the minimum endorsement criteria are not met and recommend reconsidering endorsement until these issues are addressed.

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS's Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> The Advisory Group suggested capturing where patients obtained needed care (e.g., urgent care, ED, primary care) to improve actionability. The developer noted plans can include supplemental questions and already use claims data to identify settings of care. The Recommendation Group asked the developer to provide clearer, evidence-based improvement tactics that plans can act on, along with explicit case-mix guidance for fair comparisons across plans.
Reliability	<ul style="list-style-type: none"> Public comment from the AMA expressed concern that some composites show Cronbach's α below 0.7 and that the developer did not provide measure-score-level testing for certain composites. The Recommendation Group observed that, while the developer performed the required reliability testing, the staff assessment flagged reliance on some unadjusted analyses and minimum sample sizes that may be small for certain plans. Members questioned whether case mix adjustment and minimum sample size parameters consistently support plan-level reliability across use cases. The developer indicated that case-mix adjustment typically has a modest effect on scores but is recommended for comparisons; plans may oversample relevant subgroups (e.g., members who sought specialty care) to improve precision.
Accountability	<ul style="list-style-type: none"> See CBE #0006.
Health Plan Influence and Actionability	<ul style="list-style-type: none"> See CBE #0006. The Recommendation Group echoed actionability concerns but emphasized that plans are held accountable for their network design and member experience, and that HP CAHPS provides a rare, standardized patient-voice signal at the plan level. One member expressed concern that the measures do not account for harms done to patients through delayed appointments, limits to services and medications, and changes in provider coverage.

Appeals: None

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CBE #0006-2 (Adult) and 0006-10 (Child) – HP CAHPS Survey – Getting Care Quickly [Westat/AHRQ] – Maintenance
[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-2 (Adult) Description: The Adult HP CAHPS Survey Getting Care Quickly composite measure assesses enrollees’ experiences with how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

0006-10 (Child) Description: The Child HP CAHPS Survey Getting Care Quickly composite measure assesses enrollees’ experiences with how often their child got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

0006-2 (Adult) Committee Vote: Endorse

0006-2 (Adult) Vote Count: Endorse (18 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

0006-10 (Child) Committee Vote: Endorse

0006-10 (Child) Vote Count: Endorse (18 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> The Advisory Group suggested capturing the setting of care (e.g., urgent care, ED, primary care) to improve actionability. The developer noted that plans may add supplemental questions to capture setting and already use claims data to identify where members go for urgent vs. routine needs.
Digital Tools	<ul style="list-style-type: none"> The Advisory Group and the Recommendation Group discussed telehealth and digital access. The developer confirmed the measures include telehealth; members cautioned against conflating telehealth with rural care and noted digital access disparities among vulnerable populations. The developer added that CAHPS research overall shows slight differences in patient experience for rural vs. urban settings, with a slightly better experience in rural settings.
Reliability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Health Plan Influence and	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.

Discussion Topic/Theme	Committee Discussion Summary
Accountability	

Appeals: None

CBE #0006-3 (Adult) and 0006-11 (Child) – HP CAHPS Survey – How Well Doctors Communicate [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult):** None

***Substantive Changes (Child):** None

0006-3 (Adult) Description: The Adult HP CAHPS Survey How Well Doctors Communicate composite measure assesses enrollees’ experiences with how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them.

0006-11 (Child) Description: The Child HP CAHPS Survey How Well Doctors Communicate composite measure assesses enrollees’ experiences with how often their child’s personal doctor explained things clearly both to the parent and to the child, listened carefully, showed respect, and spent enough time with the child.

0006-3 (Adult) Committee Vote: Endorse

0006-3 (Adult) Vote Count: Endorse (17 votes; 94%), Remove Endorsement (1 vote; 6%), Recusals (0).

0006-11 (Child) Committee Vote: Endorse

0006-11 (Child) Vote Count: Endorse (17 votes; 94%), Remove Endorsement (1 vote; 6%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> The Advisory Group suggested that members’ definitions of “effective communication” may differ by mode (in-person/phone/video/portal) and that practical guidance (e.g., teach-back, plain-language techniques) can improve comprehension, especially after emotionally charged news. The developer reiterated that items capture experiences over the past 6 months (not a single encounter) and that plans can add supplemental items to probe team-based care or modality-specific issues when deeper diagnostics are needed.

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Discussion Topic/Theme	Committee Discussion Summary
	<ul style="list-style-type: none"> The Advisory Group asked whether the term “doctor” accurately captures members’ experiences given many see nurse practitioners (NPs) or physician assistants (PAs) and whether skipping “personal doctor” items could miss experiences for members primarily seeing NP/PAs. The developer explained that the survey first asks whether the enrollee has a “personal doctor” (defined as the person they would see for a checkup, for advice, or when sick/hurt). Respondents who answer “no” skip these items; some respondents consider an NP/PA their personal doctor under this definition.
Reliability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Health Plan Influence and Accountability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Patient Meaningfulness	<ul style="list-style-type: none"> See CBE #0006.

Appeals: None

CBE #0006-4 (Adult) and 0006-12 (Child) – HP CAHPS Survey – Health Plan Customer Service [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult):** None

***Substantive Changes (Child):** None

0006-4 (Adult) Description: The Adult HP CAHPS Survey Health Plan Customer Service composite measure assesses enrollees’ experiences with how often customer service staff were helpful and treated them with courtesy and respect.

0006-12 (Child) Description: The Child HP CAHPS Survey Health Plan Customer Service composite measure assesses enrollees’ experiences with how often customer service staff were helpful and treated them with courtesy and respect.

0006-4 (Adult) Committee Vote: Endorse

0006-4 (Adult) Vote Count: Endorse (18 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

0006-12 (Child) Committee Vote: Endorse

0006-12 (Child) Vote Count: Endorse (18 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9](#).

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Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS's Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> • The Advisory Group recommended capturing the digital access experience (e.g., time in phone trees, number of menu selections, chatbots) and broadening scope beyond staff courtesy to the full plan experience (e.g., website navigation, billing), noting that long pre-contact waits can sour interactions even when representatives are courteous. • The developer acknowledged the importance of pre-contact wait time, will share the feedback with the CAHPS Consortium, emphasized that electronic communications (not only phone calls) can count as customer service, and noted that plans can add supplemental items to probe these areas pending any instrument-level updates. • The Recommendation Group, including a patient representative, asked whether respondents consistently understand what “customer service” entails, warning that ambiguous terminology can limit actionability. • The developer said they selected the label after cognitive testing and agreed to document the testing and terminology more fully in future submissions; they acknowledged no single term captures every aspect they aim to measure.
Reliability	<ul style="list-style-type: none"> • See CBE #0006-01/CBE #0006-9. • An Advisory Group member pointed out that the denominator is limited to enrollees who contacted customer service, leading to small and variable denominators and lower reliability in some deciles (around 0.4-0.5) and inquired about approaches to ensure reliability. • The developer confirmed the denominator limitation and said plans could oversample their members to improve reliable estimates.

Appeals: None

CBE #0006-5 (Adult) and 0006-13 (Child) – HP CAHPS Survey – Rating of All Health Care [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-5 (Adult) Description: The Adult HP CAHPS Survey Rating of All Health Care measure assesses the enrollee’s overall rating of all of their health care in the last 6 months from 0 to 10, with 0 being the worst and 10 being the best.

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0006-13 (Child) Description: The Child HP CAHPS Survey Rating of All Health Care measure assesses the enrollee’s overall rating of all of their child’s health care in the last 6 months from 0 to 10, with 0 being the worst and 10 being the best.

0006-5 (Adult) Committee Vote: Endorse

0006-5 (Adult) Vote Count: Endorse (15 votes; 88%), Remove Endorsement (2 votes; 12%), Recusals (0).

0006-13 (Child) Committee Vote: Endorse

0006-13 (Child) Vote Count: Endorse (15 votes; 88%), Remove Endorsement (2 votes; 12%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> A patient representative on the Advisory Group said they found the wording of “best possible” and “worst possible” to be unclear, as the phrases reflect a potential experience and not a patient’s actual experience. The Recommendation Group asked for clearer plan-actionable guidance tied to movements in the global rating (e.g., which operational levers most influence the overall impression), and requested explicit case-mix guidance when comparing plans. The developer agreed to consider additional documentation and to leverage supplemental items where plans want more specificity.
Patient Meaningfulness	<ul style="list-style-type: none"> See CBE #0006. A Recommendation Group patient representative questioned the meaningfulness of this measure. The technical co-chair noted that, even if the measure is not meaningful to patients, it may be driving worthy improvements not transparent at the individual level. The developer noted that, in their psychometric testing, patients have not indicated that they dislike this set of measures; rather, the question allows patients to integrate their experiences with their own weights.
Validity	<ul style="list-style-type: none"> The Advisory Group cautioned against validating composites by their correlation with the overall rating and then validating the overall rating by correlation with those same composites, noting the risk of circular reasoning. The Recommendation Group echoed the need for clearer hypotheses and stronger explanation of mechanisms linking plan actions to changes in the global rating. The developer stated that they use correlations to ensure measures are related but not overly collinear, and they pointed to external literature cited in

Discussion Topic/Theme	Committee Discussion Summary
	the submission linking CAHPS outcomes (including global ratings) to behaviors such as plan selection and adherence.
Reliability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Health Plan Influence and Accountability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.

Appeals: None

CBE #0006-6 (Adult) and 0006-14 (Child) – HP CAHPS Survey – Rating of Personal Doctor [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-6 (Adult) Description: The Adult HP CAHPS Survey Rating of Personal Doctor measure assesses the enrollee’s overall rating of their personal doctor from 0 to 10, with 0 being the worst and 10 being the best.

The rating question is as follows:

- Q16: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

0006-14 (Child) Description: The Child HP CAHPS Survey Rating of a Personal Doctor measure assesses the enrollee’s overall rating of their child’s personal doctor from 0 to 10, with 0 being the worst and 10 being the best.

0006-6 (Adult) Committee Vote: Endorse

0006-6 (Adult) Vote Count: Endorse (15 votes; 88%), Remove Endorsement (2 votes; 12%), Recusals (0).

0006-14 (Child) Committee Vote: Endorse

0006-14 (Child) Vote Count: Endorse (15 votes; 88%), Remove Endorsement (2 votes; 12%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9](#).

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> • The Advisory Group asked how the measures define “personal doctor” in complex care settings and whether the term includes specialty clinicians in addition to primary care. • The developer clarified that the composites focus on the personal/primary doctor (separate items exist for specialists), and that respondents first identify whether they have a personal doctor; those answering “no” skip these items. • The Recommendation Group highlighted that many members primarily see NPs or PAs and asked how the item accounts for those relationships. • The developer explained that respondents may consider an NP/PA as their personal doctor under the survey’s definition (“the person you would see for a checkup, advice, or when sick/hurt”), so the measures capture experiences with NP/PAs when members identify them as the personal clinician.
Reliability	<ul style="list-style-type: none"> • See CBE #0006-01/CBE #0006-9. • The Advisory Group noted that the reliability table shows that some plans have very few respondents who report having a personal doctor, which can depress accountable entity reliability. They asked whether the percentage varies across plans and how non-identification affects ratings. • The developer shared that the AHRQ database accepts submissions without a minimum respondent threshold, so some plans submit with small overall respondent counts, driving low denominators in subsets and lower reliability in some deciles. They shared further guidance recommendations that might impact reliability.
Health Plan Influence and Accountability	<ul style="list-style-type: none"> • See CBE #0006-01/CBE #0006-9.

Appeals: None

CBE #0006-7 (Adult) and 0006-15 (Child) – HP CAHPS Survey – Rating of Specialist [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-7 (Adult) Description: The Adult HP CAHPS Survey Rating of Specialist measure assesses the enrollee’s overall rating of the specialist they talked to most often in the last 6 months from 0 to 10, with 0 being the worst and 10 being the best.

0006-15 (Child) Description: The Child HP CAHPS Survey Rating of Specialist measure assesses the enrollee’s overall rating of their child’s specialist they talked to most often in the last 6 months from 0 to 10, with 0 being the worst and 10 being the best.

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0006-7 (Adult) Committee Vote: Endorse

0006-7 (Adult) Vote Count: Endorse (17 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

0006-15 (Child) Committee Vote: Endorse

0006-15 (Child) Vote Count: Endorse (17 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS's Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Attribution	<ul style="list-style-type: none"> The Advisory Group considered how plans know which specialist is being rated, and a patient representative from the Recommendation Group echoed concerns that patients may not have a clear understanding of which specialist they are being asked to assess or that they might see multiple specialists. The technical co-chair shared that, in practice, plans use claims data to know which specialist a member saw (e.g., the most recent or most frequent). The developer acknowledged attribution challenges if relying solely on survey wording, but explained plans can determine the specialist via claims or add a supplemental question for identification purposes.
Reliability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Health Plan Influence and Accountability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.

Appeals: None

CBE #0006-8 (Adult) and 0006-16 (Child) – HP CAHPS Survey – Rating of Health Plan [Westat/AHRQ] – Maintenance

[Specifications \(Adult\)](#) | [Specifications \(Child\)](#) | [Comment Summary Guide](#)

***Substantive Changes (Adult): None**

***Substantive Changes (Child): None**

0006-8 (Adult) Description: The Adult HP CAHPS Survey Rating of Health Plan measure assesses the enrollee's overall rating of their health plan from 0 to 10, with 0 being the worst and 10 being the best.

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0006-16 (Child) Description: The Child HP CAHPS Survey Rating of Health Plan measure assesses the enrollee’s overall rating of their child’s health plan from 0 to 10, with 0 being the worst and 10 being the best.

0006-8 (Adult) Committee Vote: Endorse

0006-8 (Adult) Vote Count: Endorse (17 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

0006-16 (Child) Committee Vote: Endorse

0006-16 (Child) Vote Count: Endorse (17 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

Summary of Public Comments: [See #0006-1 and #0006-9.](#)

Summary of Measure Evaluation: An endorsement committee last reviewed these maintenance measures in the Fall 2019 cycle. CMS’s Public Reporting and Regulatory and Accreditation Programs currently use the measures.

Discussion Topic/Theme	Committee Discussion Summary
Future Survey Considerations	<ul style="list-style-type: none"> The Advisory Group suggested reviewing wording such as “best possible/worst possible” to reduce ambiguity; they encouraged the use of supplemental items if plans want more specificity to explain changes in the global rating. The developer agreed to consider additional documentation and pointed to the supplemental-item pathway for deeper diagnostics.
Patient Response Bias and Inclusion	<ul style="list-style-type: none"> A patient representative asked whether responses might be negatively biased, because members often interact with their plan when problems arise. The developer replied that patients can report positive or negative experiences, that responses are aggregated using a standardized protocol, and that this potential affects all plans comparably. A Recommendation Group member asked for clarification on if the measure would count a patient’s interaction with their health plan during the renewal process. The developer said that a patient must have been enrolled for the past 6 months (and in some CMS applications, for a year). If a patient meets that inclusion criteria, however, the measure could include their experience during the renewal process.
Reliability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.
Health Plan Influence and Accountability	<ul style="list-style-type: none"> See CBE #0006-01/CBE #0006-9.

Appeals: None

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Appendix A: Initial Recognition and Management Committee Roster

Fall 2025 Cycle

Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Nicole Cable*	IGNITE HX	Patient Participant	Recommendation Group
Jennifer Bailit*	Case Western Reserve University	Other Interested Party	Recommendation Group
Stephanie Abbott	Hxology	Patient Participant	Advisory Group
Martha Abshire Saylor	Johns Hopkins School of Nursing	Researcher	Advisory Group
Kobi Ajayi	Kajayi Consulting	Patient Participant	Recommendation Group
Hadeel Alkhairw	--	Other Interested Party	Advisory Group
Hillary Alycon	Glen Falls Hospital	Facility/Institution	Advisory Group
Kory Anderson	Intermountain Physician Advisor Services	Facility/Institution	Recommendation Group
Matt Austin	Johns Hopkins; Armstrong Institute	Researcher	Advisory Group
Tom Banks	--	Population Health Expert	Advisory Group
Rebecca Bartles	Association for Professional in Infection Control and Epidemiology (APIC's) Center for Research, Practice, and Innovation	Other Interested Party	Advisory Group
Jacqueline Blauvelt	Hackensack Meridian Health	Facility/Institution	Advisory Group
Jill Blazier	Intermountain Health	Population Health Expert	Advisory Group
Darius Bradley Sr.	--	Patient Participant	Advisory Group
Billy Caceres	Columbia University; American Heart Association; National Institutes of Health	Population Health Expert	Recommendation Group
Emily Calvert	American Urological Association	Other Interested Party	Advisory Group

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
David Chand	Aetna Medical Affairs	Purchaser/Plan	Advisory Group
Ashley Comiskey	--	Clinician	Recommendation Group
Raymund Dantes	Emory University; CDC National Healthcare Safety Network	Clinician	Recommendation Group
Carrie Davis	--	Clinician	Advisory Group
Carl Donovan	--	Patient Participant	Advisory Group
Karen Fernandes	AYR Consulting Group; Diethylstilbestrol Info Association	Patient Participant	Advisory Group
Ryan Hampton	Corewell Health	Facility/Institution	Advisory Group
April Harris	--	Patient Participant	Advisory Group
Joseph Hayes	South Georgia Medical Center Health	Population Health Expert	Advisory Group
Carole Hemmelgarn	MedStar	Patient Participant	Recommendation Group
Erin Holden	--	Facility/Institution	Advisory Group
Janet Hurley	Texas Academy of Family Physicians; American Academy of Family Physicians; CHRISTUS Health	Facility/Institution	Recommendation Group
Hannah Ingber	National Academy of Medicine	Researcher	Advisory Group
Lindsey Irelan	--	Other Interested Party	Advisory Group
Sonali Iyer	UC Irvine; Sepsis Task Force	Clinician	Recommendation Group
Abraham Jacob	M Health Fairview	Clinician	Recommendation Group
Rebecca Jones	--	Other Interested Party	Advisory Group
Kamyar Kalantar-Zadeh	Harbor-UCLA; National Forum of ESRD	Clinician	Advisory Group
Barbara Kivowitz	--	Patient Participant	Recommendation Group
Tammy Love	--	Other Interested Party	Advisory Group
Laura Madarasz	Inova Health System	Researcher	Advisory Group
Precious McCowan	--	Patient Participant	Advisory Group

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Cindi McElhaney	Coimagine Health	Researcher	Recommendation Group
Rhelinda McFadden	--	Population Health Expert	Advisory Group
Patricia Merryweather-Arges	--	Patient Participant	Recommendation Group
Adam Milam	Mayo Clinic	Population Health Expert	Advisory Group
Carmen Morehead	--	Population Health Expert	Advisory Group
Denise Morse	City of Hope	Other Interested Party	Advisory Group
Vanita Pindolia	Blue Cross Blue Shield Michigan	Purchaser/Plan	Advisory Group
Sharon Powell	--	Patient Participant	Advisory Group
Harshitha Ramanan	--	Population Health Expert	Advisory Group
Darryl Roberts	DWRResearch Consulting	Researcher	Recommendation Group
Patrick Romano	UC Davis	Researcher	Advisory Group
Talia Sasson	University of Rochester School of Medicine and Dentistry	Clinician	Recommendation Group
Lisa Scott	Colorectal Cancer Prevention Network, University of South Carolina	Population Health Expert	Advisory Group
David Seidenwurm	Sutter Medical Group	Facility/Institution	Advisory Group
Thomas Spiegel	University of Chicago Medicine	Facility/Institution	Recommendation Group
Aarthi Subramani	Mary Bridge Children's Hospital	Clinician	Advisory Group
Phoebe Thriffiley	--	Other Interested Party	Advisory Group
Jean-Luc Tilly	The Leapfrog Group	Purchaser/Plan	Recommendation Group
Usha Venugopal	NYC Health + Hospitals/Lincoln	Population Health Expert	Recommendation Group
Eric Weinhandl	DaVita Clinical Research	Researcher	Advisory Group
Janice Young	HCA Florida Ocala Health	Facility/Institution	Recommendation

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
			Group

*Co-chairs

Partnership for Quality Measurement Organizations

Battelle

Measure Stewards

Agency for Healthcare Research Quality

Measure Developers

Westat

Appendix B: Acronyms

Please note: The following list encompasses acronyms that Battelle commonly encounters and uses in its work as a CBE. Not all the acronyms will appear in this document.

Acronym	Definition
ACA	Affordable Care Act
ACC	American College of Cardiology
ACO	Accountable Care Organization
AGC	After Government Contract
AHIP	Formerly known as American Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
AI Pilot	Artificial Intelligence Pilot
AIPAC	Advanced Illness and Post-Acute Care
AIR	American Institutes for Research
ANOVA	Analysis of Variance
ASCO	American Society of Clinical Oncology
ASCQR	Ambulatory Surgical Center Quality Reporting Program
ASCs	Ambulatory Surgical Centers
C&E	Cost and Efficiency
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-Based Entity
CBE ID	Consensus-Based Entity Identification
CDC	Centers for Disease Control and Prevention
CDS	Clinical Decision Support
CDSS	Clinical Decision Support System
CIS	Clinical Information Systems
CMIT	CMS Measures Inventory Tool
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CO	Contracting Officer
COIs	Conflicts of Interest
COR	Contracting Officer's Representative
CPG	Clinical Practice Guidelines

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Acronym	Definition
CQL	Clinical Quality Language
CQM	Clinical Quality Measure
CQMC	Core Quality Measures Collaborative
CSAC	Consensus Standards Approval Committee
DEL	CMS Data Element Library
Del.	Deliverable
DOI	Disclosure of Interest
dQMs	Digital Quality Measures
DRC	Direct Reference Code
E&M	Endorsement and Maintenance
EC	Electronic Copy
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
EPC	Evidence-Based Practice Center
ESRD QIP	End-Stage Renal Disease Quality Improvement Program
EVI	Expected Value of Information
FAQs	Frequently Asked Questions
FFS	Fee-For-Service
FHIR®	Fast Healthcare Interoperability Resources®
FMS	Full Measure Submission
FY	Fiscal Year
HACRP	Hospital-Acquired Conditions Reduction Program
HCBS	Home and Community-Based Services
HCD	Human-Centered Design
HEDIS	Healthcare Effectiveness Data and Information Set
HH QRP	Home Health Quality Reporting Program
HH VBP	Home Health Value-Based Purchasing
HHS	Department of Health and Human Services
HIQR	Hospital Inpatient Quality Reporting
HOPD	Hospital Outpatient Department
HOPE	Hospice Outcomes and Patient Evaluation

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Acronym	Definition
HOQR	Hospital Outpatient Quality Reporting
HQMF	Health Quality Measurement Format
HQR	Hospice Quality Reporting
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmission Reduction Program
HSAG	Health Services Advisory Group
HTML	Hypertext Markup Language
HVBP	Hospital Value-Based Purchasing
IAW	In Accordance With
ICD	International Classification of Diseases (International Statistical Classification of Diseases and Related Health Problems)
IHI	Institute for Healthcare Improvement
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act
IPF	Inpatient Psychiatric Facilities
IPF QRP	Inpatient Psychiatric Facility Quality Reporting Program
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting
IR	Initial Recognition
IRF	Inpatient Rehabilitation Facilities
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
IT	Information Technology
ITS	Intent to Submit
LLMs	Large Language Models
LTACH	Long-Term Acute Care Hospitals
LTCH	Long-Term Care Hospital
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act
MACS	Medicaid: Adult Core Set
MAQIP	Medicare Advantage Quality Improvement Program
MAT	Measure Authoring Tool
MCCS	Medicaid: Child Core Set
MCO	Managed Care Organization

Acronym	Definition
MERIT	Measures Under Consideration Entry/Review Tool
MIPPA	Medicare Improvement for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MLTSS	Managed Long-Term Service and Support
MMS	Measures Management System
MS-DOI	Measure-Specific Disclosure of Interest
MSR	Measure Set Review
MSSP	Medicare Shared Savings Program
MUC	Measures Under Consideration
n	Sample Size
NCDC	National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract
NCQA	National Committee for Quality Assurance
NHDNG	Novel Hybrid Delphi and Nominal Groups
NHQI	Nursing Home Quality Initiative
NLP	Natural Language Processing
NQF	National Quality Forum
NQS	CMS National Quality Strategy
NTTAA	National Technology Transfer and Advancement Act
OMB	Office of Management and Budget
OP	Option Period
OY	Option Year
PA	Preliminary Assessment
PAC/LTC	Post-Acute Care/Long-Term Care
PaLS	Patient Life Goals Survey
PAM	Patient Activation Measure
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
PDF	Portable Document Format
PIE Form	Pre-Meeting Initial Evaluation Form
PL	Project Leader
PM	Project Manager
PMP	Project Management Plan
POC	Point of Contact

Acronym	Definition
PPS	Prospective Payment System
PQA	Pharmacy Quality Alliance
PQM	Partnership for Quality Measurement
PRA	Paperwork Reduction Act
PRMR	Pre-Rulemaking Measure Review
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PMs	Patient-Reported Outcome Performance Measures
Q&A	Question & Answer
QC	Quality Control
QCDR	Qualified Clinical Data Registries
QDM	Quality Data Model
QI	Quality Improvement
QMDSA	Quality Measure Developer and Steward Agreement
QPP	Quality Payment Program
REHQR	Rural Emergency Hospital Quality Reporting (Program)
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SLIN	Subline Item Number
SMEs	Subject Matter Experts
SMP	Scientific Measures Panel
SNF	Skilled Nursing Facilities
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing
SOP	Standard Operating Procedure
SOW	Statement of Work
SSA	Social Security Administration
STAR	Submission Tool and Repository
SUD	Substance Use Disorder
TBD	To Be Determined
TEP	Technical Expert Panel
TL	Task Lead
UMLS	Unified Medical Language System

Acronym	Definition
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center
Yale CORE	Yale Center for Outcomes Research and Evaluation

