2025 HCAHPS Update Training Q&A Summary

May 7, 2025

This document includes questions submitted to the HCAHPS Project Team during the 2025 HCAHPS Update Training. Some questions have been slightly reworded for clarity and some answers have been updated post-training with additional information.

Question	Answer
Survey Administration	
1. For all survey modes, if outreach falls on a holiday or weekend, can it be sent on the next business day?	Flexibility for holidays and weekends applies to the mail phase—specifically the second mailing in Mail mode and the mailings for Web-First mode. This flexibility is necessary because the Post Office is closed on Sundays and holidays. Phone attempts include built-in scheduling flexibility, and email invitations can be pre-scheduled to send on weekends and holidays. It's important to consider and plan for weekends and holidays when making initial contact. For more details, see slide 36 or QAG V19.0, pages 90, 142, and 186.
2. For any of the mixed modes, for example web-mail, how do we calculate the contact schedule? If the first contact attempt is not the assumed first mode in the list then the schedule as outlined is difficult to interpret.	The first contact attempt date must be consistent for all sampled patients within a given survey mode, as indicated by the "Day of First Attempt" on the Schedule of HCAHPS Contact Attempts by Survey Mode. For Web-Mail, the "Day of First Attempt" is defined as the "Email 1st Invitation" date, which applies to all sampled patients, regardless of whether they have an email address or were sent an email invitation. The "Day of First Attempt" (i.e., Email 1st Invitation date) should be used to calculate the full contact schedule for all patients in the Web-Mail mode. The first mailing should be sent approximately 8 days after the "Day of First Attempt" (i.e., Email 1st Invitation date) and the second mailing should be approximately 30 days after the "Day of First Attempt" (i.e., Email 1st Invitation date)" to sampled patients without an email address and to non-respondents.
3. Was the wording you provided for the Opt out option for web outreach "optional" or if that opt out is used, the language used on the slide is mandated?	The unsubscribe feature is optional; however, if used, the following language must be included verbatim, "If you prefer not to receive further emails asking you to take this survey about this hospital stay, please click Unsubscribe." For more details, see slide 43 or QAG V19.0 page 150, 171 and 194.

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Data Coding/Public Reporting/Care Compare	
4. Why is Q19 reverse coded?	As a default, CAHPS ratings reports of care begin with the least positive response; HCAHPS adheres to that CAHPS design principle. There is an exception for questions with the "Yes/No" format such as screening questions like HCAHPS question 12, including questions with an expanded "Yes/No" format like "Yes, definitely/Yes, somewhat/No." For such questions, CAHPS and other surveys lead with the "Yes" response because that is a standard and expected convention for Yes/No queries, both in surveys and in conversations, and minimizes the cognitive burden of responding and minimizes errors of interpretation. Additionally, HCAHPS items for the composite measure Discharge Information (Questions 22 and 23) are similarly coded with "Yes" coming first in the response order.
5. Was there any statistical justification for the future combination of Clean and Symptom measures?	The reason they are being combined is not to put undue weight on these two single item measures in Hospital Value Based Purchasing (HVBP). By combining into one dimension it is effectively giving a weight of 0.5 to each measure.
6. Is there anywhere on the CMS Care Compare Website or Provider data site where we can see a count of hospitals in the top decile (90th percentile+) or other deciles?	The counts used in these slides are not directly published publicly. However, CMS' Provider Data Catalog (PDC) is a downloadable and interactive database for all hospital-level HCAHPS scores. This data can be filtered for hospitals with a score higher or lower than a specified value. HCAHPS Online contains national HCAHPS score percentiles for each measure and those values can be used in combination with the PDC to identify the hospitals in the 90th percentile for a given HCAHPS measure. Please see the HCAHPS Percentile table at https://www.hcahpsonline.org/en/summary-analyses/.
7. How can we best message why Summary Star is more valuable for measuring hospital quality than the singular measure of Would Recommend?	The HCAHPS Summary Star uses information from every HCAHPS measure, thus making it a more robust measure of patient experience. As seen in the improvement trend slides (example slide 97), there can be improvements in some HCAHPS dimensions but not others. And if all measures are summarized individually, it can detect more specific changes, more specific aspects of experience that can lead to better quality improvements. Additionally, it's not the case that the Recommend Hospital or the Overall Rating is necessarily more valuable or informative than any individual HCAHPS measure. Focusing on a single measure to summarize overall HCAHPS performance may provide an incomplete assessment.

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8. Regarding the new PMA with the Updated Survey: What do scores look like with and without the Patient Mix Adjustment (PMA)? Should we expect to see changes in national averages when the Planned Hospital Stay measure is included in the PMA?	First the way that PMA works, in general, is that adding or removing or changing a PMA variable will not change the national average because PMA adjusts hospitals relative to the national average for each patient characteristic. Thus, it won't by itself cause any changes to the overall national average, though it can result in changes for individual hospitals. In the 2024 HCAHPS Training (slide 253), the team walked through an example in detail about how it could change the scores for individual hospitals based on whether they have relatively high or relatively low levels of Planned Stay. CMS encourages hospitals and survey vendors to review those examples for more information on the effect Planned Stay may have on scores.
9. In experience with CAHPS surveys, how have patterns of respondent 'quietness' that is nonresponse or minimal engagement—been addressed or interpreted, and what implications do such patterns have for the validity or representativeness of submitted patient experience data?	In terms of HCAHPS response and non-response, in many ways the patterns are similar to what is observed in the survey literature in general. CMS encourages hospitals to choose survey modes that are likely to result in the highest response rates. The HCAHPS project team has shared training materials and recorded podcasts to assist hospitals and survey vendors in choosing modes that tend to generate higher response rates. The multi-modes, including the web-first ones, show positive potential with respect to response rates. CMS encourages analysis of each hospital's patient population when choosing a survey mode. The broad goal in choosing a survey mode for HCAHPS is to maximize the response from their unique patient population. Likewise, CMS suggests maximizing efforts to allow patients to respond in their preferred language. As a reminder, the analysis approach which uses both adjustment for survey mode and patient mix adjustment is designed to ensure valid and fair comparisons among hospitals irrespective of patterns of non-response by accounting for the characteristics of respondents of a given hospital vs others.
Other	
10. Any concern that with the cuts being made by DOGE, elimination of entire departments and oversight that CAHPS surveys will be eliminated?	CMS does not have any information to share about this topic at this time.