September 11, 2023

Ms. Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: File Code CMS–1786–P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating

Dear Ms. Brooks-LaSure,

The Leapfrog Group is a 501c3 national nonprofit organization governed by employers and other purchasers committed to improving patient safety and health care quality in the United States. We are one of the few organizations that both collects and publicly reports safety and quality data from health care facilities at the national level, thereby bringing a unique perspective to measurement. On behalf of our Board of Directors, members and interested parties, including hundreds of purchasers and employer organizations across the country, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services on the proposed changes to the FY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs rule.

For over 20 years, Leapfrog has been collecting quality and safety information about hospital inpatient care. In 2019, Leapfrog expanded to also collect information from ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs). Leapfrog began publicly reporting these data in September 2020. Recognizing that the majority of surgeries are performed in outpatient or ambulatory settings, employers and other purchasers as well as consumer advocates appreciate that these settings offer the opportunity for improved patient experience, greater cost-efficiency, and the prevention of unintended patient harm that can results from hospital stays (e.g., healthcare associated infections). Unfortunately, the availability of independent, publicly reported information about patient safety and quality for outpatient and ambulatory surgery is currently inadequate, so purchasers and consumers do not have the information they need to select the best place for their care.

The attached appendix contains our detailed comments. But we want to highlight a major concern: the inadequacy of measures for the Rural Emergency Hospital Quality Reporting (REHQR) Program. While we fully support creating a quality reporting program for rural emergency hospitals (REHs), beginning the REHQR Program with four measures where only two are relevant to all REHs is inadequate to inform consumers of the performance of these facilities. We urge CMS to methodically identify gaps in measurement based on the services of REHs and work to quickly fill them. In that regard, there are glaring gaps CMS can readily fill with existing measures in two key areas detailed below.

For one, we suggest implementing more measures related to avoidable morbidity and mortality. We recommend the following measures immediately:

- Severe Sepsis and Septic Shock: Management Bundle measure (SEP-1)
- Door to Diagnostic Evaluation by a Qualified Medical Professional (OP-20)

The latter measure appeared in the OPPS FY 2023 proposed rule as a measure CMS solicited comment on regarding potential REHQR Program measures. Surprisingly the measure was omitted from OPPS FY 2024 proposed rule.

Secondly, consumers accessing REHs should have access to the same ED measures used in the Hospital OQR Program where applicable. It should go without saying that we should avoid creating one standard of transparency for most consumers and another for consumers in rural settings that are more likely to access REHs. The following are the ED measures used in the Hospital OQR Program that we recommend for the REHQR Program:

- Fibrinolytic Therapy Received Within 30 Minutes of ED arrival (OP-2)
- Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate (OP-3)
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)
- Left Without Being Seen (OP-22)
- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival (OP-23)

On behalf of The Leapfrog Group, our Board, our members, and interested parties, we appreciate the opportunity to provide comments on the proposed changes to the FY 2024 proposed rule.

Sincerely,

Leah Binder, M.A., M.G.A

President & Chief Executive Officer
The Leapfrog Group

Additional Individuals and Organizations Supporting Leapfrog's comments on the CMS OPPS FY 2024 proposed rule:

Ashley Tait-Dinger, Florida Alliance for Healthcare Value
Capital Health Group, LLC
CSS/Consumers' Checkbook
DFW Business Group on Health
The Economic Alliance for Michigan
The ERISA Industry Committee
Greater Philadelphia Business Coalition on Health
Health Action Council
Health Transformation Alliance

HealthCare21 Business Coalition
Health Policy Corporation of Iowa
Healthcare Purchaser Alliance of Maine
Irene Fraser, Leapfrog Board Member
John Zern, Ryan Specialty Benefits
Karen van Caulil, Florida Alliance for Healthcare Value
Kara Sasse, Consumer
Lehigh Valley Business Coalition on Healthcare (LVBCH)
Louisiana Business Group on Health
Marlene Bandfield, Retired Physical Therapist
Maureen Ryan, Odgers Berndtson
Michelle Martin, Leapfrog Board Chair
New Jersey Health Care Quality Institute
North Carolina Business Coalition on Health
Purchaser Business Group on Health
St Louis Area Business Health Coalition
Techtronic Industries North America, Inc.

APPENDIX: THE LEAPFROG GROUP'S DETAILED COMMENTS REGARDING FY 2024 OPPS AND ASC PROPOSED RULE

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

- **Proposal to remove the Left Without Being Seen measure**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 550 – September 11, 2023

The Leapfrog Group recommends retaining the Left Without Being Seen measure. We do not concur with the rationale to remove the measure, which is stated as measure removal factor #2: "Improvement on a measure does not result in better patient outcomes." This rationale for removal contradicts CMS' statement in this subsection that there is evidence that links the measure to improved outcomes. The available evidence clearly demonstrates that people who leave without being seen are at higher risks of poor outcomes[1], higher rates of being readmitted[2] and mortality[3]. Whatever limitations exist in the literature, common sense considerations are worth noting when evaluating the importance of this measure. It is self-evident that people who seek care at an emergency department likely have symptoms that seriously trouble them; if they never receive a medical opinion from the visit, that is sub-optimal care. Sub-optimal care should be accounted for.

- **Proposal to modify three existing measures**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 552 – September 11, 2023

We commend CMS for aiming to continually improve measures. In turn, we support changes to three stated measures, which are:

- COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure (OP-38)
- Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure (OP-31)
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure (OP-29)

Regarding the cataract measure, we strongly recommend changing the measure from voluntary to mandatory reporting. Per the OPPS FY 2023 final rule, there is no stated timeframe for this measure to ever become mandatory. It is deeply concerning that only a handful of facilities are voluntarily collecting this data, which is why it should be mandatory. While we recognize this involves some work on the part of facilities, it is work that should be considered essential to the adequate delivery of services, not only a step toward reporting on the quality of care. Just as facilities sanitize instruments and scrub in prior to surgery, they should always monitor patient outcomes to assure they are performing procedures that benefit their patients. Many critical procedure outcomes, including Cataract Surgery, are only detectable in time periods after the procedure is performed.

In the OPPS FY 2023 proposed rule, the reason CMS cites to cancel its plans to make the measure mandatory is "Interested parties have indicated that they are still recovering from the COVID-19 PHE and that the requirement to report OP-31 would be burdensome due to national staffing and medical supply shortages coupled with unprecedented changes in patient case volumes." The party most interested in the outcome of

cataract surgeries are patients, Medicare beneficiaries and others, who should be the priority for CMS rulemaking.

While staffing shortages are a critical concern, patient reported outcomes should be part of the standard of care, especially in the outpatient and ambulatory setting where outcomes are often not observable as they are in the inpatient setting. Without information on patient outcomes, surgical teams could potentially repeat patterns of practice that are failing, or not take advantage of techniques that are exceptionally effective. The best way to know those outcomes is to ask the patient through a tested and reliable questionnaire. In addition to giving surgical teams critical information to assure their safety, it gives patients needed data to make informed decisions about where to seek care. Staffing shortages should be addressed not by cutting corners on the standard of care, but by doing fewer of the procedures to assure that each patient receives safe and effective care.

- **Proposal to add measures to the Hospital OQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 570 – September 11, 2023

Leapfrog supports the proposal to add three measures to the Hospital OQR Program. The present set of measures in this program is thin considering the rising use of hospital outpatient services. The three measures proposed to be added include:

- Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures
- Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO–PM)
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults

Regarding the proposed volume measure, we perceive it is directionally positive to report at the procedure level, but inadequate to limit the reporting to the five most frequently occurring procedures per clinical category. Given the ever-increasing array of procedures performed by hospital outpatient departments, the public will likely only have a fraction of procedures reported in the volume measure. In the OPPS FY 2024 proposed rule, CMS states their rationale to report procedure volume as "our belief that publicly reporting volume data would provide patients with beneficial information to use when selecting a care provider." We concur with this reason but urge CMS to extend the benefit to all consumers planning on a hospital outpatient encounter; not just those needing one of a handful of procedures.

- **Request for comment: Additional Hospital OQR Program areas for measure development to add measures to the Hospital OQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 602 – September 11, 2023

A: Promoting Safety (Patient and Workforce)

We welcome CMS furthering the dialogue on the critically important area of patient safety. In that regard, we offer the following five recommendations.

First, one prominent lesson learned during the pandemic is the inexorable tie between the well-being of the workforce and the well-being of the patients. Both must be safe or neither are safe. Thus, we would recommend CMS work with OSHA to align measures on patient safety and health care workforce safety. For example, CMS could draw on measure concepts used in OSHA's Total Recordable Incident Rate (TRIR). In the TRIR measure,

recordable events include work-related injury such as an illness that results in death, loss of consciousness, days away from work, restricted work activity, transfer to another job or medical treatment beyond first aid[4]. While the TRIR measure has a direct application to the healthcare workforce, there are concepts that can be drawn on for the development of patient safety measures that would align.

Secondly, it is essential to reliably collect and report health care-acquired infections from outpatient settings. CMS would benefit from collaboration with NHSN to create the ability to measure infections at the hospital outpatient department level. This would require CMS to work with NHSN to identify a means to distinguish between the inpatient hospital setting and the hospital outpatient department setting, but this is a problem that can be readily solved. Hospitals, ASCs, physicians, nurses, and patients themselves have no trouble distinguishing between an inpatient and an outpatient, so translating that information to a reliable national reporting system is not impossible. It is critical information for providers, employers, and the public, as well as CMS and policymakers.

Thirdly, an important national discussion over the last decade has been to align measures across settings, such as the "family of measures" concept[5]. We suggest CMS has room to act on such measure alignment even within the existing small set of ASC and HOPD measures. Specifically, we recommend aligning the measures of unplanned ED and hospital visits across these two settings. The following are the current ASC and HOPD measures of such unplanned visits and a depiction of the opportunity for alignment:

Current measure alignment = "⇨"	**HOPD measures**	**ASC measures**
⇨	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32)	Rate of unplanned hospital visits after an outpatient colonoscopy (ASC-12)
	Rate of inpatient admissions for patients receiving outpatient chemotherapy (OP-35 ADM)	
	Rate of emergency department visits for patients receiving outpatient chemotherapy (OP-35 ED)	
	Hospital Visits after Hospital Outpatient Surgery (OP-36)	
		Rate of unplanned hospital visits within 7 days of an orthopedic surgery at an ASC (ASC-17)
		Rate of unplanned hospital visits within 7 days of a urology surgery at an ASC (ASC-18)

Across the above seven unplanned visit measures, the only area where we see a measure applied to both settings is for colonoscopy. While a chemotherapy measure of unplanned ED and hospital visits only applies to the HOPD setting, there is an existing opportunity to align the remaining measures across these two settings, which are:

- Hospital Visits after Hospital Outpatient Surgery (OP-36)
- Rate of unplanned hospital visits within 7 days of an orthopedic surgery at an ASC (ASC-17)

- Rate of unplanned hospital visits within 7 days of a urology surgery at an ASC (ASC-18)

Medicare beneficiaries and others seek to compare the safety and outcomes of care in various settings in selecting a facility based on quality. This is particularly true and important in the case of ASCs and HOPDs as many procedures are performed in both types of facilities. However, without aligning measures where appropriate, consumers are unable to make such comparisons and thus unable to make such informed decisions.

Fourth, we observe that in the public reporting of OAS CAHPS, the facility level results of the "preparation for discharge and recovery" domain are suppressed in the current CMS care compare download file[6]. While OAS CAHPS is currently voluntarily reported, we are concerned about the implications of reporting on this significant domain when OAS CAHPS becomes mandatory. In corresponding with the CMS help center about this suppression the response stated, "CMS plans to publicly report [the preparation for discharge and recovery] composite in the future, however the timeline for this has not been determined[7]." If the delay in the reporting of this domain is due to issues regarding the pain management questions in the composite, we recommend calculating and reporting a domain score without these questions. When the pain management questions are later resolved (e.g. revising the questions), then integrate them and calculate the domain with these questions. Given the significance of this domain, it should not be an option to suppress reporting it due to concerns/issues regarding a couple of questions therein.

Lastly, we recommend the following areas to develop (or modify existing) measures for the HOPD setting:

- An anesthesia measure regarding the management of nausea
- A measure of DVT prophylaxis
- Adapting the following measures that will become mandatory in the near future:
    - Patient Burn (ASC-1)
    - Patient Fall (ASC-2)
    - Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (ASC-3)

B: Behavioral health

We need to focus on measure development for two primary types of measures: outcomes and patient reported outcomes. The majority of behavioral health measures are process measures. These measures tell us nothing as to the (lack of) effectiveness of the services rendered. As there is precedent for sound outcomes measures for behavioral health, we recommend CMS review and deploy such measures as appropriate. Examples of outcome measures include:

- Depression Remission at Six Months (CBE #0711)
- Depression Remission at 12 Months (CBE #0710e)
- Depression Response at Six Months – Progress Towards Remission (CBE #1884)
- Depression Response at 12 Months – Progress Towards Remission (CBE #1885)

C: Telehealth

We strongly support CMS' leadership in advancing telehealth capacity nationally, an important resource for all Americans, but especially useful for employed people seeking to minimize disruptions from the workday. It is important for CMS to work with federal agencies such as AHRQ to advance research on outcomes and effectiveness of telehealth to assure quality of care is not compromised.

We also encourage CMS to assure equity in telehealth deployment and outcomes. We recommend exploring the development of access measures in two specific areas: ADA compliance and interpreter services. Regarding ADA compliance, the ADA prohibits healthcare providers from discriminating based on disability status. This is true

for both healthcare services delivered in person or through telehealth[8]. We encourage CMS to use the ADA as a framework in developing a set of measures to gauge areas, and degree, of ADA compliance as it relates to telehealth.

Regarding interpreter services, we recommend CMS develop measures that align with guidance provided by the HHS Office of Civil Rights (OCR)[9]. Based on HIPAA rules, the guidance offered by OCR should serve as the basis for interpreter services. The OCR discusses guidance for telehealth interpreter services in such areas as quality and accuracy of the language assistance services that are provided and the providers' management of contracted interpreter services regarding appropriately receiving, transmitting and maintaining PHI.

AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM

- **Proposal to modify three existing measures**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 637 – September 11, 2023

We commend CMS for continually improving measures. In turn, we support changes to three stated measures, which are:

- COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure (ASC-20)
- Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure (ASC-11)
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure (ASC-9)

Regarding the cataract measure, we strongly recommend changing the measure from voluntary to mandatory reporting. Per the OPPS FY 2023 final rule, there is no stated timeframe for this measure to ever become mandatory. It is deeply concerning that only a handful of facilities are voluntarily collecting this data, which is why it should be mandatory. While we recognize this involves some burden on the part of facilities, it is a burden that should be considered essential to the delivery of services, not just quality reporting. Just as facilities sanitize instruments and scrub in prior to surgery, they should always monitor patient outcomes to assure they are performing procedures that benefit their patients.

In the OPPS FY 2023 proposed rule, the reason CMS cites to cancel plans to make reporting of the measure mandatory is "Interested parties have indicated that they are still recovering from the COVID-19 PHE and that the requirement to report OP-31 would be burdensome due to national staffing and medical supply shortages coupled with unprecedented changes in patient case volumes." The party most interested in the outcome of cataract surgeries are patients--Medicare beneficiaries and others--who should be the priority for CMS rulemaking. While staffing shortages are a critical concern, that should not absolve facilities of the responsibility of determining outcomes of procedures that are performed. Indeed, patient reported outcomes should be part of the standard of care, especially in the outpatient and ambulatory setting where outcomes are often not observable as they are in the inpatient setting. Without information on patient outcomes, surgical teams could potentially repeat patterns of practice that are failing, or not take advantage of techniques that are exceptionally effective. The best way to know those outcomes is to ask the patient through a tested and reliable questionnaire. In addition to giving surgical teams critical information to assure their safety, it gives patients needed data to make informed decisions about where to seek care.

- **Proposal to add measures to the ASCQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule – p. 655 – September 11, 2023

Leapfrog supports the proposal to add two measures to the ASCQR Program. The present set of measures in this program is thin considering the rising use of the hospital outpatient setting for services. The three measures proposed to be added are:

- Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures
- Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO–PM)

Regarding the proposed volume measure, we perceive it is directionally positive to report at the procedure level, but inadequate to limit the reporting to the five most frequently occurring procedures per clinical category. Given the ever-increasing array of procedures performed by hospital outpatient departments, the public will likely only have a fraction of procedures reported in the volume measure. In the OPPS FY 2024 proposed rule, CMS states their rationale to report procedure volume as “our belief that publicly reporting volume data would provide patients with beneficial information to use when selecting a care provider.” We concur with this reason but urge CMS to extend the benefit to all consumers planning on a hospital outpatient encounter; not just those needing one of a handful of procedures.

RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM

- **Proposal to introduce measures for the REHQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 696—September 11, 2023

We strongly support CMS creating a quality reporting program for Rural Emergency Hospitals, because it is an issue of health equity. Beneficiaries and other consumers who live in rural America should enjoy the same level of quality and transparency as consumers in urban or suburban parts of the country. However, we are disappointed with the proposal to begin the REHQR Program with only four measures (where only two are relevant to all REHs), which is woefully inadequate to inform consumers of the performance of these facilities. We urge CMS to methodically identify gaps in measurement based on the services of REHs and work to quickly fill them. In that regard, there are glaring gaps CMS can readily fill with existing measures in two key areas detailed below.

For one, we suggest implementing measures related to avoidable morbidity and mortality. Specifically, we recommend the following measures:

- Severe Sepsis and Septic Shock: Management Bundle measure (SEP-1)
- Door to Diagnostic Evaluation by a Qualified Medical Professional (OP-20)

The latter measure appeared in OPPS FY 2023 proposed rule as a measure CMS solicited comment on regarding potential REHQR Program measures. Surprisingly the measure was omitted from OPPS FY 2024 proposed rule.

Secondly, consumers accessing REHs should have access to the same ED measures used in the Hospital OQR Program where applicable. Again, rural Americans should expect the same level of transparency and performance monitoring from CMS as other Americans. The following are the ED measures used in the Hospital OQR Program that we recommend for the REHQR Program:

- Fibrinolytic Therapy Received Within 30 Minutes of ED arrival (OP-2)
- Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate (OP-3)
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)
- Left Without Being Seen (OP-22)

- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival (OP-23)

- **Proposed policy to immediately remove REHQR Program measures**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 702—September 11, 2023

The Leapfrog Group strongly disagrees with the proposal that would grant CMS the power to remove REHQR Program measures without going through the rule making process. Such a policy strips consumers of their rightful voice in this critical decision making, diminishes transparency and the trust it evokes, and sends the wrong message about the importance of quality and safety at REHs.

The proposed rationale for immediately removing a measure without rulemaking is that the "collection of a measure as currently specified raises potential patient safety concerns." This broadly worded and undefined criterion would permit CMS to interpret the bizarre circumstance where the act of data collection purportedly results in a patient safety hazard. If such an odd circumstance is alleged, it should be held to public scrutiny via rulemaking. The dangers to patients that are measured through data collection are very serious, and eliminating access to that data should be treated as an equally serious matter.

- **Proposed policy to adopt measure removal factors for the REHQR Program measures**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 703—September 11, 2023

First and foremost, the measure removal policy should center on the best interests of Medicare beneficiaries. Secondly, the policy should consider the best interests of the public at large. The best interests of hospital administration should not eclipse the interest of beneficiaries or the public, yet surprisingly there is no criterion proposed on whether the measure is important to them. We recommend the addition of that criterion as the new "Factor 1" to stress that the measure removal policy is indeed centered on beneficiaries.

We recommend full transparency in the defining of each criterion including how a given calculation applies to beneficiaries. To achieve this, CMS needs to develop and publicly share how the terminology in each criterion is operationalized (e.g. see "cost" and "benefit" example discussed below under "Measure Removal Factor 8"). Specifically, it should be made transparent how such terms are tested and what results will empirically determine whether the criterion is met or not. In most cases, the terminology used across these eight criteria are not defined, specified nor defended.

The following are specific recommendations regarding select Measure Removal Factors:

"Measure Removal Factor 1: *Measure performance among REHs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped-out" measures).*"
Leapfrog suggests removing the Factor 1 criterion. CMS' methodology to identify "topped out" performance in a measure is problematic for several reasons. First, some measures included in CMS quality reporting programs quantify "never events" which, while rare, are catastrophic to patients when they do happen. Secondly, CMS primarily determines "topped out" by comparing performance at the 75th and 90th percentile where a higher percentile means better performance. This too is problematic. Consumers and purchasers are often interested in avoiding the worst performers, those hospitals that are in lower percentiles. CMS' method does not consider the variation between hospitals performing at the highest versus the lowest percentiles. Additionally, our prior analysis of the application of this criterion to measures in the IPPS FY 2023 proposed rule highlighted the high degree of variation between hospitals, which could represent thousands of preventable complications and

preventable harms to hundreds of thousands of patients. Finally, many of CMS' measures used in quality reporting programs only include patients covered by Medicare fee-for-service, which ignores the nearly 50% of Medicare beneficiaries covered by Medicare Advantage plans.

"Measure Removal Factor 8: *The costs associated with a measure outweigh the benefit of its continued use in the program."*
We oppose the Factor 8 criterion unless "costs" and "benefits" are explicitly defined as "costs to Medicare beneficiaries and the public" and "benefits to Medicare beneficiaries and the public." In comments to the IPPS FY 2024 final rule where the same language for measure removal criteria was finalized, CMS responded to Leapfrog's comments on this issue, stating:

> "…[W]e note that we estimate the information collection costs and other effects associated with each quality measure we adopt in each rule... We also discuss in detail the benefits of the measure to patients and to the health care system when we propose it. For example, in the FY 2024 [IPPS proposed rule], we discussed the problems presented by hospital-acquired pressure injuries as well as the details of the Hospital Harm— Pressure Injury measure and how it assesses that clinical topic. We will, nonetheless, take the commenter's feedback into consideration for future potential refinements to the measure removal factors, as well as whether additional information on the costs and benefits beyond the discussion that we place in proposed rules would be helpful for the public."

While we appreciate that the "benefits" of a measure to patients are explained in the IPPS final rule in narrative, it is not evident that those benefits are explicitly incorporated in the measure removal formula nor does the formula or discussion of it include a consideration of the "costs" to beneficiaries of a given measure. In most cases, there is a cost to beneficiaries of not having access to insights generated by the measure. A measure removal formula should weigh the patient's cost of not knowing--which should be the primary consideration--against other costs for other stakeholders in collecting and reporting the measure.

We encourage revising the measure removal criteria to explicitly state that the priority consideration are the costs and benefits to beneficiaries and the public. Without those considerations explicitly in the formula, we reiterate our opposition to the measure removal criteria as they appear in the OPPS proposed rule. As a matter of policy, CMS should put the priority on the costs and benefits to beneficiaries and patients. Provider costs of measurement should be a secondary consideration in removal of measures, and never dwarf the rightful place of Medicare beneficiaries as the top concern. CMS is the agency responsible for paying providers on behalf of beneficiaries, and proper stewardship of that mission requires that patient needs and risks be the first and foremost concern.

- **Request for comment: eCQMs for use in the REHQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 729—September 11, 2023

The Leapfrog Group fully applauds and strongly supports CMS' plan to use eCQMs in the measurement of REH performance. We offer three specific recommendations related to the request for comment in the OPPS proposed rule.

First, in the use of eCQMs, we recommend that CMS align measures for a given concept (e.g., patient safety) across applicable settings (e.g. REHs and HOPDs). An NQF report, which was based on deliberations of the Measure Application Partnership, recommended such an approach in creating / identifying "families" of measures[5]. Medicare beneficiaries and others seek to compare the safety and outcomes of care in various settings, and without aligned data they are unable to do so.

Second, regarding the use of “meaningful measures” when identifying criteria and priorities to identify eCQMs: We encourage a focus on outcome and patient-reported measures. This is consistent with the CMS “Meaningful Measures 2.0” framework, which identifies one of the primary aims to “prioritize outcome and patient-reported measures”[10]. However, the only eCQM mentioned in this request for comment is the Excessive Radiation eCQM. While we support use of this measure in the REHQR Program, we would like to see CMS more fully operationalize their aim for their Meaningful Measures initiative to offer robust outcome measures and patient-reported measures.

Third, and related to our meaningful measures recommendation above, we suggest that CMS act on the research and recommendations in a recent Office of Inspector General (OIG) report[11] and expand the number of measures reported. The May 2022 OIG report observed that over a quarter of Medicare patients were victim to a harmful event in the inpatient hospital setting, but only 5-10% of events were accounted for in currently deployed measures. The Inspector General recommended a significant expansion of measures and CMS agreed in the report. More specifically, the most frequently occurring type of harmful event cited in this recent report was medication related. Thus, we urge CMS to use the OIG report as a guide in the identification and development of eCQMs around medication errors.

- **Request for comment: Care coordination measures for use in the REHQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 732—September 11, 2023
Regarding the measures CMS is soliciting comments on, we offer our support for the following measures:

- Medication Reconciliation Post Discharge measure (CBE #0097)
- Emergency Department Transfer Communication measure

Regarding the Emergency Department Transfer Communication (EDTC) measure, the OPPS FY 2024 proposed rule labeled the measure as “Discharge Planning” and noted it is a Medicare Beneficiary Quality Improvement Project (MBQIP) measure. In correspondence with MBQIP, we confirmed that the proposed rule is indeed referring to the EDTC measure. Given the Joint Commission reported that poor communication contributes to 65% of hospital adverse events[13], it is vital we measure and publicly report this dimension of patient care. The EDTC measure provides us with such a measure.

We strongly support this measure because it upholds a high standard of care for rural patients, an “all or none” measure where the facility must provide communication in all eight areas to have the case counted in the numerator. A further reason Leapfrog supports the measure is the rigor in which the measure was developed and improved. The measure was tested in 16 states and underwent revisions by way of a technical expert panel administered by the Rural Quality Improvement Technical Assistance program, Stratis Health and the University of Minnesota Rural Health Research Center[12].

As to the question of criteria and priorities for future care coordination measures, we recommend a focus on patient safety. Regarding care coordination, patient safety is especially important given the escalating acuity level at discharge. Such heightened acuity puts patients at greater risk of harm, such as falls and other injuries that are avoidable with high quality coordination of care at discharge.

A second area of REH coordination of care measurement that should be a priority for CMS is the development of patient reported outcome measures (PROMs). Patients are receiving a greater range of services at ever higher complexity levels. In turn, they are being discharged to a wider variety of settings at varied levels of safety/risk. The most straightforward and efficient method for assessing whether patients are well served across all of these settings is to systematically ask them.

- **Request for comment: REHQR Program tiered framework for reporting measures**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 733—September 11, 2023

We strongly disagree with the proposal to adopt a tiered approach to identifying measures that are required for REHs to report. CMS is unintentionally communicating to its Medicare beneficiaries that they do not deserve information on the performance of REHs in their area. Rural residents deserve greater accountability than this.

CMS needs to acknowledge that the people they serve come to emergency settings with life threatening situations and must entrust their lives to these facilities. With this understanding, people in rural communities deserve more transparency from REHs than reporting on a very narrow CT measure and ED discharge timing. Those measures do not account for the potential for serious harm or death. The lack of parity between ED measures publicly reported through the Hospital OQR Program and the proposed measures for the REHQR Program demonstrates inequity in the standards for quality and safety applied to people living in rural communities.

We encourage CMS to address this inequity affecting rural members of society by greatly expanding the measures that comprise the REHQR Program. We need to begin with the current measures CMS employs in the emergency department setting and apply them to REHs. Given this is still a thin set of measures, we also urge CMS to quickly identify gaps and fund measure development for all emergency departments.

- **Proposal to publicly display measures results in the REHQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 735—September 11, 2023

Leapfrog strongly supports public reporting of data in formats accessible to consumers. However, The Leapfrog Group does not support the proposal to publicly report performance in the REHQR Program as it does in the ASCQR and Hospital OQR Programs. The mode of display is not consumer friendly. For one, the directionality of the ratings (e.g. higher = better) is unstated. Even if one intuits the directionality, it takes serious effort and downloading of multiple files on CMS Care Compare to be able to calculate / discern very good from good to average performance.

Leapfrog strongly disagrees with the proposal to report by CCN. We strongly recommend that CMS align with Leapfrog and its purchaser constituency by publicly reporting data in a way that puts the needs of consumers first and foremost. Fundamental to meeting that goal is to collect and report data for individual bricks-and-mortar facilities (i.e. campuses and locations), not by CCN and shared NPI.

There are instances where up to nine hospitals several miles apart and offering very different services share a single Medicare identifier. Given the trends in ownership, mergers and acquisitions, this issue is likely similar or worse for REHs. When safety, quality and resource use metrics are reported in this way, it obscures the individual performance of a given facility delivering the care, which is misleading and unhelpful to patients. Patients do not seek care from a system; they seek care from individual facilities and clinicians. Providers and administrators can also benefit from being able to readily discern the performance at their own facility and determine where improvements are needed.

The capability to identify bricks and mortality facilities by HHS identifiers has recently become a reality. In the Office of the National Coordinator for Health Information Technology's (ONC) HTI-1 version 4 it creates the infrastructure to provide consistent identification of healthcare facilities by bricks and mortar locations. We encourage CMS to work with ONC to finally realize public reporting at the facility level, which would be vastly more useful to consumers.

- **Proposal to publicly display four strata of the Median Time from ED Arrival to ED Departure for Discharged ED Patients measures results in the REHQR Program**

The Leapfrog Group comments to CMS on the FY 2024 OPPS Proposed Rule– p. 737—September 11, 2023

While we support reporting stratified results where appropriate, we perceive the four proposed strata will likely not be feasible given lower volumes in REHs. Our concern is that stratifying a measure's results four ways where denominators are likely to already be small will in turn drive down the reliability to unacceptable levels. Because of this, we recommend stratifying the results in the same manner as the Hospital OQR Program, which follow:

- Median Time for Discharged ED Patients – Overall Rate
- Median Time for Discharged ED Patients – Psychiatric/Mental Health Patients

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