THE LEAPFROG GROUP
Giant Leaps for Patient Safety

June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD

RE: RIN 0938-AV45 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Dr. Oz,

The Leapfrog Group, our Board of Directors, and our members collectively comprise hundreds of the leading purchaser and employer organizations across the country. We are committed to improving the safety, quality and affordability of health care with meaningful metrics that inform consumer choice, payment and quality improvement. We are one of the few organizations that both collects and publicly reports safety and quality data at the national level, thereby bringing a unique perspective on measures that can be effectively collected by hospitals and reported to health care consumers. In addition, we use CMS measures in the Leapfrog Hospital Safety Grade, amplifying the measures' usefulness to consumers and strengthening the alignment between private and public purchasers.

We appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed changes to the FY 2026 Inpatient Prospective Payment System (IPPS) rule. Leapfrog was founded by employers in 2000 to drive improvements in health care quality and safety. We represent the voice of purchasers through our work, which is why the employer perspective is central to our comments below. The proposed removal of the hospital commitment to health equity and social determinants of health measures directly impacts the purchasers who fund the majority of health care and expect accountability in return.

There are three areas in the proposed rule that we'd like to draw your attention to.

1. **We strongly urge CMS to reverse its proposal to remove the Hospital Commitment to Health Equity measure from the Hospital Inpatient Quality Reporting Program.** The IPPS proposed rule recommends removing the health equity measure due to its "burden," but fails to clearly specify to whom the burden applies. CMS should be prioritizing the burdens and opportunities for Medicare beneficiaries and taxpayers, with burden to providers a secondary consideration. Nonetheless, the burden on hospitals is not substantial; hospitals spend only about six minutes and $4.13 per year on this measure. The benefit to beneficiaries is substantial, enabling clinicians to prevent known risks from escalating to poor outcomes and readmissions. These risks are well known to CMS from data collection and increasingly valuable as tools like AI enable more targeted, faster interventions.[6]

2. **We strongly urge CMS to reverse its proposal to remove the health equity adjustment (HEA) from the Hospital Value-Based Purchasing Program.** While we do not support adjusting quality measures for public reporting—since every patient deserves the same high standard of care—we recognize that hospitals serving higher-risk populations with fewer resources face added challenges and therefore support payment adjustments. The HEA was initially introduced in the FY24 IPPS rule to ensure fairness and avoid penalizing hospitals that admit these high-risk patients. Removing the HEA now creates a disincentive for hospitals to care for dual eligibles (those on both Medicare and Medicaid).

3. **We strongly urge CMS to reverse its proposal to remove social determinants of health (SDOH) measures from the Hospital Inpatient Quality Reporting Program.** This rule also proposes removing SDOH measures from the IQR program, again citing "burden." CMS should center its evaluation of burden on patient outcomes—not provider convenience. Evidence shows that people with documented social risk factors—such as poverty, unstable housing, food insecurity, and lack of transportation—incur health care costs more than double those of others ($12,967 vs. $5,152).[20] This highlights the need for targeted interventions that reduce costs and improve care quality.

   Employers have a clear stake in this issue as well. Illness-related productivity loss represents a major cost to employers—often exceeding the direct costs of medical care. As a voice for those funding health care, Leapfrog and our employer members strongly believe removing these measures reduces the ability of health care providers to achieve the best possible outcomes at the most efficient cost. The public, including employer and purchaser stakeholders, deserves to know which hospitals are screening for SDOH and thus taking a wise, prevention-driven approach to health services.

Additionally, we have recommendations on transparency that are important principles for IPPS but continue to be overlooked in rulemaking.

1. **Meaningfully differentiate the very real variation in hospital performance on the safety and quality measures published on the CMS Care Compare website.** We applaud CMS for revealing variation among hospital performance in its excellent Star Ratings program, and we encourage you to extend that leadership to make Care Compare more meaningful to consumers. For the data to be valuable for health care consumers, the data has to differentiate between hospitals on safety and quality. Publicly reporting over 90% of hospitals as "no different than the national average" sends a dangerous message to consumers: All hospitals are the same. We all know that this is not the case, and the difference can mean life or death for patients.

2. **In alignment with recommendations from the Office of the National Coordinator, we implore CMS to report results from all federal hospital programs by bricks-and-mortar facility, not CMS Certification Number (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 collecting and reporting data for individual brick-and-mortar facilities (i.e., campuses and locations), not CCN as currently constructed. There are instances where up to nine hospitals several miles apart and offering very different services share a CCN. When safety and quality metrics are reported in this way, it obscures the individual performance of the hospital delivering the care and is misleading and unhelpful to patients. Patients do not seek care from a system; they seek care from individual

hospitals and clinicians. Providers and administrators can also benefit from being able to discern the performance more easily at their own facility and determine where improvements are needed.

3. **Stop exempting hospitals from public reporting.** Patients who receive care in critical access hospitals, pediatric hospitals, hospitals in U.S. territories and other exempt facilities deserve the same safety, quality and resource use information that patients of general acute care facilities have access to. Rates of infections and hospital-acquired conditions and mortality and readmission rates are all important factors in selecting a hospital. Those in communities served by hospitals exempted from the federal reporting programs are highly disadvantaged.

4. **Continue to support and prioritize the new Patient Safety Structural Measure.** We commend CMS for working toward implementing this important measure set in fiscal year 2027. Requiring hospitals to report on their use of evidence-based safety practices include safety culture assessments, leadership engagement in safety and use of evidence-based protocols to prevent harm will help give patients and health care purchasers a clearer picture of whether hospitals have systems in place to prioritize patient safety.

In the appendix to this letter, you'll find resources that support our comments in this letter and that you might find useful.

On behalf of The Leapfrog Group, our Board, our members and others who have signed in support of our letter, we appreciate the opportunity to provide comments on the proposed changes to the FY 2026 IPPS proposed rule.

Sincerely,

Leah Binder, M.A., M.G.A
President & Chief Executive Officer
The Leapfrog Group

Cosigning Individuals and Organizations Supporting these comments on the CMS FY 2026 proposed rule:

APPENDIX: THE LEAPFROG GROUP'S CITATIONS SUPPORTING COMMENTS REGARDING FY2026 IPPS PROPOSED RULE

1. Baker, M. C., Alberti, P. M., Tsao, T. Y., Fluegge, K., Howland, R. E., & Haberman, M. (2021). Social Determinants Matter for Hospital Readmission Policy: Insights From New York City. Health Affairs, 40(4), 645 654. Available at: https://doi.org/10.1377/hlthaff.2020.01742

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3. Hill-Briggs, F. (2021, January 1). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: https://care.diabetesjournals.org/lookup/doi/10.2337/dci20-0053

4. Jaffrey, J.B., Safran, G.B., Addressing Social Risk Factors in Value-Based Payment: Adjusting Payment Not Performance to Optimize Outcomes and Fairness. Health Affairs Blog, April 19, 2021. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20210414.379479/full/

5. TK Fraze, AL Brewster, VA Lewis, LB Beidler, GF Murray, CH Colla. Prevalence of screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals. JAMA Network Open 2019; 2:e1911514.10.1001/jamanetworkopen.2019.11514.31532515.

6. Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation. Available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page

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8. American Hospital Association. Fast Facts on U.S. Hospitals, 2025. Available at: https://www.aha.org/statistics/fast-facts-us-hospitals

9. U.S. Department of Health & Human Services. (2020) Executive Summary Report to Congress: Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program. Office of the Assistant Secretary for Planning and Evaluation. Available at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//195046/Social Risk-in-Medicare%E2%80%99s-VBP-2nd-Report-Executive-Summary.pdf

10. Health Equity Strategic Pillar. Centers for Medicare & Medicaid Services. https://www.cms.gov/pillar/health equity

11. HHS Office of Minority Health. (2020). Progress Report to Congress, 2020 Update on the Action Plan to Reduce Racial and Ethnic Health Disparities. Department of Health and Human Services. Available at: https://www.minorityhealth.hhs.gov/assets/PDF/Update_HHS_Disparities_Dept-FY2020.pdf

12. Heslin KC, Hall JE. (2021). Sexual Orientation Disparities in Risk Factors for Adverse COVID-19–Related Outcomes, by Race/Ethnicity — Behavioral Risk Factor Surveillance System, United States, 2017–2019. MMWR Morb Mortal Wkly Rep, 70(5), 149. doi: 10.15585/mmwr.mm7005a1.

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19. Deans, KJ, Minneci PC, Suffredini, AF, Danner, RL, Hoffman, WD, Ciu, X, Klein, HG, Schecter, AN, Banks, SM, Eichacker, PQ, Natanson, C. Randomization in clinical trials of titrated therapies: Unintended consequences of using fixed treatment protocols. Crit Care Med 2007; 35:1509–1516.

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