THELEAPFROGGROUP
Giant Leaps for Patient Safety

June 9, 2026

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

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Dr. Mehmet 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 collect and publicly report safety and quality data at the national level, thereby bringing a unique perspective on measures that hospitals can effectively collect and report to health care consumers. In addition, we use Centers for Medicare & Medicaid Services (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 CMS on the proposed changes to the FY 2027 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.

This proposed rule is one of the most promising for quality of care that Leapfrog has ever seen. There are two areas in the proposed rule for which we'd like to express our strongest possible support.

1. **Inclusion of Medicare Advantage:** We strongly support CMS's move toward including Medicare Advantage in the calculation of some measures in the Hospital Inpatient Quality Reporting Program, as outlined in this proposed rule. With approximately half of all Medicare beneficiaries enrolled in a Medicare Advantage plan[3], their exclusion creates a significant gap in the data, overlooking the quality of care for tens of millions of beneficiaries and limiting patients' and families' ability to make fully informed decisions about where to seek care. This will close that gap, which will be very beneficial for patients, families and employers.

2. **Unique Device Identifiers:** We strongly support CMS's proposal to modify the Public Health and Clinical Data Exchange objective to add a measure tracking Unique Device Identifiers (UDI) for implantable medical devices and urge CMS to finalize it. When a device is linked to an adverse event or recall, the ability to quickly and accurately identify every affected patient can be the difference between a timely intervention and a delayed one — a challenge made more complex

by the fact that implantable devices remain in the body long after the initial procedure. Standardizing UDI capture in electronic health records will build the infrastructure needed to connect device data across care settings and over time, strengthening post-market surveillance and the nation's ability to detect safety signals early.

Additionally, we have recommendations on transparency that are important principles for IPPS but remain 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 in hospital performance through its excellent Star Ratings program, and we encourage you to extend that leadership by making Care Compare more meaningful to consumers. For the data to be valuable to health care consumers, it has to differentiate 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 this is not the case, and the difference can mean the difference between life and 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 brick-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 consumers' needs 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 in which 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 more easily discerning performance at their own facility and determining 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 at general acute care facilities have access to. Rates of infections, hospital-acquired conditions, mortality, and readmissions are all important factors in selecting a hospital. Those in communities served by hospitals that are exempt from 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 set of measures in fiscal year 2027. Requiring hospitals to report on their use of evidence-based safety practices, including safety culture assessments, leadership engagement in safety, and the use of evidence-based protocols to prevent harm, will help provide patients and health care purchasers with 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 FY2027 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 FY2027 proposed rule:

APPENDIX: THE LEAPFROG GROUP'S DETAILED COMMENTS ON THE FY2027 IPPS PROPOSED RULE

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

Proposal to adopt three measures for the Hospital IQR Program

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19315 – June 9, 2026

The proposed measures include:

- Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination.
- Hospital Harm-Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM) beginning with the FY 2030 payment determination.
- Advance Care Planning eCQM beginning with the FY 2030 payment determination.

We support the inclusion of these measures in the Hospital IQR program. We are encouraged to see CMS continue to move toward electronic clinical quality measures (eCQMs) in its public reporting programs. Reporting eCQMs allows hospitals to share more timely quality data, providing patients and their families with critical and understandable information to help inform their health care decisions[1].

We particularly support the addition to the Excess Days in Acute Care After Hospitalization for Diabetes measure and the continued focus on improving outcomes for people living with diabetes. Of the 37 million people in the U.S. living with diabetes, 8 million are admitted to the hospital each year with related complications[2]. We recognize the importance of meaningful quality measures that help drive accountability, improve care coordination and support better patient outcomes.

Through our Recognized Leader in Caring for People Living with Diabetes program, developed in partnership with the American Diabetes Association (ADA), we work directly with hospitals to advance compliance with ADA clinical guidelines. Despite the availability of these evidence-based standards, adherence remains in its early stages in most hospital settings. This measure will be an important tool in encouraging a greater focus on these highly vulnerable patients and driving the system-wide accountability needed to close that gap.

Proposal to change data reporting and submission requirements for certain measures

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19315 – June 9, 2026

The proposal includes:

- Mandatory reporting for the Malnutrition Care Score eCQM beginning with the FY 2030 payment determination.
- Establishing a mandatory reporting policy to make hospital harm eCQMs mandatory after two years of reporting, beginning with the FY 2030 payment determination.
- An update to the reporting of the Maternal Morbidity Structural Measure, beginning with the FY 2028 payment determination, to identify which perinatal quality collaborative program the hospital participates in.

We strongly support these changes and encourage CMS to continue developing and implementing eCQMs, including making their reporting mandatory. Malnutrition, hospital harm, and maternal morbidity are all critical to beneficiaries and important to employers and other purchasers of care as well. The CMS move toward eCQMs is a high priority for purchasers and consumers, to the extent that it ultimately enables more timely and accurate public reporting of important information. We would prefer a more rapid, phased approach to implementing mandatory reporting and including all adult patients, and we encourage CMS to finalize the proposals.

Proposal to adopt five modified mortality measures

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19315 – June 9, 2026

Modifications include adding Medicare Advantage patients and shortening the performance period from 3 years to 2 years for the following measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery measure.

We strongly support CMS's move toward including Medicare Advantage in the calculation of these measures. We also strongly support the use of condition-specific mortality measures and encourage CMS to finalize as proposed. With approximately half of all Medicare beneficiaries enrolled in a Medicare Advantage plan[3], their exclusion silences our knowledge of the quality of care for tens of millions of beneficiaries. It creates a significant gap in the data — one that limits patients' and families' ability to make fully informed decisions about where to seek care. Quality of care should be CMS's top priority for all beneficiaries. We also support shortening the performance period, as CMS data indicate the measure remains reliable with a shorter period; more recent data is always more helpful for consumers.

Proposal to modify three Excess Days in Acute Care after Hospitalization measures

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19590 – June 9, 2026

The proposal includes modifying the following measures, beginning with the FY 2028 payment determination. Modifications include adding Medicare Advantage patients and shortening the performance period from 3 years to 2 years:

- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction.
- Excess Days in Acute Care after Hospitalization for Heart Failure.
- Excess Days in Acute Care after Hospitalization for Pneumonia.

As stated above, we strongly support the modifications to measures to include Medicare Advantage data and shorten the performance period. We strongly support CMS's move toward including Medicare

Advantage in the calculation of these measures. With approximately half of all Medicare beneficiaries enrolled in a Medicare Advantage plan[3], their exclusion creates a significant gap in the data — one that limits patients' and families' ability to make fully informed decisions about where to seek care. This will close that gap, which will be very beneficial for patients, families and employers. We also support shortening the performance period, as CMS data indicate the measure remains reliable with a shorter period; more recent data is always more helpful for consumers.

Measures related to excess days in acute care are meaningful to employers, patients, and their families, and we support CMS's efforts to ensure these measures are meaningful and reliable.

Proposal to remove three measures

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19585– June 9, 2026

The proposal calls for removing three measures beginning with the FY 2030 payment determination:

- Venous Thromboembolism Prophylaxis (VTE-1) eCQM.
- Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM.
- Discharged on Antithrombotic Therapy (STK-02) eCQM.

As we understand it, VTE and antithrombotic therapy safety information are captured in other measures; we support the removal of these measures, provided there is no gap in public reporting, as these measures are retired. There are extremely dangerous events for patients and families, so continuous reporting is critical.

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19391 – June 9, 2026

We recommend CMS build upon the measures in the Hospital-Acquired Conditions (HAC) Reduction Program. While the program has historically focused heavily on infections, infections are not the only serious and preventable harms patients face during a hospital stay. We encourage CMS to take a broader view of the HAC program as an opportunity for continued expansion — one that keeps pace with the field as measures are validated and ready for accountability programs. Making the program more comprehensive and meaningful requires including the full spectrum of preventable harm. Several strong candidates already exist within CMS's own portfolio:

• Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)
• Hospital-Onset Bacteremia and Fungemia Outcome Measure (proposed 2023)
• Hospital Harm – Pressure Injury (HH-PI)
• Hospital Harm – Falls with Injury (HH-FI)
• Hospital Harm – Postoperative Respiratory Failure (HH-RF)
• Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (IP-ExRad)

Migrating proven IQR measures into the HAC Reduction Program would strengthen accountability, create stronger incentives for hospitals to address preventable harm, and provide patients and families with a more complete picture of hospital safety.

UNIQUE DEVICE IDENTIFICATION

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19629 – June 9, 2026

We strongly support CMS's proposal to modify the Public Health and Clinical Data Exchange objective to add a measure that tracks Unique Device Identifiers (UDIs) for implantable medical devices, and urge CMS to finalize it. Tracking UDIs for implantable medical devices has the potential to significantly reduce patient safety incidents by accurately identifying the devices involved in adverse events — information critical to post-market surveillance and tracking patient outcomes.

When a medical device is linked to an adverse event or recall, the ability to quickly and accurately identify every patient who received that device can be the difference between a timely intervention and a delayed one[4]. Without reliable UDI tracking, providers and public health officials are often left without a complete picture of which patients may be at risk, slowing response times and potentially exposing patients to continued harm[5]. Implantable devices carry unique risks precisely because they remain in the body long after the initial procedure, making longitudinal tracking not just useful, but essential[6]. Standardizing UDI capture in electronic health records through this measure will build the infrastructure needed to connect device data across care settings and, over time, strengthen the nation's ability to detect safety signals early and act on them quickly.

REQUESTS FOR INFORMATION

RFI: Potential use of the Emergency Care Access and Timeliness eCQM in the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19564 – June 9, 2026

We are pleased to see this measure added to the Hospital Outpatient Quality Reporting (HOQR) program, which was finalized in the OPPS CY 2026 final rule last year, and we support its addition to the IQR and VBP programs.

However, we do not support this “all or none” composite measure unless CMS commits to public reporting on each of the four underlying measures along with the composite performance. CMS does not discuss the public reporting intention in the proposed rule. We support publicly reporting facility-level performance at the individual measure level for the four measures that comprise this eCQM:

- Patient wait time – greater than one hour
- Whether the patient left the ED without being evaluated
- Patient ED boarding time – greater than four hours
- Patient ED length of stay – greater than eight hours

Beneficiaries and the public at large are deeply concerned about hospitals' performance on each of the four underlying measures. Still, they are less likely to care about or interpret the implications of a broad composite score. A further recommendation on granularity regarding the reporting of performance in each of the measures, we suggest that the individual measure ratings report facility-level performance regarding:

- Percent of cases in the numerator (e.g., X% of cases with a wait time greater than one hour)
- Performance in the 90th percentile for the three timed measures (e.g., X number of minutes was the 90th percentile for patient wait time)

We also offer a recommendation on the construct of the four measures related to the current stratifications by age (under 18 vs. 18 and over) and mental health status (with vs. without a mental health diagnosis). For the latter, we recommend replacing the denominator definition of "cases with a mental health diagnosis" with "patients awaiting a psychiatric bed." The presence of a mental health diagnosis alone often has little correlation with the length of time spent in the ED, as the visit may be unrelated to the individual's mental health condition. In contrast, the need to locate a psychiatric bed is a well-documented and significant driver of prolonged ED stays.

RFI: Potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19578 – June 9, 2026

According to the CDC, 1 in 3 adults who die in a U.S. hospital has sepsis during their hospital stay[8]. We strongly support CMS's work on the adult sepsis onset community measure and appreciate the focus on improving sepsis diagnosis, which is a priority for purchasers and consumers as well.

The proposed measure's criteria — requiring evidence of presumed serious infection alongside acute organ dysfunction within a defined timeframe — reflect a meaningful effort to standardize the capture of clinically significant sepsis events. We recognize that the numerator criteria are deliberately narrow, requiring either blood cultures or principal diagnosis codes with at least 4 qualifying days of antibiotic treatment, and objective evidence of organ dysfunction, such as vasopressor initiation, abnormal lab values, or respiratory support. While this specificity may limit the breadth of cases captured, we understand the value of a high-specificity definition in establishing a reliable baseline and driving consistent diagnostic practice.

We support the underlying goal of this measure: incentivizing the timely and accurate identification of sepsis. Improved diagnosis is foundational to improving outcomes, and having a nationally standardized measure focused on the community setting is a meaningful step forward.

RFI: Updating the scoring methodology associated with the Birthing Friendly Hospital designation

The Leapfrog Group comments to CMS on the FY 2027 IPPS Proposed Rule –p. 19597 – June 9, 2026

CMS seeks feedback on updating the scoring methodology associated with the Birthing Friendly Hospital designation.

Overall, Leapfrog supports the Birthing Friendly Hospital designation as baseline infrastructure but encourages CMS to continue strengthening the criteria for achieving the designation to make it more meaningful and reliable for patients, families and employers.

We provide the following feedback to the RFI:

Scoring Methodology

We have concerns that the proposed clustering approach may be difficult for consumers to interpret and for hospitals to use for quality improvement purposes. We encourage CMS to also publicly report the component measures alongside any summary designation results, so that the underlying performance data remains visible and actionable.

Small, Rural, and Safety Net Hospitals
All patients deserve a safe birth regardless of which hospital they choose for delivery. We caution against applying differing methodologies based on hospital type or size, as doing so risks creating a two-tiered standard for maternal safety.

Differential Measure Score Weighting
The proposed weighting — 55 percent for the Severe Obstetric Complications eCQM and 45 percent for the Cesarean Birth eCQM — has face validity, given that the severe obstetric complications component comprises two measures.

Tiered Approach to the Designation
We support exploring more opportunities to present variation in hospital performance. Limiting results to three categories would constrain meaningful differentiation, particularly given the significant variation among the component measures themselves. Depending on the distribution of results, hospitals with high outcome rates could still fall into a higher-performing category, obscuring important differences for consumers.

Peer Grouping
We do not support using delivery volume as a peer grouping variable, as this is inconsistent with our position that all patients should have a safe birth regardless of hospital size. We do not recommend establishing a minimum number of births for peer grouping beyond what is already required to meet the minimum sample size criteria for the outcome measures; hospitals that meet those criteria should be included. We do not have additional variables to recommend for peer grouping at this time.

Public Reporting
We recommend presenting more than three categories in the designation and being very clear about what is and is not included in each tier. Limiting the designation to one to three icons risks oversimplifying performance in a way that could mislead consumers.

We also have concerns about the designation's name. "Birthing Friendly" may be confused with "Baby-Friendly," a well-established designation awarded to hospitals that promote breastfeeding practices. This potential for confusion could undermine consumer understanding of what the designation actually represents. We encourage CMS to consider an alternative name that more clearly signals the designation's focus on maternal safety outcomes.

Information Exchange Requirements
We support removing electronic referral loop measures in favor of HIE bi-directional exchange and exchange via TEFCA as the only options to meet information exchange requirements for Promoting Interoperability beginning in CY2028. EMR adoption is now widespread, and all certified platforms have this capability. It would be disingenuous for any hospital to claim this requirement places an undue burden, and we support CMS holding all hospital types to the same standard without exception.

Consider Re-Adopting Early Elective Delivery Measure
The Early Elective Delivery (EED) measure was previously part of the Hospital Inpatient Quality Reporting (IQR) program. It was retired around 2020, largely because performance had improved significantly and the measure was deemed to have "topped out." We strongly encourage CMS to re-adopt this measure and to include it as part of the “Birthing Friendly” designation. CMS stopped requiring hospitals to report

on the measure, assuming that the vast majority of hospitals were no longer performing early elective deliveries. However, our 2025 Leapfrog Hospital Survey data show that 10% of participating hospitals lack a policy to prevent nonmedically indicated early elective delivery, the most important first step in preventing it. This suggests that hundreds of hospitals and tens of thousands of deliveries are occurring in hospitals that may be permitting early elective deliveries. The issue has been a top priority for employers, purchasers and consumers. Risks of EEDs include respiratory complications, NICU admission, and feeding difficulties in newborns[7].

CITATIONS

1. Centers for Medicare & Medicaid Services, “Get Started with eCQMs – About eCQMs,” and CMS Provider Data Catalog, “Timely & Effective Care.”
2. Centers for Disease Control and Prevention. "National Diabetes Statistics Report." U.S. Department of Health and Human Services, 2022, www.cdc.gov/diabetes/data/statistics-report/index.html.
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4. Food and Drug Administration. "Strengthening Our National System for Medical Device Postmarket Surveillance." FDA, 2019, www.fda.gov.
5. Department of Health and Human Services Office of Inspector General. "Hospitals Did Not Effectively Notify Patients About Recalled Implantable Medical Devices." HHS OIG, [year], oig.hhs.gov.
6. Food and Drug Administration. "Unique Device Identification System (UDI System)." FDA, www.fda.gov/medical-devices/device-advice-comprehensive-regulatory-assistance/unique-device-identification-system-udi-system.
7. American College of Obstetricians and Gynecologists. "Medically Indicated Late-Preterm and Early-Term Deliveries." ACOG Practice Bulletin No. 764, American College of Obstetricians and Gynecologists, Aug. 2019, www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/08/medically-indicated-late-preterm-and-early-term-deliveries.
8. Centers for Disease Control and Prevention. "About Sepsis." 2026, https://www.cdc.gov/sepsis/about/index.html.