THE LEAPFROG GROUP
Giant Leaps for Patient Safety

September 15, 2025

Mehmet Cengiz Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Dear Dr. Oz,

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 CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs rule.

For 25 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 this data in September 2020. Recognizing that most 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 result 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.

In the appendix to this letter, we detail our comments on items in this proposed rule including:

- Hospital Outpatient Quality Reporting (OQR) Program
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- Rural Emergency Hospital Quality Reporting (REHQR) Program
- Overall hospital quality star rating
- Inpatient Only List

There are a few areas of particular importance we'd like to draw your attention to.

We Urge CMS to Uphold Hospital Commitment to Health Equity (HCHE) Measure Across All CMS Programs
Although CMS finalized its decision to remove the Hospital Commitment to Health Equity (HCHE) measure in the FY 2026 IPPS rule, Leapfrog strongly urges CMS to reconsider and retain the measure in the IQR, OQR, ASCQR, and REHQR Programs. In the IPPS final rule, CMS emphasizes the importance of hospitals identifying gaps in patient care and "incorporating industry standards that may address challenges that could impact safe, high-quality health care delivery," noting that hospitals remain free to collect data they deem most important. We commend CMS for underscoring the value of hospitals proactively gathering and using safety and quality data to

best serve their patients. The OPPS 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 facilities is not substantial; hospitals spend only about six minutes and $4.18 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.[8]

We Urge CMS to Uphold Social Determinates of Health (SDOH) Measure Across All CMS Programs
As the voice for employers and other health care purchasers, Leapfrog stresses that eliminating SDOH measures undermines providers' ability to efficiently improve outcomes and control costs. Productivity losses from illness often exceed direct medical costs, making it vital for employers and the public to know which hospitals are screening for social risk factors like poverty, housing instability and food insecurity. CMS's proposal to remove these measures, citing "burden," overlooks evidence that patients with social risk factors incur more than double the costs of others and that screening reduces emergency visits and readmissions[9]. Leapfrog urges CMS to retain SDOH measures in the IQR and OQR Programs, focusing on patient outcomes rather than provider convenience.

We Support the Availability of More Data on Emergency Department Wait Times
Leapfrog supports CMS's emphasis on emergency department (ED) performance in the FY 2026 OPPS Proposed Rule, recognizing that ED wait times and related data are critically important to patients and families. Leapfrog does not support the proposed "all-or-none" composite ED measure unless CMS commits to publicly reporting results for each of the four underlying measures—wait times over one hour, patients leaving without evaluation, boarding times over four hours and length of stay over eight hours. These individual measures are more meaningful to patients than a single composite score. Leapfrog recommends that CMS report facility-level data showing both the percentage of cases meeting each threshold and the 90th percentile time for the three timed measures. Additionally, Leapfrog suggests refining the mental health stratification: rather than grouping by "cases with a mental health diagnosis," focus on "patients awaiting a psychiatric bed," as this more accurately reflects prolonged ED stays.

The Leapfrog Group, including our Board, members and interested parties, appreciates the opportunity to share our comments on the proposed changes to the CY 2026 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 CY 2026 proposed rule:

APPENDIX: THE LEAPFROG GROUP'S DETAILED COMMENTS REGARDING CY 2026 OPPS PROPOSED RULE

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

- **Request for Information: Measure Concepts Under Consideration for Future Years in the Hospital OQR Program: Well-Being and Nutrition**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 623 – September 15, 2025

We commend CMS for this area of consideration, which recognizes that a holistic view of the well-being of the patient is relevant to the quality and effectiveness of health care delivery. But rather than developing new measures, we urge CMS to focus on retaining and strengthening existing measures that are already effective and less burdensome, because infrastructure exists to collect the data—such as those addressing social determinants of health (SDOH).

Unfortunately, CMS finalized the rule to eliminate SDOH measures from the IPPS and is proposing to do so for OPPS. Maintaining SDOH measures reduces administrative burden, because SDOH measures are developed and in place in the ASCQR, OQR and REHQR Programs. It also provides evidence-based data on the full range of factors that influence patient outcomes, allowing clinicians to tailor treatment plans to the whole patient. We urge CMS to revisit SDOH measures as part of its vision for person-centered care.

- **Proposal to Remove the Hospital Commitment to Health Equity measure**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 627 – September 15, 2025

Although CMS finalized the removal of the Hospital Commitment to Health Equity (HCHE) measure in the FY 2026 IPPS rule, Leapfrog urges CMS to reconsider this decision and retain the measure in both the IQR and OQR Programs. In the IPPS final rule, CMS emphasizes the importance of hospitals identifying gaps in patient care and "incorporating industry standards that may address challenges that could impact safe, high-quality health care delivery," noting that hospitals remain free to collect data they deem most important. We commend CMS for underscoring the value of hospitals proactively gathering and using safety and quality data to best serve their patients. The OPPS 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 facilities is not substantial; hospitals spend only about six minutes and $4.18 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.[8]

- **Proposal to Remove Two Social Determinants of Health Measures**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 628– September 15, 2025

As a voice for employers and others funding health care, Leapfrog is concerned that removing these measures reduces the ability of health care providers to achieve the best possible outcomes at the most efficient cost. Illness-related productivity loss represents a major cost to employers—often exceeding the direct costs of medical care. 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.

Although CMS finalized the removal of social determinants of health (SDOH) measures in the FY 2026 IPPS rule, Leapfrog urges CMS to reverse this decision and retain these measures in the IQR and OQR Programs. This rule also proposes removing SDOH measures from the OQR 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).[9] Screening for SDOH reduces waste as it has been evidenced to lessen emergency department visits[21] and readmissions[4]. This highlights the need for targeted interventions that reduce costs and improve care quality.

- **Proposal to Update the Extraordinary Circumstances Exception Policy**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 318– September 15, 2025

We support two of the three proposals to allow for an Extraordinary Circumstances Exception (ECE), which are:

- Allowing hospitals to request an ECE within 30 days
- CMS notifying the requestor whether the agency has granted the hospital an extension of time to comply with one or more reporting requirements

We object to the introduction of the third allowance for an ECE, which is stated as:

- *"CMS granting an ECE to facilities that haven't requested an ECE if CMS determines a systemic problem with a CMS data collection system directly impacted the ability of the facility to comply with a quality data reporting requirement, or that a circumstance affected an entire region or locale."*

While Leapfrog supports ECEs for individual hospitals, we are concerned that granting wholesale exceptions for entire regions or locales is not in the best interest of beneficiaries or the public at large who depend on access to this information. Public reporting on quality by facility is a major resource for purchasers and employers who depend on CMS data to assess the quality and safety of care delivered to their employees and their dependents. Given the importance of quality reporting, we suggest CMS remove this third ECE criterion from the policy.

- **Proposal to Add the Emergency Care Access and Timeliness eCQM**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 634– September 15, 2025

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 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 the performance of hospitals in each of the four underlying measures but 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[2,3].

- **Proposal to Remove Two Emergency Department Measures**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 645– September 15, 2025

We conditionally support retiring the two proposed emergency department (ED) measures. The stipulation for removing these measures is that the proposed Emergency Care Access and Timeliness eCQM is adopted without a gap of time between publicly reporting the eCQM and the retirement of these two ED measures. There is already a thin set of ED measures and the public has a right to be able to evaluate the performance of EDs in their area.

- **Proposal to Suspend Mandatory Reporting Plans for the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Outpatient) Measure (Excessive Radiation eCQM)**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 648– September 15, 2025

We support a temporary extension of voluntary reporting for this eCQM, coupled with a defined two-year timeline for making the measure mandatory. In the meantime, CMS should move quickly to identify and enable alternative reporting options beyond the current sole software available from UCSF.

Diagnostic imaging is presently a significant area of harm[11,12] to patients and a contributor towards waste in health care [13,14]. Yet there are few inpatient or outpatient imaging quality measures available. There needs to be a rapid movement towards creating other solutions to measuring and improving imaging, such as maximizing the use of AI. Broadly speaking, we urge CMS to move quickly in the direction of measure development in this current gap of diagnostic imaging.

AMBULATORY SURGERY CENTER QUALITY REPORTING (ASCQR) PROGRAM

- **Request for Information: Measure Concepts Under Consideration for Future Years in the ASCQR Program: Well-Being and Nutrition**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 623 – September 15, 2025

We commend CMS for this area of consideration, which recognizes that a holistic view of the well-being of the patient is relevant to the quality and effectiveness of health care delivery. But rather than developing new

measures, we urge CMS to focus on retaining and strengthening existing measures that are already effective and less burdensome, because infrastructure exists to collect the data—such as those addressing social determinants of health (SDOH).

Unfortunately, CMS finalized the rule to eliminate SDOH measures from the IPPS and is proposing to do so for OPPS. Maintaining SDOH measures reduces administrative burden, because SDOH measures are developed and in place in the ASCQR, OQR and REHQR Programs. It also provides evidence-based data on the full range of factors that influence patient outcomes, allowing clinicians to tailor treatment plans to the whole patient. We urge CMS to revisit SDOH measures as part of its vision for person-centered care.

- **Proposal to Remove the Commitment to Health Equity measure**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 627 – September 15, 2025

Although CMS finalized the removal of the Hospital Commitment to Health Equity (HCHE) measure in the FY 2026 IPPS rule, Leapfrog strongly urges CMS to reconsider this decision and retain the measure in both the IQR and ASCQR Programs. In the IPPS final rule, CMS emphasizes the importance of hospitals identifying gaps in patient care and "incorporating industry standards that may address challenges that could impact safe, high-quality health care delivery," noting that hospitals remain free to collect data they deem most important. We commend CMS for underscoring the value of facilities proactively gathering and using safety and quality data to best serve their patients. The OPPS 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 facilities is not substantial; hospitals spend only about six minutes and $4.18 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.[8]

- **Proposal to remove two social determinants of health measures**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 628– September 15, 2025

As a voice for employers and others funding health care, Leapfrog is concerned that removing these measures reduces the ability of health care providers to achieve the best possible outcomes at the most efficient cost. Illness-related productivity loss represents a major cost to employers—often exceeding the direct costs of medical care. 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.

Although CMS finalized the removal of social determinants of health (SDOH) measures in the FY 2026 IPPS rule, Leapfrog urges CMS to reverse this decision and retain these measures in the IQR and OQR Programs. This rule also proposes removing SDOH measures from the ASCQR 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).[9] Screening for SDOH reduces waste as it has been evidenced to lessen emergency department visits[21] and readmissions[4]. This highlights the need for targeted interventions that reduce costs and improve care quality.

- **Proposal to update the Extraordinary Circumstances Exception policy**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 318– September 15, 2025

We support two of the three proposals to allow for an Extraordinary Circumstances Exception (ECE), which are:

- Allowing hospitals to request an ECE within 30 days
- CMS notifying the requestor whether the agency has granted the hospital an extension of time to comply with one or more reporting requirements

We object to the introduction of the third allowance for an ECE, which is stated as:

- *"CMS granting an ECE to facilities that haven't requested an ECE if CMS determines a systemic problem with a CMS data collection system directly impacted the ability of the facility to comply with a quality data reporting requirement, or that a circumstance affected an entire region or locale."*

While Leapfrog supports ECEs for individual hospitals, we are concerned that granting wholesale exceptions for entire regions or locales is not in the best interest of beneficiaries or the public at large who depend on access to this information. Public reporting on quality by facility is a major resource for purchasers and employers who depend on CMS data to assess the quality and safety of care delivered to their employees and their dependents. Given the importance of quality reporting, we suggest CMS remove this third ECE criterion from the policy.

- **Proposal to add the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM)**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 683– September 15, 2025

We support the Information Transfer PRO-PM as it addresses an important component of the outpatient care delivery process that we need to get right to ensure success after discharge. Evidence demonstrates that poor discharge information results in poor outcomes, such as mortality and readmissions [15,16]. As the measure was finalized in the OPPS CY25 rule for inclusion in the OQR Program, adding this measure to the ASCQR Program is a positive step to aligning measures across settings.

The measure is also important to add because performance in the Information Transfer PRO-PM is indicative of waste. The patient's level of comprehension of their follow up care needs post-procedure is linked to their return to the emergency department [18] and hospital readmissions [19,20].

We offer several suggestions aimed at improving the measure. First, while we support implementation of the measure in the timeframe per the OPPS proposed rule, we recommend beginning to plan for integrating the measure into the OAS CAHPS instrument. With the recent introduction of OAS CAHPS and the forthcoming addition of the Information Transfer PRO-PM, individuals will soon be required to complete at least two surveys regarding their recent procedure. While it appears that administering the Information Transfer PRO-PM two to seven days post-procedure will help with the completion rate, we are all very aware that CAHPS instruments generally are experiencing declining response rates overtime. A recent study across eight CAHPS tools revealed an 18% drop in survey response rates in a seven year period [17]. We need to address and mitigate the impact that adding the Information Transfer PRO-PM will have on the rate of patients completing both surveys. We urge CMS to consider consolidating these two instruments to potentially enhance the response rates for both the Information Transfer PRO-PM and OAS CAHPS surveys.

Second, the testing of the Transfer PRO-PM instrument needs to quickly expand beyond being offered in only English and Spanish. Given that the HCAHPS survey is available in nine languages, CMS has established a standard that all other survey tools should also meet. We need one standard for the languages in which surveys

required by CMS will be available. We strongly recommend facilities be required to offer the survey in the language preferred by the person when it is one of these nine languages. It is aligned with the ethics and inclusivity efforts. Further, such a requirement (vs. allowing it to be voluntary) mitigates gaming the measure when the facility perceives it may receive a poor rating from a particular person or population.

RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM

- **Request for Information: Measure Concepts Under Consideration for Future Years in the REHQR Program: Well-Being and Nutrition**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 623 – September 15, 2025

While this area may be relevant in certain settings (e.g., inpatient hospital or primary care), it is a low priority in the settings covered by the OPPS (e.g., ASCs and HOPDs). Rather than developing new measures, CMS should focus on retaining and strengthening existing measures that are already effective—such as those addressing social determinants of health (SDOH). In this very RFI, CMS acknowledges that factors beyond health status influence outcomes. Removing SDOH measures would contradict that recognition and risk losing valuable insights into how these broader factors impact patient care.

Further, CMS already has solid SDOH measures developed and in place in the ASCQR, OQR and REHQR Programs. Improving a facility's ability to access an individual's SDOH has the potential to reduce barriers to accessing care, address disproportionate expenditures on high-risk groups and improve the health care quality[4,5,6,7]. The Well-Being and Nutrition RFI notes this is an area that "emphasizes person-centered care." We contend that a key initial step to person-centered care is first accessing and understanding where patients are in terms of their SDOH.

- **Proposal to Remove the Hospital Commitment to Health Equity measure**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 627 – September 15, 2025

Although CMS finalized the removal of the Hospital Commitment to Health Equity (HCHE) measure in the FY 2026 IPPS rule, Leapfrog strongly urges CMS to reconsider this decision and retain the measure in both the IQR and REHQR Programs. In the IPPS final rule, CMS emphasizes the importance of hospitals identifying gaps in patient care and "incorporating industry standards that may address challenges that could impact safe, high-quality health care delivery," noting that hospitals remain free to collect data they deem most important. We commend CMS for underscoring the value of hospitals proactively gathering and using safety and quality data to best serve their patients. The OPPS 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 facilities is not substantial; hospitals spend only about six minutes and $4.18 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.[8]

- **Proposal to remove two social determinants of health measures**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 628– September 15, 2025

As a voice for employers and others funding health care, Leapfrog is concerned that removing these measures reduces the ability of health care providers to achieve the best possible outcomes at the most efficient cost.

Illness-related productivity loss represents a major cost to employers—often exceeding the direct costs of medical care. 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.

Although CMS finalized the removal of social determinants of health (SDOH) measures in the FY 2026 IPPS rule, Leapfrog urges CMS to reverse this decision and retain these measures in the IQR and OQR Programs. This rule also proposes removing SDOH measures from the REHQR 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).[9] Screening for SDOH reduces waste as it has been evidenced to lessen emergency department visits[21] and readmissions[4]. This highlights the need for targeted interventions that reduce costs and improve care quality.

- **Proposal to update the Extraordinary Circumstances Exception policy**

The Leapfrog Group comments to CMS on the FY 2026 OPPS Proposed Rule –p. 318– September 15, 2025

We support two of the three proposals to allow for an Extraordinary Circumstances Exception (ECE), which are:

- Allowing hospitals to request an ECE within 30 days
- CMS notifying the requestor whether the agency has granted the hospital an extension of time to comply with one or more reporting requirements

We object to the introduction of the third allowance for an ECE, which is stated as:

- *"CMS granting an ECE to facilities that haven't requested an ECE if CMS determines a systemic problem with a CMS data collection system directly impacted the ability of the facility to comply with a quality data reporting requirement, or that a circumstance affected an entire region or locale."*

While Leapfrog supports ECEs for individual hospitals, we are concerned that granting wholesale exceptions for entire regions or locales is not in the best interest of beneficiaries or the public at large who depend on access to this information. Public reporting on quality by facility is a major resource for purchasers and employers who depend on CMS data to assess the quality and safety of care delivered to their employees and their dependents. Given the importance of quality reporting, we suggest CMS remove this third ECE criterion from the policy.

- **Proposal to Add the Emergency Care Access and Timeliness eCQM**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 634– September 15, 2025

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 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 the performance of hospitals in each of the four underlying measures but 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[2,3].

OVERALL HOSPITAL QUALITY STAR RATING

- **Proposal to Emphasize Safety of Care in the Star Rating Methodology**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 701 – September 15, 2025

We commend CMS for proposing to emphasize patient safety more in the Star Ratings. This is a bold vision that puts the well-being of patients first. No facility with a poor track record on patient safety should ever be considered high quality. If patients are being harmed or killed from avoidable accidents, errors and infections, they are not getting quality care and CMS should ensure that is clear in public reporting.

In light of the preeminent importance of patient safety, we would urge CMS to consider going even further and capping at two stars for facilities with poor performance in the Safety of Care measure group, as defined in the OPPS proposed rule example—i.e., hospitals in the lowest (worst) quartile. If patients are not safe, CMS should not classify a facility as "average" (three stars) or higher, regardless of its performance in other measure groups. Star ratings should not reassure patients that a hospital is average quality (i.e., three stars) if that same facility has an exceptionally poor track record protecting them from avoidable harm.

INPATIENT ONLY LIST

- **Proposal to Eliminate the Inpatient Only List**

The Leapfrog Group comments to CMS on the CY 2026 OPPS Proposed Rule –p. 453 – September 15, 2025

While we support innovations in health care delivery that reduce or eliminate inpatient hospital stays and make care safer and more affordable, Leapfrog does not support elimination of the Inpatient Only List unless and until CMS has better and more comprehensive reporting on quality of care for procedures. Patients deserve to have systematic data on quality regardless of the setting of procedures, but to date reporting on outpatient settings has been far less robust than reporting on inpatient surgical procedures. Shifting a procedure from inpatient to outpatient settings, particularly a complex procedure that has never been performed outpatient, should require the highest levels of accountability for patient safety and outcomes. Thus, we do not support free movement of procedures to the outpatient setting when quality outcomes and patient safety are not fully reported in the outpatient setting. We recommend CMS moves to align quality reporting for inpatient and outpatient procedures, including health care associated infections, and then work on a system for permitting the shift to

outpatient when quality metrics are acceptable. Public reporting of those metrics will also allow beneficiaries, other patients and purchasers to make responsible decisions about where to seek services.

Unfortunately, we see nothing in the proposed rule noting a specified commitment from CMS to measure patient safety and quality issues arising from three year phased in removal of the IPO list. Note that where the proposed rule claims CMS has an increasing "ability" to measure safety of procedures in the outpatient setting, it stops short of shifting from an "ability" of the agency to a proposal to assure the implementation of such systemic and specific measurement and reporting to monitor procedures removed from the IPO list.

CITATIONS

1. AppriseMD. Eliminating the CMS IPO List will continue to complicate hospital stays. 2021. Available at: https://apprisemd.com/eliminating-the-cms-inpatient-only-list-will-continue-to-complicate-hospital-stays/#:~:text=%E2%80%9CGiven%20the%20depth%20and%20breadth,conduct%20in%20the%20outpatient%20setting.%E2%80%9D

2. Tuttle GA (2008). Access to psychiatric beds and impact on emergency medicine. Report of the Council on Medical Service, prepared for the American Medical Association (AMA). Chicago, IL: AMA. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a08-cms-psychiatric-beds-emergency-medicine.pdf

3. Lippert, S. C., Jain, N., Nesper, A., Fahimi, J., Pirrotta, E., & Wang, N. E. (2016). Waiting for care: Differences in emergency department length of stay and disposition between medical and psychiatric patients. Annals of Emergency Medicine, 68(4), S97. Available at: https://www.annemergmed.com/article/S0196-0644(16)30721-1/fulltext

4. Baker MC, Alberti PM, Tsao TY, Fluegge K, Howland RE, 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

5. Hammond G, Johnston K, Huang K, Joynt Maddox K (2020). Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death. Circulation: Cardiovascular Quality and Outcomes, 13 (6) 290-299. Available at: https://doi.org/10.1161/CIRCOUTCOMES.120.006752

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

7. Jaffrey JB, Safran GB (2021). 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/

8. Centers for Medicare and Medicaid Services (2022). 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

9. Aswani MS, Do LA, Shafer PR (2025). Use of Social Determinants of Health Z Codes Was Sparse, 2016-2022. Health Affairs. 44(5), 631-635. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01033

10. National Quality Forum (2014). Finding common ground for healthcare priorities: Families of measures for assessing affordability, population health, and person- and family-centered care. Final report July 1, 2014. Available at: file:///C:/Users/john6/Downloads/map_families_report%20(2).pdf

11. Berner ES, Graber ML (2008). Overconfidence as a cause of diagnostic error in medicine. Am J Med. 2008;121:S2–23. doi: 10.1016/j.amjmed.2008.01.001. Available at: https://pubmed.ncbi.nlm.nih.gov/18440350/

12. Roosen J, Frans E, Wilmer A, Knockaert DC, et al. (2000). Comparison of premortem clinical diagnoses in critically ill patients and subsequent autopsy findings. Mayo Clin Proc. 2000;75:562–567. doi: 10.4065/75.6.562. Available at: https://www.mayoclinicproceedings.org/article/S0025-6196(11)64581-3/abstract#:~:text=Results%3A,class%20I%20missed%20major%20diagnoses).

13. Bassett, M (2014). Unnecessary imaging: Up to $12 billion wasted each year. Fierce Healthcare. Questex LLC. Available at: https://www.fiercehealthcare.com/it/unnecessary-imaging-costs-u-s-up-to-12-billion-annually

14. Anudjo MNK, Vitale C , Elshami W, Hancock A, Adeleke S, Franklin JM, Akudjedu TN (2023). Considerations for environmental sustainability in clinical radiology and radiotherapy practice: a systematic literature review and recommendations for a greener practice. Radiography, 29 (6), pp. 1077-1092. Available at: https://pubmed.ncbi.nlm.nih.gov/37757675/

15. Agency for Healthcare Research and Quality. Readmissions and Adverse Events After Discharge. Available at: https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge

16. Gabriel S, Gaddis J, Mariga NN, Obanor O, Okafor T (2017). Use of a daily discharge goals checklist for timely discharge and patient satisfaction. MedSurg Nursing. 2017; (4):236. Available at:

https://go.gale.com/ps/i.do?id=GALE%7CA503466842&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=10920811&p=AONE&sw=w&userGroupName=anon%7E2b4e36fd&aty=open-web-entry

17. Czajka JL, Beyler A (2016). Background paper declining response rates in federal surveys: Trends and implications. Mathematica Policy Research. 2016; 1, 1–86. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/255531/Decliningresponserates.pdf

18. DeSai C, Janowiak K, Secheli B, Phelps E, McDonald S, Reed G, Blomkalms A (2021). Empowering patients: simplifying discharge instructions. BMJ Open Quality; 10(3)001419. Available at: https://bmjopenquality.bmj.com/content/10/3/e001419

19. Choudhry, AJ, Younis, M., Ray-Zack, MD, Heller SF, Schiller HJ, Zielinski MD (2019). Enhanced readability of discharge summaries decreases provider telephone calls and patient readmissions in the posthospital setting. Surgery. 165(4):789-794. Available at: https://www.surgjournal.com/article/S0039-6060(18)30726-8/abstract

20. Becker C, Zumbrunn S, Beck K, Vincent A, Loretz N, Muller J, Amacher SA, Schaefert R, Hunziker S (2021). Interventions to Improve Communication at Hospital Dischargeand Rates of Readmission: A Systematic Review and Meta-analysis. JAMA Netw Open. 4(8):e2119346. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783547#google_vignette

21. Centers for Medicare & Medicaid Services. (2023). Accountable Health Communities (AHC) Model Evaluation: Second Evaluation Report. CMS Innovation Center. Previously available at the following link, but the report has been subsequently removed: https://www.cms.gov/priorities/innovation/data and-reports/2023/ahc-second-eval-rpt