



Patients For Patient Safety US

Submitted electronically on September 15, 2025

Honorable Mehmet Oz, MD, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Proposed Rule: Outpatient Prospective Payment System (OPPS) CY 2026

Dear Dr. Oz,

Patients for Patient Safety US (PFPS US) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed CY 2026 Outpatient Prospective Payment System (OPPS) rule.

PFPS US is a patient and family led network of individual patient safety advocates and strategic partner organizations working to elevate patient safety as a public health priority in the United States. Although led by users of care, our nationwide network includes a wide range of stakeholders: patients, family caregivers, healthcare providers, researchers, educators, employers, systems safety experts and stakeholder organization leaders, all dedicated to expediting the systemic changes needed to reduce preventable health care harm.

PFPS US and its partners strive to create a healthcare system that prioritizes the safety and well-being of every patient across health care settings. Improving patient safety, including accountability for the safety of care, will also reduce unnecessary health care spending, waste, and associated taxpayer burden. Our policy priorities align with CMS's emphasis on transparency, measurement, and public reporting, fortified by patient/family engagement, as drivers of improvement.

Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs:

Structural Measures

We are pleased to see stability in the Patient Safety Structural Measure (PSSM) and the Age Friendly Hospital Measure in the FY 2026 Proposed Rule. PFPS US strongly supports CMS's PSSM to advance hospital and facility leadership commitment to, and accountability for, establishing and maintaining a true patient safety culture. From Demming to Donebedian, structural measures have been critical to complement outcomes and process measures by actively engaging leadership and governance boards of health care organizations in establishing and maintaining organizational best practices. Sustainability is a stubborn challenge that historically



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has undermined continual progress in reducing preventable harms such as surgical site infection, falls with injury, pressure ulcers and other costly patient safety events. A recent Agency for Healthcare Research and Quality (AHRQ) **white paper** issued this spring reviewed the evidence on the effect of patient safety best practices and found that a lack of leadership engagement and maintenance of clear protocols in healthcare provider organizations were major barriers to improved safety. We are confident that CMS's advancement of the PSSM will incentivize leadership commitment and high reliability processes for patient safety improvement.

In the same vein, as with the IPPS rule, we are disappointed to see recommendations for the removal of the Social Determinants of Health (SDOH) and Hospital Commitment to Health Equity structural measures. Most hospitals collected SDOH data because it helps them understand their variance in their patients' needs and to connect with community organizations that can support patients. We remain concerned that removing these measures now signals that CMS no longer views leadership commitment and infrastructure as essential to delivering safe care for *each and every patient*. This would be a retreat on the promise to advance every American's well-being. We note that structural measures do not have financial penalties nor do they divert frontline healthcare workers from patient care. They create an incentive for good processes and establish standards that hospitals should strive to meet. To Make America Healthy Again, CMS should strengthen the connection between screening and care coordination for All Americans. Hospitals need support in making this data actionable, not leeway to avoid it. All Americans deserve to receive safe, person-centered care.

Hospital Outpatient Quality Reporting (OQR) Program:

Revise the **Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Outpatient)** measure (Excessive Radiation eCQM) **from mandatory reporting beginning with the CY 2027 reporting period to continue voluntary reporting in the CY 2027 reporting period and subsequent years.**

We strongly urge CMS to maintain the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) measure as a mandatory reporting requirement in the Hospital Outpatient Quality Reporting (OQR) Program. We oppose the proposed change to make this critical quality measure indefinitely voluntary, as doing so would undermine efforts to standardize practices and improve patient safety.

Standardized measurement is a proven driver of quality improvement, and consistent application of this measure across all outpatient hospitals is essential to ensuring that CT radiation doses are optimized for patient care. While diagnostic CT imaging provides indisputable and often life-saving benefits, the historical lack of standardization and oversight has resulted in radiation doses that are highly variable, frequently unoptimized, and often higher than necessary for diagnosis. This variability in dosing practice is unacceptable, especially given the scale of CT usage in the U.S. — with over 90 million exams performed in 2024 alone.



The potential consequences of excessive radiation exposure are clear and devastating. Studies have shown that unnecessarily high doses of radiation from CT imaging can lead to tens of thousands of preventable, iatrogenically induced cancers each year. The thresholds outlined in this measure provide hospitals with vital guardrails to optimize CT imaging practices, ensuring both patient safety and diagnostic accuracy. By adhering to these limits, hospitals can protect tens of thousands of patients annually from harmful radiation exposure while maintaining high quality care.

We urge CMS to stay the course and maintain this measure as a mandatory requirement in the Hospital OQR Program. Making it optional would be a step backward, weakening efforts to reduce unnecessary radiation exposure and compromising patient safety nationwide.

Replace the two chart-abstracted measures: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients and the Left Without Being Seen with the Emergency Care Access and Timeliness eCQM;

PFPS US applauds this strategy to improve outcomes for patients requiring emergency care. Delays in the timeliness of ED care are associated with significant patient harm, as is ED boarding after the patient has been seen and the decision made to admit. The Emergency Care Access & Timeliness eCQM measures boarding time in the ED, and time from arrival to placement in a treatment room, which are not currently captured by any other measure currently in the Hospital OQR Program measure set. These are vital indicators for everyone in the facility to understand.

That said, these are measures of timely access that are **very** important to patients. Therefore, we urge CMS to publicly report on each of the four underlying measures along with the composite performance and to do so at the facility level. 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.

With regard to the stratification of the measure by mental health status (with vs. without a mental health diagnosis), 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.

We understand that updating EHRs with new eCQM measures requires some initial investment from hospitals, but in the long-term it will automate timely collection of more useful information crucial to improving patient safety. Indeed, the measure was developed in response to comments about the importance of having such information and through a multi-stage, multi-stakeholder process and has been endorsed by the Consensus-Based Entity. We appreciate that CMS has committed to close review of its performance and any unintended



consequences, including potentially inappropriate use of “observation” status to circumvent the measure’s intent.

Rural Emergency Hospital Quality Reporting (REHQR) Program

We agree that Emergency Care Access and Timeliness eCQM measure is important and appropriate to include under the REHQR Program because ED care is the primary focus of REHs.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

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).

PFPS US strongly supports the Information Transfer Patient-Reported Outcome Performance Measure as it addresses an important component of the delivery process where there is significant variation from facility to facility, and where significant safety risks occur - i.e., in the effective (or not) communication of information that patients need to know following a surgery or procedure, including the expected course of recovery, concerning signs or symptoms, and instructions for medication and follow-up, among others items. We are very pleased to see CMS tapping into the only source of “ground truth” to assess and improve the effectiveness of such communication – patients themselves. PFPS US urges CMS to quickly expand offering this measure from just English and Spanish to include all nine languages in which HCAHPS surveys are offered.

Overall Hospital Quality Star Rating Modification to Emphasize the Safety of Care Measure Group:

PFPS US strongly concurs that patient safety must be given greater weight in the Overall Hospital Quality Star Ratings methodology in order to better inform patients about the safety of the institutions where they are considering getting care, as well as to create incentives for provider organizations to invest in safety.

Reviewing the findings set forth in the original Request for Information and the updated July 2024 refresh, it is appalling that *any* hospitals in the lowest quartile of safety performance received a 5-stars Overall Hospital Quality rating. A public-facing score that conveys a high rating for *quality* when an organization is a poor performer on *safety* is misleading to say the least, and an unacceptable dilution of foundation role of patient safety in any formula for assessing quality. Nor does it provide the transparency of information needed to inform choice or protect patients who are trying to direct their care to institutions that prioritize safety. Moreover, as a reward methodology, it creates little incentive for organizational leadership to invest in and improve safety.



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CMS proposes a two-stage strategy to address the problem of hospitals in the lowest quartile of performance on safety nevertheless receiving 5 stars for overall quality:

Stage 1: For CY 2026, cap hospitals in the lowest quartile of Safety of Care (based on at least three measure scores) to a maximum of 4 stars out of 5. This aims to provide a targeted, direct, and timely solution to the acute concern of hospitals receiving the highest possible 5-star rating despite performing in the lowest quartile of the Safety of Care measure group.

Stage 2: Reduce the overall Hospital Quality Star Ratings of any hospital in the lowest quartile of Safety of Care (based on at least three measure scores) by 1 star, to a minimum 1-star rating. This proposed update would emphasize safety by applying a higher standard for patient safety to hospitals across a broad range of overall performance, rather than limiting it to the few 5-star hospitals in the lowest quartile of Safety of Care.

PFPS US **strongly supports** the direction of these proposed changes to emphasize safety as absolutely foundational to the Star Ratings (and any other quality rating) system. Ideally, CMS would go further, and establish a policy that **above average** (4 or 5) stars ratings will NEVER be rewarded to hospitals that are in the bottom quartile of the Safety of Care measures group. Accordingly, we continue to support ratings being lowered by one star **and** a prohibition of above average stars ratings for any organization in the lowest quartile of Safety of Care measures. We believe this would both provide better information to patients and create motivating incentives to invest in safety.

In addition, we note that in the July 2024 data, there were 100 hospitals in the lowest quartile of Safety of Care performance who did not submit 3 measures in that group, 18 of which still received a 4- or 5-star rating. To prevent gaming the system by not reporting Safety of Care measures that would drag on their Star Ratings, PFPS US urges CMS to establish that only hospitals that submit 3 or more Safety of Care measures should be able to be awarded a 4- or 5-stars rating.

We also strongly reiterate the importance of basing and reporting Overall Hospital Quality Star ratings at the individual provider organization CCN (CMS Certification Number) level, not at the system level. Beneficiaries and other patients have the right to know the performance rating for the actual bricks and mortar facilities they use or consider using. Rolling the Stars Ratings up to a multiple-facility, system-level composite score could mask actual performance that is low at individual facilities.

Thank you for this opportunity to share our views. We appreciate the opportunity to contribute.

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