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APIC COMMENTS ON PROPOSED CHANGES TO THE 2026 LEAPFROG HOSPITAL SURVEY
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APIC supports the science of re-baselining and Leapfrog's adoption of the NHSN 2022 baseline. Our comments address avoidable methodological discontinuity, and comparisons with CMS programs and prior Leapfrog results that the public may misread. We request your consideration of the following recommendations.

1) Consider treating 2026 as a transition year and label the baseline used.

Leapfrog will report results under both the 2015 and 2022 baselines within the 2026 cycle. CMS has moved Care Compare to the 2022 baseline, but it is phasing the new baseline into its payment programs over two years (HAC Reduction Program in FY 2028, Hospital VBP in FY 2029) and does not mix baselines within a single scoring period. We ask Leapfrog to consider a similar transition: publicly report 2022-baseline SIRs during the 2026 cycle without assigning new performance categories, or delay categorical scoring under the new model until the next full survey cycle. In either case, public reports should:

- State which baseline was used for each result, and that scores under different baselines are not directly comparable.
- Avoid describing a category change caused solely by re-baselining as improvement or decline.
- Show a visible break or annotation in historical trend displays where the 2022 baseline begins.

Without this, consumers and stakeholders may read a recalibration of the benchmark as a change in hospital performance.

2) Display the measurement period for each HAI result.

Leapfrog's reporting windows (July 2025 – June 2026, or July 2024 – June 2026 for hospitals with 50 or fewer beds) differ from the calendar-year data on Care Compare. Displaying the exact data period beside each result would help hospitals and consumers understand differences between Leapfrog scores and CMS-reported values.

3) **Publish the methodology behind the HAI cut-points.**

We ask Leapfrog to publish, for each measure:

- The number of hospitals included
- SIR distribution statistics
- The percentiles used to set thresholds
- The rationale for selecting the 27.5th and 50th percentiles.

We also ask Leapfrog to explain how it accounts for setting cut-points from CY 2025 SIRs while scoring hospitals on July 2025 – June 2026 data, since continued national improvement could shift the distribution between the two periods.

4) **Explain how the cut-points relate to CMS performance standards.**

Hospital VBP uses the national median as its achievement threshold and the mean of the top decile as its benchmark. Leapfrog's use of the 50th percentile as the boundary between Considerable and Some Achievement is broadly consistent with that approach, but the 27.5th percentile threshold for Achieved the Standard has no CMS counterpart. We recommend that Leapfrog compare its cut-points with CMS's 2022-baseline VBP performance standards when CMS releases them, and explain any material differences.

We are also concerned about measures with small predicted counts, particularly MRSA bacteremia and SSI Colon, where a single infection can move a hospital across more than one category. We ask Leapfrog to consider the confidence interval around each SIR, or a minimum number of predicted infections, before assigning the highest or lowest category. Because the SIR is a point estimate, small, predicted counts produce wide confidence intervals, and an SIR assigned to the highest or lowest category may not be statistically different from the national baseline. Basing categories on statistical significance, consistent with NHSN's 95% confidence intervals and CMS Care Compare's benchmark comparisons, would ensure hospitals are distinguished by true differences in performance rather than random variation.

5) **Hold HAI thresholds stable through the 2027 Survey cycle.**

We support maintaining fixed thresholds through the 2027 Survey, including any revisions made in response to public comment. Hospitals are adjusting to the 2022 baseline at the same time, and further changes would make performance evaluation difficult and reduce year-to-year comparability. Any future threshold changes should be announced at least one full survey cycle before implementation.

6) **Clarify the small-hospital reporting period and address measures that cannot be scored.**

We support efforts to include more small hospitals. Leapfrog should clarify:

- That eligibility is determined solely by "Total Number of Beds Set Up and Staffed" on the 2025 NHSN Annual Survey
- How hospitals may review and correct an inaccurate bed count before scoring
- Whether a formal appeal or correction process will be available.

Bed size is an imperfect proxy for statistical reliability. Hospitals with more than 50 beds can also have fewer than 1 predicted infection for a given measure over 12 months. In that case no SIR is calculated and the measure is reported as "Unable to Calculate Score," even if the hospital had infections. For example, a hospital with 2 observed infections and 0.8 predicted would in effect have a SIR above 2.0, yet those infections would not appear in its public results. We recommend that Leapfrog:

- Set the reporting period by measure-specific reliability (for example, extending to 24 months for any measure with fewer than 1 predicted infection in 12 months), or publish the analysis showing that the 50-bed threshold minimizes systematic bias.
- Display observed and predicted infection counts when a SIR cannot be calculated, and explain that "Unable to Calculate Score" reflects data volume, not performance.
- Ensure "Unable to Calculate Score" does not count against a hospital in any composite rating, including the Hospital Safety Grade.
- Report after the first cycle how many hospitals gained a SIR under the 24-month window, and whether 24-month results differed systematically from 12-month results.

A longer window is less responsive to recent improvement or deterioration, while a short period of unusually poor or favorable performance can have an outsized effect in a 12-month window. The measurement period should be displayed prominently with each score.

7) **Publish final methodology earlier and offer a preview.**

Final changes are expected before October 31, after the October 21 join-by date and the October 22 NHSN download. Earlier publication would let hospitals validate their NHSN data, evaluate expected performance under the 2022 baseline, and identify data

issues before public reporting. We also ask Leapfrog to give hospitals a preview of their scored results before public release, so they can verify data and prepare staff, boards and communities for changes driven by re-baselining.

8) **Explain how Leapfrog scoring relates to CMS HAI programs.**

We recommend educational materials describing key differences between Leapfrog HAI scoring, CMS HAC Reduction Program scoring, Care Compare reporting, and NHSN national benchmark methodology. The timelines differ in ways that are easy to misread: for example, CY 2026 HAI data will be scored on the 2022 baseline in the FY 2028 HAC Reduction Program but on the 2015 baseline in FY 2028 Hospital VBP. We also ask Leapfrog to clarify how 2022-baseline SIRs and the new cut-points will be used in upcoming Hospital Safety Grade calculations, including how results scored on different baselines within the same period will be handled.

9) **Publish an impact analysis of the transition.**

Before full implementation, Leapfrog should publish aggregate analyses showing:

- Expected score shifts due solely to re-baselining
- The number and percentage of hospitals expected to change performance categories
- Measure-specific impact.

This would help stakeholders distinguish actual performance changes from methodological ones.

APIC appreciates Leapfrog's efforts to improve hospital safety and infection prevention and control. We thank you for your work to make infection data available for more hospitals.