Important Note: Due to a delay in the January CMS data refresh, the Staff Responsiveness (H-COMP-3) measure was present in the CMS dataset downloaded on January 31 and will be included in the spring 2026 Hospital Safety Grade. Leapfrog will delay the temporary removal of Staff Responsiveness (H-COMP-3) to the fall 2026 Safety Grade.

Final Updates to the Leapfrog Hospital Safety Grade Methodology for the 2026 and 2027 Safety Grades

Leapfrog Hospital Safety Grades are issued twice per year, once in the spring and once in the fall, to nearly 3,000 acute care hospitals nationwide. On August 14, 2025, Leapfrog published planned updates to the Hospital Safety Grade methodology and held a public comment period through October 14, 2025. We received a variety of thoughtful comments from different perspectives, which were helpful in finalizing the methodology. We thank all the commenters for their insights. This document includes the final updates to the methodology as well as responses to the comments received.

The changes outlined in this document come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine and in response to stakeholder feedback. More information can be found on the Hospital Safety Grade website at hospitalsafetygrade.org/for-hospitals/key-dates-and-information.

SUMMARY OF CHANGES

~~**Spring 2026 and**~~ **Fall 2026 Safety Grades**

1. **Methodology update in response to CMS' temporary removal of Staff Responsiveness (H-COMP-3):** Given a recent change to a question in the "Staff Responsiveness" domain of the HCAHPS Survey, CMS plans to pause the public reporting of the domain on Care Compare for one year. In response to the pause, Leapfrog will temporarily remove Staff Responsiveness (H-COMP-3) and increase the weight of Nurse Communication (H-COMP-1).

Spring 2027 Safety Grade and Beyond

1. **Methodology update in response to CMS' permanent removal of PSI 4**: CMS will replace PSI 4 (Death Rate among Surgical Inpatients with Serious Treatable Complications) with the new Failure-to-Rescue measure. In response to this change, Leapfrog will remove PSI 4 and add Failure-to-Rescue to the Safety Grade methodology in spring 2027.

2. **NHSN update to the SIR model for healthcare-associated infections:** The spring 2027 Safety Grade will likely be the first cycle to incorporate healthcare-associated infections (HAI) measures calculated using the new NHSN 2022 baseline.
3. **Planned updates to the weighting methodology**: Leapfrog's national expert panel has convened a subcommittee to review the weighting methodology used in the Hospital Safety Grade. If a new weighting methodology is proposed, changes will be released for public comment in 2026 and not incorporated into the Safety Grade until spring 2027.

PLANNED UPDATES FOR THE ~~SPRING 2026 AND~~ FALL 2026 SAFETY GRADES

METHODOLOGY UPDATE IN RESPONSE TO CMS' TEMPORARY REMOVAL OF STAFF RESPONSIVENESS (H-COMP-3)

CMS introduced updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in January 2025. CMS modified one domain included in the Leapfrog Hospital Safety Grade: Responsiveness of Hospital Staff (H-COMP-3). The survey question previously asked about staff responsiveness after the "Call Button" was used. The "Call Button" component was removed from the question, and the question now asks about staff responsiveness after the patient asks for help. To ensure data is reflective of a single survey version, CMS temporarily stopped reporting the measure. CMS is expected to resume public reporting of the measure in October 2026. For more information, please see hcahpsonline.org/en/updated-hcahps-survey/.

In response to this change, Leapfrog will temporarily remove the Staff Responsiveness (H-COMP-3) measure and introduce a temporary scoring adjustment in the ~~spring and~~ fall 2026 Safety Grades. Removing the Staff Responsiveness (H-COMP-3) measure, with no other change to the methodology, places a greater weight on all measures in the process and structural domain. This would in turn prompt sudden and impermanent grade fluctuations. Therefore, Leapfrog and its research team, under the guidance of the national expert panel, sought to find a scoring adjustment that would most closely simulate the presence of the measure.

The analysis found that the relationship between Staff Responsiveness (H-COMP-3) and Nurse Communication (H-COMP-1) was stronger than the relationship of Staff Responsiveness (H-COMP-3) and the other HCAHPS measures included in the Safety Grade. Staff Responsiveness (H-COMP-3) linear mean scores have a strong positive correlation to Nurse Communication (H-COMP-1) linear mean scores (R^2= 0.731). One likely explanation is that nurses are most often responsible for responding to patient requests, and a positive experience with staff responsiveness would likely correspond to an overall positive interaction with nursing staff.

Due to this strong relationship, Leapfrog will temporarily increase the standard weight of Nurse Communication (H-COMP-1) by increasing the number of component measures from one to two. The estimated change to the standard weight for Nurse Communication measures is an increase from 3.0% to 5.1% (Table 1). This change is temporary and will revert once CMS resumes public reporting of the H-COMP-3 sub-domain.

Table 1. Estimated 2026 Hospital Safety Grade Weighting for the Process and Structural Measure Domain Using Spring 2025 Statistics*

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	New Standard Measure Weight	Previous Standard Measure Weight
CPOE	2	1.43	3	1	6.3%	6.2%
BCMA	2	1.37	3	1	6.1%	6.0%
IPS	2	1.67	3	1	7.0%	6.9%
SP 1	1	1.06	2	1	3.1%	3.1%
SP 2	1	1.12	2	1	3.2%	3.2%
Total Nursing Care Hours per Patient Day	2	1.41	2	1	4.8%	4.7%
Hand Hygiene	2	1.49	2	1	5.0%	4.9%
H-COMP-1	1	1.03	2	**2**	**5.1%**	3.0%
H-COMP-2	1	1.03	2	1	3.1%	3.0%
H-COMP-3	N/A	N/A	N/A	N/A	**0.0%**	3.0%
H-COMP-5	1	1.06	2	1	3.1%	3.1%
H-COMP-6	1	1.04	2	1	3.1%	3.0%

*Note: These weights and values are likely to change with the refresh of data in spring and fall 2026.

PLANNED UPDATES FOR THE SPRING 2027 SAFETY GRADE AND BEYOND

METHODOLOGY UPDATE IN RESPONSE TO THE CMS'S PERMANENT REMOVAL OF PSI 4

In October 2026, CMS plans to replace PSI 4 (Death Rate Among Surgical Inpatients with Serious Treatable Complications) with a new claims-based measure: The Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue). To align, Leapfrog will replace the PSI 4 measure with the Failure-to-Rescue measure in the spring 2027 Safety Grade and beyond. The first reporting period will be 07/01/2023- 06/30/2025. For more information about the measure, please see qualitynet.cms.gov/inpatient/measures/psi/upcoming.

NHSN UPDATE TO THE SIR MODEL FOR HEALTHCARE-ASSOCIATED INFECTIONS

CMS announced that they do not plan to publicly report data that uses NHSN HAI 2022 national baseline until the 2026 October Care Compare data refresh. As a result, the spring 2027 Safety Grade, which has a Data Snapshot Date of January 31, will likely be the first Safety Grade round to include data with the new baseline.

To ensure both sources of Safety Grade HAI data use the same baseline, the Leapfrog Hospital Survey will transition to the 2022 national baseline on a similar schedule as CMS. A Leapfrog transition plan for NHSN data downloads will be included in the 2026 Leapfrog Hospital Survey proposed changes.

For more information about the CDC HAI rebaseline initiative, please see cdc.gov/nhsn/2022rebaseline.

PLANNED UPDATES TO THE WEIGHTING METHODOLOGY

The Leapfrog Hospital Safety Grade national expert panel, which was convened this past May, seeks to ensure that the relative weights assigned to each measure reflect the latest evidence about each harm included in the score and its impact on patients' safety. A subcommittee was formed to review the weighting methodology and incorporation of the new "Failure-to-Rescue" measure in the Hospital Safety Grade. The work of the subcommittee will be supported by a research team at Johns Hopkins Medicine. The subcommittee will conduct its review and any proposed changes to the weighting algorithm will be shared with the full expert panel for a recommendation.

Any planned changes will be released for public comment in 2026 and incorporated in the spring 2027 Safety Grade.

RESPONSES TO PUBLIC COMMENTS

Six commenters supported the proposed methodology update to Staff Responsiveness (H-COMP-3). However, one of the five commenters suggested that Leapfrog explore splitting the weight previously allocated to Staff Responsiveness between both Nurse and Doctor Communication to acknowledge the broader team's role in responsiveness.
Response: We agree that doctors' communication is a crucial aspect of patient experience and can play a pivotal role in preventing errors or misdiagnoses. However, our analysis concluded that the correlation between Staff Responsiveness (H-COMP-3) and Doctor Communication (H-COMP-2) was not as strong ($R^2 = 0.467$) when compared to Nurse Communication ($R^2 = 0.731$).

One commenter requested detailed weighting rationale and additional analysis showing how this change impacts hospital Safety Grade distributions. They also requested that Leapfrog provide a timeline for reinstating the Staff Responsiveness measure (H-COMP-3).
Response: The weighting scheme and anticipated weight is provided in Table 1. Justification for the reweighting of Nurse Communication (H-COMP-1) is also provided above. Leapfrog completed a grade sensitivity analysis with the various options. Removing the Staff Responsiveness measure (H-COMP-3) with no additional allocation of weight caused the most grade changes. The other two options, redistributing the weight evenly to all HCAHPS measures or increasing the weight for H-COMP-1, resulted in almost half as many grade changes, with very little variation in overall grade changes between the two options. Ultimately, the decision to choose the latter was based on the rationale provided above. Additionally, we have stated that this change is temporary. Allocating a value of two for the "Number of Component Measures" of Nurse Communication (H-COMP-1) is dependent on the Staff Responsiveness measure (H-COMP-3) being unavailable. We anticipate that this increase in weight for Nurse Communication (H-COMP-1) will only be necessary for spring and fall 2026.

One commenter suggested applying the weight of Staff Responsiveness (H-COMP-3) evenly among the other HCAHPS measures to emphasize that all patient experience domains are equally critical in the care continuum.
Response: The mathematical correlation between Staff Responsiveness (H-COMP-3) and Nurse Communication (H-COMP-1) is unique, in that these two measures are more related than the other patient experience measures. While reallocating the weight to the other patient experience measures was considered as an option, it is a less optimal way to simulate the presence of Staff Responsiveness data and would cause more disruption to the grade distribution in the interim.

One commenter opposed the methodology update and proposed applying the weight of Staff Responsiveness (H-COMP-3) evenly among the other HCAHPS measures due to concerns about the overrepresentation of Nurse Communication. Additionally, they believed there was a lack of precedence and evidence that Nurse Communication is a substitute for measuring staff responsiveness and that this may unfairly impact some hospital types with different staffing models.
Response: Each of the HCAHPS measures included in the Leapfrog Hospital Safety Grade were selected by our national expert panel because they are important to patient safety. In making a temporary adjustment to the weights, we are not asserting that Nurse Communication is any more important than the other patient experience measures. Most hospitals that perform well in Nurse Communication also perform well in Staff Responsiveness, and vice versa. Regardless of hospital type, the proposed allocation of weight will likely represent a more accurate portrayal of hospital performance in Staff Responsiveness, compared to allocating its weight to all patient experience domains. Leapfrog would like to emphasize that this methodological change is temporary and less disruptive than removing the measure.

One commenter expressed support for replacing the PSI 4 measure with the Failure-to-Rescue measure in spring 2027 to align with CMS.
Response: We thank the commentor for their support. We are pleased that CMS has implemented a measure that covers a wider range of hospital-acquired complications and incorporates data for both Medicare Advantage and Medicare fee-for-service patients. While some complications after surgery may not be preventable, health care teams should be poised to anticipate or quickly recognize complications and respond to prevent harm to patients during their hospital stay.

One commentor requested that Leapfrog delay the adoption of the measure to allow stakeholders more time to evaluate the effectiveness and appropriateness of the measure. They also argued it was unfair that the measure included mortalities that could be unrelated to the patients' surgery.
Response: While Leapfrog understands the challenges of becoming familiar with a new safety and quality measure, we support CMS initiatives to improve and select more optimal measures for their reporting programs. The experts of the Partnership for Quality Measurement (PQM), managed by Batelle, have reviewed and endorsed the measure. In the FY 2025 IPPS Final Rule, CMS approved the removal of PSI 4 and addition of Failure-to-Rescue to the IQR Program Measure Set for FY 2027 payment determination and the Transforming Episode Accountability Model (TEAM). We believe that CMS has sufficiently validated the measure and presented substantial evidence that the metric can be used to evaluate organizational resilience and help hospitals improve existing structures and protocols to respond to patient deterioration.

The Failure-to-Rescue measure was introduced to address the limitations and coding challenges of PSI 4. The new measure is more encompassing, and similarly to PSI-4, its results should not be interpreted as if all deaths are the result of an untreated complication or delay in care. In the Leapfrog Hospital Safety Grade, hospitals are evaluated using their score in relation to the national average. In other words, hospitals are not expected to have a score of zero. They would be expected to perform on average or better than average.

Two commentors requested that Leapfrog delay the adoption of the measure to allow hospitals more time to become familiar with the measure. One of the commenters suggested hospitals need time to see how the measure will be publicly reported and assess the accuracy of the data. The other commenter suggested they should be given time to improve upon the measure before its adoption.
Response: CMS has stated that the measure uses administrative claims that are regularly submitted to CMS and will be calculated and reported in the same rolling 24-month period as PSI 4 and PSI 90. There will be no gap in reporting. Hospitals are encouraged to review the technical specifications already provided by CMS and utilize CMS preview periods to review data for accuracy. We do hope that hospitals use the metric for benchmarking and galvanizing change, but we advise that they don't wait until the measure's introduction to the Safety Grade to do so. Resources for providing timely and effective care are available.

Three commentors agreed with Leapfrog's alignment with CMS' timeline for implementing the new NHSN 2022 national baseline. One of the three commenters requested that Leapfrog take special precautions in the messaging around general increases of SIR values due to the recalibrations.
Response: We appreciate the positive response to our anticipated rollout of the 2022 Baseline HAI data. We are aware that the SIRs calculated using the new baseline will not be comparable to previous SIRs that were calculated using the 2015 Baseline and will not make direct comparisons to past years. A goal of the Leapfrog Hospital Safety Grade program is to evaluate hospitals in relation to other hospitals nationwide, and this will of course be done using the same SIR model for all hospitals.

One commenter requested that Leapfrog consider stakeholder input on the updates to the reweighting methodology, a methodology transition document and responses to public comments.
Response: We appreciate stakeholders' interest and input on the Leapfrog Hospital Safety Grade methodology. This is precisely why proposed methodology updates are published and open to public comment. It is our practice to closely consider these comments when finalizing the changes and ultimately publish a summary of those comments with responses. All 2026 and 2027 planned methodology updates that have been finalized are available in this document, so please use this document for planning purposes. The proposed reweighting methodology will be published in a similar manner and open for public comments in 2026. Please be sure to sign up for our hospital newsletter for all future announcements regarding proposed changes.

The same commenter requested that Leapfrog incorporate equity considerations into the Hospital Safety Grade.
Response: The Leapfrog Hospital Safety Grade methodology does not include equity adjustments to the overall scores because we believe that all hospitals have the duty to provide safe care for their patients regardless of resources. While we do include risk adjusted measures in the composite, not all measures are appropriate for risk adjustment, such as the DRA HAC measures, which are considered never events. Further, Leapfrog has long supported the stratification of patient safety measures to identify high risk populations, but adjustments are not appropriate for all patient safety measures.