

06/30/2026

RE: CBE IDs: 5601, 5602, 5603, 5604

Dear Partnership for Quality Measurement (PQM) Team:

LifeGift (TXGC) appreciates the opportunity to provide comments on the following measures:

- **CBE ID: 5601** Rate of Hospital Referrals of Potential Organ Donors Made to the Organ Procurement Organization (OPO) from within the OPO's Donation Service Area in a Calendar Year.
- **CBE ID: 5602** Rate of Referred Patients that are Approached for an Organ Donation in the Organ Procurement Organization's Donation Service Area in a Calendar Year.
- **CBE ID: 5603** Authorization Rate for Organ Donation Among Approached, Referred Potential Organ Donors in the Organ Procurement Organization's Donation Service Area in a Calendar Year.
- **CBE ID: 5604** Rate of the Number of Organ Donors to the Potential Donors in an Organ Procurement Organization's Donation Service Area in a Calendar Year.

As a member of the Organ Procurement Organization (OPO) community, we support the proposed measures with some recommendations for endorsement.

Background

LifeGift (TXGC) is a federally designated nonprofit OPO that serves the areas of Houston, Fort Worth, Lubbock, and Amarillo, Texas. This donation service area is one of the largest in the United States, with a population of 12 million people. We serve 339 hospitals, 10 transplant centers, and the Texas Medical Center, which receives over 10 million patient visits per year. We provide comprehensive organ donation and recovery services in many of the nation's largest and most progressive hospitals and transplant centers.

Discussion

Improvements in the organ donation system cannot happen unless there are metrics that accurately measure the performance of the different stakeholders in the system. The metrics and oversight within the system should reflect how each part of the system performs and not just the final outcome. When metrics are inaccurate or poorly designed, they affect organizational performance due to confounding possible conclusions, impacting service, organizational goals, and operations. As consistently described and published by CMS in all references to health system measurement, it is critical to design and use both process and outcome measures that actually reflect the work done, in the geography and region where that work is conducted.

The two current CMS metrics being used for organ procurement organization performance—donation rate and transplant rate—do not fully reflect the role of OPOs in the system. They do not account for regional variation in population demographics or mortality patterns, nor do they incorporate the standard risk-adjustment approaches used elsewhere in health system measurement, whether for certification or process improvement purposes. Additionally, the current transplant rate reflects the performance of the entire system, especially transplant centers and logistics, not OPOs. The use of transplant rate as an OPO performance measure fundamentally misaligns accountability by assigning responsibility for outcomes that depend on stakeholders over which OPOs have no control. This makes it impossible to fairly evaluate performance or identify where improvements are truly needed.

As a result, the current framework risks generating misleading conclusions about performance that drive unintended consequences for patients and donor families. Under the current framework, over half of OPOs could face decertification or competition this year. Based on current data, OPOs serving up to 72 percent of the U.S. population will be impacted by the end of 2026. This creates the likelihood of widespread disruption across the donation and transplant system. Organ donation and transplantation is a highly coordinated, time-sensitive process, and instability anywhere can impact patients everywhere. The focus should be on improving performance while maintaining continuity of care for patients and donor families.

AOPO, in partnership with 53 OPOs and Econometrica, Inc., launched a national effort to develop attributable performance metrics identified as the four measures referenced above. These measures are the result of a rigorous, multi-stakeholder development process that included independent measure development experts, technical expert panel input, stakeholder interviews, site visits, literature review, and testing consistent with CMS measure development standards. This coordinated effort has ensured the proposed metrics are objective, scientifically sound, and trusted by policymakers.

These four measures provide a comprehensive assessment of the organ donation process—from hospital referral of possible donors to OPO approach for authorization and through authorization to actual donation recovery. This allows OPOs and stakeholders to identify opportunities for improvement at specific stages of the donation process and implement targeted, area-specific quality improvement efforts informed by community-level demographic and clinical profiles. This level of transparency and actionable insight is not possible when performance is evaluated solely through summarized outcome measures, where critical phases of the process are not accounted for.

At LifeGift, we use data-driven quality improvement efforts to strengthen hospital partnerships, improve family authorization processes, and maximize donation opportunities. The proposed measures provide actionable information that supports these efforts and helps ensure continuous improvement across the donation process.

Shared Accountability Between OPOs and Hospitals

Importantly, the referral and approach measures (CBE IDs 5601 and 5602) highlight stages of the donation process where hospital engagement is a critical determinant of outcomes. OPOs cannot generate referrals—hospitals must identify and refer eligible patients in accordance with CMS Conditions of Participation. Similarly, the approach conversation occurs within the hospital environment, often alongside clinical teams whose support directly influences family decision-making. By measuring these stages explicitly, the proposed framework creates meaningful shared accountability between OPOs and their hospital partners, rather than attributing system-wide outcomes solely to OPOs. This transparency also benefits hospitals by providing data they can incorporate into their own quality improvement processes related to donation system effectiveness. Future iterations of these measures should continue to recognize the distinct responsibilities of hospitals and OPOs within the referral process to ensure referral performance is attributed appropriately.

Denominator Construction and Donor Potential Estimation

We also note that the proposed measures meaningfully improve denominator construction by excluding cases where donation was not clinically feasible. This refinement yields a more accurate estimate of the eligible donor pool than the current framework provides. However, without the ability to account for ventilator status at the time of death, the denominator still includes decedents for whom organ donation was not physiologically feasible. As a result, the measures provide a more objective but still imperfect approximation of true donor potential. Until this information can be incorporated, the denominator will continue to overestimate true donor potential in some service areas.

Ultimately, the denominator should be based on a transparent, replicable, case-level count of in-hospital deaths attributable to each OPO's service area, not an estimate, so OPOs and stakeholders can validate the data, monitor performance in real time, identify opportunities, and implement meaningful improvement.

A foundational concern underlying any denominator derived from administrative data is the accuracy and consistency of death certificate reporting itself. The current CMS CALC framework relies on the CDC's National Center for Health Statistics Multiple Cause of Death File, which draws directly from state death certificates. However, death certificates do not require the listing of secondary diagnoses, meaning that conditions such as active malignancy or systemic infection that would preclude donation may go unrecorded. When these decedents are counted in the denominator, they inflate the estimate of donor potential and penalize OPO performance against a population subset of decedents that was never clinically viable. Additionally, cause-of-death coding practices vary by jurisdiction, certifier training, and local reporting conventions, creating inconsistency across donation service areas that is unrelated to OPO performance.

We encourage HRSA and CMS to pursue patient-level data collection as a complement to, and eventual replacement for, reliance on death certificate-derived denominators. The HRSA Ventilated Patient Form (VPF) represents an important step in this direction, expanding visibility into patients referred to OPOs and enabling more granular, clinically

informed measurement. As VPF data submission scales across all OPOs, the integration of VPF data into the performance measurement framework should be a priority so that donor potential can be assessed using direct clinical information rather than administrative proxies. Aligning VPF processes with these proposed measures would strengthen the accuracy of the denominator while preserving the process-oriented structure that makes CBE IDs 5601 through 5604 a meaningful improvement over the current framework.

Conclusion

LifeGift appreciates the opportunity to provide comments on the proposed measures—CBE IDs 5601, 5602, 5603, and 5604—for endorsement. As an organization committed to advancing strategies that increase the number of lives saved through organ donation and transplantation, LifeGift offers these comments in support of that mission.

We recommend that PQM endorse all four measures and urge their incorporation into the CMS performance evaluation framework, either alongside or in place of the current outcome-only metrics. Process measures that reflect the actual work of OPOs and the shared responsibilities of hospitals are essential to driving meaningful, sustained improvement in the organ donation system. We further encourage continued refinement of denominator definitions as clinical data infrastructure matures, so that future iterations of these measures can more precisely capture true donor potential.