2025 Measure Set Review (MSR): 00410-01-C-HOQR Preliminary Assessment

I. Measure Overview[1]

CMIT ID	Title
Link to CMIT measure record: 00410-01-C-HOQR	Left Without Being Seen
Measure Steward	**CMS Program**
Louisiana State University	Hospital Outpatient Quality Reporting Program Link: Hospital Outpatient Quality Reporting Program | CMS

CBE Endorsement Status	CBE Endorsement History
Endorsement Removed	• Endorsement removed, National Voluntary Consensus Standards for Emergency Care - Phase II: Hospital ED Measures, 2012 • Initial endorsement, 2008 Link to endorsement measure record: Left Without Being Seen

Measure Overview
Rationale for Use: Not Available.
CMS-Provided Rationale for Use in Program: We are proposing to remove this measure and the Median Time for Discharged ED Patients measure beginning with the CY 2028 reporting period/2030 payment determination, contingent upon finalization of adoption of the Emergency Care Access and Timeliness (ECAT) Electronic Clinical Quality Measure (eCQM). These changes are the result of growing concerns about the quality and timeliness of care in the emergency department (ED) as well as the burden associated with two chart-abstracted ED measures. The OP-22 measure reflects ED overcrowding and prolonged wait times, highlighting operational inefficiencies rather than directly correlating with clinical outcomes.[2] [3] [4] Patients who leave without

[1] The information in this PA is sourced from the CMS Measures Inventory Tool (CMIT) and the PQM Submission Tool and Repository (STAR) Measure Database. This document reflects the content available as of September 2025.
[2] Smalley CM, Meldon SW, Simon EL, Muir MR, Delgado F, Fertel BS. Emergency Department Patients Who Leave Before Treatment Is Complete. West J Emerg Med. 2021 Feb 26;22(2):148-155. https://doi.org/10.5811/westjem.2020.11.48427. PMID: 33856294; PMCID: PMC7972384.
[3] Li DR, Brennan JJ, Kreshak AA, Castillo EM, Vilke GM. Patients Who Leave the Emergency Department Without Being Seen and Their Follow-Up Behavior: A Retrospective Descriptive Analysis. J Emerg Med. 2019 Jul;57(1):106-113. https://doi.org/10.1016/j.jemermed.2019.03.051. Epub 2019 May 8. PMID: 31078346.
[4] Bernstein SL, Aronsky D, Duseja R, Epstein S, Handel D, Hwang U, McCarthy M, John McConnell K, Pines JM, Rathlev N, Schafermeyer R, Zwemer F, Schull M, Asplin BR; Society for Academic Emergency Medicine, Emergency Department Crowding Task Force. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med. 2009 Jan;16(1):1-10. doi: 10.1111/j.1553-2712.2008.00295.x. Epub 2008 Nov 8. PMID: 19007346.

Measure Overview	
being seen are often younger, male, of lower acuity, and may face socioeconomic challenges such as lack of insurance or homelessness.[5] [6] [7] While the mortality rate among these patients is low (0.17%), many return within 24 hours or seek outpatient care, with about 14% requiring admission upon return, indicating some may have needed urgent care.[8] [9] The primary impacts of why people leave without being seen are decreased patient satisfaction due to long waits and potential financial losses from unbilled services.[10] [11]	
Description: Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA). Definition for Physician/APN/PA: • Patients who are seen by a resident or intern are to be considered as seen by a physician. • An institutionally credentialed provider, acting under the direct supervision of a physician for healthcare services in the emergency department (e.g., an obstetric nurse providing assessment of an obstetric patient) are to be considered as seen by a physician. • Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are: ○ Nurse Practitioner (NP) ○ Certified Registered Nurse Anesthetist (CRNA) ○ Clinical Nurse Specialist (CNS) ○ Certified Nurse Midwife (CNM)	
Numerator: The total number of patients who left without being evaluated by a physician/APN/PA. Definition for patients who presented to the ED: Patients who presented to the ED are those that signed in to be evaluated for emergency services. **Exclusions:** None	
Denominator: The total number of patients who presented to the ED. **Exclusions:** None	
CMS Program History: In Hospital Outpatient Quality Reporting Program since 2012.	**Cascade of Meaningful Measures Priority:** Person-Centered Care
Measure Type: Structure	**Is the Measure Digital or an Electronic Clinical**

[5] Carter EJ, Pouch SM, Larson EL. The relationship between emergency department crowding and patient outcomes: a systematic review. J Nurs Scholarsh. 2014 Mar;46(2):106-15. https://doi.org/10.1111/jnu.12055. Epub 2013 Dec 19. PMID: 24354886; PMCID: PMC4033834.

[6] Yeung HM, Ifrah A, Rockman ME. Quantitative Analysis of Characteristics Associated with Patient-Directed Discharges, Representations, and Readmissions: A Safety-Net Hospital Experience. J Gen Intern Med. 2024 May;39(7):1173-1179. https://doi.org/10.1007/s11606-023-08563-z. Epub 2023 Dec 19. PMID: 38114868; PMCID: PMC11116360.

[7] Rathlev NK, Visintainer P, Schmidt J, Hettler J, Albert V, Li H. Patient Characteristics and Clinical Process Predictors of Patients Leaving Without Being Seen from the Emergency Department. West J Emerg Med. 2020 Aug 25;21(5):1218-1226. https://doi.org/10.5811/westjem.2020.6.47084. PMID: 32970578; PMCID: PMC7514399.

[8] See Footnote 2.

[9] Lovett PB, Kahn JA, Greene SE, Bloch MA, Brandt DR, Minckler MR. Early quick acuity score provides more complete data on emergency department walkouts. PLoS One. 2014 Jan 17;9(1):e85776. https://doi.org/10.1371/journal.pone.0085776. PMID: 24465699; PMCID: PMC3894997.

[10] See Footnote 2.

[11] See Footnote 5.

Measure Overview	
	Quality Measure (eCQM)? No
Level(s) of Analysis/Measured Entity: Facility, Hospital, or Agency Level	**Care Setting(s):** Emergency Department, Inpatient Acute Care Facility
Does the Measure Fill a Statutorily Required Category for the Program? No	**Is the Measure Included in Upcoming Rulemaking?** Yes, this measure is proposed for removal beginning with the CY 2028 reporting period/CY 2030 payment determination. The measure plans to be replaced by the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM).

II. Measure Performance in Program

For this measure, the MSR evaluation and analysis team reviewed the publicly available datasets:

- hospitals_04_2025.zip (which contains data from January 2023-December 2023 and is referred to as PY2023 in this assessment)
- hospitals_10_2024.zip (which contains data from January 2022-December 2022 and is referred to as PY2022 in this assessment)
- hospitals_11_2023.zip (which contains data from January 2021-December 2021 and is referred to as PY2021 in this assessment)

About Figure 1: Figure 1 is a boxplot that shows how scores have changed over the past 3 years of publicly available data. For each year, the boxplot displays a box with lines and dots to help visualize the range and distribution of scores. The dots represent the points where the lowest 5% and highest 5% of scores fall, and the line connecting them shows where 90% of the scores are located. The box itself covers the middle half of the scores, from the 25th to the 75th percentile. Inside the box, a horizontal line marks the median score, which is the middle value, while a "+" sign shows the average score. This type of graph makes overall trends in scores over time as well as the consistency and spread of the results easier to understand.

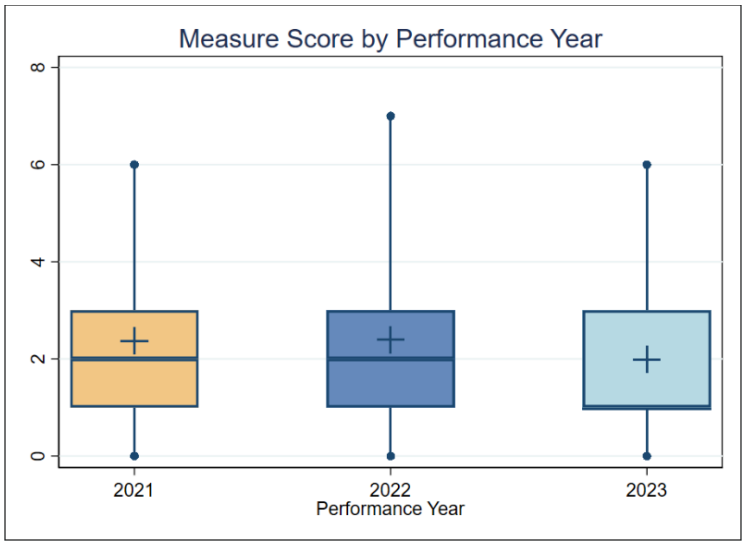

Figure 1. Boxplot of Measure Score by Year

Figure 1 Interpretation: In the boxplot above, the median score is 2% for PY2021 and PY2022, and 1% for PY2023. For this measure, a lower score indicates better quality of care. This relatively stable but widespread performance across entities in the lookback period indicates that entities performing near the median have relatively little change or improvement over these 3 years, but that there are outlier low performers at lower scores that may find greater utility in implementing improvement initiatives.

 The analyses upon which this publication (or document) is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Restricted:

About Table 1: Table 1 illustrates the distribution of scores and the number of patients represented within each group. It is important to note that the groups with the lowest or highest scores (referred to as deciles, each comprising 10% of the entities) may contain more or fewer patients than other groups. For example, if the lowest-scoring decile includes only 5% of the total patient population, this smaller group size may be associated with lower performance scores.

For this measure, Decile 10 represents a grouping of organizations who have the lowest measure scores and Decile 1 shows those with the highest measure scores. The arrow denotes improving performance on the measure.

Table 1. Importance (Decile by Measure Score, PY2023)

Highest Performers ← **Lowest Performers**

	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Average Score (Standard Deviation)	1.99 (2.63)	0	0	0.95	1.00	1.00	1.80	2.00	2.77	3.62	6.77
Entities	3,860	386	386	386	386	386	386	386	386	386	386
Patients	136,851,910	6,497,824	6,086,507	6,740,161	23,209,776	10,515,795	10,429,301	21,249,856	16,847,585	16,114,181	19,160,924

Table 1 Interpretation: To estimate the number of negative outcomes (patients who left without being seen), the number of patients is multiplied by the average score for each decile. Right now, the total estimated number of positive outcomes across all deciles is about 3,400,000. Assuming it would be plausible for entities in deciles 4-10 to improve and reach the average score of the 3rd decile (which more than 20% of the entities have already achieved), we can use that score to estimate possible improvement in outcomes. For example, if the average performance of Decile 3 (0.95%) is considered a plausible, achievable score and the entities in Deciles 4 through 10 improved to reach that score, the estimated number of eligible patients who left without being seen would go down by about 1.6%. This means that improving performance on this measure could help ensure that hundreds of thousands of patients do not leave the ED without being seen, potentially leading to better health outcomes.

About Figure 2: Figure 2 is a bar graph displaying average change in performance by performance decile on this measure. Battelle developed this graph by first assigning each entity's year 1 performance score to a decile (1-10). For each entity, the change in performance score from year 1 was then calculated for both year 2 and year 3. The resulting changes in performance for year 2 and year 3 were plotted against the year 1 decile assignments, allowing for visualization of performance trends over time by initial performance level.

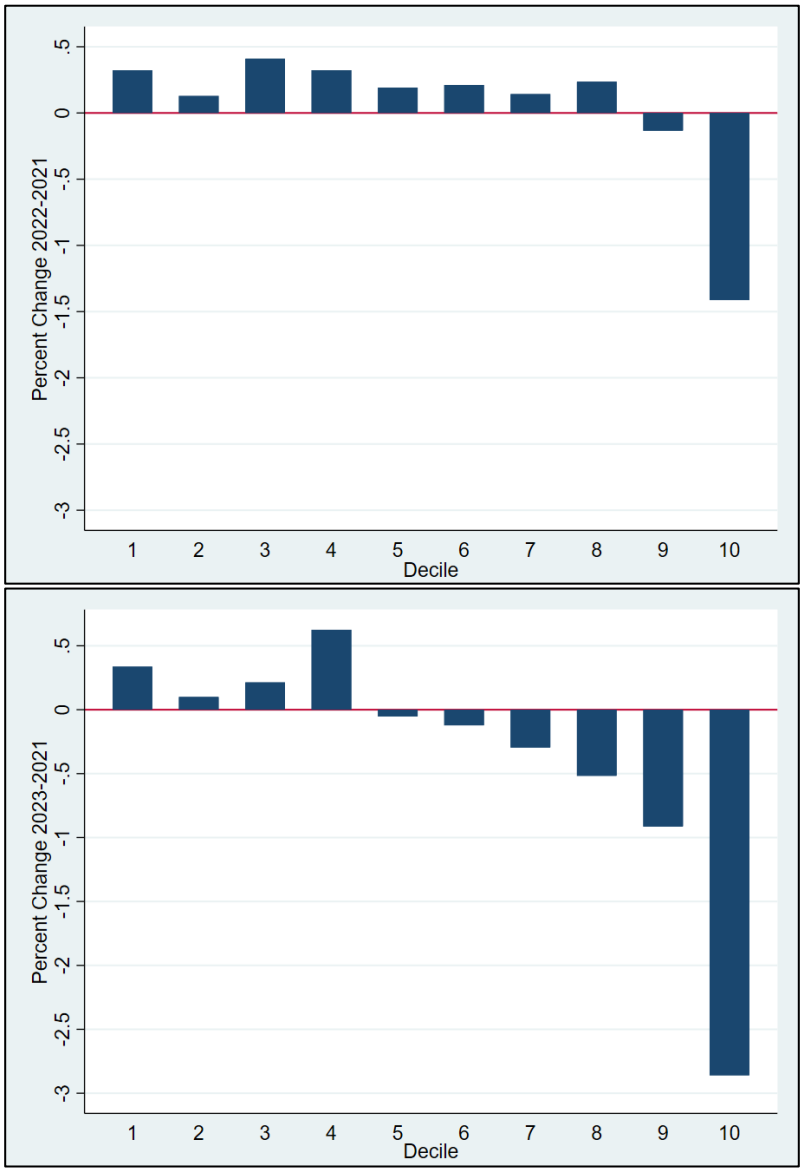

Figure 2. Mean Change in Performance by Decile

Figure 2 Interpretation: For this measure, lower scores indicate better performance. The upper graph shows that Decile 10 (entities with 10% highest scores in PY2021) was the only decile that showed substantial average improvement in performance from PY2021 to PY2022. Decile 9 showed slight average improvement, while Deciles 1-8 show a slight worsening in performance. The lower graph suggests that between PY2021 and PY2023, improvement in

performance was proportional to decile, particularly for the lower-performing deciles (Deciles 7-10). Together, the graphs indicate that while only the highest-performing entities showed notable gains from PY2021 to PY2022, broader and more proportional improvements—especially among lower-performing deciles—emerged by PY2023.

III. Evaluation Criteria

Meaningfulness

Importance
Guiding Questions: Does the evidence show that the focus of the measure is linked to meaningful outcomes for patients and health care organizations? Do the data demonstrate that using this measure within the quality program results in benefits that outweigh any associated burdens or costs?
Evidence in the published literature shows that leaving the emergency department (ED) without being seen is associated with increased mortality and readmission.[12] Figure 1 shows a slight improvement in performance from 2021 to 2023. Because this measure is not yet "topped out", there is still room for entities to improve their performance. Table 1 and Figure 2 outline the impacts on the patient population that improvement on this performance score could have over time. Table 1 indicates that if Deciles 4 through 10 were to match the benchmark score of 0.95%, 1,200,000 fewer eligible patients would not leave the ED without being seen. Current performance on this measure and potential improvements by measured entities demonstrate benefit to the program population. **Committee Member Considerations:** Based on reviewing measure performance and professional and personal experiences, consider the balance of implementation costs or burdens with the benefit of measure use within the program. Committee members will have a chance to share these thoughts with the broader committee via Pre-Meeting Initial Evaluation (PIE) Forms and group discussion.
Staff Rating: Met

Conformance
Guiding Question: Do measure components and specifications align with the measure intent and target population?
The intent of the measure is to reduce the number of patients who leave the ED without being seen by a physician/APN/PA by measuring the percentage of patients who left the ED without being seen out of the total number of patients that presented to the ED in outpatient settings. This measure supports the Hospital Outpatient Quality Reporting Program objectives of improving the quality of care that hospitals provide and distributing clearly defined and objective data about hospital performance. The measure numerator, denominator, and exclusions are appropriate for measuring the number of patients who left the ED without being seen by a physician/APN/PA. **Committee Member Considerations:** Committee members should review the list of active measures within this CMS program in the appendix and consider this measure's alignment with the group. The appendix lists all active measures reported in this program.
Staff Rating: Met

[12] Turbulence in the system: Higher rates of left-without-being-seen emergency department visits and associations with increased risks of adverse patient outcomes since 2020. McNaughton, Candace D. et al. JACEP Open, Volume 5, Issue 6, e13299

Feasibility
Guiding Question: Are the tools, processes, and people necessary to implement and report on the measure reasonably available for measured entities in the CMS program?
All required data elements are reported annually using administrative data and entered via the CMS QualityNet website. Some measured entities lack the necessary health IT infrastructure to collect or report required data elements electronically. Additional investment in technology or alternative reporting methods may be needed to address these barriers. **Committee Member Considerations:** Committee members with experience implementing this or similar measures in emergency department settings should reflect on potential challenges to feasibility of data collection and reporting.
Staff Rating: Met

Validity
Guiding Question: Do the data and/or logic support the idea that the measured entity can improve their performance on the measure?
Measure performance from 2021-2023 demonstrates that improvement on this measure is possible for measured entities and that there is additional room for improvement among these entities. Process improvement in the ED and implementing triage processes can improve entity-level performance on the measure; however, inadequate staffing and resource availability within the ED might impact entities' ability to improve performance. **Committee Member Considerations:** Committee members with experience implementing this or similar measures in emergency departments and inpatient acute care facility settings should reflect on potential methods to improve ED processes to decrease the number of patients who leave without being seen.
Staff Rating: Met

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Reliability

The two tables below summarize reliability. Table 2 sorts entities by the number of patients and reports average reliability along with the number of entities and average number and total patients for each decile. This table can be used to assess the impact of population size on the reliability of an entity's measure score. Population size can impact reliability estimates because larger populations generally provide more stable and consistent measure scores, while smaller populations can lead to greater variation. In cases where reliability has a strong relationship to population size, reliability will be the lowest at Decile 1 and progressively increase up to Decile 10.

Table 3 sorts entities by reliability and reports the average reliability by decile. The table also includes the mean, standard deviation,[13] and interquartile range (IQR).[14] This table can be used to see the distribution of the reliability of the entities. A measure is generally considered reliable when the reliability for at least 70% of the individual entities is above 60%.

Table 2. Reliability (Decile by Denominator – Target Population Size)

	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Mean Target Population Size	35,454	1,744	5,528	9,720	14,755	21,296	28,804	37,528	48,862	65,903	120,399
Mean Reliability	99.6	97.1	99.6	99.8	99.9	99.9	99.9	99.9	100.0	100.0	100.0
Entities	3,860	386	386	386	386	386	386	386	386	386	386
Total Patients	136,851,910	673,333	2,133,684	3,751,946	5,695,449	8,220,146	11,118,481	14,485,635	18,860,684	25,438,648	46,473,904

[13] Standard deviation is a number that shows how spread out the values in a group of numbers are. If the standard deviation is small, most values are close to the average; if it's large, the values are more spread out and indicate greater variation in performance.
[14] IQR, or interquartile range, is a number that shows how spread out the middle half of a group of numbers is. It measures the range between the value at the 25th percentile and the value at the 75th percentile, indicating how tightly or loosely the middle values are grouped.

Table 3. Mean Reliability (By Reliability Decile)

Mean	SD	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	IQR
99.6	2.42	97.1	99.6	99.8	99.9	99.9	99.9	99.9	100.0	100.0	100.0	0.2

Tables 2 and 3 Interpretation: Reliability was estimated using a modification of the Adams[15] signal-to-noise method where the reliability for each entity *i* is estimated by[16] $100 * \frac{n_i}{\hat{\alpha}+\hat{\beta}+n_i}$ where n_i is the total number of patients for entity *i*, and $\hat{\sigma}$ and $\hat{\beta}$ are estimates of the beta binomial parameters. This method helps show how much the difference in scores between groups is due to real differences in quality rather than just random chance. In this case, the mean reliability was 99.6 and all entities had a reliability score higher than 60%. This means that the measure can reliably tell the difference between those who are performing better or worse, making it a useful tool for comparing quality of care.

[15] Adams, John L., *The Reliability of Provider Profiling: A Tutorial*. Santa Monica, CA: RAND Corporation, 2009.
[16] Nieser, K.J. and Harris, H.S. *Comparing methods for assessing the reliability of health care quality measures.* Statistics in Medicine: 43(23), 2024.

Reliability
Guiding Question: Does the evidence show that changes in measure performance are due to improvements in quality of care? In other words, do the data demonstrate that variation in measure performance is linked to changes made to processes or behaviors to improve care?
Tables 2 and 3 show that almost all entities are well above the 60% reliability threshold that indicates that a measures score is generally reliable, meaning the measure consistently reflects true differences in care quality and can be used confidently for quality improvement. **Committee Member Considerations:** Committee members should reflect on implications of the measure's reliability on program use and what the reliability may mean for individual measured entities.
Staff Rating: Met

Usability
Guiding Questions: Are there any known barriers or facilitators that determine whether the person or entity could improve on the measure focus? Are these barriers addressable?
The measure is reported annually to the Hospital OQR program and is a pay-for-reporting measure. Variation in resource availability and ED staffing across entities may limit some entities' ability to improve on the measure. **Committee Member Considerations:** Based on professional/personal experiences, committee members should consider any barriers to using this measure for certain measured entities as well as any potential facilitators that might promote usability within the program.
Staff Rating: Met

Data Stream Parsimony

Data Stream Parsimony
Guiding Question: Does the clinical data flow required for the measure promote non-burdensome data collection and reporting?
The measure uses administrative claims data, and authorized users can report using an online tool through the Hospital Quality Reporting (HQR) system. The reporting increases staff workload and may introduce inefficiencies in the reporting process. This measure is not in any other CMS programs and reporting minimally overlaps with other active measures in the Hospital Outpatient Quality Reporting (OQR) Program. **Committee Member Considerations:** Based on professional/personal experiences, committee members should reflect on any additional barriers to the clinical data flow that collection may add as well as potential mitigation strategies.

Patient Journey

Patient Health Journey
Guiding Question: Does the measure address the appropriate aspects of care to align with the patient health care journey?

Patient Health Journey
The measure addresses the appropriate timepoint during the patient health care journey as it relates to ED visits. The measure promotes ED efficiency, which is important in ensuring patients receive care in a timely manner and reduces risk of patients leaving the ED only to return later with later-stage illness or injury. **Committee Member Considerations:** Based on professional/personal experiences, committee members should consider if the measure identifies an appropriate and critical time to assess patients leaving the ED without being seen. Reflect on if this timepoint is meaningful to patients and any potential barriers or burdens associated with this timepoint in the care journey.

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Appendix: Active Measures in the Hospital Outpatient Quality Reporting Program

Measures Included in the Hospital Outpatient Quality Reporting Program	
CMIT ID	**Measure Title**
00005-01-C-HOQR	Abdomen Computed Tomography (CT) - Use of Contrast Material
00021-02-C-HOQR	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
00071-02-C-HOQR	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
01648-01-C-HOQR	Breast Cancer Screening Recall Rates
00116-01-C-HOQR	Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
00180-02-C-HOQR	COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination)
00253-01-C-HOQR	Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy
00299-01-C-HOQR	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival
01660-02-C-HOQR	Hospital Commitment to Health Equity (HCHE)
00344-01-C-HOQR	Hospital Visits After Hospital Outpatient Surgery
00410-01-C-HOQR	*Left Without Being Seen*
00427-01-C-HOQR	Median Time from ED Arrival to ED Departure for Discharged ED Patients
00162-01-C-HOQR	Outpatient and Ambulatory Surgery Consumer Assessment (OAS CAHPS)
01625-01-E-HOQR	ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM)