

A.2 Optimal Care for Kidney Health MVP

The proposed Optimal Care for Kidney Health MVP focuses on the clinical theme of providing fundamental treatment and management of costly clinical conditions that contribute to, or may result from, kidney disease. This proposed MVP would be most applicable to clinicians who treat patients within the practice of nephrology.

Quality Measures

We propose to include eight MIPS quality measures within the quality component of this MVP, which promote the management and risks associated with kidney disease. We reviewed the MIPS quality measure inventory and believe the following quality measures provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in treating patients with kidney disease conditions:

- Q001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): This MIPS quality measure assesses diabetic patients for hemoglobin A1c control.
- Q482: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate: This MIPS quality measure represents an intermediate outcome for maintenance hemodialysis patients by assessing for continuous catheter use.
- TBD: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy: This MIPS quality measure assesses for the prescribing of an ACE inhibitor or ARB therapy for patients diagnosed with chronic kidney disease (Stages 1-5, not receiving Renal Replacement Therapy (RRT)) and proteinuria.

In conjunction with the aforementioned nephrological measures, we propose to include the following broadly applicable MIPS quality measures that are relevant to kidney care. The quality measures below capture the patient's voice regarding their care, the assessment and administration of the influenza and pneumococcal vaccinations, documentation of current medications, and blood pressure control—all of which support the safety and general health of patients that are experiencing disease of the kidney:

- Q047: Advance Care Plan: This MIPS quality measure captures the clinical interaction of documenting a patient's voice for possible, future life-sustaining medical intervention. This engagement between the clinician (or clinician staff) and the patient allows the patient to be autonomous and communicate their ideal of clinical care that ensures coordinated care is implemented as documented in the patient's medical record.
- Q110: Preventive Care and Screening: Influenza Immunization: This MIPS quality measure assesses for the administration or previous receipt of the influenza immunization for pediatric and adult patients.
- Q111: Pneumococcal Vaccination Status for Older Adults: This MIPS quality measure assesses that patients receive the pneumococcal vaccinations.
- Q130: Documentation of Current Medications in the Medical Record: This MIPS quality measure bases performance on clinicians documenting the list of current medications using all immediate resources for capture of this important clinical topic.
- Q236: Controlling High Blood Pressure: This MIPS quality measure promotes controlling blood pressure in patients diagnosed with essential hypertension with a goal to maintain a systolic pressure of < 140 mmHg and diastolic pressure of < 90 mmHg.

In developing this proposal, we also considered including the following quality measure for this proposed MVP. However, we ultimately decided not to include it because the clinical action represented within this measure would most likely be performed by a primary care clinician and would support the referral of the patient to a nephrologist for their initial assessment. Therefore, this measure would likely not be appropriate for this MVP topic due to the quality action being more frequently performed by primary care rather than the nephrologist.

- TBD: Kidney Health Evaluation: This MIPS quality measure assesses patients that are diagnosed with diabetes for receipt of a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) and Urine Albumin-Creatinine Ratio (uACR).

Improvement Activities

Within the improvement activities component of this MVP, we propose to include thirteen improvement activities that reflect actions and processes undertaken by clinicians who specialize in treating patients with kidney disease conditions, as well as activities that promote patient engagement and patient-centeredness, health equity, shared decision making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care patients with kidney disorders. The following improvement activities are proposed for inclusion in this MVP:

- IA_AHE_3: Promote Use of Patient-Reported Outcome Tools
- IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
- IA_BE_14: Engage Patients and Families to Guide Improvement in the System of Care
- IA_BE_15: Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- IA_BE_16: Promote Self-management in Usual Care
- IA_CC_2: Implementation of improvements that contribute to more timely communication of test results
- IA_CC_13: Practice Improvements for Bilateral Exchange of Patient Information
- IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation
- IA_PM_11: Regular review practices in place on targeted patient population needs

- IA_PM_14: Implementation of methodologies for improvements in longitudinal care management for high risk patients
- IA_PM_16: Implementation of medication management practice improvements
- IA_PSPA_16: Use of decision support and standardized treatment protocols

Cost Measures

Within the cost component of this MVP, we propose two measures: The Acute Kidney Injury (AKI) Requiring New Inpatient Dialysis episode-based cost measure and Total Per Capita Cost (TPCC) measure. The AKI Requiring New Inpatient Dialysis episode-based measure applies to nephrologists and other clinicians providing hemodialysis or dialysis procedures for acute kidney failure during inpatient hospitalizations. This aligns with the intent of the MVP to focus on kidney disease. We also propose the TPCC measure because it is a broad measure that includes nephrologists and aligns with the similarly broad quality measures included in the MVP. Two episode-based cost measures are currently under development for chronic kidney disease (CKD) and end-stage renal disease (ESRD). The measures would focus on outpatient management of these conditions. The measures could be considered for future inclusion in this MVP.

TABLE A.2: Optimal Care for Kidney Health MVP

As noted in the introduction of this appendix, we considered measures and improvement activities available within the MIPS inventory and selected those that we determined best fit the clinical concept of the proposed Optimal Care for Kidney Health MVP. We request comment on the measures and activities included in this MVP.

Quality	Improvement Activities	Cost
(*)(!) Q001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) (!) Q047: Advance Care Plan (Collection Type: Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications) (*)(**) Q110: Preventive Care and Screening: Influenza Immunization (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) (*)(**) Q111: Pneumococcal Vaccination Status for Older Adults (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) (*)(!) Q130: Documentation of Current Medications in the Medical Record (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) (*)(!) Q236: Controlling High Blood Pressure (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) (!!) Q482: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate (Collection Type: MIPS CQMs Specifications) (^) TBD: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy (Collection Type: MIPS CQMs Specifications)	(~) IA_AHE_3: Promote Use of Patient-Reported Outcome Tools (High) IA_BE_4: Engagement of patients through implementation of improvements in patient portal (Medium) IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings (High) IA_BE_14: Engage Patients and Families to Guide Improvement in the System of Care (High) IA_BE_15: Engagement of Patients, Family, and Caregivers in Developing a Plan of Care (Medium) IA_BE_16: Promote Self-management in Usual Care (Medium) IA_CC_2: Implementation of improvements that contribute to more timely communication of test results (Medium) (*) IA_CC_13: Practice Improvements for Bilateral Exchange of Patient Information (Medium) (%) IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation (~) IA_PM_11: Regular review practices in place on targeted patient population needs (Medium) (~) IA_PM_14: Implementation of methodologies for improvements in longitudinal care management for high risk patients (Medium) IA_PM_16: Implementation of medication management practice improvements (Medium) IA_PSPA_16: Use of decision support and standardized treatment protocols	Acute Kidney Injury Requiring New Inpatient Dialysis (AKI) Total Per Capita Cost (TPCC)

	(Medium)	
Foundational Layer		
Population Health Measures	Promoting Interoperability	
(!!) Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims) (!!) Q484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims)	Security Risk Analysis Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) e-Prescribing (*) Query of the Prescription Drug Monitoring Program (PDMP) Provide Patients Electronic Access to Their Health Information Support Electronic Referral Loops By Sending Health Information AND Support Electronic Referral Loops By Receiving and Reconciling Health Information OR Health Information Exchange (HIE) Bi-Directional Exchange OR (^) Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) Immunization Registry Reporting Syndromic Surveillance Reporting (Optional) Electronic Case Reporting Public Health Registry Reporting (Optional) Clinical Data Registry Reporting (Optional) Actions to Limit or Restrict Compatibility or Interoperability of CEHRT ONC Direct Review	