



Promote Transparency and Accountability in Medicare Quality Measure Development and Review

It is estimated that more than 37 million Americans suffer from chronic kidney disease, including 400,000 individuals who are undergoing treatment for end-stage renal disease (ESRD), or kidney failure. Most commonly caused by diabetes or high blood pressure, kidney failure is expected to claim more than 2 million lives by 2030. Without dialysis or a kidney transplant, patients suffering from kidney failure will not survive. Since transplant organs are in short supply, most patients must undergo dialysis treatment, a process that substitutes for healthy kidneys by mechanically filtering body wastes and excess fluids from the bloodstream, provided three or more times per week, but does not provide the physiologic equivalent of the native kidneys.

Nephrologists provide care to persons with kidney disease largely under the umbrella of Medicare's ESRD program; therefore, the nephrology specialty is disproportionately affected by policies developed by the Centers for Medicare and Medicaid Services (CMS). One aspect of CMS policy of particular concern is the development and ongoing review of quality measures used broadly in the Medicare Quality Payment Program (QPP), and specifically, those used in the Merit-based Incentive Payment System (MIPS).

Like all physicians treating Medicare beneficiaries, nephrologists are evaluated based on quality metrics selected by CMS. RPA fully supports such robust evaluation when it is meaningful and relevant to nephrology practice. From the beginning of MIPS, CMS has stated that it wants to reduce burden, encourage the use of reporting through electronic means, promote the use of qualified clinical data registries (QCDRs) and increase reporting on outcome and patient reported outcome measures. However, recent policy development has diminished the relevance of the CMS nephrology measures to real-life nephrology practice.

For example, for the 2020 program year, CMS eliminated all of the nephrology-specific measures in MIPS. Additionally, CMS increased the data reporting threshold for quality measures which will increase reporting burden on clinicians with no clear benefit to patient care and disproportionately impact small practices, and instituted QCDR measure testing and harmonization requirements without adequate time or rationales for doing so. CMS also finalized the new acute kidney injury cost measure despite the medical community's concerns with the measure regarding both attribution issues and variability in the patient-level comorbidities and acuity/intensity of care.

RPA is committed to quality measurement in kidney care, as evidenced by our history as the lead nephrology organization for measure development with the AMA-convened Physician's Consortium for Performance Improvement (PCPI), and continued involvement in the PCPI Foundation, and by being the only nephrology organization with a QCDR. RPA believes that a portfolio of appropriate quality measures that are applicable to each physician specialty to help improve the care of their patients and that a specialty specific approach to measurement allows clinicians to make better assessments about care and helps create greater value and higher quality care. However, CMS' unilateral decisions to eliminate the nephrology-specific measures and make other changes over the objections of the kidney care community, compels RPA to seek additional Congressional oversight of the CMS quality measure development and review process.

Recommendation: *To improve the quality of care for kidney patients and reduce administrative burden on nephrology practices, Congress should exercise its oversight authority to ensure transparency and accountability in the CMS quality measure development and review process.*

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goal is to ensure quality care under the highest standards of medical practice for patients with kidney disease and related disorders.

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