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2026 QE Measures Report

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PURPLELAB QE STANDARD MEASURES REPORT

This report highlights one standard measure through the QE program. The measure tracks utilization rates of three laboratory tests — estimated glomerular filtration rate (eGFR), quantitative urine albumin, and urine creatinine (used together to calculate the urine albumin-creatinine ratio, or uACR) — to manage diabetic patients at risk of Chronic Kidney Disease (CKD).

- **CMS MIPS Measure Quality ID #488: Kidney Health Evaluation (KHE)**

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INTRODUCTION

Diabetic kidney disease remains a leading contributor to end-stage renal disease (ESRD), a condition that significantly reduces life expectancy and quality of life of affected patients. Proper kidney health monitoring in diabetic populations is a critical preventive measure. National guidelines, including those from the American Diabetes Association (ADA) and National Kidney Foundation (NKF), emphasize annual comprehensive testing to detect early signs of nephropathy and guide timely intervention and care management. PurpleLab's standard measures report will focus on the following Standard Merit-based Incentive Payment System (MIPS) Measure: Kidney Health Evaluation.

Full attainment, as defined in this analysis, involves the completion of the following three tests within a calendar year:

1. **Estimated Glomerular Filtration Rate (eGFR)**
2. **Quantitative Urine Albumin**
3. **Urine Creatinine**

The quantitative urine albumin and urine creatinine results are used to calculate the Urine Albumin-to-Creatinine Ratio (uACR). Together, the eGFR and uACR can be ordered together by a clinician as a **"Kidney Health Evaluation."**

In addition, to qualify as fully adherent, the urine albumin and urine creatinine tests (tests 2 and 3) must be completed within four days of each other. This timing ensures a valid urine albumin-to-creatinine ratio (uACR), a key indicator for detecting albuminuria—an early sign of kidney damage that enables timely intervention to slow the progression of chronic kidney disease (CKD).

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ABOUT THE QE PROGRAM

The Qualified Entity (QE) program was created as part of the Affordable Care Act to combine Medicare data with a commercial claims data set and use it to report health system quality measures publicly. In April 2022, PurpleLab became the 17th nationally certified QE, gaining access to Medicare Parts A and B Fee-for-Service (FFS) claims as well as Part D prescription drug event (PDE) data. This comprehensive dataset includes acute care, post-acute care, and physician office services, along with pharmacy records for over 59 million annual beneficiaries. PurpleLab combined the Medicare data with its already rich set of commercial claims from 330+ million unique individuals, 50+ billion claims, and additional Social Determinant of Health (SDOH) attributes, augmenting the inferential capacity of the data.

For more information, visit www.qemedicaredata.org.

ABOUT PURPLELAB

PurpleLab is a health-tech company driven by one clear philosophy: outcomes matter most. We help organizations drive decisive action based on precise insights from real-world data—*with the ultimate goal of giving everyone a fighting chance at the best possible health outcome*.

EXECUTIVE SUMMARY

DATA

This analysis uses de-identified, patient-level medical and pharmacy claims data accessed through the PurpleLab® CLEAR™ Claims. This repository aggregates claims from a diverse network of payers, providers, and clearinghouses to support robust, longitudinal analysis. This dataset enables high-confidence quality evaluation across Commercial, Medicare, and Medicaid populations, with a strong emphasis on representativeness, timeliness, and relevance for population health insights.

OBJECTIVE

The purpose of this report is to examine trends in the utilization of kidney monitoring tests among diabetic populations. To do this, we are reporting CMS MIPS Measure Quality ID #488: Kidney Health Evaluation using our combined set of Medicare Fee-for-Service (FFS) integrated with PurpleLab® CLEAR™ Claims data from 2020 to 2024. Analyses are stratified by payer type— Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service—to assess measure attainment and evaluate the uptake of recommended testing practices over time, with attention to equity across coverage types.

To guide this analysis, we established the following goals:

- Analyze trends in national adherence to kidney health monitoring guidelines
- Identify disparities in attainment across insurance types and geographies (US States)
- Recommend actionable strategies for improving quality outcomes, particularly in underserved groups

The value of PurpleLab's approach to QECP public reporting lies in providing Merit-based Incentive Payment System (MIPS)-eligible clinicians nationwide with crucial population performance benchmarks, stratified by various demographic characteristics. These findings may be used by clinicians, public health experts, and policymakers to assess the effectiveness of their internal quality monitoring and population health programs, enabling them to track progress and identify areas for improvement.

EXECUTIVE SUMMARY

HOW TO USE THIS REPORT

As a QECP, PurpleLab is committed to the QECP's purpose and goals for public reporting and to supporting performance improvement nationwide. This report evaluates aggregated provider performance at the payer and geographic levels. These are important dimensions that can be used by a variety of stakeholders to spur further quality improvement, particularly in kidney disease monitoring.

In particular, collaborating provider and payer organizations managing population health for individuals with diabetes may use this report to identify benchmarks at the payer-channel and state levels to determine their relative performance on a regional basis, most relevant to their managed populations.

METHODOLOGY

DATA SOURCING

Claims Data - PurpleLab procures medical claims data via relationships with a network of source partners and data aggregators, including CMS which provides PurpleLab with Medicare data under the QECP. These data are tokenized for de-identification purposes to protect patient privacy, and then ingested into PurpleLab's secure data environment. Once ingested, all claims data sources are converted into the PurpleLab CLEAR™ Claims data model to enable the combined analyses presented in this report.

Any tokenized data (Medical claims or QE Claims) can be matched by finding common tokens in each dataset that meet the project specifications.

Diabetic patients were identified using PurpleLab® combined QE Claims and CLEAR™ Closed Claims data warehouse as of January 1 of each measurement year (2020–2024), including individuals aged 18–75 who had at least one outpatient visit during the measurement year. Full kidney health evaluation was defined as the completion of three diagnostic procedures within the measurement year: an eGFR test (CPT codes: 80047, 80048, 80050, 80053, 80069, or 82565), a quantitative urine albumin (CPT code: 82043), and a urine creatinine (CPT code: 82570). To constitute a valid albumin-to-creatinine ratio (ACR), the urine albumin and urine creatinine tests must be completed within four days of one another. Patients were excluded from the denominator if they carried a diagnosis of End Stage Renal Disease (ESRD), Stage 5 Chronic Kidney Disease (CKD), or had an active order for or were receiving hospice or palliative care during the measurement year.

To ensure the robustness of estimates at the provider level and to minimize the instability of estimates associated with practitioners with low patient counts, the analytic cohort was restricted to providers with at least 11 attributed patients. Additionally, subgroup and geographic estimates with fewer than 50 patients in the denominator were suppressed to prevent unreliable rate calculations.

METHODOLOGY

SAMPLE CALCULATIONS

FULL ATTAINMENT RATE CALCULATION:

$$\frac{\text{Full Attainment Population per Year}}{\text{Eligible Population per Year}} = \text{Attainment Rate}$$

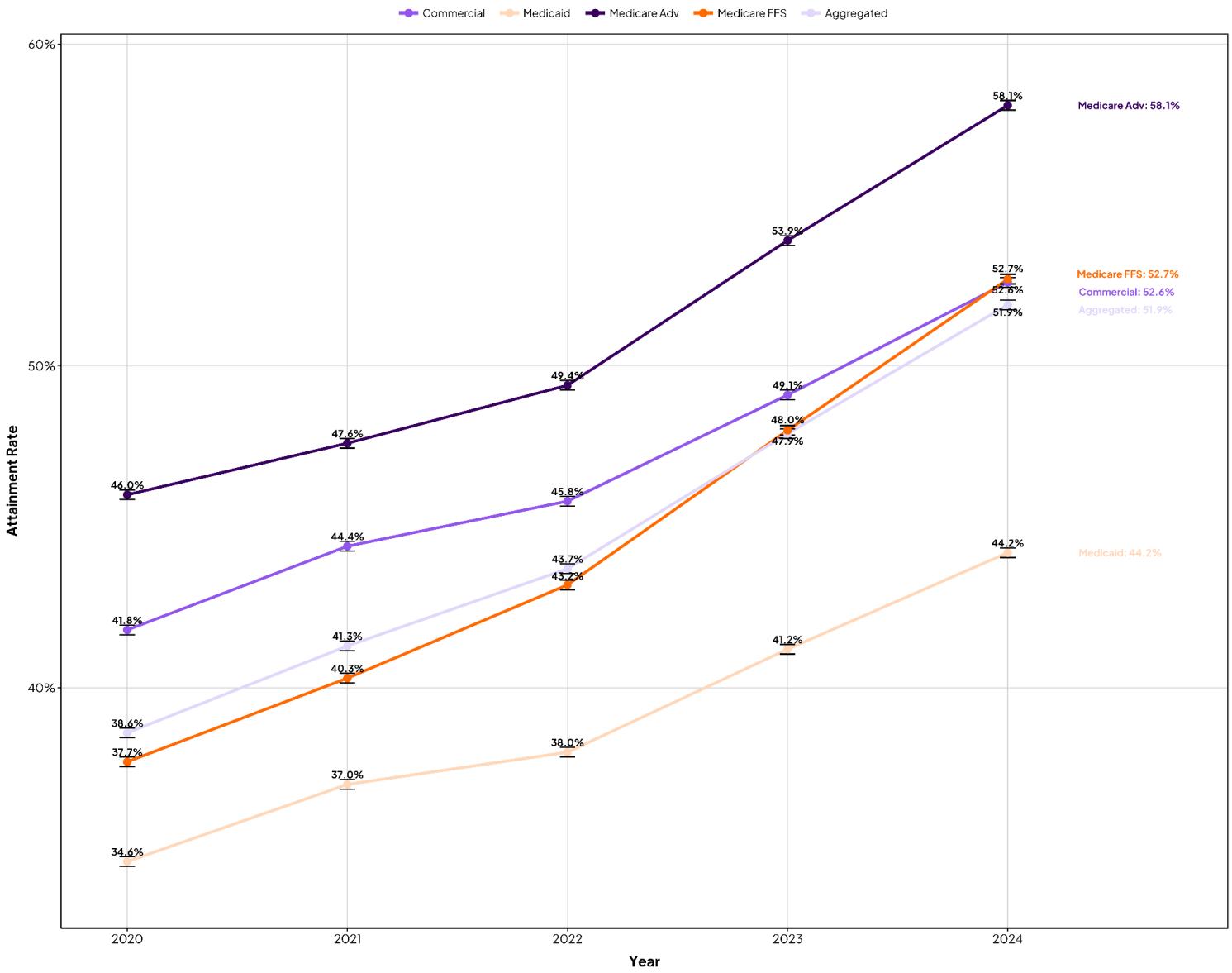
Example:

$$\frac{1060816}{2759021} = 0.384\ (38.4\%)$$

This calculation is iterated for each year in the 2020–2024 period, encompassing all sources (QE, Closed) and channels (Commercial, Medicaid, Medicare Advantage, Medicare Fee-for-Service, and Overall). Additionally, each state's population is analyzed individually with a relative growth map illustrating the year-over-year rate changes (increases or decreases).

KEY FINDINGS

KHE ATTAINMENT, OVERALL AND BY PAYER (2020–2024)



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KEY FINDINGS

KHE ATTAINMENT, OVERALL AND BY PAYER (2020–2024)

Aggregated (All Payers):

- The aggregate rate for the attainment of full clinical measures reached 51.9% in 2024. This figure remained below the rates observed within Medicare Advantage and Medicare-Fee-for-Service, indicating that the mode of coverage may influence the rigor of monitoring for kidney health.

Medicare Advantage:

The Medicare Advantage attainment rate reached **58.1% in 2024**, **the highest among all payer categories** and above the national mean. These trends may be driven by:

- Structured care models in senior populations.
- Stronger incentive alignment and provider performance monitoring.

Medicare FFS:

- Medicare FFS full attainment rates rose from 37.7% in 2020 to **52.7% in 2024**. This represents a **relative increase of approximately 40% in just four years**.
- Between 2020 and 2024, Medicare FFS beneficiaries exhibited a 15 percentage point increase in the full attainment of kidney-health laboratory tests.
- Several policies and payment changes may support this improvement. For example, Medicare's quality reporting requirements under MIPS created stronger incentives for clinicians to complete and document recommended kidney health screening for at-risk diabetic patients, and increased CMS focus on preventive CKD management during this period may have contributed to broader uptake of guideline-concordant testing practices.

Commercial:

- Commercial plans reached **52.6% full attainment in 2024**, nearly matching Medicare FFS (52.7%) and trailing only Medicare Advantage (58.1%). This may reflect stronger access to diagnostic services and provider engagement in preventive care, possibly due to:
    - Broader access to diagnostic services.
    - Higher provider engagement in preventive care.
    - Fewer social and transportation barriers.

KEY FINDINGS

KHE ATTAINMENT, OVERALL AND BY PAYER (2020–2024)

Medicaid:
The Medicaid population had the **lowest attainment rate, at 44.2% in 2024**. This variation from the mean may reflect systemic barriers to consistent preventive care delivery, including:

- Reduced access to care and lower provider or lab availability in Medicaid-predominant geographies.
- Administrative hurdles and inconsistent patient engagement with recommended screening services.

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KEY FINDINGS

RELATIVE IMPROVEMENT OF KHE ATTAINMENT, OVERALL AND BY PAYER (2020–2024)

We can quantify payer progress using relative (%) improvement:

$$\frac{\text{Rate of 2024} - \text{Rate of 2020}}{\text{Rate of 2020}} = \text{Relative Change Rate}$$

Payer	2020 (%)	2024 (%)	Relative Δ (%)
Commercial	41.8%	52.6%	+25.84%
Medicare Adv	46.0%	58.1%	+26.30%
Medicaid	34.6%	44.2%	+27.75%
Aggregated	38.6%	51.9%	+34.46%
Medicare FFS	37.7%	52.7%	+39.79%

KEY FINDINGS

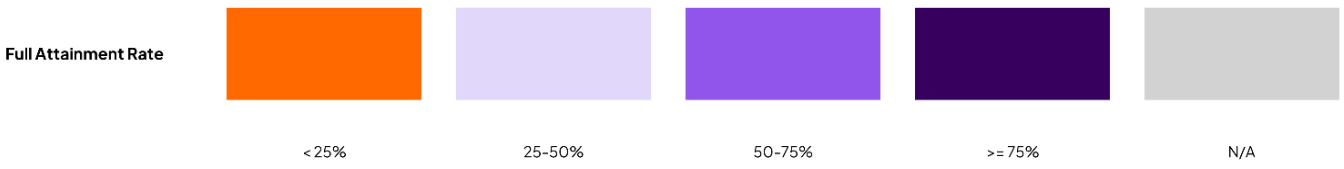
STATE POPULATION: RATING ASSIGNMENT DESCRIPTION

Methodology for Performance Analysis:
To provide a clear and consistent assessment of performance, we used two distinct methods: a state performance rating to show relative full attainment and a categorization of change to illustrate full attainment performance trends over time.

State Performance Ratings:
To enable meaningful comparisons across different states and lines of business, each state's performance on a given measure was categorized into one of four rating levels.

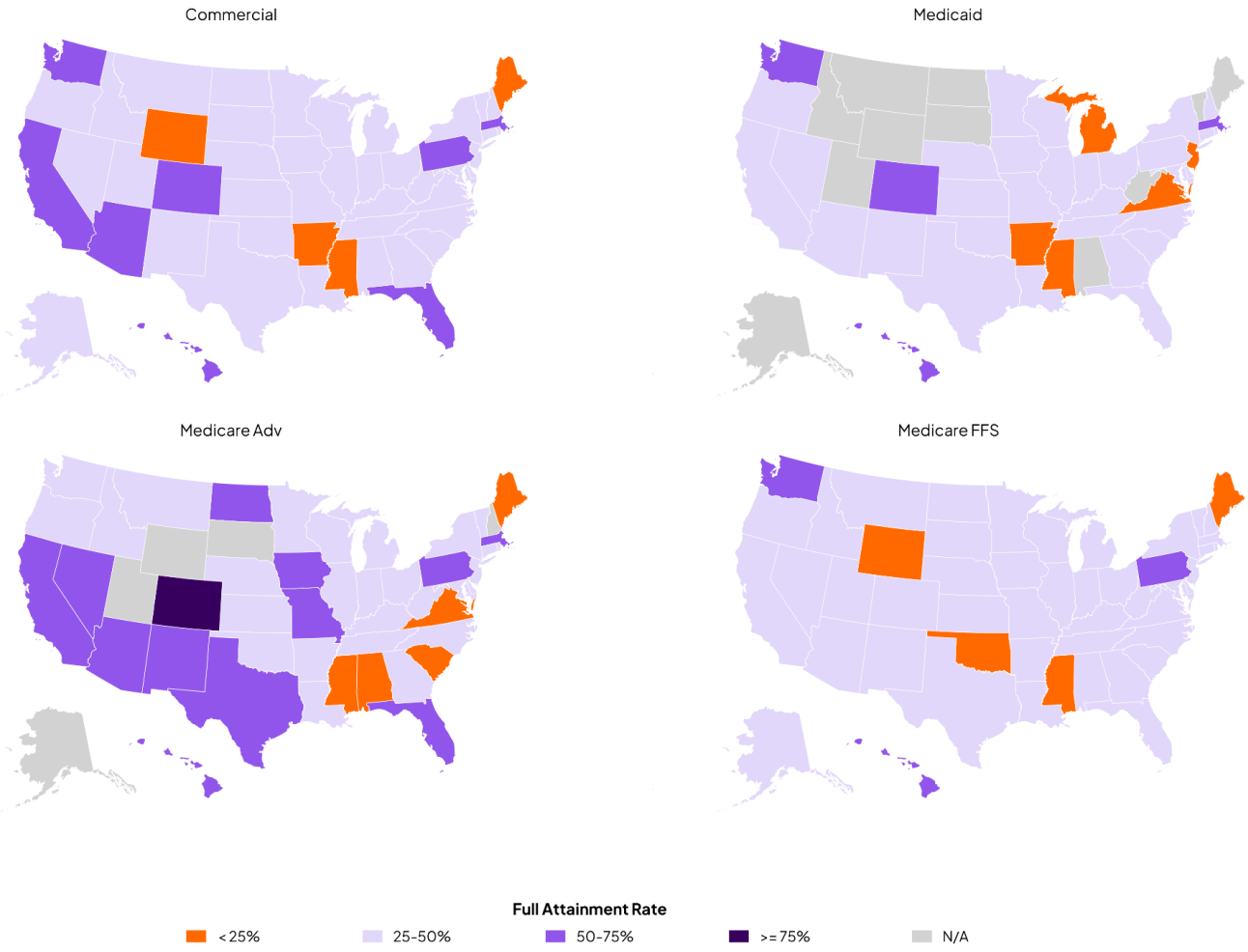
These ratings are based on fixed absolute attainment thresholds applied uniformly across all states and lines of business: below 25%, 25–50%, 50–75%, and 75% or above. The color categories therefore reflect actual testing rates, not a state's rank relative to peers — a state in the 50–75% category achieved a true attainment rate in that range, regardless of how other states performed. Using consistent cut points across all payers (Commercial, Medicaid, Medicare Advantage, and Fee-for-Service) and years allows direct comparisons of attainment levels over time and across coverage types.

The maps in the report use the following system to visualize these relative performance ratings:



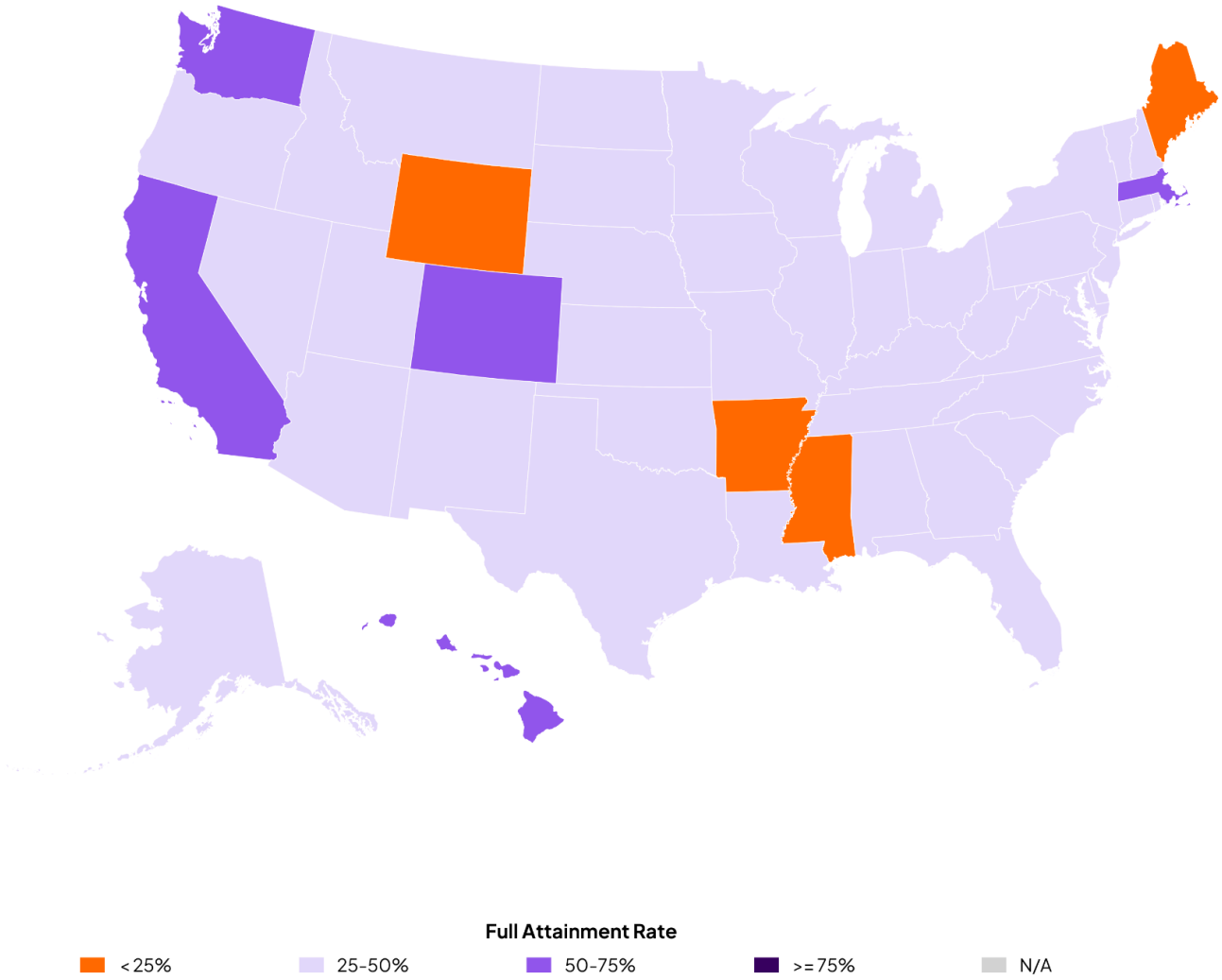
KEY FINDINGS

RATE CATEGORIES BY PAYER AND STATE (2020)



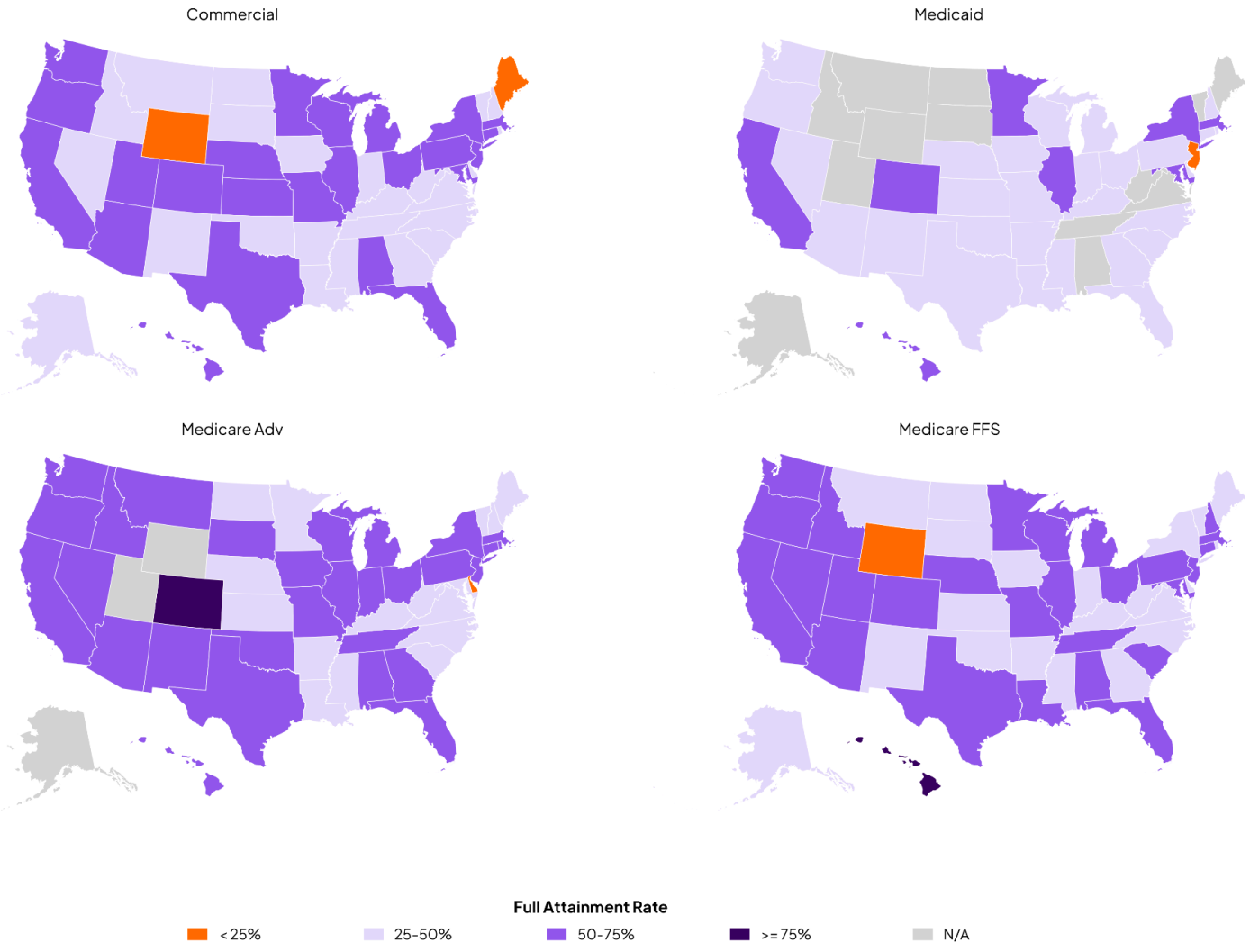
KEY FINDINGS

RATE CATEGORIES AGGREGATED ACROSS PAYERS (2020)



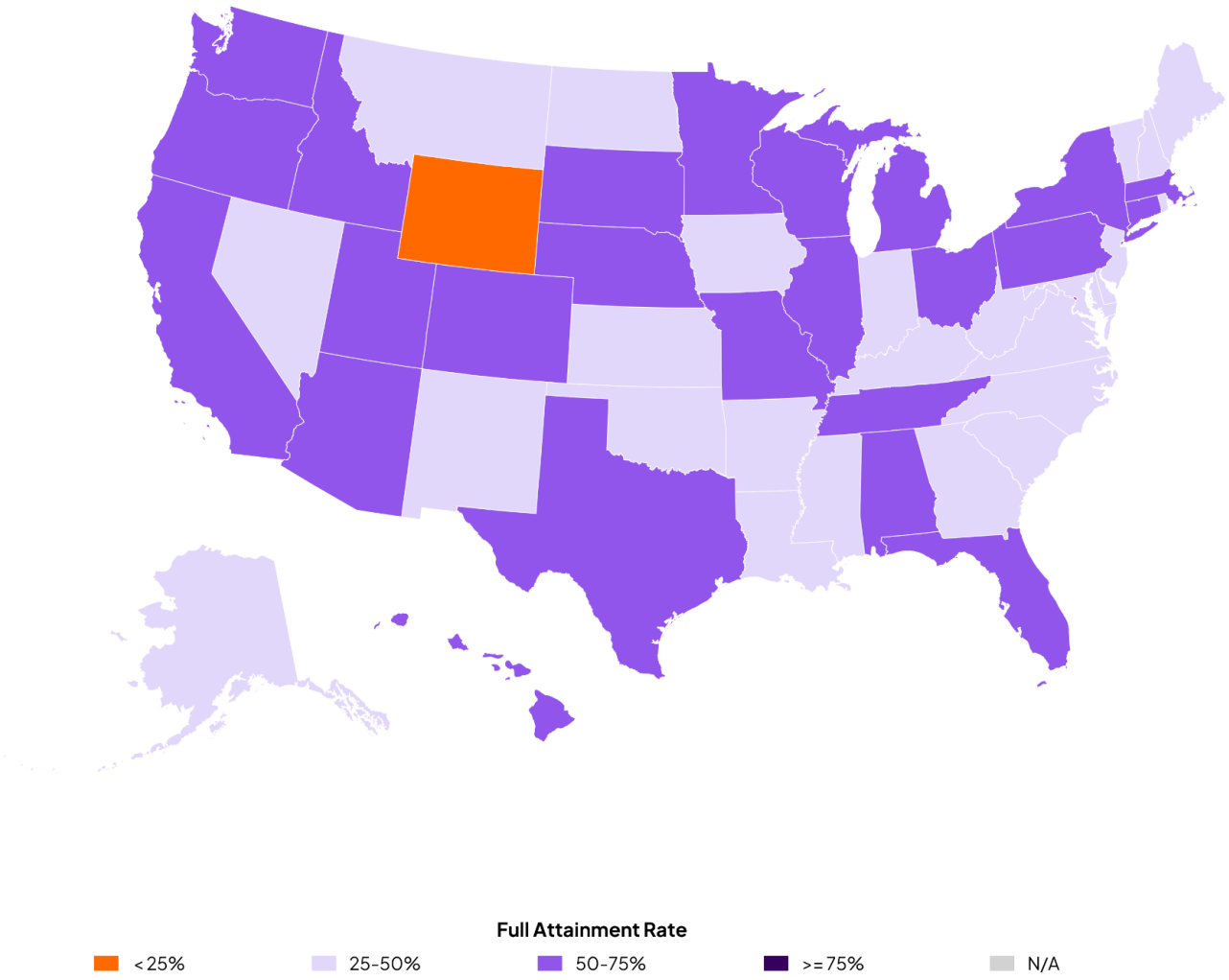
KEY FINDINGS

RATE CATEGORIES BY PAYER AND STATE (2024)



KEY FINDINGS

RATE CATEGORIES AGGREGATED ACROSS PAYERS (2024)



KEY FINDINGS

RELATIVE CHANGE BY PAYER AND STATE (2020–2024) DESCRIPTION

This map illustrates the relative change in performance rates across U.S. states from 2020 to 2024, segmented by line of business (LOB):

- Commercial
- Medicaid
- Medicare Advantage
- Fee-for-Service (FFS)

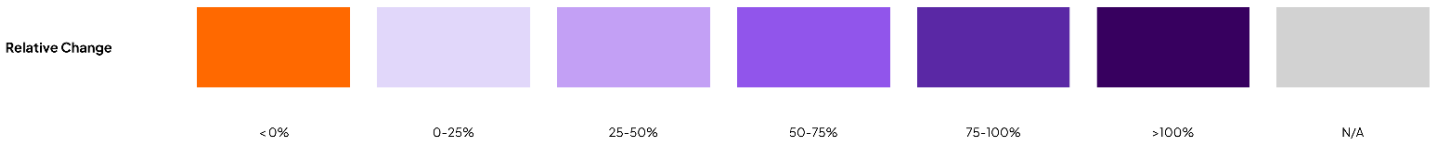
Relative Change Calculation

For each state and LOB, the relative change was computed using the formula:

$$\frac{\text{Rate of 2024} - \text{Rate of 2020}}{\text{Rate of 2020}} = \text{Relative Change Rate}$$

Categorization of Change Over Time

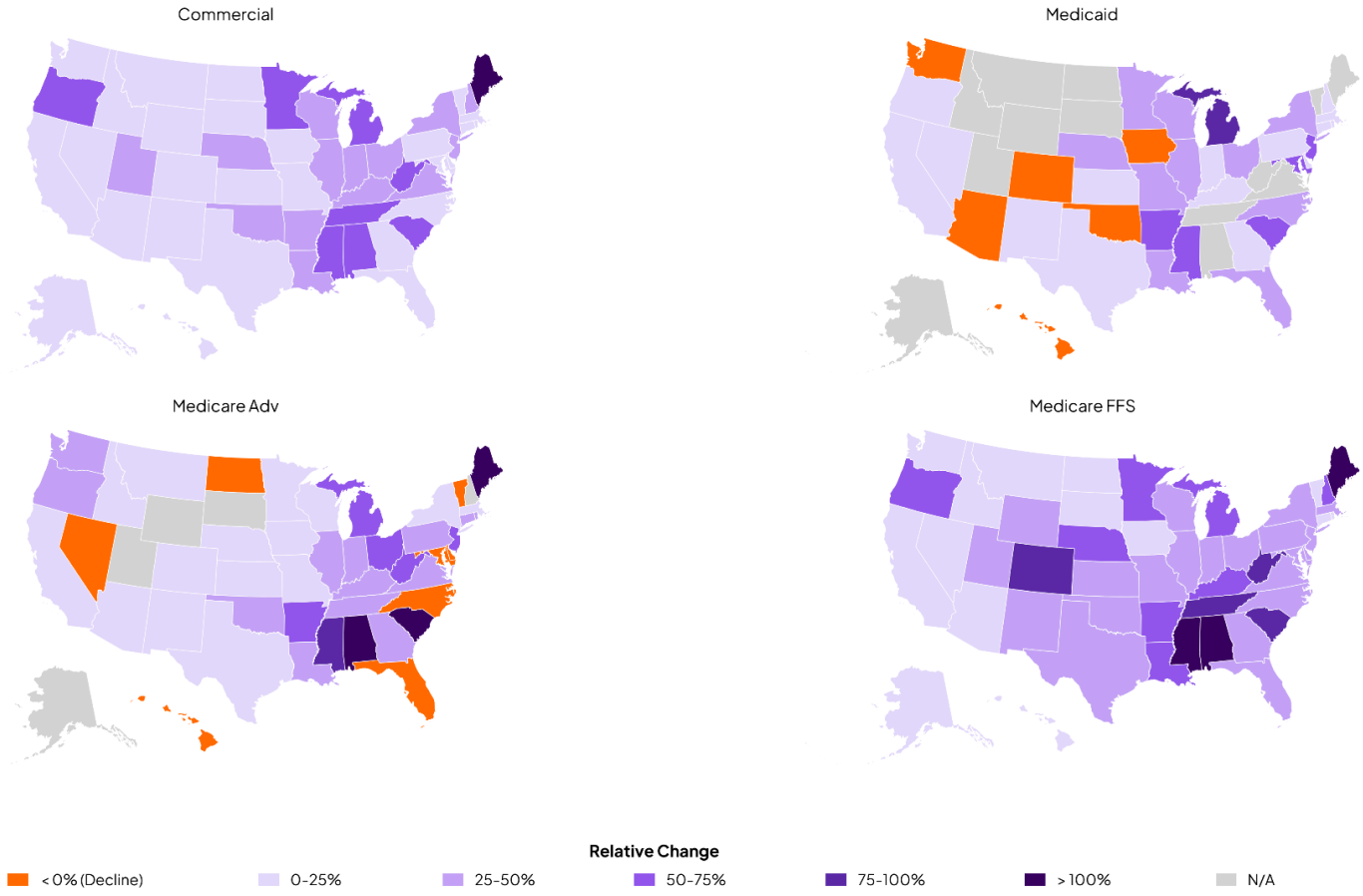
To show how state full attainment performance has evolved, we calculated the relative change for each state. These values were grouped into four categories to highlight the magnitude and direction of the trend. These results are shown on U.S. maps, separated by line of business. The following color-coded categories are used to represent performance change:



KEY FINDINGS

RELATIVE CHANGE BY PAYER AND STATE (2020–2024)

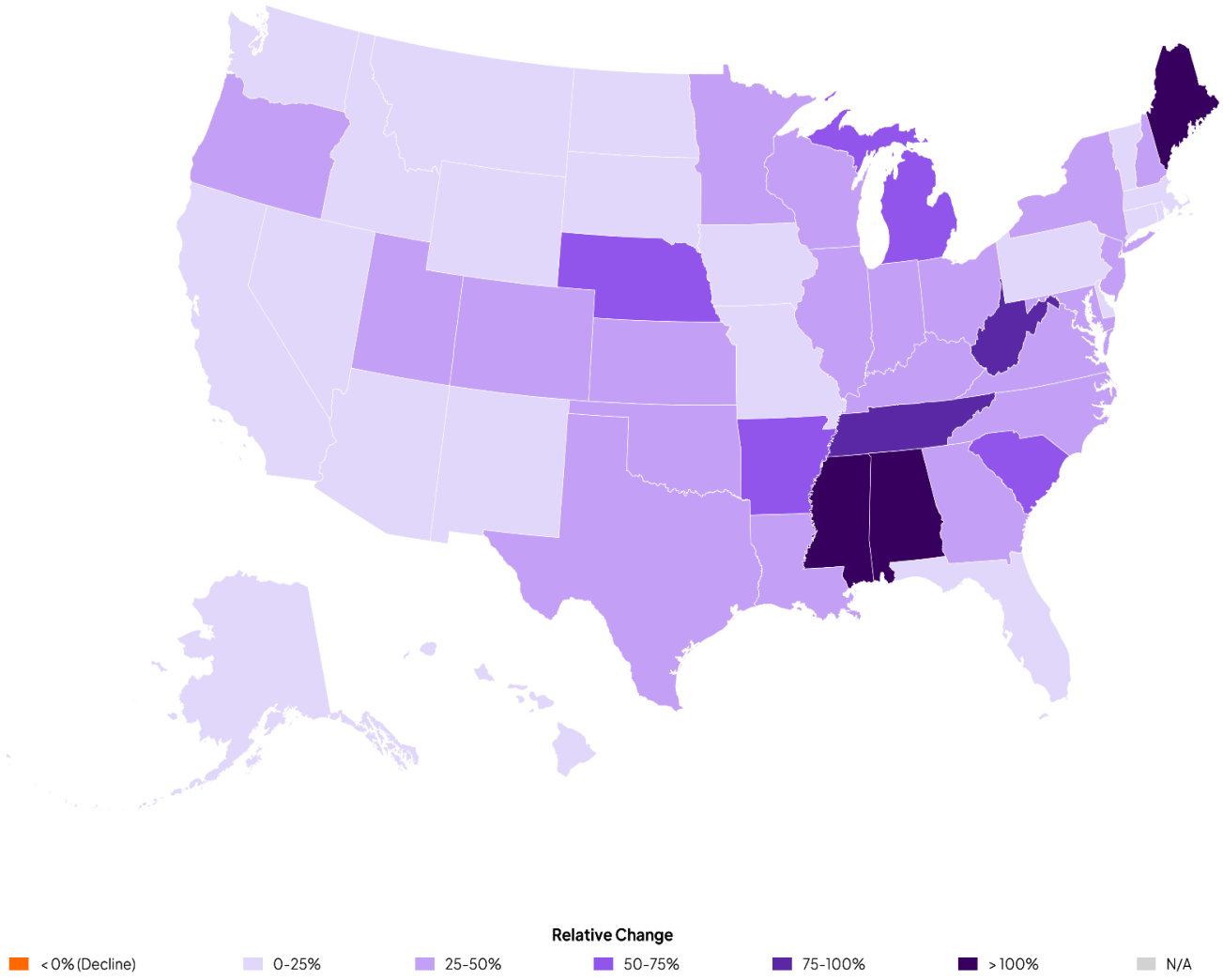
Dark Purple States = Best Improvement from 2020 – 2024



KEY FINDINGS

RELATIVE CHANGE AGGREGATED ACROSS ALL PAYERS (2020–2024)

Dark Purple States = Best Improvement from 2020 – 2024



INSIGHTS

RATE CATEGORY SHIFTS BY PAYER AND STATE (2020–2024)

Visually, several shifts in rate categories can be observed between 2020 and 2024 across the different lines of business:

Commercial: In 2020, most states fell in the 0.25–0.50 range, with only a handful in the West and Northeast reaching 0.50–0.75. By 2024, roughly half of all states shifted into the 0.50–0.75 range, reflecting broad geographic diffusion of improvement in commercial kidney health monitoring. Wyoming and Maine are notable outliers, remaining in the < 0.25 range.

Medicaid: Medicaid shows the most variability across both years and the slowest overall progress. In 2020, most states sat in the 0.25–0.50 range, and by 2024 the majority of states still remain there. While several states transitioned into the 0.50–0.75 range, a meaningful number of states stayed in or moved into the < 0.25 range, indicating persistent gaps in Medicaid kidney health monitoring relative to other lines of business.

MA: Medicare Advantage achieved the highest absolute attainment of any line of business in 2024, reaching 58.1%. In 2020, most states fell in the 0.25–0.50 range, with Colorado as the only state reaching ≥ 0.75. By 2024, nearly every state has shifted into the 0.50–0.75 range, with Colorado remaining the only state at ≥ 0.75. This broad upward movement reflects consistent improvement across the Medicare Advantage population.

INSIGHTS

RATE CATEGORY SHIFTS BY PAYER AND STATE (2020–2024)

Medicare FFS: Medicare FFS showed the strongest relative improvement of any line of business between 2020 and 2024, with a 39.8% relative gain in full attainment. At the 2020 baseline, Medicare FFS attainment in most states was concentrated within the lowest tiers, reflecting a low to moderate frequency of clinical monitoring. By 2024, most states had advanced into the 0.50–0.75 range, with Hawaii reaching ≥ 0.75. Wyoming and Colorado are the only states remaining in the < 0.25 range.

Overall, the maps reveal a clear upward shift in rate categories from 2020 to 2024. In 2020, nearly every state fell in the 0.25–0.50 or < 0.25 range, whereas by 2024 nearly all states had moved out of the < 0.25 range and the majority had advanced into the 0.50–0.75 range. Improvement was broadly distributed across the West Coast, Northeast, and Upper Midwest, while several states across the Southeast and Mountain West remained in the 0.25–0.50 range. This pattern reflects broad national improvement in full attainment over the four-year period, with some regional gaps still evident.

INSIGHTS

RELATIVE CHANGE BY PAYER AND STATE (2020–2024)

This figure presents a series of U.S. state-level maps showing the relative change in full kidney health evaluation attainment from 2020 to 2024 across four lines of business: Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service (FFS).

Key observations:

- **Commercial and Medicare FFS** lines generally show widespread positive changes across most states.
- **Medicaid** displays more variability, with several states experiencing declines, particularly in the Mountain West, Plains, and Pacific Northwest.
- **Medicare Advantage** exhibits a mix of positive and negative trends, with notable declines scattered across the Mountain West and Southeast, alongside strong improvement in the Deep South and Northeast. Aggregated across all lines of business, Maine and the Deep South, particularly Alabama and Mississippi, showed the strongest relative gains nationally.

Overall, all four lines of business showed improvement in most states between 2020 and 2024, though the magnitude and distribution of change varied meaningfully by payer. Medicare FFS showed the strongest relative improvement nationally (+39.8%), followed by Medicaid (+27.8%), Medicare Advantage (+26.3%), and Commercial (+25.8%). However, relative gains should be interpreted alongside absolute attainment levels. Medicaid's improvement, while comparable in relative terms, reflects a rise from 34.6% to 44.2%, leaving it the lowest-attaining payer in both years. Medicaid also showed the greatest geographic variability, with several states experiencing declines despite the overall upward trend.

This visualization highlights geographic and programmatic variation in full kidney health evaluation attainment over the four-year period and can inform targeted policy or programmatic interventions.

INSIGHTS

HEALTH EQUITY INSIGHTS

The gap between Medicaid and other payers reflects a persistent **quality divide**, where social determinants of health (SDOH)—such as income, health literacy, and care access—impact adherence. This observation suggests that tailoring interventions may be a relevant strategy for improving the consistency of monitoring.

WHY FULL ATTAINMENT MATTERS

The assessment of individual components in isolation may provide an incomplete representation of renal health. When **all components are performed together** and ACR is calculated correctly, early-stage kidney disease can be more reliably identified.

Measuring Full Attainment:

Using composite adherence rather than single-test completion provides a **more rigorous and meaningful measure** of quality care, aligning with best practices in modern quality frameworks (e.g., MIPS, NCQA, HEDIS).

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CONCLUSION

The past four years have brought steady improvement in diabetic kidney health monitoring across payer channels. Still, just over half of patients (51.9%) reach full attainment nationally, and significant disparities remain by insurance type and geography. The following items may help enhance the effectiveness of this measure and support accurate tracking of attainment:

- Ensure EHR and clinical decision support tools are properly implemented to identify patients that have not received appropriate eGFR and uACR testing and provide appropriate interventions.
- Prioritize Medicaid-focused qualifying individual interventions, such as mobile labs, patient navigators, or bundled incentives.
- Track composite adherence instead of individual test completion to reflect the true clinical standard.

Sustained progress will require multi-level collaboration—across payers, providers, labs, and public health—to ensure every diabetic patient receives the kidney care needed to prevent complications and prolong life.

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