Select Health Quality Provider Program

DIABETES CARE: KIDNEY HEALTH EVALUATION

2026 Quality Measure Reference Guide

What's Inside

Other Online Resources

- Adult/Pediatrics Measures Quick Guide
- Demographic Allowable Corrections
- Report Hub Instructions: Basic User
- Formatting a Gaps List in Excel
- Quality Data Correction (QDC) Tool: Submitting Corrections
- National Committee for Quality Assurance (NCQA) Kidney Health Toolkit

Select Health

This measure is included in the Primary Care and Endocrinology Quality Provider Programs.

Measure Description

Description	The percentage of members ages 18–85 with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)
Denominator	Members 18 to 85 who have been identified as having diabetes (type 1 or type 2) using claim/encounter data and pharmacy data
Numerator	Members who received both of the following during the measurement year on the same or different dates of service: • At least 1 eGFR (blood test) • At least 1 uACR* (urine test)
Intake and Measurement Periods	January 1 through December 31 of the measurement year
Exclusions	**Members who:** • Have PCOS (polycystic ovarian syndrome) • Do not have diabetes
Correction Allowed	"Patient completed an eGFR, urine albumin, and urine creatinine." **NOTE:** All missing KED components can be entered in 1 correction. If submitting both eGFR and uACR results, select the 2-entry option. If only 1 of these components is missing, select the 1-entry option.

* uACR is a quantitative urine albumin and a urine creatinine test with service dates four or less days apart.

Allowable Corrections

General Guidance

- Include a copy of EHR note, progress note, or screen print signed by MA/RN/MD including member name, DOB, and provider.
- Submit corrections using **this online tool**.
- Wait 6 weeks from the date of service to enter corrections to allow for claim lag.
- Don't attach multiple patient records to a single correction.
- Kidney health evaluation does not require separate entries.

Kidney Health Evaluations (KED) Allowable Corrections						
Allowable Correction	**Submission Correction Process**				**Additional Required Documentation** (see "General Guidance" for Standard Requirements)	**Notes for Entering Corrections**
	Category	**Measure**	**Component**	**Correction Type**		
Unaccounted for estimated glomerular filtration rate (eGFR)	Chronic Disease	Kidney Health Evaluation for Patients with Diabetes	KED1 Numerator (1-element entry)	• eGFR • Urine Creatinine • Urine Albumin • uACR	Lab test with results date; be sure to USE: • The **resulted date** if available • The **collected date** if only that is listed • The **received date** if multiple dates are listed (collected, resulted, received) • The **last day of the month** (e.g., "3/2026" → enter as 3/31/2026) if the result is recorded as month and year only	• **Do not use** the nephropathy option under Comprehensive Diabetes Care. • **Members must have all 3 components to be compliant for this measure**. All 3 components can be entered as one correction submission.
Unaccounted for albumin-creatinine ratio (uACR)			KED2 Numerator (2-element entry) KED3 Numerator (3-element entry)			

Access guidance for general corrections to demographics.

Frequently Asked Questions

Q: Why does this measure matter?

A: Diabetes affects more than 30 million people in the U.S. and is the 7th leading cause of death.[1] In addition to these human costs, the 2017 estimated total financial cost of diagnosed diabetes in the U.S. was $327 billion.[2]

When managed, we can prevent or delay diabetic complications. However, for about 20% of Americans, their diabetes is undiagnosed.[3]

Another 88 million adults have elevated blood glucose levels, increasing their risk of developing type 2 diabetes in the next few years.[4] Among those whose diabetes is poorly controlled, complications tend to be more common and more severe. Better health outcomes rely on preventive care practices.

Q: What is Select Health doing to help?

A: Outreach to Select Health members includes:

- Providing care management services that help members manage health conditions, such as diabetes. Members, or providers can contact Care Management at **800-442-5305** or by email at **SHTOC@imail.org**.
- Sending a biannual diabetes newsletter to members with diabetes with information about managing diabetes and healthy lifestyle tips.
- Using computer-generated calls to provide diabetes care reminders and education to Medicaid members with diabetes. During the fourth quarter of the year, Medicare members receive live diabetes reminder calls about their Nations Benefit reward to close gaps in care.

Select Health Quality Provider Program provides an up-to-date registry of patients who have diabetes and are included in the glycemic status, diabetic eye exam, and kidney health evaluations measures.

This registry includes compliance status.

Q: What are best practices for this measure?

A: Best practices include:

- Creating workflow processes that use collaborative, team-based care focused on evidence-based guidelines. Some examples of processes include diabetes care reminders and follow-up appointments.
- Partnering with patients to develop an individualized plan based on medical history, preferences, comorbidities, and individual prognosis and risk.
- Supporting positive lifestyle changes, including using available education for weight loss and nutrition, medication management, or medical visit follow-up.
- Evaluating social determinants of health (SDoH) and available community resources that support diabetes management (e.g., access to food, medications, transportation).
- Using payor or electronic medical record patient registries or reports, decision-support tools, or clinic huddles to identify patients missing screenings or services.[5]
- Measuring progress toward your goals and adjusting process when needed by:
  - Establishing a baseline screening rate and setting an ambitious goal
  - Discussing how your screening system is working during staff meetings
  - Making process adjustments as needed to ensure success

References:

1 U.S. Department of Health and Human Services. *Healthy People 2030: Diabetes.* HealthyPeople.gov. Available at: **https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes**. Accessed February 16, 2026.

2 Parker ED, Lin J, Mahoney T, et al. Economic costs of diabetes in the U.S. in 2022. *Diabetes Care 2024;47(1):26–43.*

3 American Diabetes Association. *Statistics About Diabetes.* **diabetes.org**. 2026. Available at: **https://diabetes.org/about-diabetes/statistics/about-diabetes**. Accessed February 16, 2026.

4 National Institute of Diabetes and Digestive and Kidney Diseases. *Diabetes Statistics.* NIDDK.NIH.gov. Available at: **https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics**. Last reviewed January 2024. Accessed February 16, 2026.

5 American Diabetes Association. Standards of medical care in diabetes—2019 abridged for primary care providers. *Clinical Diabetes.* 2019;37(1):11-34.

Select Health

Working Your Open Gaps List

STEP 1
Create a current gaps-in-care list: 1. Open your Gaps-in-Care-for-Download report: **QPP Report Hub** 2. Apply these filters: — **Super clinic:** Choose your clinic. — **Measure:** Click on "Diabetes Care: Kidney Health Evaluation (KED)." — **Status:** Unclick the "Compliant" box. This will filter for only the achievable members. 3. In the drop-down menu on the top right side of the page, change the view from **"Member"** to **"Download."** 4. Follow the instructions on the screen to export the data to Excel. Refer to **Report Hub Instructions: Basic User**.
STEP 2
Format your Excel export. (Refer to **Formatting a Gaps List in Excel**.)
STEP 3
Review tips for working your gaps-in-care list (**page 6**).

Measure Information

The American Diabetes Association (ADA) and the National Kidney Foundation (NKF) recommend screening patients with diabetes for kidney disease every year using estimated Glomerular Filtration Rate (eGFR) and urine abumin-to-creatinine ratio (uACR).[1]

- eGFR — Assesses kidney function (blood test)
- uACR — Assesses kidney damage (urine test)

NOTE: Examples used in this document are for instructional purposes only; the dates that appear are only representative of what a user might see.

For this measure:

- The beginning of the calendar year is the measurement start date.
- The end of the calendar year becomes the measurement end date. Your gaps-in-care list has the measurement end date noted in the "Measure Instructions" column.

Measure Name	Status	Status Detail	Achievable Date	Measure Instructions
Diabetes Care: Kidney Health Eval (KED)	Achievable	To Be Completed	MM/DD/YYYY	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule testing.
Diabetes Care: Kidney Health Eval (KED)	Achievable	Completed elements: (DT: MM/DD/YYYY TYP:QUA SRC:S DT: MM/DD/YYYY TYP:UACR SRC:S DT: MM/DD/YYYY TYP:UCR SRC:S)	MM/DD/YYYY	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule eGFR testing.
Diabetes Care: Kidney Health Eval (KED)	Achievable	Completed elements: (DT: MM/DD/YYYY TYP:EGFR SRC:P)	MM/DD/YYYY	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule uACR testing.

- Any testing completed before or after the measurement year will **NOT** count as compliance for this measure.

Corrections Pro Tip

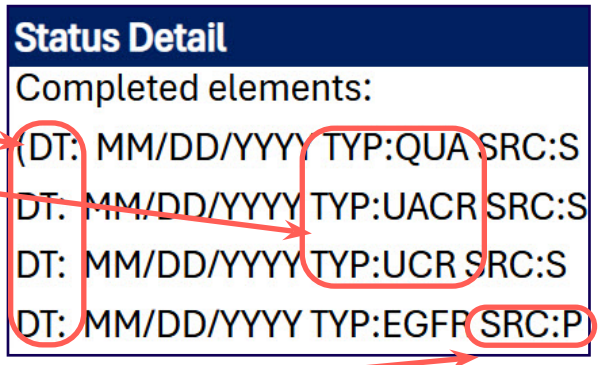
Please wait 6 weeks from the date of service before determining if a correction is needed. This allows time for claims to be processed, ultimately ensuring that only needed corrections are submitted.

Continued on page 6...

Working Your Open Gaps List, Continued

Tips for Working your Gaps-in-Care List

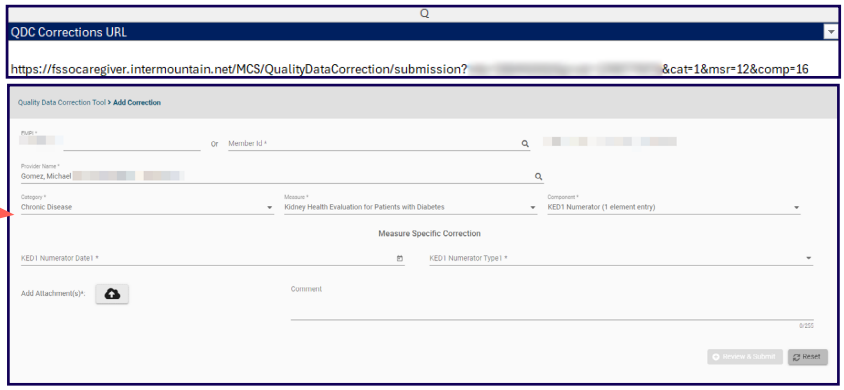
1. **Learn how to decode the information in the "Status Detail" column:**
   - **DT** = The date the test was done
   - **TYP** = The type of test that was done
     - — EGFR — estimated glomerular filtration rate
     - — UCR — urine creatinine
     - — QUA — quantitative albumin
     - — UACR — urine albumin-to-creatinine ratio
   - **SRC** = The source from where we received the information
     - — P = Primary (claims)
     - — S = Supplemental (lab feed, data submission, direct EHR access, etc.)



2. Follow the guidance provided in the "Measure Instruction" column. When working through this list of "achievable" members, you will encounter 3 possible scenarios:

Scenarios	Status Detail Examples	Tips
No kidney health testing has been completed this year	To Be Completed	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule testing.
ACR testing completed, GFR still needed	Completed elements: (DT: MM/DD/YYYY TYP:QUA SRC:S DT: MM/DD/YYYY TYP:UACR SRC:S DT: MM/DD/YYYY TYP:UCR SRC:S)	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule eGFR testing.
GFR testing completed, ACR still needed	Completed elements: (DT: MM/DD/YYYY TYP:EGFR SRC:P)	Member needs Kidney Health Evaluation by MM/DD/YYYY. Schedule uACR testing.

3. As you review charts, you will discover completed labs for which Select Health has not received a claim. In these cases, you can submit the labs as corrections by:
   - — Accessing the Quality Data Corrections (QDC) Tool
   - — Using the link(s) provided in the downloaded Gaps-in-Care Excel file to have member and measure information pre-populated



Learn More: Refer to the **Quality Data Correction (QDC) Tool: Submitting Corrections** for more information.

References:

[1] National Committee for Quality Assurance. *Let's Talk About Diabetes and Kidney Health Ready – Set – Test.* **NCQA.org** website. March 2021. https://wpcdn.ncqa.org/www-prod/wp-content/uploads/NCQA-Kidney-Health-Provider-Guide.pdf. Accessed February 17, 2026.

Best Practices

To help close gaps in care:

- Update your diabetes order sets to include both blood glomerular filtration rate (GFR), and urine albumin creatinine ratio (ACR) testing as albumin is often missed.
- If missed, urine albumin and creatinine should be reordered and retested to close this gap.
- Focus on education—many diabetes-related complications can develop without noticeable symptoms.
- Hold daily or weekly huddles to review members with upcoming diabetes care gaps and to plan outreach for those who have missed their appointments.
- Make sure the correct labs are built into your provider order sets as follows:
  - eGFR billing codes: **80047**, **80048**, **80050**, **80053**, **80069, 82565**
  - uACR billing codes: **82043**, **82570**
- Designate staff to review charts prior to each visit and send notes to the medical assistant or provider indicating whether the patient is due for an A1c or other glycemic monitoring test, annual eye exam, or kidney health testing (e.g., UACR and eGFR).

Questions about the Quality Provider Program?
Contact us at QualityProvider@selecthealth.org.

Select Health