Gold Coast Health Plan℠
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2023 MCAS MEASURE: HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD)

Measure Steward: National Committee for Quality Assurance (NCQA)

Gold Coast Health Plan's (GCHP) goal is to help its providers gain compliance with their annual Managed Care Accountability Set (MCAS) scores by providing guidance and resources. This tip sheet will provide the key components to the MCAS measure, *"Hemoglobin A1c Control for Patients With Diabetes (HBD)."*

Measure Description: Members 18–75 years of age with a diagnosis of diabetes. This measure looks at whether these members have had:

- HbA1c poor control (>9.0%)

Data Collection Method: Hybrid[1]

HBD Clinical Code Sets

- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for al clinical conditions evaluated, and services provided.

Methods used to identify members diagnosed with diabetes.

Method 1: Members with a diagnosis of diabetes during the measurement year or year prior to the measurement year.	• ICD-10-CM Codes E10.10-E13.9, O24.011-O24.33, O24.811-O24.83
Method 2: Members who received insulin or hypoglycemics / antihyperglycemics during the measurement year or year prior to the measurement year.	• Alpha-glucosidase inhibitors • Amylin analogs • Antidiabetic combinations • Insulin • Meglitinides • Glucagon-like peptide-1 (GLP1) agonists • Sodium glucose cotransporter 2 (SGLT2) inhibitor • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase-4 (DDP-4) inhibitors

Note: Glucophage / metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Methods used to identify members diagnosed with diabetes.

Description	CPT II
HbA1c < 7.0	3044F
HbA1c > 9.0	3046F
HbA1c 7.0 to 8.0	3051F
HbA1c 8.0 to 9.0	3052F

Exclusion Criteria – Members who meet the following criteria are excluded from the HBD measure:

- Members who do not have a diagnosis of diabetes and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness.

The Medical Record Must Include:

- At a minimum, a note indicating the date when the HbA1c test was performed and the result. The record is compliant for poor control if the result for the most recent HbA1c level is > 9.0% or missing, or if an HbA1c test was not done during the measurement year.
- Ranges and thresholds do not meet criteria for the measure. A distinct numeric result is required for compliance.

Best Practices:

- Use the Inovalon® INDICES® Provider Insights Dashboards to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a preventive care visit
- Use telehealth visits as appropriate to monitor patients with diabetes and order HbA1c tests accordingly.
- Perform the A1c test at least two times per year in patients who are meeting treatment goals and who have stable glycemic control.
- Perform the A1c test every three months in patients whose therapy has changed or who are not meeting glycemic goals (>8.0 HbA1c).
- Set appropriate individualized A1c goals based on relevant comorbidities, demographic factors, and other considerations.
- Point-of-care (POC) testing for A1c provides the opportunity for more timely treatment changes.
- Recommend lifestyle changes as appropriate.
- Ensure your documentation is clear and concise.
- Use proper coding.
- GCHP's team of nurses, social workers and care management coordinators work together to empower members to exercise their options and access the services appropriate to meet their individual health needs to promote quality outcomes. GCHP Care Management includes complex and non-complex care management that includes transition to adult services, disease specific education, identification of social determinants of health and linkage to appropriate resources in the community.
  - To learn more, please call GCHP's Care Management Team at:
    - Providers, call: 1-805-437-5777
    - Members, call: 1-805-437-5656
    - GCHP website, Care Management: Click Here
  - GCHP offers free health education services, materials and classes to help members achieve a healthy lifestyle. Providers can contact the Health Education Department or refer patients/guardians/caregivers to the following information:
    - Providers, call: 1-805-437-5718
    - Members, call: 1-888-301-1128 / TTY 1-888-310-7347
    - GCHP website, Health Education Resources (provided in English and Spanish): Click Here

[1] For those measures in which there is an option to choose between the hybrid and administrative reporting methodology, Gold Coast Health Plan has chosen to report using the hybrid methodology. Measures reported using the *hybrid* data collection method report on a sample of the eligible population (usually 411) and use both administrative and medical record data sources to evaluate if services were performed.