Gold Coast Health Plan℠
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GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

MCAS/STAR MEASURE: GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

Measure Steward: National Committee for Quality Assurance (NCQA)

Gold Coast Health Plan Total Care Advantage's (HMO D-SNP) 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 provides the key components to the MCAS measure, *"Glycemic Status Assessment for Patients with Diabetes (GSD)."*

Measure Description: Members 18 to 75 years of age with a diagnosis of diabetes (type 1 and 2) whose most recent glycemic status (hemoglobin A1C[HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year. This measure looks at whether these members have had:

- Glycemic Status >9.0%
- Glycemic Status <8%

Data Collection Method: Hybrid[1]

GSD 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 at least two diagnoses of diabetes on different dates of service during the measurement year or year prior to the measurement year.	Click here for the list of diabetes diagnosis codes.
Method 2: Members with at least one diagnosis of diabetes and at least one diabetes medication dispensing event of insulin or hypoglycemic medication during the measurement year or year prior to the measurement year.	Click above for the list of diabetes diagnosis codes. Click here for the list of diabetes medications.

Codes used to identify an HbA1c lab test was completed.

Description	CPT Code	LOING Code
HbA1c Test	83036, 83037	4548-4, 17855-8, 4549-2,17856-6, 96595-4

Codes used to identify HbA1c status.

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

Required Exclusions Criteria – Members who meet the following criteria are excluded from the GSD measure:

- 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 at least two indications of frailty and advanced illness.
- Members 66 years of age and older as of December 31 of the measurement year who are either enrolled in the Institutional SNP (I-SNP) anytime during the measurement year or are living long-term in an institution as identified by the LTI flag in the Monthly Membership Detail file.
- Members who die any time during the measurement year.

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® Provider Enable Quality Gaps insights 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.
- Gold Coast Health Plan's (GCHP) Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help GCHP members manage their health. GCHP Care Management referrals can be made by submitting the referral form available on the GCHP website or by contacting the Care Management team by phone or email.
  - Care Management Contact: 1-805-437-5656
  - Care Management Email: CareManagement@goldchp.org
  - English Referral Form: Click Here
  - Spanish Referral Form: 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: 1-805-437-5961
  - Members, call: 1-888-301-1128 / TTY 711
  - GCHP Health Education Webpage (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.