2021 MCAS MEASURE: COMPREHENSIVE DIABETES CARE
HbA1c POOR CONTROL > 9.0% (CDC-H9)

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, “Comprehensive Diabetes Care HbA1c Poor Control > 9% (CDC-H9).”

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

► An HbA1c test in poor control (> 9%) in the measurement year.

Data Collection Method: Hybrid'

CDC Clinical Code Sets

► For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.
► Use CPT-II codes to report HbA1c test results in claims submissions.
Methods used to identify member diagnosed with diabetes.

### Method 1: Identify members with diabetes through claims and encounter data.

**ICD-10-CM Codes**

E10.10-E13.9, 024.011-024.33, 024.811-024.83

**SNOMED Codes**

2751001, 4855003, 5969009, 8801005, 9859006, 19378003, 23045005, 24203005, 25412000, 26298008, 28032008, 3055886100132104
Method 2: Identify members who were dispensed insulin or hypoglycemic / anti-hyperglycemic medication on an ambulatory basis through pharmacy data.

**Diabetic Medication**
- 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

**Codes used to identify the clinic setting where diabetes was diagnosed.**

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UB REV</th>
<th>SNOMED</th>
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<td>0510-0517, 0519-0523, 0526-0529, 0982-0983</td>
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<td>Online Assessment</td>
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<td>G0071, G2010, G2012, G2061-G2063</td>
<td>0450-0452, 0456, 0459, 0981</td>
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<tr>
<td>Description</td>
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<td>HCPCS</td>
<td>UB REV</td>
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**Codes used to identify HbA1c test results.**

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<th>Description</th>
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<td>HbA1c &lt; 7.0</td>
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<tr>
<td>HbA1c ≥ 8.0 to ≤ 9.0</td>
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<tr>
<td>HbA1c 7.0 – 9.0</td>
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<td>451051000124101</td>
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Exclusion Criteria – Members with any of the following conditions are excluded from the CDC measure:

► Members who did not have a diagnosis of diabetes in 2019 or 2020 and had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in 2019 or 2020.
► Members receiving hospice care during the measurement year.
► Members receiving palliative care during the measurement year.
► Members 66 years of age and older as of Dec. 31, 2020 who were diagnosed with both frailty and advanced illness.

The Medical Record Must Include:

► A note indicating the date when the most recent HbA1c test was performed and the result.
► A distinct numeric result, which is required for compliance. Ranges and thresholds do not meet criteria for the measures.
► Notation of A1c, Hemoglobin A1c, Glycohemoglobin A1c, Glycohemoglobin, Glycated hemoglobin, and Glycosylated hemoglobin count for the measure.

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 / parents of the need for a visit.
► Use telehealth visits to monitor patients with diabetes and order HbA1c tests accordingly.
► Perform A1C test at least two times per year in patients who are meeting treatment goals (and who have stable glycemic control).
► Perform A1C test every 3 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 testing for A1C provides the opportunity for more timely treatment changes.
► Recommend lifestyle changes as appropriate.

CDC Best Practices:

► 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, Community Resources (provided in English and Spanish): Click Here

1 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.