MEASUREMENT YEAR 2026

Quality Measures Reference Guide

Measurement Year 2026 | Reporting Year 2027

Gold Coast Health Plan℠ A Public Entity

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

Table of Contents

Measure	Measure Acronym	Page
Introduction		3
2026 Measurement Year Quality Measures Quick Reference Guide		4
Managed Care Accountability Set (MCAS) Frequently Asked Questions (FAQs)		14
Medicare Star Rating System Frequently Asked Questions (FAQs)		19
Follow-Up After Acute and Urgent Care Visits for Asthma	(AAF-E)	25
Breast Cancer Screening	(BCS-E)	27
Controlling High Blood Pressure	(CBP)	29
Cervical Cancer Screening	(CCS-E)	31
Childhood Immunization Status – Combo 10	(CIS-10-E)	33
Care for Older Adults - Medication Review	(COA-MED)	36
Care Older Adults - Pain Assessment	(COA-PAIN)	38
Colorectal Cancer Screening	(COL-E)	40
Developmental Screening in the First Three Years of Life	(DEV)	42
Depression Screening and Follow-Up for Adolescents and Adults	(DSF-E)	44
Eye Exam for Patients with Diabetes	(EED)	47
Follow-Up After Emergency Department Visit for Substance Use	(FUA)	50
Follow-Up After Emergency Department Visit for Mental Illness	(FUM)	54
Glycemic Status Assessment for Patients with Diabetes	(GSD)	57
Immunizations for Adolescents	(IMA-2-E)	59
Kidney Health Evaluation for Patients With Diabetes	(KED)	61
Lead Screening in Children	(LSC-E)	64
Medication Adherence for Cholesterol	(MAC)	65
Medication Adherence for Diabetes Medication	(MAD)	67
Medication Adherence for Hypertension	(MAH)	69
Plan All-Cause Readmission	(PCR)	71
Postpartum Depression Screening and Follow-Up	(PDS-E)	74
Prenatal Depression Screening and Follow-Up	(PND-E)	77
Prenatal and Postpartum Care	(PPC)	80
Prenatal Immunization Status	(PRS-E)	83
Statin Therapy for Patients with Cardiovascular Disease	(SPC)	85
Topical Fluoride for Children	(TFL)	87
Well-Child Visits in the First 30 Months of Life	(W30)	88
Child and Adolescent Well-Care Visits	(WCV)	89

Introduction

Gold Coast Health Plan (GCHP) monitors and reports the Managed Care Accountability Set (MCAS) and Star performance measures to assess and improve clinical quality of care. To help providers understand the MCAS and Star performance measure requirements, GCHP's Quality Improvement Department has developed this tip sheet reference guide to share key information on individual MCAS and Star measures. This guide is not intended to direct clinical judgment, but to serve as a resource in understanding measure specifications while providing guidance for measure compliance.

For more information, email the Quality Improvement Department at QualityImprovement@goldchp.org.

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E) ECDS Measure[5]	MCAS	The percentage of persons 5 to 64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or emergency department (ED) visit with a diagnosis of asthma between Jan. 1 and Dec. 1 of the measurement period that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.	Claims / encounter data from urgent care, acute inpatient discharge, observation stay discharge or ED and a follow-up visit within 30 days of the ED with an asthma diagnosis.	**CPT:** 98000 - 98016 **HCPCS:** G0071 **ICD-10-CM:** J45.20
Breast Cancer Screening (BCS-E) ECDS Measure[5]	MCAS/ STAR	Women, 40 to 74 years of age, who had a mammogram to screen for breast cancer between Oct. 1, 2024 and Dec. 31, 2026.	Claims / encounter data indicating one of the following types of mammograms was performed: screening, diagnostic, film, digital or digital breast tomosynthesis. **Note:** MRIs, ultrasounds and biopsies do not count as screening mammograms.	**CPT:** 77061-77063, 77065-77067
Care for Older Adults (COA) – Medication Review Hybrid[3] Measure	Star	The percentage of plan members whose doctor or clinical pharmacist reviewed a list of everything the members take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	Medication reviews must: • Show evidence the review was conducted by a prescribing practitioner or clinical pharmacist • Include a medication list in the medical record that includes all medications (prescription and over-the-counter medications and herbal or supplemental therapies) » Must be signed and dated during the measurement year	**CPT:** 90863, 99483, 99495 **CPT II:** 1159F, 1160F **HCPCS:** G8427
Care for Older Adults (COA) – Pain Screening Hybrid[3] Measure	Star*	The percentage of plan members aged 66 and older who had a pain screening at least once during the measurement year.	Medical record documentation signed and dated, that notes: patient was assessed for pain, results (positive or negative) of the assessment, use of a standardized pain assessment tool.	**CPT II:** 1125F, 1126F

*For COA – the Star Rating System is transitioning to COA-Functional Assessment, but COA-Pain Screening remains a TCA Model of Care objective.

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
*Care for Older Adults (COA) – Functional Assessment Hybrid[3] Measure	Star	The percentage of members aged 66 and older received at least one functional status assessment during the measurement year.	Document, with date, that activities of Daily Living (ADL) were assessed or at least five of the following were assessed: • Bathing, dressing, eating, transferring, using toilet, walking Document, with date, that Instrumental Activities of Daily Living (IADL) were assessed or that at least four of the following were assessed: • Grocery shopping driving/using public transportation, telephone use, cooking/meal prep, housework, home repair, laundry, taking medications, finances	**CPT II:** 1170F **HCPCS:** G0438, G0439 **CPT:** 99483
Cervical Cancer Screening (CCS-E) ECDS Measure[5]	MCAS	Women, 21 to 64 years of age, who were screened for cervical cancer using one of the following methods: • Women 21 to 64 years of age who had a Pap exam between Jan. 1, 2024 to Dec. 31, 2026. • Women 30 to 64 years of age who had a cervical high-risk human papillomavirus (hrHPV) test between Jan. 1, 2022 to Dec. 31, 2026. • Women 30 to 64 years of age, who had a Pap/hrHPV co-test between Jan. 1, 2022 to Dec. 31, 2026.	Claims / encounter or lab data indicating a cervical cancer screening was completed or clinical documentation or lab reports that includes the following: • The date of the cervical cancer screening. • The result or finding.	**CPT:** Pap Test: 88141-88143, 88147-88148, 88150, 88164-88167, 88174-88175 HPV Test: 87624, 87625
Child and Adolescent Well-Care Visits (WCV) Administrative Measure[4]	MCAS	Children and adolescents, 3 to 21 years of age, who had at least one comprehensive well-care exam with a PCP or OB/GYN in 2026.	Claims / encounter data indicating the member had a well-care exam in 2026.	**CPT:** 99381-99385, 99391-99395, 99461 **ICD-10-CM:** Z00.00, Z00.110, Z00.111, Z00.121

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Childhood Immunization Status (CIS) Combo 10-E ECDS Measure[5]	MCAS	Children who received the following immunizations on or before their second birthday in 2026: • 4 DTaP • 4 PCV • 3 Hib • 3 IPV • 3 Hep B • 1 Hep A • 2 Influenza (Flu) • 1 MMR • 1 VZV • RV (two 2-dose or three 3-dose)	Claims / encounter data with codes indicating the vaccine and dose administered or clinical documentation and/or immunization records documenting the vaccine, dose and date administered. **Note:** All PCPs are required to enter vaccines into the California Immunization Registry (CAIR). DHCS recommends entering information within 14 days of administering an immunization to ensure all historical vaccines and doses are entered into the registry for children that have moved out of the area. https://cairweb.org/	**CPT:** DTaP: 90698, 90700 Hep B: 90723, 90740 Hep A: 90633 IPV: 90698, 90713 Flu: 90655, 90657 MMR: 90707, 90710 PCV: 90670, 90671 RV: 90680, 90681 VZV: 90710, 90716 HiB: 90644,90648
Colorectal Cancer Screening (COL-E) ECDS Measure[5]	MCAS/ STAR	The percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer.	Claims / encounter data indicating one of the following exams were completed: • FOBT in 2026 • Flexible sigmoidoscopy 2022-2026 • Colonoscopy 2017-2026 • CT colonography 2022-2026 • FIT-DNA 2024-2026	**CPT:** 82270, 45330, 44388, 74261, 81528 **HCPCS:** G0328 **ICD-10-PCS:** 0DTE0ZZ **LOINC:** 12503-9
Controlling Blood Pressure (CBP) Hybrid[3] Measure	MCAS/ STAR	Adults, 18 to 85 years of age, with a diagnosis of hypertension that had adequately controlled blood pressure (<140/90 mm Hg) in 2026.	Claims / encounter data with codes indicating a hypertension diagnosis on two separate dates between Jan. 1, 2025 to June 30, 2026 and claims / encounter or clinic documentation of the most recent blood pressure (BP) reading in 2026. **Note:** The BP reading must occur on or after the date of the second diagnosis of hypertension.	**CPT:** 98970-98972, 99202-99205, 99211-99215 **CPT II:** 3074F, 3075F, 3077F – 3080F **ICD-10-CM:** I10 **LOINC:** 75995-1, 75997-7

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) ECDS Measure[5]	MCAS	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	ECDS data (e.g., claims, encounter, EHR, HIE, registry) indicating a depression screening was completed on a standardized tool and positive screenings had a follow-up visit.	**CPT:** 98960, 99366, 90791 **HCPCS:** G0071, G0512, G0155 **LOINC:** 44261-6, 55758-7, 89204-2
Developmental Screening (DEV) Administrative Measure[4]	MCAS	Children, 1 to 3 years of age, who were screened for risk of developmental, behavioral, and social delays, using a standardized screening tool, on or before their first, second, or third birthday in 2026.	Claims / encounter data with a code indicating a developmental screening was completed using a standardized screening tool.	**CPT:** 96110
Eye Exam for Patients with Diabetes (EED) Administrative Measure[4]	Star	The percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.	Claims / encounter data indicating the member had a dilated retinal eye exam or fundus photography. Eye exam report or progress notes documenting history of a dilated retinal eye exam – including date of service, the test or result, and the care provider's credentials.	**ICD-10-CM:** E10.10 **CPT:** 92002, 92230, 92227 **CPT II:** 2022F, 2024F **HCPCS:** S0620 **LOINC:** 105914-6 with result
Follow-Up After Emergency Department Visit for Alcohol and Other drug Abuse or Dependence (FUA) Administrative Measure[4]	MCAS	Members, 13 years of age and older, who had an emergency department (ED) visit between Jan. 1, 2026 and Dec. 1, 2026 with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and had two follow-up visits with a principal diagnosis of AOD within seven and 30 days after the ED visit.	Claims / encounter data indicating the member had a principal diagnosis of AOD in the ED and in the two follow-up visits within seven and 30 days of the ED visit.	**ICD-10-CM:** F10.10, F15.20, F19.29 **CPT:** 90791, 98971, 99281, 99510

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Follow-Up After Emergency Department Visit for Mental Illness (FUM) Administrative Measure[4]	MCAS/ STAR	Members, 6 years of age and older, who had an emergency department (ED) visit between Jan. 1, 2026 and Dec. 1, 2026 with a principal diagnosis of mental illness or intentional self-harm and had two follow-up visits with a principal diagnosis of mental illness or intentional self-harm within seven and 30 days after the ED visit.	Claims / encounter data indicating the member had a principal diagnosis of mental illness or intentional self-harm in the ED and in the two follow-up visits within 7 and 30 days of the ED visit.	**ICD-10-CM:** F20.0, F32.1, F93.0, T14.91XA, T53.5X2A, T71.112A **CPT:** 90791, 98960, 98966, 99245, 99281
Glycemic Status Assessment for Patients with Diabetes (GSD) Hybrid Measure[3]	MCAS/ STAR	Adults, 18 to 75 years of age, with a diagnosis of diabetes (type 1 and type 2) who had the following screening in 2026: • Glycemic Status > 9.0%	Claims / encounter and lab data with codes reporting glycemic status assessment (HbA1c test or glucose management indicator), or clinical documentation of HbA1c test date with results.	**CPT II:** 3044F, 3046F, 3051F, 3052F
Immunizations for Adolescents - Combination 2 (IMA-2-E) ECDS Measure[5]	MCAS	Adolescents who received the following immunizations on or before their 13th birthday in 2026: • 1 MCV (between the 11th and 13th birthday) • 1 Tdap (between the 10th and 13th birthday) • HPV series (between the 9th and 13th birthday)	Claims / encounter data with codes indicating the vaccine and dose administered or clinical documentation and/or immunization records documenting the vaccine, dose and date administered. **Note:** All PCPs are required to enter vaccines into the California Immunization Registry (CAIR). DHCS recommends entering information within 14 days of administering an immunization to ensure all historical vaccines and doses are entered into the registry for children that have moved out of the area. https://cairweb.org/	**CPT:** Meningococcal: 90734 Tdap: 90715 HPV: 90649

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Kidney Health Evaluation for Patients with Diabetes (KED) ECDS Measure[5]	Star	Percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) as of Dec. 31 of the measurement year who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR), during the measurement year.	Claims / encounter data with codes indicating a diabetes (type 1 or 2) diagnosis and the completion of at least one eGFR and at least one uACR test identified by one of the following: a quantitative urine albumin test AND a urine creatinine test (billed for service dates four days or less apart) or a uACR. Medical records verifying the required tests were completed and results documented.	**ICD-10-CM:** E10.10 **CPT:** 80047, 82043, 82570 **LOINC:** 102097-3, 100158-5, 20624-3, 13705-9
Lead Screening in Children (LSC) Hybrid[2] / Administrative[4] Measure	MCAS	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	Claims / encounter data, lab date, medical record documentation with date of lab and results.	**CPT:** 83655 **LOINC:** 10368-9, 10912-4
Medication Adherence for Cholesterol / Statins (MAC) Administrative[4] Measure	Star	The percentage of members 18 years of age or older who are adherent to their prescription for a cholesterol medication (a statin drug) at least 80% of the time or more are supposed to be taking the medication.	Prescription Drug Event (PDE) Claims data indicating fills of cholesterol medications. Note: Medications included in this measure include statin and statin combinations.	NDC codes for cholesterol medication (statin drugs).
Medication Adherence for Hypertension (MAH) Administrative[4] Measure	Star	The percentage of members 18 years of age or older who are adherent to their blood pressure medication at least 80% of the time or more are supposed to be taking the medication.	Prescription Drug Event (PDE) Claims data indicating fills of blood pressure medications. Note: Medications included in this measure: Renin-Angiotensin System (RAS) antagonists, defined as angiotensin converting enzyme (ACE) inhibitors and Angiotensin II receptor blockers (ARBs), or direct renin inhibitors.	NDC codes for blood pressure medications.

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Medication Adherence for Diabetes Medications (MAD) Administrative[4] Measure	Star	The percentage of members 18 years of age or older who are adherent to their diabetes medication at least 80% or more of the time they are supposed to be taking the medication.	Prescription Drug Event (PDE) Claims data indicating fills of diabetes medications. Note: Drug therapy across these classes of diabetes medications is included in this measure: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.	NDC codes for diabetes medications.
Plan All-Cause Readmission (PCR) Administrative[4]	Star	Members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Claims data indicating a hospital admission, discharge date, readmission date. Medical records including health history and physical, home health records, progress notes. Note: Patients with multiple co-morbidities are expected to be readmitted, so medical records should document all conditions using diagnosis codes.	**UB REV:** 0100, 0150, 0200, 0760, 1000
Postpartum Depression Screening and Follow-Up (PDS-E) ECDS Measure[5]	MCAS	The percentage of deliveries, between Sept. 8, 2025, to Sept. 7, 2026, in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.	ECDS data (e.g., claims, encounter, EHR, HIE, registry) indicating a depression screening was completed on a standardized tool and positive screenings had a follow-up visit.	**CPT:** 98960, 99366, 90791 **HCPCS:** G0071, G0512, G0155 **LOINC:** 44261-6, 55758-7, 89204-2

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Prenatal and Postpartum Care (PPC) Hybrid[3] / Administrative[4] Measure	MCAS	Women, with a live birth delivery between Oct. 8, 2025 to Oct. 7, 2026, who had prenatal and postpartum care within the following time periods: • A prenatal exam within the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan. • A postpartum exam within seven to 84 days after delivery.	**Prenatal Exam:** Claims / encounter data indicating a prenatal exam was completed or clinical documentation with the date of a prenatal care visit AND evidence of ONE of the following: • Physical obstetrical exam that includes auscultation for fetal heart tone or fundus height or pelvic exam with obstetric observations. • Evidence that a prenatal care procedure was performed, i.e., ultrasound, obstetric panel, or TORCH antibody panel. • Documentation of pregnancy or reference to pregnancy, i.e., LMP or EDD, prenatal risk assessment or complete obstetrical history.	**Prenatal:** **CPT:** 99202-99205, 99242-99245, 59400, 59425, 59510, 99500 **ICD-10-CM:** 009.0x
			Postpartum Exam: Claims / encounter data indicating a postpartum exam was completed or clinical documentation with the date of a postpartum visit AND evidence of ONE of the following: • Pelvic exam • Evaluation of weight, BP, breasts, and abdomen • Notation of postpartum care (PP care, six-week check, or pre-printed postpartum care form) • Perineal or cesarean wound check • Screening for depression, tobacco use, substance use disorder • Glucose screening for GDM women • Family planning, resumption of intercourse • Infant care or breastfeeding	**Postpartum:** **CPT:** 57170, 59400, 88141 **ICD-10-CM:** Z01.411, Z01.419, Z01.42

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

Measure	Measure Set	Description	Required Documentation	Sample Codes[2]
Prenatal Depression Screening and Follow-Up (PND-E) ECDS Measure[5]	MCAS	The percentage of deliveries in which members were screened for clinical depression while pregnant, and if screened positive, received follow-up care.	ECDS data (e.g., claims, encounter, EHR, HIE, registry) indicating a depression screening was completed on a standardized tool and positive screenings had a follow-up visit.	**CPT:** 98960, 99366, 90791 **HCPCS:** G0071, G0512, G0155 **LOINC:** 44261-6, 55758-7, 89204-2
Statin Therapy for Patients with Cardiovascular Disease (SPC) ECDS Measure[5]	Star	The percentage of male members 21 to 75 years of age and females 40 to 75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication.	Claims data indicating a diagnosis of ASCVD and that the member was dispensed at least one high or moderate-intensity statin medication.	**ICD-10-CM:** I20.0, I63.20 **ICD-10-PCS:** 0210083, 021109C **CPT:** 33510, 92920 **HCPCS:** C9600, S2205
Topical Fluoride for Children (TFL) Administrative Measure[4]	MCAS	The percentage of children 1 through 20 years of age who received at least two topical fluoride applications in 2026.	Claims / encounter data indicating a dental varnish service was completed.	**CPT:** 99188 **CDT:** D1206, D1208
Well-Child Visits in the First 30 Months of Life (W30) Administrative Measure[4]	MCAS	Children who had the following number of well-child visits with a PCP during the last 15 months: • Children who turned 15 months old in 2026 and had six or more well-child visits. • Children who turned 30 months old in 2026 and had two or more well-child visits.	Claims / encounter data indicating a well-care exam were completed in 2026.	**CPT:** 99381-99385, 99391-99395 **ICD-10-CM:** Z00.110, Z00.111, Z00.121, Z00.129

[1] The 2026 measurement year / 2027 reporting year Managed Care Accountability Set (MCAS) is a set of performance measures selected by the state Department of Health Care Services (DHCS) to monitor the performance of Medi-Cal managed care health plans in California. The MCAS measures are based on the Centers for Medicare and Medicaid (CMS) Adult and Child Core Sets for Medicaid.

[2] This is a sample list of codes from each measure's technical specification guidelines and does not represent the complete list of codes used to evaluate compliance with the measure indicators.

2026 MEASUREMENT YEAR QUALITY MEASURES QUICK REFERENCE GUIDE

The data collection methods defines the types of data sources used to evaluate if services were performed and report rates.

Data Collection Method	Denominator Used to Calculate Rate	Data Sources Used to Evaluate if Services Were Performed
Hybrid[3]	A sample (usually 411) of the eligible population for the measure.	• Administrative data sources (e.g., claims, encounter, lab, radiology, pharmacy, immunization registries) • Medical Record Reviews (e.g., progress notes, immunization records)
Administrative[4]	The entire eligible population for the measure.	Administrative data sources (e.g., claims, encounter, lab, radiology, pharmacy, immunization registries)
Electronic Clinical Data Systems (ECDS)[5]	The entire eligible population for the measure.	ECDS is a HEDIS® reporting methodology that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease / case management systems) to report rates on ECDS designated measures.

[3] 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.

[4] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

[5] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

[6] For those measures in which there is an option to choose between the hybrid and administrative reporting methodology, Gold Coast Health Plan (GCHP) 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.

Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

MANAGED CARE ACCOUNTABILITY SET (MCAS) FREQUENTLY ASKED QUESTIONS

1. What is MCAS?

The Managed Care Accountably Set (MCAS) is a standardized set of performance measures selected by the state Department of Health Care Services (DHCS). Gold Coast Health Plan (GCHP) monitors and reports MCAS measures to assess and improve quality of care and services provided to GCHP Members. MCAS is based on the Centers for Medicare & Medicaid Services (CMS) Child and Adult Core Set for Medicaid measures, which includes Health Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA) and other measure stewards such Dental Quality Alliance (DQA). All state Medi-Cal Managed Care Plans are required to report MCAS measures to DHCS annually.

2. Who participates in MCAS?

All Managed Care Plans (MCPs) in California.

3. What is the purpose of MCAS?

- Evaluate quality of care and services provided to health plan members.
- Evaluate accessibility of care.
- Develop performance improvement initiatives based on identified opportunities.
- Compare performance with other health plans.

4. How is MCAS reported?

MCAS performance measures typically evaluate the previous year's clinical data. For example, most MCAS rates reported in 2027 are based on clinical services performed in 2026. However, some measures, such as the Cervical Cancer Screening (CCS) measure, look for services performed up to five years prior to the reporting year.

The results of GCHP's annual MCAS reviews are reported to DHCS in June each year. In addition, HEDIS® measures will continue to be reported to NCQA.

5. How can providers track their MCAS performance?

For annual performance reviews, providers may review the annual MCAS Provider Report Cards distributed by GCHP, which detail clinic-level outcomes on each performance measure and identify areas of high and low performance to help determine future improvement opportunities.

For monthly prospective reporting, providers may use Inovalon's Provider Enablement Quality Gaps Insights platform. This platform is a group of data visualization and reporting dashboards designed to support quality improvement efforts by monitoring measure performance and producing member-level gap reports to enable outreach to identified members to close gaps in care. For additional information regarding the Provider Enablement Quality Gaps Insights platform, please contact the Quality Improvement Department at QualityImprovement@goldchp.org.

6. What is a provider's role in MCAS reporting?

Providers play a central role in promoting the health of GCHP members. Providers and office staff can help facilitate MCAS performance and process improvement by:

- Providing appropriate care within designated timeframes, i.e., annual screenings.
- Monitoring patients with chronic conditions and/or who are on persistent medications.
- Documenting all care in a patient's medical record.
- Coding for all services completed and submitting claims timely.
- Responding timely to requests for medical records.
- Staying up-to-date with MCAS measure criteria.

7. Do I need member consent to release personal health information (PHI) for MCAS reporting?

No. Under the Health Information Portability and Accountability Act (HIPAA), data collection for MCAS is permitted. Health plan requests for medical records do not require additional patient consent or authorization.

GCHP members' PHI is maintained in accordance with all state and federal laws.

8. What data sources are used in MCAS Reporting?

- Medical records.
- Administrative data: claims, encounter, pharmacy, member and provider data.
- Supplemental data: lab, vision, immunization registry, electronic medical records.

9. How are MCAS performance measures evaluated?

MCAS measures can require either an administrative or hybrid review of data.

- Measures reported using the *administrative* data collection method report on the entire eligible population. These use only administrative data sources, such as claims, encounter, lab, and immunization registries to evaluate if services were performed.
- Measures reported using the *hybrid* data collection method report on a sample of the population (usually 411) and use administrative and medical record data sources to evaluate if services were performed.
- Measures reported using the *Electronic Clinical Data Systems (ECDS)* data collection method is a HEDIS reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information, exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

10. What MCAS performance measures are reported?

There are 21 MCAS performance measures for Measurement Year (MY) 2026 / Reporting Year (RY) 2027. The following 20 MCAS performance measures are held to a minimum performance level (MPL) that is set by DHCS.

MCAS RY 2027

Children's Health

- CIS 10 - Childhood Immunization Status Combination 10
- DEV - Developmental Screening in the First Three Years of Life
- IMA 2 - Immunizations for Adolescents Combination 2
- LSC - Lead Screening in Children
- TFL - Topical Fluoride for Children
- W30-Well-Child Visits in the First 15 Months of Life
- W30-Well-Child Visits in the First 30 Months of Life
- WCV - Child and Adolescent Well-Care Visits

Behavioral Health

- FUM - Follow-up After ED Visit for Mental Illness - 30 days
- FUA - Follow-Up After ED Visit for Substance Abuse - 30 days
- DSF-E - Depression Screening and Follow-Up for Adolescents and Adults-Screening

Cancer Prevention

- BCS - Breast Cancer Screening
- CCS - Cervical Cancer Screening
- COL-E - Colorectal Cancer Screening

Reproductive Health

- PPC Pre - Timeliness of Prenatal Care
- PPC Pst - Postpartum Care
- PDS-E - Postpartum Depression Screening and Follow-up Screening
- PND-E - Prenatal Depression Screening and Follow-Up Screening

Chronic Disease Management

- CBP - Controlling High Blood Pressure
- GSD - Glycemic Status Assessment for Patients with Diabetes (>9%)

The remaining MCAS performance measure is not held to the MPL but is monitored for performance by DHCS.

Chronic Conditions

- AAF-E - Follow-up After Acute and Urgent Care Visits for Asthma

11. How will GCHP collect MCAS medical records?

- GCHP has partnered with ComplexCare Solutions, a subsidiary of Inovalon, to handle the HEDIS® medical record data abstraction.
- Each request will include the members and measure(s) selected for review and the relevant portions of medical records that are requested.
- Data collection methods include fax, mail, onsite visits, and remote electronic medical record (EMR) system access.
- Providers should submit requested documentation within five days of the request.

12. Who is the contact for MCAS for medical record requests?

- When the record requests are sent, contact instructions will be listed on the request.
- Questions can also be submitted to GCHP via email at QualityImprovement@goldchp.org.

13. When does medical record review begin and end?

Medical record requests will begin in February and end in early May.

14. Should the entire medical record be sent?

No. Please provide the specific records noted in the medical record request.

Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

15. Where can I find more on these MCAS measures?

To educate and assist providers with increasing their MCAS rates, GCHP has created MCAS tip sheets for each measure reported. These tip sheets outline the key aspects of each MCAS measure, the medical codes associated with each measure, and documentation guidance. They are located on the GCHP website.

Click here to view the MCAS tip sheets.

To view the 2026 CMS Child and Adult Core set measure technical specifications, click the links below:

- 2026 CMS Child Core Set
- 2026 CMS Adult Core Set

Learn about HEDIS® measures on NCQA's website here.

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

MEDICARE STAR RATING SYSTEM FREQUENTLY ASKED QUESTIONS

1. What is the Medicare Star Ratings System?

The Centers for Medicare & Medicaid Services (CMS) uses the Medicare Star Ratings System to evaluate the quality and performance of Medicare Advantage (MA) plans and Part D prescription drug plans. Plans are rated from 1 to 5 stars, with 5 being the highest score a plan can achieve.

The Medicare Star Ratings for health plans are updated and published annually and enables individuals, payers, and others to compare plans across multiple dimensions. It helps individuals find and select the best plan to meet their health care needs. It also helps plans earn quality bonus payments from CMS to improve their member services.

2. Who participates in the Medicare Star Ratings System?

- Medicare Advantage (MA) Plans (Part C)
  - » Health plans that provide Medicare benefits under contract with CMS
  - » Includes Special Needs Plans (SNPs), like Dual Eligible SNPs (D-SNPs)
- Medicare Prescription Drug Plans (PDPs, Part D)
  - » Stand-alone Part D plans that cover prescription drugs
  - » Rated separately from MA plans
- Medicare Advantage – Prescription Drug Plans (MA-PDs)
  - » Most MA plans also include drug coverage
  - » These plans are rated on both health care quality (Part C) and drug plan performance (Part D)
- Note: Gold Coast Health Plan Total Care Advantage (HMO D-SNP) is a Medicare Advantage – Prescription Drug plan (MAPD).

3. What is the purpose of the Medicare Star Ratings System?

The Medicare Star Ratings System was designed to empower beneficiaries and drive quality improvement among Medicare Advantage plans in the following ways:

- Help beneficiaries make informed choices
  - » Give Medicare members an easy way to compare health and drug plans on quality, service, and performance.
  - » The 1 to 5 Star scale is designed to be simple and consumer-friendly.
- Measure and improve quality of care
  - » Evaluate how well MA and Part D plans deliver preventive services, manage chronic conditions, and support medication adherence.
  - » Encourage health plans (and their provider networks) to focus on quality and outcomes.

- Evaluate accessibility of care.
- Develop performance improvement initiatives based on identified opportunities.
- Compare performance with other health plans.

- Incentivize high performance
  - Plans that earn 4 Stars or higher qualify for CMS quality bonus payments, which they can reinvest in extra benefits, lower premiums, or provider incentive programs.
  - This creates competition that drives improvements in care.

4. What is the difference between the Medicare Star Ratings System and HEDIS®?

HEDIS® is a comprehensive set of more than 90 standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to evaluate health plan quality across commercial, Medicare and Medicaid populations. It evaluates preventive care, chronic disease management, behavioral health, utilization, and access to care.

The Medicare Star Ratings System, in contrast, was developed by CMS and is applied only to Medicare Advantage (Part C) and Drug Prescription Drug plans (Part D).

The system consists of 42 to 45 measures that use a subset of HEDIS® measures and additional data sets such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience survey, a Health Outcomes Survey (HOS), prescription drug event data (PDE), and operations data to assess areas like customer service.

5. How is the Medicare Star Rating System reported?

- Health plans submit star measure data to CMS annually.
  - Total Care Advantage will submit HEDIS® data in June and PDE data continuously.
    - Medicare Star Ratings measure data is submitted through Health Plan Management System (HPMS), a secure online system for Medicare Advantage and Part D sponsors to upload, manage, and preview their performance data, including that for the Star Ratings program.
  - CAHPS surveys are conducted by a CMS-approved vendor once a year, typically March through May.
  - HOS surveys are conducted by a CMS-approved vendor once a year, typically April through July.
- CMS also collects administrative data for health plans, including complaints, appeals, and call center performance, throughout the year.
- CMS then combines all this data and calculates the plan's Star Ratings, which it releases each October.
  - The ratings are posted on the public CMS consumer website, www.medicare.gov.
  - ► Note: After CMS calculates preliminary Star Ratings, but before public release, there is a preview period giving health plans a chance to review their measure data in HPMS, verify accuracy, and submit corrections or disputes so the final ratings accurately reflect their performance.
  - Providers can support the Medicare Star Ratings preview period by:
    - Ensuring timely, complete, accurate documentation

- During each visit, documenting / updating all chronic conditions thoroughly, using correct coding, and including severity and treatment plan
- Verifying coding and claims submissions accurately reflect services provided

6. What is a provider's role in Medicare Star Ratings performance?

Providers play a significant role in promoting the health of Total Care Advantage members. The following practices outline specific ways providers can contribute to improved Medicare Star Ratings performance:

- Prioritize preventive care:
  - Proactively remind patients to get recommended cancer screenings (like mammograms and colonoscopies), annual wellness visits, and flu shots.
  - Screen all patients aged 65 and older for fall risk, especially those who report a fall, have issues with balance, or use walking aids.
  - Use the Inovalon® Provider Enablement 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 visit or screening.
  - Include educational information with outreach.
  - Track and document completion and when the member declines.
- Assess timeliness of care / appointments and work with office staff to optimize scheduling.
- Manage chronic conditions:
  - Closely track and manage patients with chronic diseases like diabetes and cardiovascular disease.
  - Ensure they receive all required labs and screenings (e.g., eye exams for diabetics) and that their conditions are well-controlled.
- Improve medication adherence:
  - Review and discuss medications with patients and caregivers, as appropriate, at every visit.
  - Instruct patients to contact your office if they are experiencing side effects and not to stop the medication before doing so.
  - Provide written instructions to reinforce teaching and include caregivers as appropriate.
  - Encourage members to utilize pillboxes or organizers.
  - Address barriers to medication adherence.
- Coordinate care effectively:
  - When members need to see a specialist or get follow-up care after a hospital stay, seamless coordination between providers is critical.
  - Ensure members discharged form the hospital or ER are seen timely.
    - Document follow-up plans, visits, medication reconciliation, and member / caregiver education
  - Refer to GCHP Care Management to assist: 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
- Document all care in the patient's medical record.
  - Clearly document and code ALL chronic conditions - diagnosis, severity, and status.

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

- Use the most specific ICD-10 codes available.
- Code for all services completed and submit claims timely.
- Respond timely to requests for medical records.
- Stay up-to-date with Medicare Star Measure requirements, coding, and documentation by reviewing GCHP Provider Star Measure Tip Sheets and clinical updates.

7. Do I need member consent to release personal health information (PHI) for Medicare Star Measure reporting?

- No. Under the Health Information Portability and Accountability Act (HIPAA), data collection for Medicare Star Ratings is permitted.
  - Health plan requests for medical records do not require additional patient consent or authorization.
- Total Care Advantage members' PHI is maintained in accordance with all state and federal laws.

8. What data sources are used in Medicare Star Ratings Reporting?

- Medical records
- Administrative data: claims, encounter, pharmacy, member and provider data
- Supplemental data: lab, vision, immunization registry, electronic health records
- Survey sources: CAHPS and HOS. Member-reported data collected by CMS-approved vendors

9. What Medicare Star Ratings performance measures are reported?

There are 42 to 45 Medicare Star performance measures for Measurement Year (MY) 2026 / Reporting Year (RY) 2027.

CMS organizes Star Measures into domains - groups of related measures that reflect different aspects of care and plan performance.

- Part C Domain and Measure Details
  Domain: 1 - Staying healthy: screenings, tests and vaccines
  Domain: 2 - Managing chronic (long-term) conditions
  Domain: 3 - Member experience with health plan
  Domain: 4 - Member complaints and changes in health plan's performance
  Domain: 5 - Health plan customer service
- Part D domain & measure details
  Domain: 1 - Drug plan customer service
  Domain: 2 - Member complaints and changes in drug plan's performance
  Domain: 3 - Member experience with the drug plan
  Domain: 4 - Drug safety and accuracy of drug pricing

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

Part C (Medicare Advantage) — Five Domains

Domain	Focus	Examples of Measures
1. Staying Healthy: Screenings, tests, and vaccines	Preventive care and early detection.	• Breast cancer screening (BCS) • Colorectal cancer screening (COL) • Osteoporosis management in Women who had a fracture (OMW) • Kidney health evaluation for diabetes (KED) • Flu vaccine
2. Managing chronic conditions	Managing and monitoring members with chronic diseases.	• Controlling blood pressure (CBP) • Diabetes care - blood sugar controlled • Eye exam for patients with diabetes (EED) • Statin therapy for patients with cardiovascular disease (SPC) • Reducing the risk of falling • Improving bladder control • Care for older adults (COA) – medication review • Care for older adults (COA) – Pain screening • Plan all-cause readmissions (PCR) • Medication reconciliation post-discharge (MRP) • Transitions of care (TRC) • Follow-up after emergency department visit for people w/multiple high-risk chronic conditions (FMC)
3. Member experience with health plan	How members rate their care and service.	• Getting needed care • Getting appointments & care quickly • Customer service • Rating health care quality • Rating health plan • Care coordination
4. Member complaints and changes in the health plan's performance	Frequency of complaints, plan improvement trends, and member retention.	• Complaints about the health plan • Members choosing to leave the plan • Health plan quality improvement
5. Health plan customer service	Responsiveness and quality of plan operations.	• Call center accessibility-interpreter/TTY services • Appeals processing timeliness • Reviewing appeals decision

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

Part D (Prescription Drug Plan) — 4 Domains

Domain	Focus	Examples of Measures
1. Drug plan customer service	Quality and timeliness of service to members.	• Call center accessibility-interpreter/TTY services • Appeals timeliness • Reviewing appeals decisions
2. Member Complaints and Changes in the Drug Plan's Performance	Member satisfaction, complaints, and plan stability.	• Complaints about the drug plan • Members choosing to leave the plan • Drug plan quality improvement
3. Member Experience with the Drug Plan	Member perceptions of access and service.	• Getting needed prescriptions • Rating of the drug plan
4. Drug Safety and Accuracy of Drug Pricing	Safety, adherence, and pricing accuracy.	• Medication adherence for diabetes medications (MAD) • Medication adherence for hypertension (RAS antagonists) (MAH) • Medication adherence for cholesterol (statins) (MAC) • MTM program completion rate for CMR • Statin use in persons with diabetes (SUPD) • MPF price accuracy (Part D)

10. Where can I find more information on Medicare Star Ratings measures?

To educate and assist providers with increasing their Star Measure performance, GCHP has created Provider Tips Sheets for measures where actions have the greatest impact.

- These tips sheets outline the key aspects of the Star Measures, the medical codes associated with each, and documentation guidance.
- They are located on the GCHP website at: www.goldcoasthealthplan.org > providers > resources > Medicare Star Ratings Measures.
- You can click here to view the Medicare Star Measure Tips Sheets.
- You can learn more about Star Measures, including detailed explanations and technical guidance, as well as how CMS calculates and reports Medicare Star Ratings, by clicking here.
- You can learn about HEDIS® measures on NCQA's website by clicking here.
- You can also submit questions about the Medicare Star Ratings system to qualityimprovement@goldchp.org.

2026 Measurement Year

MCAS MEASURE: FOLLOW-UP AFTER ACUTE AND URGENT CARE VISITS FOR ASTHMA (AAF-E)

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 provides the key components to the MCAS measure, *"Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)."*

Measure Description: This measures the percentage of members 5 to 64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or emergency department (ED) visit with a diagnosis of asthma between Jan. 1 and Dec. 1 of the measurement period that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.

Data Collection Method: Administrative[1]

AAF-E Clinical Code Sets

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

Codes to identify members with a diagnosis of asthma during an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit.

Setting	ICD-10-CM	CPT	HCPCS	UBREV
Urgent Care (Outpatient and Telehealth)	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98979, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99470, 99483	G0071, G0402, G0438, G0439, G0463, G0544, G2010, G2012, G2250, G2251, G2252, T1015	0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Emergency Department		99281, 99282, 99283, 99284, 99285		0450, 0451, 0452, 0456, 0459, 0981
Acute Inpatient				0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

Setting	ICD-10-CM	CPT	HCPCS	UBREV
Observation Stay				0760, 0762, 0769

Codes to identify follow-up care within 30 days in an outpatient visit, telephone visit, e-visit or virtual check-in with a diagnosis of asthma.
Note: Cannot include visits that occur on the same day as the acute asthma episode.

Setting	ICD-10-CM	CPT	HCPCS	UBREV
Outpatient and Telehealth	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015	0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Exclusionary Criteria – Members with any of the following conditions are excluded from the AAF-E measure:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who die anytime during the measurement year
- Member with a diagnosis of cystic fibrosis anytime during the member's history through the measurement period.

Best Practices:

- Streamline transfer of patient information among urgent care, ED, and hospitals by sharing patient information electronically, such as through Health Information Exchanges.
- Establish clinic protocols for clinic staff to scheduled visits and prepare necessary documentation such as discharge summaries and medication lists.
- Offer flexible scheduling and appointment options, such a telehealth, to increase access to care and make it easier for members to attend their appointments.
- Utilize automated appointments reminders to reduce no-shows.
- Document and code for all clinical conditions evaluated and services completed and submit claims timely.
- Ensure your documentation is clear and concise.
- Use proper coding.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS/STAR MEASURE: BREAST CANCER SCREENING (BCS-E)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the MCAS measure, *"Breast Cancer Screening (BCS-E)."*

Measure Description: This measures the percentage of women ages 40 to 74 who had a mammogram to screen for breast cancer anytime on or between October 1 two years prior to the measurement year through December 31 of the measurement year.

Data Collection Method: Electronic Clinical Data Systems (ECDS)[1]

BCS Clinical Code Set

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

Codes used to identify mammograms (includes screening diagnostic, film, digital, or digital breast tomosynthesis).

Description	CPT	LOINC
Mammograms	77061-77063, 77065-77067	24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3, 103885-0, 103886-8, 103892-6, 103893-4, 103894-2

Note: Magnetic resonance imaging, ultrasounds and biopsies do not count as screening for breast cancer since these screenings are performed as an adjunct to mammography.

Exclusion Criteria – Members with any of the following conditions are excluded from the BCS measure:

- A bilateral mastectomy or both right and left unilateral mastectomies any time during the members history through the end of the measurement period (See Mastectomy Codes Table).
- Bilateral mastectomy.
- Unilateral mastectomy ***with*** a bilateral modifier.
- History of bilateral mastectomy.
- Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service.
- 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 December 31 of the measurement year who were diagnosed with frailty and advanced illness.
- Medicare enorllees 66 years of age and older as of December 31 of the measurement year who were in an institutional SNP or living in long-term in an institution.
- Any member who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of measurement period.
- Members who die any time during the measurement period.

Mastectomy Codes

Description	ICD-10-CM	ICD-10-PCS	CPT
Bilateral Mastectomy		0HTV0ZZ	
Unilateral Mastectomy with Bilateral CPT Modifier 50 or Unilateral CPT Modifiers RT or LT.			19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307
Right Unilateral Mastectomy		0HTT0ZZ	
Left Unilateral Mastectomy		0HTU0ZZ	
Absence of Right Breast	Z90.11		
Absence of Left Breast	Z90.12		
History of Bilateral Mastectomy	Z90.13		

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit. Ensure that outreach methods include educational information.
- Schedule mammogram screenings for your female patients ages 40 to 74 who have not had a mammogram screening since October 1 (two years prior).
- Encourage testing by educating your patients on the importance of early detection at every point of contact. This includes during clinic visits, telehealth or phone calls and outreach methods.
- Promote Gold Coast Health Plan's (GCHP) Breast Cancer Screening Member Incentive:
  - Members 40 to 74 years of age can earn a $50 gift card to Target, Wal-Mart or Amazon for completing a breast cancer screening within the measurement year. Members will need to mail or fax GCHP the completed form that includes a signature from their doctor and date of the exam. The member incentive form can be downloaded here.
- Document and code screening mammograms and mastectomies (bilateral or unilateral) on claims / encounter data in a timely manner.
- Note: Mammograms do not require prior authorization. Provide the member with a list of nearby contracted imaging / mammography centers.
- Assist members by scheduling an appointment, whenever possible, to increase probability of compliance.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP website, Health Education Resources (provided in English and Spanish): Click Here

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease / cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

MCAS/STAR MEASURE: CONTROLLING HIGH BLOOD PRESSURE (CBP)

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) / Centers for Medicare & Medicaid (CMS) Star Measure scores by providing guidance and resources. This tip sheet provides the key components to the MCAS measure, *"Controlling High Blood Pressure (CBP)."*

Measure Description: This measures the percentage of members ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

This measure requires the following:

- Two separate outpatient visits with a diagnosis of hypertension, including telephone, e-visits or virtual check-ins, on or between Jan. 1, 2025 and June 30, 2026. Visit types do not need to be the same.
- The most recent BP assessment in the measurement year that was on or after the second HTN diagnosis date.
- Blood pressure readings reported or taken by the member using a digital device, as well as blood pressure readings obtained from any remote digital device, count toward the measure.
- If multiple BP measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading is used.

Data Collection Method: Hybrid[1]

CBP 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 BP results on claims and clinical data systems such as electronic health records.

Codes used to identify members diagnosed with essential hypertension.

Description	ICD-10-CM
Essential Hypertension	I10

Codes used to identify BP.

Description	CPT II	LOINC
Systolic	3074F, 3075F, 3077F	75997-7, 8459-0, 8480-6, 8508-4, 8546-4, 8547-2
Diastolic	3078F, 3079F, 3080F	75995-1, 8453-3, 8462-4, 8496-2, 8514-2, 8515-9

Codes used to identify clinic setting of BP reading.

Description	CPT	HCPCS
Outpatient	99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483	G0402, G0438, G0439, G0463, T1015
Telephone Assessment	98966-98968, 99441-99443	
Online Assessment	98970-98972, 98980, 98981, 99421-99423, 99457, 99458	G0071, G2010, G2012, G2250, G2251, G2252
Remote BP Monitoring	98979, 99457, 99470	
Telehealth	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016	G0544

Exclusion Criteria – Members with any of the following conditions are excluded from the CBP measure:

- Members receiving hospice care during the measurement year.
- Members receiving palliative care during the measurement year.
- Members 66 to 80 years of age as of Dec. 31, 2025 who were diagnosed with at least two indications of frailty ***and*** advanced illness, with different dates of service during the measurement year or year prior.
- Members 81 years of age and older as of Dec. 31, 2025 who were diagnosed with at least two indications of frailty with different dates of service during the measurement year.
- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant.
- Members with a pregnancy diagnosis during the measurement year.
- Members who die any time during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- For patients seen via telehealth, clearly document BP readings reported or taken by the patient or obtained by any remote digital device.
- Instruct staff to always take a repeat reading if an abnormal BP value is obtained.
- Encourage the use of proper technique when obtaining BP readings:
  - Ensure the patient's bladder is empty.
  - Do not have a conversation.
  - Support the patient's back and feet.
  - Use the correct cuff size.
  - Place the cuff on the bare arm.
  - Support the arm at heart level.
  - Keep the patient's legs uncrossed.
- Treat associated cardiovascular risk factors as part of managing hypertension to lower overall cardiovascular risk.
- Encourage lifestyle changes (improved diet, exercise, smoking cessation, stress reduction).
- Initiate appropriate pharmacologic treatment to lower blood pressure.
- Make sure patients receive at least one blood pressure check per year.
- 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 offers 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, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP website, Health Education Webpage (resources 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.

2026 Measurement Year

MCAS MEASURE: CERVICAL CANCER SCREENING (CCS-E)

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 provides the key components to the MCAS measure, *"Cervical Cancer Screening (CCS-E)."*

Measure Description: This measures the percentage of members 21 to 64 years of age who were recommended for a routine cervical cancer screening during the measurement year using either of the following criteria:

- Women ages 21 to 64 who had cervical cytology screening within the last three years.
- Women ages 30 to 64 who had a cervical high-risk human papillomavirus (hrHPV) test within the last five years.
- Women ages 30 to 64 who had a cervical cytology / high-risk human papillomavirus (hrHPV) co-testing within the last five years.

The medical record must include:

- The date of the cervical cytology and/or the date the hrHPV test was performed.
  AND
- The result or finding.

Data Collection Method: ECDS[1]

CCS 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.

Codes used to identify cervical cytology and high-risk human papillomavirus (hrHPV) tests and results.

Description	CPT	HCPCS	LOINC
Cervical Cytology Test	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001	10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
hrHPV Test	87624, 87625, 87626, 0502U	G0476	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 104752-1, 104766-1, 104783-6, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3, 104132-6, 104170-6, 106508-5, 106509-3

Exclusion Criteria – Women with any of the following conditions are excluded from the CCS measure:

- Women who received hospice care in 2026.
- Women who received palliative care in 2026.
- Women who had evidence of absence of cervix or hysterectomy with no residual cervix anytime during their medical history up to Dec. 31, 2026 (see table below).
- Women who had evidence of cervical agenesis or acquired absence of cervix any time during their history through December 31, 2026.
- Members who die any time during the measurement year.
- Members with an assigned sex of male at birth.

Codes used to identify women excluded from the CCS measure due to absence of cervix or hysterectomy with no residual cervix.

Description	ICD-10-CM	ICD-10-PCS	CPT
Absence of Cervix	Q51.5, Z90.710, Z90.712		
Hysterectomy with No Residual Cervix		0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135

Screenings That Do Not Meet the CCS Measure Specifications:

- Cervical cytology lab results that explicitly state the sample was inadequate or that "no cervical cells were present."
- Biopsies.
- Cervical cytology / HPV Reflex Testing. For example, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet criteria for cervical cytology / HPV co-testing.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for cervical cancer screenings.
- Designate a care team member to reach out to patients due for cervical cancer screening.
- Ensure screening is ordered when it is due, regardless of the reason for the visit.
- Empower your medical assistants and nurses with standing orders to screen and identify patients who are currently due or past due for their pap.
- U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every three years with cervical cytology alone in women 21 to 29 years of age. This recommendation applies to all asymptomatic individuals with a cervix.
- Send targeted mailings, text messages or emails and follow-up telephone calls to chronically non-compliant patients.
- Display culturally-appropriate posters and brochures at an appropriate literacy level in patient areas to encourage patients to talk to providers about cervical cancer screenings.
- Cultural competency is not just limited to race, ethnicity and culture. Perceptions, values, beliefs and trust can also be influenced by factors such as religion, age, sexual orientation, gender identity and socioeconomic status.
- For patients who completed their cervical cancer screening at a different clinic, assess and document the date, location, and result of their last screening and have the physician sign the note. Also, have the patient sign a release of records.
- Create prompts in your EMR for screening that do not turn off until results are received, rather than when the test is ordered.
- Document the current care plan and routinely provide a copy to the patient.
- Promote GCHP's Cervical Cancer Screening Member Incentive:
    - Members 21 to 64 years of age can earn a $50 gift card to Target, Wal-Mart or Amazon for completing a cervical cancer screening (Pap test) within the measurement year. Members will need to mail or fax GCHP the completed form that includes a signature from their doctor and date of the exam. The member incentive form can be downloaded here.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
    - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease / cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

MCAS MEASURE: CHILDHOOD IMMUNIZATION STATUS – COMBO 10 (CIS-10-E)

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 provides the key components to the MCAS measure, *"Childhood Immunization Status – Combo 10 (CIS-10-E)."*

Measure Description: Children 2 years of age and under who completed their childhood immunizations before turning 2 in the measurement year. One dose of MMR, one dose of VZV, and one dose of Hep A must be given on or between the child's first and second birthday. One dose of the flu vaccine can be an LAIV vaccination that must be administered on the child's second birthday.

▸ 4 DtaP/DTP	▸ 4 PCV
▸ 3 IPV	▸ 3 Hep B
▸ 3 Hib	▸ 2 or 3 Rotavirus
▸ 2 Influenza	▸ 1 Hep A
▸ 1 MMR	▸ 1 VZV

This measure follows the immunization guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Any exclusions to this measure must have occurred by the child's second birthday.

Data Collection Method: Electronic Clinical Data Systems (ECDS)[1]

CIS 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.

Codes used to identify vaccines administered or evidence of disease.

Vaccine / Disease	ICD-10-CM*	ICD-10-PCS	CPT	HCPCS	CVX
Diphtheria, Tetanus, Pertussis (DTaP)			90697, 90698, 90700, 90723		20, 50, 106, 107, 110, 120, 146, 198
Haemophilus Influenzae Type B (HiB)			90644, 90647, 90648, 90697, 90698, 90748		17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198
Hepatitis A*	B15.0, B15.9		90633		31, 83, 85
Hepatitis B*	B16.0, B16.1, B16.2, B16.9, B18.0, B18.1, B19.10, B19.11	3E0234Z	90697, 90723, 90740, 90744, 90747, 90748	G0010	08, 44, 45, 51, 110, 146, 198
Influenza			90655, 90656, 90657, 90658, 90661, 90674, 90685, 90686, 90687, 90688, 90689, 90756, 90660, 90672		88, 111, 140, 141, 149, 150, 153, 158, 161, 171, 186, 320, 333
Inactivated Polio Vaccine (IPV)			90697, 90698, 90713, 90723		10, 89, 110, 120, 146
Measles*	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9				

Vaccine / Disease	ICD-10-CM*	ICD-10-PCS	CPT	HCPCS	CVX
Mumps*	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9				
Measles, Mumps, Rubella (MMR)			90707, 90710		03, 94
Pneumococcal Conjugate (PCV)			90670, 90671, 90677	G0009	109, 133, 152, 215, 216
Rotavirus Two-Dose Rotavirus Three-Dose			90681 90680		119 116, 122
Rubella*	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9				
Varicella Zoster (VZV)*	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9		90710, 90716		21, 94

* History of disease before the child's 2nd birthday meets criteria for evidence of antigen.

Exclusionary Criteria:

- Members receiving hospice care during the measurement year.
- Members who had a contraindication to a vaccine on or before their second birthday. Click here for a complete list of the contraindication diagnosis codes.
- Members who die any time during the measurement year.

CIS Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members / parents of the need for a visit.
- The American Academy of Pediatrics (AAP) recommends health care professionals review a child's immunization record at every encounter to administer or schedule needed vaccines.
- Hold in-service staff meetings to educate team members about vaccines and correct common misconceptions.
- Provide resources to educate parents about the importance of vaccines and to correct any misinformation.
- Use available immunization registries and make sure staff have access to the California Immunization Registry (CAIR).
- Document all seropositive test results and illnesses of chicken pox, measles, mumps, and rubella with a note indicating the date of the event – all of which occur by the child's second birthday.

- For additional materials for clinical staff and parents, visit the California Department of Public Health website.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

STAR MEASURE: CARE FOR OLDER ADULTS – MEDICATION REVIEW (COA-MED)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Care for Older Adults - Medication Review (COA-Med)."*

Measure Description: This measures the percentage of members 66 years of age and older who received at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

Measure Specification: Either of the below meets measure criteria:
- Both of the following during the same visit during the measurement period where the provider type is a prescribing practitioner or clinical pharmacist:
  - At least one medication review
  - The presence of a medication list in the medical record
- Transitional care management services during the measurement period.

Data Collection Method: Hybrid[1]

COA – Medication Review Clinical Code Set
- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify Medication Review:

Description	CPT	CPT-II
Medication Review	90863, 99483, 99605, 99606	1160F

Codes used to identify Medication List:

Description	HCPCS	CPT-II
Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	G8427	
Definition Medication list documented in medical record		1159F

Codes used to identify Transitional Care Management Services:

Description	CPT
Transitional Care Management	99495, 99496

Exclusion Criteria – Members with any of the following conditions are excluded from the COA – Medication Review measure:
- Members in hospice or using hospice services anytime during the measurement year.
- Services provided in an acute inpatient setting.
- Members who died any time during the measurement year.

Medical Record Must Include:

- Medication list, including all medications.
  - Prescription, OTC, herbal, supplements
- Review of the medication list.
  - Conducted by a prescribing practitioner or clinical pharmacist
  - Documentation explicitly states the provider reviewed the list
- Signature and date.
  - Review must be signed and dated by the reviewer during the measurement year

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Ask members to bring all pill bottles (including OTCs, supplements, vitamins) to visits.
- Involve caregivers as appropriate (including for members with cognitive impairment)
- Incorporate the medication review into:
  - Annual Wellness Visits
  - Follow-ups
  - Transitions of Care encounters
- Keep the medication list current.
  - Document all medications, prescriptions, OTCs, vitamins, supplements, herbals a member is taking and update the list at EVERY visit.
- Always include a statement similar to: "Medication list reviewed with patient/caregiver," with supporting documentation.
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage 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
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[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.

2026 Measurement Year

STAR MEASURE: CARE FOR OLDER ADULTS – PAIN ASSESSMENT (COA-PAIN)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Care for Older Adults – Pain Assessment (COA-Pain)."*

Measure Description: This measures the percentage of members 66 years of age and older who received at least one pain assessment plan during the measurement year.

Measure Specification: A valid pain assessment is defined as the use of a standardized tool or instrument to evaluate the presence or absence of pain and its severity. Valid pain assessments include:

- Numeric Rating Scale (0–10)
- Verbal Descriptor Scale (none, mild, moderate, severe)
- Visual Analog Scale (VAS)
- Wong-Baker FACES Pain Rating Scale
- Brief Pain Inventory (BPI)
- PAINAD, Abbey Pain Scale, CNPI (for dementia or nonverbal patients)

Data Collection Method: Hybrid[1]

COA – Pain Assessment Clinical Code Set

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

Codes used to identify a diabetic eye exam (retinal eye exam, fundus photography).

Description	CPT-II
Pain Assessment	1125F, 1126F

Compliant Measure Summary: The below are required to meet measure criteria:

- ▶ If using claims / encounter data, code submission is adequate, a separate note is NOT required (though is recommended for audit readiness).
- ▶ If using medical record review, a note must show pain assessment was performed, tool / scale used/patient response, date of service.

Exclusion Criteria – Members with any of the following conditions are excluded from the COA – Pain Assessment measure:

- ▶ Members in hospice or using hospice services anytime during the measurement year.
- ▶ Services provided in an acute inpatient setting.
- ▶ Members who died any time during the measurement year.

Medical Record Must Include:

Documentation of a valid pain assessment that meets the measure includes:

- ▶ Use of a specified standardized tool or scale
- ▶ Patient's pain score or response
- ▶ Date of assessment

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Involve caregivers as appropriate (including for members with cognitive impairment) when conducting assessment.
- Incorporate pain assessment into every visit, including:
  - Annual Wellness Visits
  - Follow-ups
  - Transitions of Care encounters
- Leverage care team support, including training about the pain assessment measure, valid tool to use, and required documentation for provider to review during the encounter.
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage 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
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[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.

2026 Measurement Year

MCAS/STAR MEASURE: COLORECTAL CANCER SCREENING (COL-E)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the MCAS measure, *"Colorectal Cancer Screening (COL-E)."*

Measure Description: This measures the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer.

Data Collection Method: ECDS[1]

One or more of the following meet the measure's criteria for colorectal cancer screening:

- Fecal occult blood test (FOBT) lab test during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

COL Clinical Code Sets

- For billing, reimbursement and reporting of services completed, submit claims in a timely manner with appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify colorectal cancer screening.

Description	CPT	HCPCS	LOINC
Fecal Occult Blood Test (FOBT)	82270, 82274	G0328	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6, 104738-0, 107189-3, 107190-1, 107191-9
Flexible Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350	G0104	
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398	G0105, G0121	
CT Colonography	74261, 74262, 74263		60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
FIT-DNA Test	81528, 0464U		77353-1, 77354-9

Exclusion Criteria:

- Members in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Medicare enrollees 66 years of age or older as of Dec. 31, 2026, who were enrolled in an Institutional SNP or living in long-term care anytime during the measurement year.
- Members 66 years of age or older as of Dec. 31, 2026, with a diagnoses of frailty and advanced illness during the measurement year.

- Members with colorectal cancer or total colectomy anytime during the member's history through Dec. 31, 2026.
- Medicare enrollees, 66 years of age and older, by the last day of the measurement year, in an institutional SNP or living long-term in an institution.
- Members who die anytime during the measurement year.

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed.

- A result is not required if the documentation is clearly part of the member's "medical history." If this is not clear, the result or finding must also be present.
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a screening.
- For the United States Preventive Task Force (USPTF) recommendations regarding Colorectal Cancer Screening, click here.
- Gold Coast Health Plan's (GCHP) 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 offers 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, material, classes, and online resources to help members achieve a healthy lifestyle. Providers can contact the Health Education Department or refer patients / guardians / caregivers to the following:
  - Providers, call: 1-805-437-5961
  - Members, call: 1-888-301-1228 / TTY 711
  - GCHP's Health Education webpage (in English and Spanish): Click Here
- Ensure your documentation is clear and concise.
- Use proper coding.

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

MCAS MEASURE: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE (DEV)

Measure Steward: Oregon Health and Sciences University (OHSU)

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 provides the key components to the MCAS measure, *"Developmental Screening in the First Three Years of Life (DEV)."*

Measure Description: This measures the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Data Collection Method: Administrative[1]

DEV Clinical Code Sets

For billing, reimbursement, and reporting of services completed, submit claims in a timely manner with the appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify developmental screening using a standardized developmental screening tool.

Description	CPT
Developmental screening using a standardized developmental screening tool with interpretation and report.	96110

Tools must meet the following criteria:

1. Developmental Domains	Motor, language, cognitive, and social-emotional.
2. Established Reliability	Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity	Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity / Specificity	Sensitivity and specificity scores of approximately 0.70 or above.

The following tools meet the above criteria and are included in the American Academy of Pediatrics Bright Futures Recommendations for Preventive Care:

Screening Tools	Age Group
Ages and Stages Questionnaire (ASQ – 3)	Ages 1 month to 5 1/2 years
Battelle Developmental Inventory Screening Tool (BDI-ST)	Birth to 95 months of age
Bayley Infant Neuro-Developmental Screen (BINS)	Ages 3 months to 2 years
Brigance Screens II	Birth to 90 months of age
Child Development Inventory (CDI)	Ages 18 months to 6 years
Infant Development Inventory	Birth to 18 months of age
Parents' Evaluation of Developmental Status (PEDS)	Birth to 8 years of age
Parents' Evaluation of Developmental Status – Developmental Milestones (PEDS-DM)	Birth to 8 years of age
Survey of Well-Being in Young Children (SWYC)	Ages 1 month to 65 months

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- According to Help Me Grow Ventura County, early developmental identification consists of three components:
  - *Surveillance* is the process of recognizing children at risk for developmental delays and should occur at every well-child visit.
  - *Screening* is the use of standardized tools to identify children at risk of developmental delays or disorders.
  - *Evaluation* is the in-depth process of identifying children with developmental delays or disorders and referring them to qualified professionals and early intervention services.
- Follow the American Academy of Pediatrics (AAP) Bright Futures™ Periodicity Schedule recommendation of completing child developmental screenings at 9, 18 and 30 months of age using a standardized screening tool. Screening tools are completed by the parent, then scored by the health care provider, and include standardized sets of questions to evaluate if a child's motor, language, cognitive, social, and emotional development are on track for their age.
- The following organizations provide information for health care providers on developmental screening resources and trainings:
  - Help Me Grow Ventura County
  - American Academy of Pediatrics
  - Centers for Disease Control and Prevention
- Developmental screenings using standardized developmental screening tools can be reviewed and scored by any qualified clinic staff (e.g., doctor, nurse, medical assistants).
- CPT code 96110 (developmental screening, with scoring and documentation, per standardized instrument) is reimbursed by Medi-Cal at ages specified in the Bright Futures / AAP Periodicity Schedule (9, 18 and 30 months of age) and when medically indicated. The frequency limit for general developmental screening is twice a year for children ages 0 to 5, any provider. For more information, click here.
- Establish clinic work flows to ensure standardized screening tools are completed at the appropriate ages. To view an example of a pediatric developmental screening flowchart, click here.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS/STAR MEASURE: DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS (DSF-E)

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) /Centers for Medicaid & Medicare (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the MCAS measure, *"Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)."*

Measure Description: This measures the percentage of members 12 years of age and older who were screened for clinical depression using an age-appropriate standardized instrument and, if screened positive, received follow-up care.

- Depression Screening: The percentage of members who were screened for clinical depression using a standardized instrument between January 1 and December 1 of the measurement year.
- Follow-Up on Positive Screen: The percentage of members who received follow-up care on or within 30 days of a positive depression screening.

Data Collection Method: Electronic Clinic Data Systems (ECDS)[1]

Standardized Instruments: A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Standardized Instruments	Age ≤ 17	Age 18+	Positive Finding	LOINC Code
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	X		Total Score ≥ 10	89204-2
Patient Health Questionnaire (PHQ-9)®	X	X	Total Score ≥ 10	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[2]	X	X	Total Score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[2,3]	X	X	Total Score ≥8	89208-3
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	X	X	Total Score ≥ 17	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	X	X	Total Score ≥ 10	99046-5
PROMIS Depression	X	X	Total Score ≥ 60	71965-8
Beck Depression Inventory (BDI-II)		X	Total Score ≥ 20	89209-1
Duke Anxiety-Depression Scale (DUKE-AD)®[2]		X	Total Score ≥ 30	90853-3
My Mood Disorder (M-3)®		X	Total Score ≥ 5	71777-7
Clinically Useful Depression Outcome Scale (CUDOS)		X	Total Score ≥ 31	90221-3
Geriatric Depression Scale Short Form (GDS)[1]		X	Total Score ≥ 5	48545-8
Geriatric Depression Scale Long Form (GDS)		X	Total Score ≥ 10	48544-1
PROMIS Emotional Distress Depression Short Form		X	Total Score ≥ 60	77861-3

DSF-E Clinical Code Set

- For billing, reimbursement, and reporting of services completed, submit claims in a timely with the appropriate medical codes for all conditions evaluated and services completed.

Methods identify a follow-up on a positive screening within 30-Days:

- A clinic encounter (outpatient, telephone, e-visit, virtual check-in, depression case management, behavioral health encounter, exercise counseling).
- A dispensed antidepressant medication.

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
- Encounter for exercise counseling.

Codes to identify follow-up on positive screening.

Description	ICD-10-CM	CPT	HCPCS	UBREV
An outpatient, telephone, e-visit, or virtual check-in with a diagnosis of depression or behavioral health condition. Click here for list of the diagnosis codes.		98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98979, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99470, 99483	G0071, G0463, G0544, G2010, G2012, G2250, G2251, G2252, T1015	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Depression case management encounter with a diagnosis of depression or behavioral health condition. Click the link above for a complete list of diagnosis codes.		99366, 99492, 99493	G0512, T1016, T1017, T2022, T2023	
Behavioral Health Encounter		90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
Encounter for exercise counseling	Z71.82			

Evidence of an antidepressant medication dispensing event.
Click here for the list of antidepressant medications.

Exclusion Criteria – Members with any of the following conditions are excluded from the DSF-E measure:

- Members with history of bipolar disorder any time until the end of the year prior to the measurement year.
- Depression that started in the prior measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement period.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a visit.
- Clinical Recommendations:
  - The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years of age and the general adult population, including pregnant and postpartum women.
  - The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
- Members of the care team understand the importance of depression screening.
- Patients are screened at new visits, on an annual basis at well care visits, or when clinically indicated.
- Behavioral health referrals can be made through Carelon Behavioral Health (formerly Beacon Health Options). Providers may also use this link to access valuable information, forms and documents: Click Here
- 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

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

[2] Brief screening instruments. All other instruments are full-length.

[3] Proprietary; may be cost or licensing requirement associated with use.

2026 Measurement Year

STAR MEASURE: EYE EXAM FOR PATIENTS WITH DIABETES (EED)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet will provide the key components to the Star measure, *"Eye Exam for Patients with Diabetes (EED)."*

Measure Description: This measures the percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam during the measurement year.

Measure Specification: Identify persons with a diagnosis of diabetes. Either of the following meets criteria:
- Claim / encounter data. At least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period.
- Pharmacy data. At least one diagnosis of diabetes **and** at least one diabetes medication dispensing event of insulin or a hypoglycemic/anti-hyperglycemic medication (Diabetes Medications List) during measurement period.

Data Collection Method: Administrative[1]

EED Clinical Code Set
- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.

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 (MY) or year prior to measurement year (PMY).	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 MY or PMY.	Click above for the list of diabetes diagnosis codes. Click here for the list of diabetes medications.

Codes used to identify a diabetic eye exam (retinal eye exam, fundus photography).

Description	Year of Screening	ICD-10-CM	CPT	CPT II	HCPCS	LOINC
Retinal eye exam by eye care professional	MY		92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245		S0620, S0621, S3000	
Retinal eye exam by eye care professional with diagnosis of diabetes ***without*** complications	PMY	E10.9, E11.9, E13.9				
Retinal eye exam billed by any provider	MY			2022F, 2024F, 2026F, 2023F, 2025F, 2033F, 3072F		

Description	Year of Screening	ICD-10-CM	CPT	CPT II	HCPCS	LOINC
Retinal imaging interpretation billed by any practitioner	MY		92227, 92228			
Autonomous eye exam billed by any provider	MY		92229			105914-6 with result
Eye exam with no evidence of retinopathy billed by any provider	PMY			2023F, 2025F, 2033F,		

Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined.

Description	Year of Screening	ICD-10-PCS	LOINC
Left eye with retinopathy	MY		LOINC 71490-7 with any of the following: LA18643-9, LA18644-7, LA18645-4, LA18646-2, LA18648-8
Left eye without retinopathy	PMY		LOINC code 71490-7 with LA18643-9
Left eye enucleation anytime during the member's history	Lifetime	08T1XZZ	
Right eye with retinopathy	MY		LOINC 71491-5 with any of the following: LA18643-9, LA18644-7, LA18645-4, LA18646-2, LA18648-8
Right eye without retinopathy during prior MY	PMY		LOINC code 71491-5 with LA18643-9
Right eye enucleation anytime during the member's history	Lifetime	08T0XZZ	

Exclusion Criteria – Members with any of the following conditions are excluded from the EED measure:

- Members who do not have a diagnosis of diabetes during the measurement year or the year prior.
- Members with bilateral absence of eyes or eye enucleation.
- Members who have received hospice services any time during the measurement year.
- Members age 66 and older with advanced illness and frailty.
- Members who passed away during the measurement year.
- Members who received palliative care during the measurement year.
- Medicare members age 66 and older as of Dec. 31 of the measurement year who are either enrolled in an institutional Special Needs Plan (I-SNP) or living long term in an institution (LTI).
- Note: Blindness is not an exclusion for a diabetic eye exam.

Medical Record Must Include:

- To document a history of a dilated eye exam without the official report, you must include the date of service, the name or specialty of the assessing eye care professional (optometrist or ophthalmologist), and the exam findings or results (stating whether retinopathy was present).
  - For example: "Last diabetic eye exam with John Smith, OD, was June 2024 with no retinopathy."
- The medical record must indicate that a dilated or retinal exam was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- If history of a dilated retinal eye exam and result is in your progress notes, please ensure that a date of service, the test or result, and the care provider's credentials are documented.

- The care provider must be an optometrist or ophthalmologist. Including only the date of the progress note will not count.
- For fundus photography to count toward the EED measure, strict documentation requirements must be met:
  - The results of the fundus photography must be interpreted by a qualified eye care professional, such as an optometrist or an ophthalmologist.
  - Documentation must indicate an optometrist or ophthalmologist read / reviewed the results.
  - The patient's medical record must include the date of the service, results of the retinal photography, and the name and credentials of the interpreting eye care professional.
  - The photographs themselves must be retained in the patient's record.
  - For remote imaging (teleretinal screening): Images captured by a non-eye professional and sent to a specialist for interpretation and the specialist's report must be retained in the medical record.

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit.
- Ensure that outreach methods include educational information.
- Ensure members with positive retinopathy are receiving a retinal or dilated eye exam from an eye care professional annually, and every two years for patients without evidence of retinopathy.
- Document date of service, eye exam results, and eye care professional's name with credentials in the patient's medical history to meet measure criteria.
- Total Care Advantage offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP website, Health Education Resources (provided in English and Spanish): Click here
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage Care Management referrals can be made by submitting the referral form available on the Gold Coast Health Plan (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
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS MEASURE: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)

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. *"Follow-Up After Emergency Department Visit for Substance Use (FUA)."*

Measure Description: The percentage of emergency department (ED) visits among members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

Two rates are reported:

- The percentage of ED visits, between January 1 and December 1 of the measurement year, for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits, between January 1 and December 1 of the measurement year, for which the member received follow-up within seven days of the ED visit (eight total days).

Data Collection Method: Administrative[1]

FUM 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 provided.

Codes used to identify an emergency department visit.

CPT	UBREV
99281, 99282, 99283, 99284, 99285	0450, 0451, 0452, 0456, 0459, 0981

Sample codes to identify emergency department visit with a principal diagnosis of SUD or any diagnosis of drug overdose. For a complete list of diagnosis codes with definitions, click here.

Description	ICD-10-CM
Alcohol or Other Drug Abuse and Dependence	F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188
Unintentional Drug Overdose	T40.0X1A, T40.0X1D, T40.0X1S, T40.0X4A, T40.0X4D, T40.0X4S, T40.1X1A, T40.1X1D, T40.1X1S, T40.1X4A, T40.1X4D, T40.1X4S, T40.2X1A, T40.2X1D

Codes to identify a follow-up visit: (1) follow-up visit with a diagnosis of substance use disorder or drug overdose, (2) follow-up visit with a mental health provider, or (3) a pharmacotherapy dispensing event.

Type of Visit	ICD-10-PCS	CPT	POS	HCPCS	UBREV
Behavioral health screening or assessment		99408, 99409		G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049	

Type of Visit	ICD-10-PCS	CPT	POS	HCPCS	UBREV
Behavioral health outpatient	Substance use disorder or drug overdose diagnosis	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510		G0155, G0176, G0177, G0409, G0463, G0512, G0533, G0560, G2067, G2068, G2073, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
Behavioral health outpatient visit ***with a mental health provider***					
Opioid treatment services	Substance use disorder or drug overdose diagnosis			G2069, G2086, G2087, G2074, G2075, G2076, G2077, G2080	
Peer support services	Substance use disorder or drug overdose diagnosis			G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017	
Substance use disorder services		99408, 99409		G0396, G0397, G0443, H0001, H0005, H0006, H0007, H0015, H0016, H0022, H0028, H0047, H0050, H2035, H2036, T1006, T1012	0906 0944 0945
Substance use disorder counseling and surveillance	Z71.41, Z71.51				
Telephone visit	Substance use disorder or drug overdose diagnosis	98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98966, 98967, 98968, 98979, 98980, 98981, 99441, 99442, 99443, 99457, 99458, 99470		G0544	
Telephone visit ***with a mental health provider***					
E-Visits / virtual check-in	Substance use disorder or drug overdose diagnosis	98016, 98970, 98971, 98972, 99421, 99422, 99423		G0071, G2010, G2012, G2250, G2251, G2252	
E-Visits / virtual check-in ***with a mental health provider***					

Type of Visit	ICD-10-PCS	CPT	POS	HCPCS	UBREV
Outpatient visit	Substance use or drug overdose diagnosis	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 27, 33, 49, 50, 71, 72		
Outpatient visit ***with a mental health provider***					
Intensive outpatient or partial hospitalization	Substance use or drug overdose diagnosis		52		
Intensive outpatient or partial hospitalization ***with a mental health provider***			52		
Non-residential substance abuse treatment facility	Substance use or drug overdose diagnosis		57, 58		
Non-residential substance abuse treatment facility ***with a mental health provider***					
Community mental health center	Substance use disorder or drug overdose diagnosis		53		
Community mental health center ***with a mental health provider***					
Telehealth	Substance use disorder or drug overdose diagnosis		02, 10		
Telehealth ***with a mental health provider***					
Intensive outpatient or partial hospitalization	Substance use disorder or drug overdose diagnosis			G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	0905, 0907, 0912, 0913
Intensive outpatient or partial hospitalization ***with a mental health provider***					
Pharmacotherapy dispensing event or medication treatment event. Click here for list of medications.				G0533, G2067, G2068, G2069, G2073, G2078, G2079, H0020, H0033, J0571, J0572, J0573, J0574, J0575, J0577, J0578, J2315, Q9991, Q9992, S0109	

Exclusion Criteria – Members with the following condition(s) are excluded from the FUA measure:

- Members receiving hospice care during the measurement year.
- Members who were admitted for an inpatient visit on or within 30 days of the ED visit for any condition, because this may prevent an outpatient follow-up visit from occurring.
- ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit.
- Members who die at any time during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit
- Timely identification and referral of patients who have SUD.
- Referral resources for SUD:
  - California Department of Public Health Action Notice
  - Ventura County Behavioral Health Substance Use Services
  - Ventura County Health Care Agency Alcohol and Drug Programs
- Ensure timely follow up appointments for patients who meet the measure description and criteria.
- Evaluate access to real-time data sources, such health information exchange (HIE) and electronic health record (EHR) data, to identify and schedule follow-up appointments for patients with ED visits for SUD conditions.
- Promote use of telehealth to schedule the follow-up appointments.
- Utilize behavioral healthcare staff and SUD health navigators to facilitate care coordination.
- Ensure your documentation is clear and concise.
- Use proper coding.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS/STAR MEASURE: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)

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)/Centers for Medicaid & Medicare (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the MCAS measure, *"Follow-Up After Emergency Department Visit for Mental Illness (FUM)."*

Measure Description: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Two rates are reported:

- The percentage of ED visits, between January 1 and December 1 of the measurement year, for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits, between January 1 and December 1 of the measurement year, for which the member received follow-up within seven days of the ED visit (eight total days).

Data Collection Method: Administrative[1]

FUM 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 provided.

Codes used to identify an emergency department visit.

CPT	UBREV
99281, 99282, 99283, 99284, 99285	0450, 0451, 0452, 0456, 0459, 0981

Sample codes used to identify an emergency department visit with a principal diagnosis of mental illness or any diagnosis of intentional self-harm. For the complete list of diagnosis codes with definitions, click here.

ICD-10-CM codes
Mental Illness Codes
F20.0, F20.1, F30.10, F30.11 F30.4, F30.8, F30.9, F31.0, F31.10, F31.70, F32.0, F32.1, F33.0, F33.1, F34.1, F39, F42.2, F43.0, F43.20, F44.89, F60.0, F60.9, F63.0, F68.10, F84.0, F90.0, F91.0, F93.0, F94.0
Intentional Self-Harm Codes
T14.91XA, T14.91XD, T36.3X2D, T41.0X2A, T46.6X2A, T47.2X2S, T48.3X2A, T49.1X2S, T50.0X2A, T51.3X2D, T52.1X2S, T52.2X2A, T53.5X2A, T54.0X2A, T56.0X2A, T57.0X2A, T58.92XD, T59.6X2S, T60.8X2D, T61.772D, T62.2X2S, T63.022S, T64.02XA, T65.0X2A, T65.0X2D, T71.112A, T71.232D, T71.232S

Codes used to identify follow-up services for mental health. Visits with an * must be coded with a mental health diagnosis code. For the complete list of codes, click here.

FUM Follow-Up Service Codes

<table>
<tr><th>Type of Visit</th><th>ICD-10-CM</th><th>CPT</th><th>POS</th><th>HCPCS</th><th>UBREV</th><th>ICD-10-PCS</th></tr>
<tr><td>Telehealth*</td><td>Mental health diagnosis</td><td rowspan="5">90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255</td><td>02, 10</td><td></td><td></td><td></td></tr>
<tr><td>Community Mental Health Center</td><td></td><td>53</td><td></td><td></td><td></td></tr>
<tr><td>Outpatient Visit*</td><td>Mental health diagnosis</td><td>03, 05, 07, 09, 11 -20, 22, 27, 33, 49, 50, 52, 56 71, 72</td><td></td><td></td><td></td></tr>
<tr><td>Intensive outpatient encounter of partial hospitalization in psychiatric facility</td><td></td><td>52</td><td></td><td></td><td></td></tr>
<tr><td>Psychiatric Residential Treatment</td><td></td><td>56</td><td></td><td></td><td></td></tr>
<tr><td>Behavioral Health Outpatient Visit*</td><td>Mental health diagnosis</td><td>98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510</td><td></td><td>G0155, G0176, G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015</td><td>0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983</td><td></td></tr>
<tr><td>Telephone Visit*</td><td>Mental health diagnosis</td><td>98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98966, 98967, 98968, 98979, 98980, 98981, 99441, 99442, 99443, 99457, 99458, 99470</td><td></td><td>G0544</td><td></td><td></td></tr>
<tr><td>E-visit, Virtual Check-In, or Online Assessment*</td><td>Mental health diagnosis</td><td>98016, 98970, 98971, 98972, 99421, 99422, 99423</td><td></td><td>G0071, G2010, G2012, G2250, G2251, G2252</td><td></td><td></td></tr>
</table>

Type of Visit	ICD-10-CM	CPT	POS	HCPCS	UBREV	ICD-10-PCS
Electroconvulsive Therapy		90870	03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72			GZB0ZZZ, GZB2ZZZ, GZB4ZZZ
Intensive outpatient or partial Hospitalization*	Mental health diagnosis			G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	0905, 0907, 0912, 0913	
Psychiatric collaborative care management		99492, 99493		G0512		
Psychiatric residential treatment				H0017, H0018, H0019, T2048		
Behavioral healthcare setting					0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001	
Peer support services*	Mental health diagnosis			G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017		

Exclusion Criteria – Members with the following condition(s) are excluded from the FUM measure:

- Members who receive hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
- Members who were admitted for an inpatient visit on or within 30 days of the ED visit for any diagnosis, because this may prevent an outpatient follow-up visit from occurring.
- Members who die during the measurement year.

Best Practices:

- Timely screening, identification and referral of patients who have mental illness or intentional self-harm issues.
- Referral resources for mental illness issues include:
  - Carelon Behavioral Health (formerly Beacon Health Options)
  - Ventura County Behavioral Health
- Ensure timely follow up appointments for patients who meet the measure description and criteria.
- Evaluate access to real-time data sources, such health information exchange (HIE) and electronic health record (EHR) data, to identify and schedule follow-up appointments for patients with ED visits for substance use disorder (SUD) conditions.
- Promote use of telehealth to schedule the follow-up appointments.
- Utilize behavioral health care staff and SUD health navigators to facilitate care coordination.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

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.

2026 Measurement Year

MCAS MEASURE: IMMUNIZATIONS FOR ADOLESCENTS-COMBINATION 2 (IMA-2-E)

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 provides the key components to the MCAS measure, *"Immunizations for Adolescents-Combination 2 (IMA-2-E)."*

Measure Description: This measures the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. This measure calculates a rate for each vaccine and two combination rates.

This measure requires members to have received the following vaccination combinations by their 13th birthday:

- One dose of meningococcal vaccine on or between the child's 11th and 13th birthdays.
- One Tetanus, diphtheria toxoids and acellular pertussis (Tdap) on or between the child's 10th and 13th birthdays ***AND***
- At least two HPV vaccines with different dates of service at least 146 days between them on or between the adolescent's 9th and 13th birthdays, ***OR***
- At least three HPV vaccines with different dates of service on or between the adolescent's 9th and 13th birthdays.

Data Collection Method: Electronic Clinical Data Systems (ECDS)[1]

IMA 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.

Codes used to identify vaccines administered for the IMA measure.

Description	CPT	CVX
Meningococcal	90619, 90623, 90624, 90733, 90734	32, 108, 114, 136, 147, 167, 203, 316, 328
Tdap	90715	115
HPV	90649, 90650, 90651	62, 118, 137, 165

Exclusion Criteria:

- Members receiving hospice care during the measurement year.
- Members who die anytime during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members / parents on the need for a visit.
- The American Academy of Pediatrics (AAP) recommends health care professionals review the patient's immunization record at every encounter to administer or schedule needed vaccines.
- Hold in-service staff meetings to educate team members about vaccines for adolescents, correct common misconceptions, and answer questions.
- Provide resources to educate your adolescent patients and their parents about the importance of vaccines and to correct any misinformation.
- Use available immunization registries:
  - California Immunization Registry (CAIR)
- Assure that vaccines administered to patients, prior to becoming members, are included on the members' vaccination records, even if your office did not administer the vaccines.
- For additional material for clinical staff and parents, visit the California Department of Public Health website here.

- View the American Academy of Family Physicians (AAFP) “20 Best Practices for Adolescent Immunizations” here.
- Promote GCHP’s HPV vaccine member incentive:
  - Members 9 to 13 years of age can earn a $25 gift card to Amazon, Target, or Walmart for completing their second dose of the HPV vaccine series on or before their 13th birthday. Members will need to mail or fax GCHP the completed form that includes a signature from their doctor. The member incentive form can be downloaded here.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-805-437-5691
  - Members, call: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here
- **Clinical Recommendations:**
  - **HPV:** The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at 9 years of age. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is five months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received two doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated.
  - **Tdap:** ACIP recommends a single dose of vaccine be administered at age 11 or 12 years.
  - **Meningococcal:** ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years, or vaccination with a pentavalent vaccine for adolescents ages 10 years and older when both meningococcal B and meningococcal A, C, W and Y are indicated.

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

STAR MEASURE: KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

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) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Kidney Health Evaluation for Patients with Diabetes (KED)."*

Measure Description: This measures the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) as of Dec. 31 of the measurement year who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR), during the measurement year.

Measure Specification: Identify persons with a diagnosis of diabetes. EITHER of the following meets criteria:

- Claim / encounter data. At least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period.
- Pharmacy data. At least one diagnosis of diabetes and at least one diabetes medication dispensing event of insulin or a hypoglycemic/ antihyperglycemic medication (Diabetes Medications List) during measurement period.

Data Collection Method: Administrative[1]

KED Clinical Code Set

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

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 (MY) or year prior to measurement year (PMY).	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 MY or PMY.	Click above for the list of diabetes diagnosis codes. Click here for the list of diabetes medications.

Codes to identify a member who received both an eGFR and a uACR during the measurement year on the same or different dates of service. Note: a uACR can be completed by (1) a quantitative urine albumin test and urine creatinine test or (2) a urine albumin creatinine ratio lab test.

Description	CPT	LOINC
Estimated Glomerular Filtration Rate Lab Test	80047, 80048, 80050, 80053, 80069, 82565	102097-3, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
Quantitative Urine Albumin Test	82043	100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
Urine Creatinine Test	82570	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Urine Albumin Creatinine Ratio Tet		13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Compliant Measure Summary: A diabetic member meets the measure if they have had BOTH of these during the measurement year: at least one eGFR test result and at least one uACR test result.

Medical Record Must Include:

- Claims / encounter data must include valid codes for both eGFR to meet the measure.
- The medical record must clearly document the below to meet the measure:
  - Both eGFR and uACR were performed
  - Results
  - Date of the test

Exclusion Criteria – Members with any of the following conditions are excluded from the EED measure:

- Members who do not have a diagnosis of diabetes during the measurement year or the year prior.
- Members with a diagnosis of end stage renal disease (ESRD) or who had dialysis at any time in their history or during the measurement year.
- Members who have received hospice services any time during the measurement year.
- Members who received palliative care during the measurement year.
- Members 66 years of age and older with advanced illness and frailty.
- Members who passed away during the measurement year.
- Medicare members 66 years of age and older as of Dec. 31 of the measurement year who are either enrolled in an institutional Special Needs Plan (I-SNP) or living long term in an institution (LTI).

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit.
- Ensure that outreach methods include educational information.
- Order laboratory tests ahead of a patient's appointment.
- Routinely refer members with a diagnosis of diabetes for both eGFR and uACR.
  - A quantitative urine albumin test and a urine creatinine test require service dates four or less days apart
- Include electronic lab results or scanned lab reports in the medical record.
- Ensure provider notes specifically reference:
  - Test performed
  - Date of the test
  - Result of the test
- While claims / encounter data or medical records alone can satisfy the measure, having both documented ensures star measure capture and audit readiness.
- Follow up with patients to discuss and educate on lab results.
- Total Care Advantage offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP website, Health Education Resources (provided in English and Spanish): Click Here
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage 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
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS MEASURE: LEAD SCREENING IN CHILDREN (LSC-E)

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 provides the key components to the MCAS measure, *"Lead Screening in Children (LSC-E)."*

Measure Definition: This measures the percentage of children, 2 years of age, who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Data Collection Method: Hybrid[1]

LSC 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.

Codes used to identify lead screening tests in children.

Lab Test	CPT	LOINC
Lead Screening Test	83655	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5674-7, 77307-7

Exclusion Criteria - Members with the following condition are excluded from the LSC measure:

- Members who received hospice care during the measurement year.
- Members who died during the measurement year.

Medical Record - Documentation in the medical record must include BOTH of the following:

- The date the test was performed.
- The result or finding.

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit.
- Lead screening can be performed adjacent with well-child exams or part of enrollment at a patient's first visit to establish care. If a parent / guardian refuses lead screening for their child, be sure to document the refusal in their medical record using a lead screening refusal form. A lead screening refusal form is available to you on GCHP's website, in English and Spanish.
- Free lead testing, anticipatory guidance materials, and other services are available for all Medi-Cal enrolled members through the Childhood Lead Poisoning Prevention Program (CLPPP) of Ventura County. Providers and members can contact CLPPP at 1-805-981-5291.
- Promote GCHP's Lead Screening Member Incentive:
  - Members up to 2 years of age can earn a $25 gift card to Amazon, Target or Walmart for completing a blood lead test on or before their second birthday. Members will need to mail or fax GCHP the completed form that includes a signature from their doctor and date of the exam. The member incentive form can be downloaded here.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here
  - Ensure your documentation is clear and concise.
  - Use proper coding.

[1] Measure reported using *hybrid* data collection method report on a sample of the eligible population (usually 411) and use both administrative and medical record sources to evaluate if services were performed.

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

STAR MEASURE: MEDICATION ADHERENCE FOR CHOLESTEROL (MAC)

Measure Steward: National Committee for Quality Assurance (NCQA)

Gold Coast Health Plan Total Care Advantage's (HMO D-DSNP) goal is to help its providers gain compliance with their annual Managed Care Accountability Set (MCAS)/Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Medication Adherence for Cholesterol (Statins) (MAC)."*

Measure Description: This measures the percentage of members 18 years of age or older with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication in the measurement period.

Measure Specification:

- Members are included in the measure if they have at least two fills of a cholesterol medication (statin) during the measurement year.
- Members are considered adherent if they have cholesterol medications (statins) available at least 80% of the days in the measurement year.
  - The Proportion of Days Covered (PDC) is the standard metric used to measure adherence
  - Definition: PDC is the percentage of days in a measurement year that a patient has their medication available, based on pharmacy claims
  - Adherence Threshold: Patients are considered adherent if PDC ≥ 80%
  - Calculation: Days' supply available ÷ total days in measurement period
- Medications that count toward the MAC measure include the following Statins / Statin Combinations:
  - Advicor
  - Altoprev ER
  - Altoprev
  - Amlodipine/Atorvastatin
  - Atorvastatin/COQ10
  - Atorvastatin
  - Caduet
  - Crestor
  - Ezetimibe/Simvastatin
  - Flolipid
  - Fluvastatin
  - Lescol
  - Lesxol XL
  - Lipitor
  - Livalo
  - Lovastatin
  - Mevacor
  - Pravachol
  - Pravastatin
  - Rosuvastatin
  - Simcor
  - Simvastatin
  - Vytorin
  - Zocor

Data Collection Method: Administrative[1]

MAC Clinical Code Set: The MAC measure is entirely based on Prescription Drug Event (PDE) data from pharmacy claims.

Exclusion Criteria – Members with any of the following conditions are excluded from the MAC measure:

- ESRD or dialysis during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls to schedule appropriate follow-up with members to assess if medication is taken as prescribed if current treatment is appropriate.
- Remind members to use their insurance card to fill their prescriptions.
  - Gap closure is dependent upon pharmacy claims
- Encourage members to obtain 90-day supplies of the medication at their pharmacy.
  - Members and/or caregivers can obtain support signing up for a mail order pharmacy option (allowing them to fill a 90-day supply) by calling Member Services at 1-888-301-1228 (TTY: 711)
- Counsel members on their medication, why they are on it, and the importance of taking medications as prescribed (even when they feel well)
  - Explain to patients what cholesterol is, how the medication works, and the proven link between consistent statin use and a lower risk of heart attacks and strokes
- Educate members on most common side effects, noting that severe symptoms are rare.
- Instruct patients to contact your office if they are experiencing side effects and not to stop the medication before doing so.
- Provide written instructions to reinforce teaching and include caregivers as appropriate.
- Encourage members to utilize pillboxes or organizers.
- Address barriers to medication adherence. Refer to GCHP Care Management to assist with barriers.
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage Care Management referrals can be made by submitting the referral form available on the Gold Coast Health Plan (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
- Ensure your documentation is clear and concise.
  - Though tracked through pharmacy claims, documentation and coding all conditions is key to representing member complexity for risk adjustment and identifying excluded conditions.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

STAR MEASURE: MEDICATION ADHERENCE FOR DIABETES MEDICATIONS (MAD)

Measure Steward: Pharmacy Quality Alliance

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)/Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Medication Adherence for Diabetes Medications (MAD)."*

Measure Description: This measures the percentage of members 18 years of age or older who are adherent to their diabetes medication at least 80% or more of the time they are supposed to be taking the medication.

Measure Specification:

- Members are included in the measure if they have at least two fills of non-insulin diabetes medication during the measurement year.
- Members are considered adherent if they have their diabetes medications available at least 80% of the days in the measurement year.
  - This is calculated using pharmacy claims data
- The medications that count toward this measure include the below classes:
  - Biguanides
  - Sulfonylureas
  - Thiazolidinediones
  - Dipeptidyl peptidase (DPP)-IV inhibitors
  - Glucagon-like peptide-1 (GLP-1) receptor agonists*
  - Meglitinides
  - Sodium glucose cotransporter 2 (SGLT2) inhibitors

Data Collection Method: Administrative[1]

MAD Clinical Code Set: The MAD measure is entirely based on Prescription Drug Event (PDE) data from pharmacy claims.

Exclusion Criteria – Members with any of the following conditions are excluded from the MAD measure:

- ESRD or dialysis during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year.
- Members with one or more prescriptions for insulin during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls to schedule appropriate follow-up with members to assess if medication is taken as prescribed and if current treatment is appropriate.
- Remind members to use their insurance card to fill their prescriptions.
  - Gap closure is dependent upon pharmacy claims
- Encourage members to obtain 90-day supplies of the medication at their pharmacy.
  - Members and/or caregivers can obtain support signing up for a mail order pharmacy option (allowing them to fill a 90-day supply) by calling Member Services at 1-888-301-1228 (TTY: 711)
- Counsel members on their medication, why they are on it, and the importance of taking medications as prescribed (even when they feel well)
- Educate members on most common side effects, noting that severe symptoms are rare.
- Instruct patients to contact your office if they are experiencing side effects and not to stop the medication before doing so.
- Provide written instructions to reinforce teaching and include caregivers as appropriate.
- Encourage members to utilize pillboxes or organizers.
- Address barriers to medication adherence. Refer to GCHP Care Management to assist with barriers.

- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage Care Management referrals can be made by submitting the referral form available on the Gold Coast Health Plan (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
- Ensure your documentation is clear and concise.
    - Though tracked through pharmacy claims, documentation and coding all conditions is key to representing member complexity for risk adjustment and identifying excluded conditions.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

STAR MEASURE: MEDICATION ADHERENCE FOR HYPERTENSION (MAH)

Measure Steward: Pharmacy Quality Alliance

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)/Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Medication Adherence for Hypertension (RAS antagonists) (MAH)."*

Measure Description: This measures the percentage of members 18 years of age or older with a prescription for a blood pressure medication (RAS antagonist) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication in the measurement period.

Measure Specification:

- Members are included in the measure if they have at least two fills of blood pressure medication (RAS antagonist) during the measurement year.
- Members are considered adherent if they have blood pressure medications available at least 80% of the days in the measurement year.
  - The proportion of days covered (PDC) is the standard metric used to measure adherence
  - Definition: PDC is the percentage of days in a measurement year that a patient has their medication available, based on pharmacy claims
  - Adherence Threshold: Patients are considered adherent if PDC ≥ 80%
  - Calculation: A day's supply available divided by total days in measurement period
- RAS antagonist medications that count toward the MAH measure include:
  - Angiotensin II receptor blockers (ARB)
  - Angiotensin-converting enzyme inhibitors (ACEI)
  - Direct renin inhibitors

Data Collection Method: Administrative[1]

MAH Clinical Code Set: The MAH measure is entirely based on prescription drug event (PDE) data from pharmacy claims.

Exclusion Criteria – Members with any of the following conditions are excluded from the MAH measure:

- ESRD or dialysis during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year.
- One or more prescription claim for sacubitril / valsartan (Entresto®) during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls to schedule appropriate follow-up with members to assess if medication is taken as prescribed if current treatment is appropriate.
- Remind members to use their insurance card to fill their prescriptions.
  - Gap closure is dependent upon pharmacy claims
- Encourage members to obtain 90-day supplies of the medication at their pharmacy.
  - Members and/or caregivers can obtain support signing up for a mail order pharmacy option (allowing them to fill a 90-day supply) by calling Member Services at 1-888-301-1228 (TTY: 711)
- Counsel members on their medication, why they are on it, and the importance of taking medications as prescribed (even when they feel well)
- Educate members on most common side effects, noting that severe symptoms are rare.
- Instruct patients to contact your office if they are experiencing side effects and not to stop the medication before doing so.
- Provide written instructions to reinforce teaching and include caregivers as appropriate.

- Encourage members to utilize pillboxes or organizers.
- Address barriers to medication adherence. Refer to GCHP Care Management to assist with barriers.
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage Care Management referrals can be made by submitting the referral form available on the Gold Coast Health Plan (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
- Ensure your documentation is clear and concise.
  - Though tracked through pharmacy claims, documentation and coding all conditions is key to representing member complexity for risk adjustment and identifying excluded conditions.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

STAR MEASURE: PLAN ALL-CAUSE READMISSION (PCR)

Measure Steward: National Committee for Quality Assurance

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)/Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Plan All-Cause Readmission (PCR)."*

Measure Description: This measures the percentage of plan members 18 years of age and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.

Measure Specification:

- Denominator (Index Stay) includes acute inpatient or observation hospital admissions in the measurement year with a discharge on or between Jan. 1 and Dec. 1 of the measurement period.
  - The index stay must end in a discharge to the community or non-acute setting
- Numerator (Readmission) includes those index stays that are followed by an unplanned readmission within 30 days of discharge (for any diagnosis).
  - The readmission must be to an acute inpatient facility

Data Collection Method: Administrative[1]

PCR – Clinical Code Set:

- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.
  - Index hospital stays are identified from UB revenue codes on hospital facility claims.
    - UB Revenue codes used to identify inpatient stays between Jan. 1, 2026, to Dec. 1, 2026.

0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

    - UB revenue codes used to identify observation stays between Jan. 1, 2026, to Dec. 1, 2026.

0760, 0762, 0769

  - Providers determine coding accuracy through their clinical documentation
    - Document clear, complete, and specific notes that include diagnoses and comorbidities for conditions evaluated and treated.
    - Differentiate planned versus urgent admissions in supporting documentation.
    - Ensure all chronic conditions are accurately documented in the medical record.

Medical Record Should Include:

- Key areas to document in the medical record to support / supplement the accuracy of hospital facility claims.
  - Diagnosis specificity: The exact reason for admission and all active conditions
  - Planned versus urgent admission: Note if the admission / procedure was scheduled or emergent
  - Comorbidities: Document and code (using the most specific ICD-10 codes) all comorbidities including the below that have a high-impact on the PCR measure:
    - Congestive heart failure (CHF)
    - Chronic kidney disease (CKD)
    - Chronic obstructive pulmonary disease (COPD)
    - Diabetes (type 1 or 2)
    - Hypertension

    - Cancer
    - Obesity
    - Cerebrovascular disease
    - Liver disease
    - Mental health disorders

Exclusion Criteria – Members with any of the following conditions are excluded from the MAD measure:

- Members in hospice or using hospice services anytime during the measurement year.
- Members with acute hospitalizations for the following reasons:
  - Principal diagnosis of pregnancy on the discharge claim
  - Principal diagnosis of a condition originating in the perinatal period on the discharge claim
  - Planned admissions for:
    - Chemotherapy maintenance
    - Principle diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis
- Exclude the hospital stay if the direct transfer's discharge date occurs after Dec. 1 of the measurement year.
- Members who died during the inpatient stay.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with risk for readmission.
  - Attempt multiple outreach efforts to members who are at risk for readmission.
  - For members at risk of readmission, provide:
    - Medication reconciliation
    - Self-management training for members and caregivers to help members identify when/how to manage acute symptoms and when to seek timely care from their PCP
    - Regular follow-up appointments
- Once notified of an admission, reach out to the hospital's discharge team to share the member's baseline health status, medication list, and any known social needs that could impact discharge planning.
  - Coordinate with the discharge team to ensure the member has a clear, written, and easy-to-understand plan that covers all aspects of their post-hospital care.
- Contact the member by phone within two to three days of discharge to check on their condition, address any questions, and ensure they have understood their care plan.
- If a follow-up was not scheduled while member was still in the hospital, schedule a follow-up visit for within seven days of discharge.
  - Reserve appointment slots for members who are discharged from the hospital, so they can be seen within seven days of discharge
- During the initial follow-up, perform a thorough medication reconciliation. Review and reconcile the member's new and existing medication lists to avoid issues with adherence or interactions.
- Use the "teach-back" method to confirm the member and/or caregiver understands their medications and care plan by asking them to repeat key information in their own words.
- Ensure discharged members understand their local community support resources.
- Refer for Transitional Care Management.
  - Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health and provide transitional care management services (structured support for 30 days post-discharge).
    - Total Care Advantage 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

- Members with multiple comorbidities are expected to be readmitted at a higher rate. Ensure all conditions are appropriately identified in the member's medical record and claims.
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.

Gold Coast Health Plan[SM]
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

2026 Measurement Year

MCAS MEASURE: POSTPARTUM DEPRESSION SCREENING AND FOLLOW-UP (PDS-E)

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 provides the key components to the MCAS measure, *"Postpartum Depression Screening and Follow-Up (PDS-E)."*

Measure Description: The percentage of members with deliveries, between Sept. 8, 2025, and Sept. 7, 2026, who were screened for clinical depression during the postpartum period (7-84 days following delivery), and if screened positive, received follow-up care.

- Depression Screening: The percentage of members with deliveries who were screened for clinical depression using an age-appropriate standardized instrument during the postpartum period (7-84 days following the date of delivery).
- Follow-Up on Positive Screen: The percentage of members with deliveries who received follow-up care within 30 days (31 days total), of a positive depression screening OR documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument..

Data Collection Method: Electronic Clinic Data Systems (ECDS)[1]

Standardized Instruments

- A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Standardized Instruments	Age ≤ 17	Age 18+	Positive Finding	LOINC Code
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	X		Total Score ≥ 10	89204-2
Patient Health Questionnaire (PHQ-9)®	X	X	Total Score ≥ 10	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[2]	X	X	Total Score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[2,3]	X	X	Total Score ≥8	89208-3
Center for Epidemiologic Studies Depression Scale – Revised (CESD-R)	X	X	Total Score ≥ 17	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	X	X	Total Score ≥ 10	99046-5
PROMIS Depression	X	X	Total Score ≥ 60	71965-8
Beck Depression Inventory (BDI-II)		X	Total Score ≥ 20	89209-1
Duke Anxiety-Depression Scale (DUKE-AD)®[2]		X	Total Score ≥ 30	90853-3
My Mood Disorder (M-3)®		X	Total Score ≥ 5	71777-7
Clinically Useful Depression Outcome Scale (CUDOS)		X	Total Score ≥ 31	90221-3
PROMIS Emotional Distress-Depression-Short Form		X	Total Score ≥ 60	77861-3

Methods used to identify a follow-up on a positive screening within 30-Days:

- A clinic encounter (outpatient, telephone, e-visit, virtual check-in, depression case management, behavioral health encounter, exercise counseling).
- A dispensed antidepressant medication.
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
- Encounter for exercise counseling.

PDS-E Clinical Code Set

- For billing, reimbursement, and reporting of services completed, submit claims in a timely with the appropriate medical codes for all conditions evaluated and services completed.

Codes to identify follow-up on positive screening.

Description	ICD-10-CM	CPT	HCPCS	UBREV
An outpatient, telephone, e-visit, or virtual check-in with a diagnosis of depression or behavioral health condition. Click here for list of the diagnosis codes.		98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98979, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99470, 99483	G0071, G0463, G0544, G2010, G2012, G2250, G2251, G2252, T1015	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Depression case management encounter with a diagnosis of depression or behavioral health condition. Click the link above for a complete list of diagnosis codes.		99366, 99492, 99493	G0512, T1016, T1017, T2022, T2023	
Behavioral Health Encounter		90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
Encounter for exercise counseling	Z71.82			

Evidence of an antidepressant medication dispensing event.

- Click here for list of antidepressant medications.

Exclusion Criteria – Members with the following conditions are excluded from the PDS-E measure:

- Deliveries in which members were in hospice or using hospice services any time during the measurement period.
- Members who die anytime during the measurement period.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a visit.
- Clinical Recommendations:
  - The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women.
  - The American College of Obstetricians and Gynecologists (ACOG) recommends that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits with a standardized, validated instrument.
  - The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's one-, two-, four- and six-month visits.
  - The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
- Behavioral health referrals can be made through Carelon Behavioral Health (formerly Beacon Health Options). Providers may also use this link to access valuable information, forms and documents: Click Here
- GCHP's 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

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

[2] Brief screening instruments. All other instruments are full-length.

[3] Proprietary; may be cost or licensing requirement associated with use.

2026 Measurement Year

MCAS MEASURE: PRENATAL DEPRESSION SCREENING AND FOLLOW-UP (PND-E)

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 provides the key components to the MCAS measure, *"Prenatal Depression Screening and Follow-Up (PND-E)."*

Measure Description: This measures the percentage of members with deliveries who were screened for clinical depression while pregnant, and if screened positive, received follow-up care.

- Depression Screening: The percentage of members with deliveries who were screened for clinical depression during pregnancy using an age-appropriate standardized screening instrument.
- Follow-Up on Positive Screen: The percentage of members with deliveries who received follow-up care within 30 days of a positive depression screen finding.

Data Collection Method: Electronic Clinic Data Systems (ECDS)[1]

Standardized Instruments:

- A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Standardized Instruments	Age ≤ 17	Age 18+	Positive Finding	LOINC Code
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	X		Total Score ≥ 10	89204-2
Patient Health Questionnaire (PHQ-9)®	X	X	Total Score ≥ 10	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[2]	X	X	Total Score ≥ 3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[2,3]	X	X	Total Score ≥ 8	89208-3
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	X	X	Total Score ≥ 17	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	X	X	Total Score ≥ 10	99046-5
PROMIS Depression	X	X	Total Score ≥ 60	71965-8
Beck Depression Inventory (BDI-II)		X	Total Score ≥ 20	89209-1
Duke Anxiety-Depression Scale (DUKE-AD)®[2]		X	Total Score ≥ 30	90853-3
My Mood Disorder (M-3)®		X	Total Score ≥ 5	71777-7
Clinically Useful Depression Outcome Scale (CUDOS)		X	Total Score ≥ 31	90221-3
PROMIS Emotional Distress Depression Short Form		X	Total Score ≥ 60	77861-3

PND-E Clinical Code Set

For billing, reimbursement, and reporting of services completed, submit claims in a timely with the appropriate medical codes for all conditions evaluated and services completed.

Methods to identify a follow-up on a positive screening within 30-Days:

- A clinic encounter (outpatient, telephone, e-visit, virtual check-in, depression case management, behavioral health encounter, exercise counseling).
- A dispensed antidepressant medication.

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
- Encounter for exercise counseling.

PND-E Clinical Code Set

- For billing, reimbursement, and reporting of services completed, submit claims in a timely with the appropriate medical codes for all conditions evaluated and services completed.

Codes to identify follow-up on positive screening.

Description	ICD-10-CM	CPT	HCPCS	UBREV
An outpatient, telephone, e-visit, or virtual check-in with a diagnosis of depression or behavioral health condition. Click here for the list of diagnosis codes.		98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98979, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99470, 99483	G0071, G0463, G0544, G2010, G2012, G2250, G2251, G2252, T1015	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Depression case management encounter with a diagnosis of depression or behavioral health condition. Click the link above for a complete list of diagnosis codes.		99366, 99492, 99493	G0512, T1016, T1017, T2022, T2023	
Behavioral Health Encounter		90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
Encounter for exercise counseling	Z71.82			

Evidence of an antidepressant medication dispensing event.
Click here for the list of antidepressant medication.

Exclusion Criteria – Members with the following conditions are excluded from the PND-E measure:
- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which members were in hospice or using hospice services any time during the measurement period.
- Members who die anytime during the measurement period.

Best Practices:
- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a visit.
- Clinical Recommendations:
    - The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women.
    - The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized, validated tool.
    - The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Members of the care team understand the importance of depression screening and to recognize the risk factors for depression in pregnancy.
- Work with a care manager or team member to coordinate care and follow-up for members with a positive screening.
- Behavioral health referrals can be made through Carelon Behavioral Health (formerly Beacon Health Options). Providers may also use this link to access valuable information, forms and documents: Click Here
- GCHP's 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
    - Ensure your documentation is clear and concise.
    - Use proper coding for conditions evaluated and services provided.

[1] MECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

[2] Brief screening instruments. All other instruments are full-length.

[3] Proprietary; may be cost or licensing requirement associated with use.

2026 Measurement Year

MCAS MEASURE: PRENATAL AND POSTPARTUM CARE (PPC)

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 provides the key components to the MCAS measure, *"Prenatal and Postpartum Care (PPC)."*

Measure Description: This measures the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Timeliness of Prenatal Care – The percentage of women who received a prenatal care visit during the first trimester, on or before the enrollment start date, or within the first 42 days of enrollment with GCHP.
- Postpartum Care – The percentage of women who had a postpartum visit between 7 to 84 days after delivery.

Data Collection Method: Hybrid[1]

PPC Clinical Code Sets

- For billing, reimbursement, and reporting of services completed, submit claims in a timely manner with the appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify prenatal services within the first trimester, on or before the enrollment start date, or within 42 days of enrollment.

Description	ICD-10-CM	CPT	CPT II	HCPCS
Prenatal Visit with a Pregnancy Diagnosis	Click here for a complete list of the pregnancy diagnosis codes.	99202-99205, 99211-99215, 99242-99245, 99483		G0463, G0544, T1015
Telephone Assessment or Evaluation with a Pregnancy Diagnosis		98966-98968, 99441-99443		
Synchronous Audio or Video Visit with a Pregnancy Diagnosis		98000-98016		
Online Assessment or Remote Monitoring with a Pregnancy Diagnosis		98970-98972, 98979, 98980, 98981, 99421-99423, 99457, 99458, 99470		G0071, G2010, G2012, G2250, G2251, G2252
Prenatal Bundled Services		59400, 59425, 59426, 59510, 59610, 59618		H1005
Standalone Prenatal Visit		99500	0500F, 0501F, 0502F	H1000 - H1004

Codes used to identify postpartum exams completed 7 to 84 days after delivery.

Description	ICD-10-CM	CPT	CPT II	HCPCPS	LOINC
Postpartum Exam	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	57170, 58300, 59430, 99501	0503F	G0101	
Postpartum Bundled Services		59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622			
Cervical Cytology Exam		88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175		G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001	10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 104866-9

Exclusion Criteria - Members with the following conditions are excluded from the PPC measure:

- Women with non-live birth deliveries during the measurement period.
- Members who received hospice care in the measurement year.
- Members who died during the measurement year.

Medical records MUST include:

- For Timeliness of Prenatal Care
  - Prenatal care visit date AND evidence of ONE of the following:
    - Documentation in a standardized prenatal flow sheet.
    - Physical obstetrical exam that includes auscultation for fetal heart tone.
    - Pelvic exam with obstetric observations.
    - A positive pregnancy test result.
    - Documentation of gravidity and parity.
    - Measurement of fundus height.
    - Evidence that a prenatal care procedure was performed, i.e. ultrasound, obstetric panel, or antibody test.
    - Documentation of last menstrual period (LMP) or estimated date of delivery (EDD), prenatal risk assessment and counseling/ education, or complete obstetrical history.
- For Postpartum Care
  - Postpartum visit date AND evidence of ONE of the following:
    - Pelvic exam.
    - Evaluation of weight, blood pressure, breasts, and abdomen.
    - Notation of postpartum care. This can include: "PP care," "six-week check," or a pre-printed postpartum care form.
    - Perineal or cesarean wound check.
    - Screening for mental health, tobacco use, and substance use disorder.
    - Glucose screening for gestational diabetes mellitus (GDM) women.
    - Family planning and resumption of intercourse.
    - Sleep / fatigue.
    - Resumption of physical activity and attainment of healthy weight.
    - Documentation of infant care or breastfeeding.

Best Practices for Prenatal Care:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members on the need for a visit.
- Clinicians should identify potential barriers to receiving care when pregnancy is confirmed and ensure members are aware of available resources.
- Follow the guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG) for establishing an ongoing prenatal care plan.
- All women should receive the influenza vaccine, especially during the prenatal and postpartum periods.
- Recommend that patients eliminate smoking and alcohol use to reduce chances of Sudden Infant Death Syndrome (SIDS).
- Encourage patients to follow a safe and healthy diet, get regular exercise, and avoid exposure to harmful substances such as lead and radiation.
- Remind patients to ensure their prenatal vitamin contains 400 or more micrograms of folic acid.
- Review prescriptions, over-the-counter medications and herbal products that the mother is currently taking to ensure they are not harmful to the fetus.

Best Practices for Postpartum Care:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members on the need for a visit.
- Clinicians providing antenatal care should actively engage families in their care and identify the health care professionals who will comprise the postpartum care team for the woman and her infant.
- Formulate a postpartum care plan during pregnancy and identify which health care providers will provide care for the woman and infant.
- At discharge from maternity care, provide the member with written contact information for the postpartum care team and instructions on timing of follow-up postpartum care.
- Obstetricians should offer long-acting reversible method of contraception (LARC) insertion prior to hospital discharge as well as during the postpartum office visit.
- Behavioral health referrals can be made through Carelon Behavioral Health (formerly Beacon Health Options). Providers may also use this link to access valuable information, forms and documents.
- The American College of Obstetricians and Gynecologists (ACOG) encourages clinics to ask women about pregnancy intendedness and encourages patients to develop a reproductive life plan or a set of personal goals about when to have children.

[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.

2026 Measurement Year

MCAS MEASURE: PRENATAL IMMUNIZATION STATUS (PRS-E)

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 provides the key components to the MCAS measure, *"Prenatal Immunization Status (PRS-E)."*

Measure Description: This measures the percentage of deliveries in the measurement period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

- Influenza Immunization Status:
  - Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date.
  - Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date.
- Tdap Immunization Status:
  - Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or
  - Deliveries where members had any of the following:
    - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
    - Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
- Combination Immunization Status:
  - Deliveries that met criteria for influenza and Tdap.

Data Collection Method: Electronic Clinic Data Systems (ECDS)[1]

PRS-E Clinical Code Set

- For billing, reimbursement, and reporting of services completed, submit claims in a timely with the appropriate medical codes for all conditions evaluated and services completed.

Description	CPT	CVX
Adult Influenza	90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205, 320
Tdap	90715	115

Exclusion Criteria – Members with the following conditions are excluded from the PRS-E measure:

- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which members were in hospice or using hospice services any time during the measurement period.
- Members who die during the measurement period.

Best Practices:

- Use the Inovalon® Provider Enablement 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 visit.
- The American Academy of Pediatrics (AAP) recommends health care professionals review a patients immunization record at every encounter to administer or schedule needed vaccines.
- Encourage scheduling appointments in advance.
- Pursue missed appointments with letters and reminder calls.
- Use alerts in the EMR system for outreach to members who are due for immunizations.
- Hold in-service staff meetings to educate team members about vaccines for adults, address common misconceptions, and answer questions.
- Provide resources to educate patients about the importance of vaccines.

- Use available immunization registries to enter vaccines administered and track each patient's vaccination status: California Immunization Registry (CAIR).
- View the American Academy of Family Physicians (AAFP) 20 Best Practices for Adolescent Immunizations.
- For additional materials for clinical staff and parents, visit the California Department of Public Health website.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here
- Clinical Recommendation
  - Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27 to 36, regardless of prior history of receiving Tdap.

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

STAR MEASURE: STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Measure Steward: National Committee for Quality Assurance (NCQA)

Gold Coast Health Plan Total Care Advantage's goal is to help its providers gain compliance with their annual Managed Care Accountability Set (MCAS) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Statin Therapy for Patients with Cardiovascular Disease (SPC)."*

Measure Description: This measures the percentage of male members 21 to 75 years of age and females 40 to75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication.

Measure Specification: Two rates are reported:
- Received statin therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
- Statin adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Measure Medications: The statins and dosages that count toward this measure include the below:
- High-intensity statins
  - Atorvastatin (Lipitor): 40–80 mg daily
  - Rosuvastatin (Crestor): 20–40 mg daily
  - Simvastatin (Zocor): 80 mg daily
  - Combination medications:
    - Ezetimibe-simvastatin (Vytorin): 80 mg daily
    - Amlodipine-atorvastatin (Caduet): 40-80 mg daily
- Moderate-intensity statins
  - Atorvastatin (Lipitor): 10–20 mg daily
  - Rosuvastatin (Crestor): 5–10 mg daily
  - Simvastatin (Zocor): 20–40 mg daily
  - Pravastatin (Pravachol): 40–80 mg daily
  - Lovastatin (Mevacor): 40 mg daily
  - Fluvastatin (Lescol XL): 80 mg daily
  - Pitavastatin (Livalo): 1–4 mg daily
  - Combination medications:
    - Ezetimibe-simvastatin (Vytorin): 20–40 mg daily
    - Amlodipine-atorvastatin (Caduet): 10–20 mg daily

Data Collection Method: ECDS[1]

SPC – Clinical Code Set
- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.

Click here for diagnosis codes used to identify members with ASCVD during the measurement year (MY) prior to the measurement year (PMY).

Description	Period of Diagnosis or Procedure
Discharged with a diagnosis of myocardial infarction	Prior to measurement year
Coronary artery bypass graft (CABG) in any setting	Prior to measurement year
Percutaneous coronary intervention (PCI) in any setting	Prior to measurement year

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

Description	Period of Diagnosis or Procedure
Revascularization procedures in any setting	Prior to measurement year
Two diagnoses of cardiovascular disease on different dates of services.	Measurement year or prior to measurement year

Exclusion Criteria – Members with any of the following conditions are excluded from the SPC measure:

- Pregnancy during the measurement year or year prior to the measurement year.
- In-vitro fertilization in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.
- End stage renal disease or dialysis during the measurement year or the year prior to the measurement year.
- Cirrhosis during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.
- Members in hospice or using hospice services any time during the measurement year.
- Members who died any time during the measurement year.
- Members receiving palliative care any time during the measurement year.
- Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Evaluate all members with ASCVD that are taking a low-intensity statin to increase to a moderate or high intensity statin, if clinically appropriate.
- Schedule appropriate follow-up with patients to assess if medication is taken as prescribed.
- Remind members to use their insurance card to fill their prescriptions
  - Gap closure is depended on pharmacy claims
- Encourage member to obtain 90-day supplies at their pharmacy.
  - Members and/or caregivers can obtain support signing up for a mail order pharmacy option (allowing them to fill a 90-day supply) by calling Member Services at 1-888-301-1228 (TTY: 711)
- Educate members on most common statin adverse effects, noting that severe symptoms are rare.
- Instruct patients to contact your office if they are experiencing adverse effects and not to stop the medication before doing so.
- Educate patients and/or caregivers about the value of prescribed statin medications for managing cardiovascular disease and the importance of adherence/the need for consistent and ongoing use of the medication.
  - Total Care Advantage offers free health education services, materials, classes, and online resources to help members achieve a healthy lifestyle
  - Providers can contact the Health Education Department or refer members / guardians / caregivers to the following information:
    - Providers, call: 1-805-437-5961
    - Members, call: 1-888-301-1228 / TTY 711
    - GCHP Health Education Webpage (resources in English and Spanish): Click Here
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage 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
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] ECDS is a HEDIS® reporting standard that uses structured data systems (e.g., administrative claims, clinical registries, health information exchanges, electronic health records, disease/cases management systems) to report rates on ECDS designated measures.

2026 Measurement Year

MCAS MEASURE: TOPICAL FLUORIDE FOR CHILDREN (TFL)

Measure Steward: Dental Quality Alliance

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 provides the key components to the MCAS measure, *"Topical Fluoride for Children (TFL)."*

Measure Description: This measures the percentage of children ages 1-20 who received at least two topical fluoride applications at a dental or oral health service during the measurement year.

Data Collection Method: Administrative[1]

TFL 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 provided.

Codes used to identify fluoride varnish application.

Description	CPT	CDT
Fluoride Varnish Application	99188	D1206, D1208

Exclusion Criteria – None.

Best Practices:

- Use the Inovalon® INDICES® Provider Insights Dashboards to identify members with gaps in care.
- **CDPH Oral health for infants and Toddler's provider's guide for oral assessment**:
  - Begin oral assessment at birth.
  - Assess for signs of decay.
  - Assess fluoride intake; Rx as needed.
- **United States Preventive Services Task Force (USPSTF) recommends**:
  - PCPs apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- **The American Academy of Pediatrics recommends**:
  - Apply fluoride varnish according to the recommended periodicity schedule. Fluoride varnish is a proven tool in early childhood caries prevention.
  - Smear or grain of rice-sized amount is recommended for children younger than 3 years, and a pea-sized amount of toothpaste is appropriate for most children starting at 3 years of age.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS MEASURE: WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE (W30)

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 provides the key components to the MCAS measure, *"Well-Child Visits in the First 30 Months of Life (W30)."*

Measure Description: This measures the percentage of members who had the following number of well-child visits with a primary care provider (PCP) during the last 15 months. The following rates are reported:

- **Well-Child Visits in the First 15 Months.** Children who turned 15 months of age during the measurement year: Six or more well-child visits.
- **Well-Child Visits for Ages 15 Months to 30 Months.** Children who turned 30 months of age during the measurement year: Two or more well-child visits.

Data Collection Method: Administrative[1]

W30 Clinical Code Sets

- For billing, reimbursement, and reporting of services completed, submit claims in a timely manner with the appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify well-care exams with a PCP.

Description	ICD-10-CM	CPT	HCPCS
Well-Care Exam	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2, Z01.411, Z01.419, Z02.84	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461	G0438, G0439, S0302, S0610, S0612, S0613

Please note: Telehealth well-care visits will not meet compliance for this measure.

Exclusion Criteria - Members with the following condition are excluded from the W30 measure:

- Members receiving hospice care during the measurement year.
- Members who die anytime during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members / parents of the need for a visit.
- Report correct preventive visit billing codes when services are provided and documented.
- Encourage scheduling appointments in advance.
- Pursue missed appointments with letters and reminder calls.
- When patients are seen for acute visits, take the opportunity to provide and document preventive services, when appropriate.
- Use alerts in the electronic medical record (EMR) system for outreach to members who are due for preventive services.
- Providers can review the Bright Futures Periodicity Table for a recommended schedule of well-care visits.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
    - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

2026 Measurement Year

MCAS MEASURE: CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

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 provides the key components to the MCAS measure, *"Child and Adolescent Well-Care Visits (WCV)."*

Measure Description: This measures the percentage of members ages 3-21 who had at least one comprehensive well-care visit with a primary care provider (PCP) or an OB/GYN practitioner during the measurement year.

Data Collection Method: Administrative[1]

WCV Clinical Code Sets

- For billing, reimbursement, and reporting of services completed, submit claims in a timely manner with the appropriate medical codes for all clinical conditions evaluated and services completed.

Codes used to identify well-care exams with a PCP or OB/GYN.

Description	ICD-10-CM	CPT	HCPCS
Well-Care Exam	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2, Z02.84	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461	G0438, G0439, S0302, S0610, S0612, S0613

Please note: Telehealth well-care visits will not meet compliance for this measure.

Exclusion Criteria:
Members who had the following condition are excluded from the WCV measure:

- Members receiving hospice care during the measurement year.
- Members who die anytime during the measurement year.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gap Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members / parents of the need for a visit.
- Report correct preventive visit billing codes when services are provided and documented.
- Encourage scheduling appointments in advance.
- Pursue missed appointments with letters and reminder calls.
- When patients are seen for acute visits, take the opportunity to provide and document preventive services, when appropriate.
- Use alerts in the electronic medical record (EMR) system for outreach to members who are due for preventive services.
- Contact the parent / legal guardian of those children with no well-care visit in the last 12 months to schedule an appointment.
- Promote GCHP's Child / Adolescent Well-Care member incentive:
  - Members 3 to 21 years of age can earn a $25 gift card to Target, Wal-Mart or Amazon for completing a well-care exam within the measurement year. Members will need to mail or fax GCHP the completed form that includes a signature from their doctor and date of the exam. The member incentive form can be downloaded here.
- GCHP offers free health education services, materials, classes, and online resources 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: 1-888-301-1228 / TTY 711
  - GCHP Health Education Webpage (resources in English and Spanish): Click Here

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g., claims, encounter, lab, immunization registries) to evaluate if services were performed.

MEASUREMENT YEAR 2026

Quality Measures Reference Guide

711 East Daily Drive, Suite 106
Camarillo, CA 93010-6082
1.888.301.1228

www.goldcoasthealthplan.org