



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Diabetes Care • Blood Sugar Controlled Quick Reference Guide

2026

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MEASURE SNAPSHOT

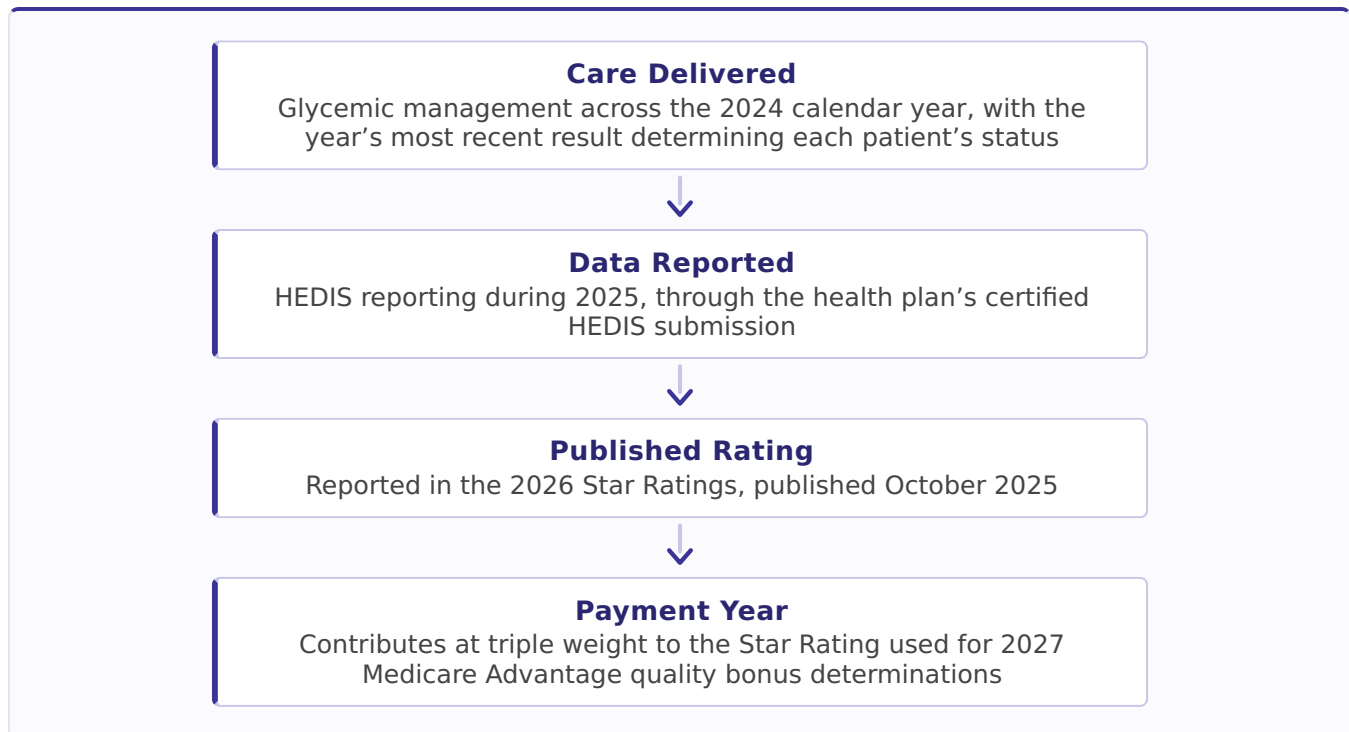
CMS Part C Star Measure: C12 - Diabetes Care - Blood Sugar Controlled

CMS Definition: The percentage of patients with diabetes, ages **18 to 75**, whose most recent **HbA1c** result exceeded **9%**, or who had no HbA1c test during the measurement year.¹

FIELD	ENTRY
CMS measure name	Diabetes Care - Blood Sugar Controlled, GSD
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Intermediate Outcome Measure
Weight	3, triple-weighted
Primary data source	HEDIS; laboratory results, claims, and eligible clinical data
Unit of measurement	CMS health plan-level measure; individual clinicians and practices do not receive a C12 Star Rating.
Trend direction	Higher is better ; CMS reverse-scores this rate (100 minus the poor-control rate)
Case-mix adjusted	No ¹
Measurement period	01/01/2024 - 12/31/2024; two years before reporting year ¹
Star measure credit	The most recent glycemic result of the measurement year, at or below 9.0% , an HbA1c, or a glucose management indicator from CGM data where the specification's requirements are met. A patient with no result at all counts as poor control ^{1,2}
Statistical method	Clustering, with Tukey outer-fence outlier deletion applied before cut points are set. Cut points are recalculated each year and are not fixed targets ¹
Not reported for	Prescription Drug Plans. Reported for all other health plan types, including I-SNP-only health plans, though many institutional patients 66 and older exit through the exclusions ¹

FIELD	ENTRY
Reporting codes (support administrative documentation)	CPT 83036 (laboratory HbA1c) 83037 (point-of-care HbA1c by an FDA-cleared device, requires a CLIA waiver) CPT II result bands: • 3044F (<7.0%) • 3051F (7.0–<8.0%) • 3052F (8.0–≤9.0%) • 3046F (>9.0%) A CPT II result code on a laboratory claim, or carrying a performance-exclusion modifier, does not count. Pair the band code with the visit claim²
ABBREVIATIONS: CGM = continuous glucose monitor; CLIA = Clinical Laboratory Improvement Amendments; CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; GSD = Glycemic Status Assessment for Patients With Diabetes (HEDIS label); HbA1c = hemoglobin A1c; I-SNP = Institutional Special Needs Plan	

How the Years Line Up



The 2026 Star Rating reflects results from 2024. Because HbA1c reflects approximately **ninety days** of average glucose, a patient's November result is determined primarily by glycemic control from **August onward**. Effective performance on this measure therefore requires initiating treatment changes early in the year and timing the recheck late enough to document their effect. Care delivered this year will be reflected in the **2028 Star Ratings**.^{1,4}

In One Sentence

Of the health plan's patients aged 18 to 75 with diabetes, this measure counts the share whose last glycemic result of the year was **9.0% or better**. **No result** scored is considered a **negative score**.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024 measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<54%	≥54% to <77%	≥77% to <87%	≥87% to <91%	≥91%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance

- **National numeric average: 84%**, for an average measure rating of **3.6 Stars** in the 2026 Star Ratings, one of the **stronger-performing** measures in the Part C set¹
- **Cut-point bands are not evenly distributed.** The 3-star band spans 10 percentage points (**77% to 87%**), while the 4-star band spans only 4 points (**87% to 91%**). Since most plans fall in this narrow, triple-weighted middle band, a modest gain in documentation can meaningfully shift the overall plan rating¹
- **Broader MA market context:** roughly **64% of MA-PD enrollees** are in health plans rated four or more stars for 2026, and 18 MA-PD health plans earned an overall 5-star rating³

WHAT THE MEASURE IS ASKING

In Plain Language

Every patient included in this measure is scored on the most **recent HbA1c** (or CGM-derived GMI) result of the year. **GMI is an estimated A1c calculated from continuous glucose monitor data, and it can be used in place of a lab-drawn HbA1c when properly documented.** A result at or below **9.0%** counts as controlled and a result **above 9.0%**, or **no test at all**, counts as poor control. A patient whose diabetes is well managed but whose only lab of the year was drawn at an outside facility and never reached the chart, scores as poor control, identically to a patient with an A1c above threshold.^{1,2}

Why it Exists

This measure exists because **sustained hyperglycemia is the direct driver of the microvascular and macrovascular complications that define diabetes morbidity**, such as retinopathy, nephropathy, neuropathy, and cardiovascular disease. The 9.0% threshold was chosen because harm above that level is well established across nearly all adults with diabetes, regardless of age or comorbidity.⁴

The 9.0% threshold is a single population-level cutoff used for measurement purposes. It does not replace individualized treatment targets, which vary by patient: **younger, healthier patients** with long life expectancy are often managed to a tighter goal (**below 7.0%**) for greater long-term protection, while **frail older adults** are often managed to a relaxed goal (**8.0% to 8.5%**) because hypoglycemia poses the greater risk for them.⁴ The measure identifies patients whose glycemic control has crossed a threshold where harm might occur. Clinical judgment continues to set the specific target for each patient.



QUALITY OUTCOME — WHAT THIS MEASURE PROTECTS

A patient with an A1c above 9.0% for a full year may be accumulating retinal, renal, and vascular damage. The interventions that improve this measure directly affect that trajectory. In a meta-analysis of **twelve primary-care studies**, pharmacist-led diabetes management improved glycemic control.⁵ Continuous glucose monitoring reduced HbA1c by approximately **0.3 percentage points** vs standard monitoring in meta-analysis.⁶ **Therefore, pharmacist-led management and continuous glucose monitoring are both proven to lower A1c.**

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance. What follows is the part of this measure a care team can influence directly.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Making sure every patient has a result on file, using point-of-care testing at any visit • Adjusting therapy at the same visit when the A1c result is above 9.0% • The September- November recheck for any patient above 9% • A distinct, dated numeric result in the chart, with the corresponding band code on the claim	• Whether outside-lab and endocrinology results reach the record • Medication affordability and formulary fit for diabetes agents • CGM access and data flow for glucose monitoring • Dietitian, CDCES and pharmacist capacity	• Who is enrolled and the 18-75 denominator • Cut points, clustering, and Tukey deletion • The Categorical Adjustment Index • What the specification counts as a valid result

DIRECTLY WITHIN THE
PRACTICEINFLUENCED, SHARED WITH
OTHERS

OUTSIDE THE PRACTICE

ABBREVIATIONS: CDCES = Certified Diabetes Care and Education Specialist; CGM = continuous glucose monitor



AAVBC PERSPECTIVE

Two distinct patient groups fail this measure: those with **uncontrolled A1c**, and those who were **never tested**, or **tested at a location the record cannot identify**. The second group can be corrected with a point-of-care test at any encounter, or retrieval and filing of an outside result. Identify these patients **before** intensifying treatment for anyone. Some patients currently scored as **uncontrolled** are actually **controlled**.²

MEASURE SPECIFICATION

HEDIS Intermediate Outcome Measure

ELEMENT	SPECIFICATION
Denominator	MA enrollees 18 to 75 with diabetes (type 1 or 2), identified by two diabetes diagnoses on different dates of service, or a dispensed insulin or hypoglycemic/antihyperglycemic agent plus at least one diabetes diagnosis, in the measurement year or the year prior. Continuous enrollment for the measurement year, allowing no more than one gap of up to 45 days ^{1,2}
Numerator	Patients whose most recent glycemic status assessment of the measurement year (HbA1c, or a glucose management indicator from CGM data) is greater than 9.0%, or missing, or who were not tested . That poor-control rate is subtracted from 100 for public reporting ^{1,2}
The most recent score	The result closest to December 31 determines the score; an 8.2% in June overwritten by a 9.4% in November scores as poor control. Multiple results on the same date: use the lowest ²
GMI from CGM	The specification accepts a glucose management indicator where the CGM data date range is documented; the range's end date serves as the assessment date, and patient-supplied CGM data in the record is eligible. Confirm plan handling before relying on it at scale ²
What does not count	Ranges and thresholds written in notes ("A1c <9"), "unknown," patient-reported values without the source result, and self-tested A1c not processed per the specification. A CPT II band code on a laboratory claim, or carrying a performance-exclusion modifier, also does not count ²

ELEMENT	SPECIFICATION
Diabetes-type exclusion	Patients without a diabetes diagnosis in the measurement year or prior year whose only qualifying diagnosis is polycystic ovarian syndrome (E28.2), gestational diabetes (O24.41-O24.44), or steroid-induced diabetes (E09.x) are excluded ¹
Age 66+ exclusions	I-SNP enrollment or long-term institutional residence at any time in the measurement year; or frailty plus advanced illness, both evidenced per the specification. Frailty alone does not exclude ¹
Other exclusions	Hospice or hospice services, death, and palliative care during the measurement year, plus health plan-level small-plan rules ¹
Measurement window	January 1 – December 31, 2024 for the 2026 Star Ratings ¹

ABBREVIATIONS: CGM = continuous glucose monitor; CPT = Current Procedural Terminology; GMI = glucose management indicator; HbA1c = hemoglobin A1c; I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage
****Measure logic in this section is stated at the level supported by sources AAVBC currently holds. NCQA HEDIS Volume 2 for the current measurement year is the citation of record for denominator, numerator, exclusion and timing detail; any element not traceable to a held primary source is flagged for verification rather than stated confidently**



RED FLAG — 9.0% IS THE THRESHOLD

Clinical targets are tighter than 9.0% for most healthy adults, and looser than 8.0% for frail older patients at risk of hypoglycemia.⁴ Treating every patient to the measure's **9.0% threshold** falls short of established targets for certain patients, and pushing frail older adult below **7.0%** raises fall risk from hypoglycemia.

Commonly Misunderstood

- An untested patient is assumed to be neutral → **no result scores as poor control**^{1,2}
- A good HbA1c result earlier in the year does not guarantee credit for the measurement year → **the most recent HbA1c result is what counts**. If a later recheck comes back high, it replaces the previous result. Skipping a needed recheck in order to preserve an earlier good result on record is **not an acceptable practice**²
- A specialist's lab result is often assumed to count automatically → it only counts if it **reaches the plan** through a supplemental data feed, or is retrieved and entered into the chart with the exact collection date and value²
- The 8.0% indicator does not define the clinical target → **CMS uses only the >9.0% indicator for C12**. Plans may report both; clinicians should base treatment decisions on individualized clinical goals rather than either indicator^{1,2,4}

HOW PERFORMANCE IS MEASURED

From Lab Value to Credit

Credit is assigned through one of three data pathways: a **claims-visible result** (a laboratory claim, or a CPT II band code paired correctly with a visit claim), **eligible supplemental and clinical data**, or **the record reviewed directly**. Point-of-care devices that interface with the EHR document the value and date directly into structured fields at the moment of testing, with no intermediate scanning or data-entry step.²

CMS assigns measure stars through clustering, after removing outliers using the **Tukey out-of-fence method**. This measure is also included in the **Part C Improvement Measure**, with a correlation of **0.792**, and in the **Categorical Adjustment Index**. No case-mix adjustment is applied.¹



CLINICAL PEARL — SCHEDULE RECHECKS EARLY TO AVOID YEAR-END RESULT DELAYS

An external lab ordered at a **late-November** visit may not result until **January**, causing a compliant patient to score as untested. The correction is timing-based: recheck every patient above **9.0%** during the **September to November window**, use point-of-care testing for any patient seen in December, and reserve the final six weeks of the year for documentation rather than new testing.³

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The health plan-level result calculated and published by CMS using its own data and methodology
Internal proxy	An organization's internal estimate based on its own patient population and available records. Useful for improvement work, but not equivalent to the official result
Documentation completeness	How consistently the care delivered is documented in structured fields
Patient understanding	Whether patients leave encounters with a clear understanding of what care they received, supported by an accessible record

CALL IT THIS

WHICH MEANS

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services

Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

This measure is not case-mix adjusted.¹ Plans with higher rates of food insecurity, medication cost burden, or limited pharmacy access among their members may score lower on the unadjusted rate, and this measure carries triple weight.

HIGH-YIELD INTERVENTIONS

This measure identifies three patient cohorts: the **unmeasured** (automatic non-compliance, often clinically stable), the **uncontrolled** (A1c above 9.0%, requiring same-visit treatment escalation), and the **drifting** (A1c between 8.0% and 9.0% on an unchanged regimen, without improvement). Because HbA1c reflects a rolling three-month average, any change made today will not appear in the next lab value for roughly ninety days, making early action the priority. **The following are high-yield interventions for each cohort.**

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Generate the registry report and prioritize unmeasured patients until every patient has a result on file	Week 1, then continuous Panel manager/MA	Unmeasured patients are scored as poor control regardless of actual glycemic status. ^{1,2} Point-of-care testing at any encounter, including sick visits, plus retrieval of outside-lab and endocrinology results corrects this at minimal cost
Test with a point-of-care device at intake whenever a result is due	Every eligible visit MA, under CLIA waiver	Many patients given an outside lab slip never complete the test. ³ In-room testing guarantees completion and captures late-year values before the deadline. Bill CPT 83037 ²
Escalate therapy the same visit for any result above 9%: titrate, add an agent, or start injectable therapy	Same visit PCP, with pharmacist ping while the patient is roomed	Uncontrolled status persists by default. Newly adjusted regimens take roughly thirty days to steady state and ninety to show fully in the HbA1c. Earlier escalation allows more of the measurement year for the change to take effect ⁴

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Refer to the pharmacist for a barrier assessment covering affordability, side effects, regimen complexity, and refill logistics	Same visit or within 72 hours Clinical pharmacist	Pharmacist-led intervention in primary care improved glycemic control with a moderate pooled effect across twelve studies ⁵
Schedule the September–November recheck for all patients above 9%, and move stable patients to twice-yearly testing	Quarterly for uncontrolled patients and twice yearly for patients at goal Panel manager	CMS scores the last recorded value of the calendar year. Uncontrolled patients need time before year-end to show improvement: escalate by summer, recheck in the fall window, reserve December for remaining patients ^{2,5}
Use CGM and GMI where clinically indicated and ensure the data reaches the record	At CGM initiation and at each subsequent office visit PCP with pharmacist review	A documented GMI can satisfy the numerator without a blood draw, provided the date range is documented per specification ^{2,6}
Refer to Medical Nutrition Therapy and diabetes self-management education	At diagnosis and whenever A1c rises above 9.0% Referral coordinator books	MNT and self-management education improve glycemic control through day-to-day diet, medication adherence, and glucose monitoring ⁸

ABBREVIATIONS: CGM = continuous glucose monitor; CLIA = Clinical Laboratory Improvement Amendments; EHR = electronic health record; GMI = glucose management indicator; MA = medical assistant; MNT = medical nutrition therapy; PCP = primary care provider

Risk Stratification — Who to Reach First

TIER	CRITERIA	RESPONSE
Urgent: the unmeasured	No valid glycemic result on file for the measurement year	Schedule these patients proactively , obtain a point-of-care test at any encounter, and retrieve outside records in parallel
Priority: above 9%	Most recent result >9.0% , or diabetes-related ED or hospital use	Same-visit escalation with pharmacist handoff ; 14- and 30-day follow-up contacts for tolerability and adherence; fall-window recheck booked before the patient leaves

TIER	CRITERIA	RESPONSE
Routine: the drifting	8.0-9.0% on an unchanged regimen for months	Review before intensifying treatment: assess adherence, affordability and side effects checked before assuming the dose is insufficient; quarterly testing until at the individualized goal ⁴
Maintenance: at goal	At or below the individualized target , stable regimen	Twice-yearly testing; annual re-check of exclusion status so frail patients are correctly removed ^{1,4}

ABBREVIATIONS: ED = emergency department



QUALITY OUTCOME — COLLABORATIVE CARE IMPROVES DEPRESSION AND GLYCEMIC CONTROL TOGETHER

Depression and diabetes distress impair the **planning, memory, and follow-through** that diabetes self-management requires, including testing, dosing, and refilling medications on schedule. **Collaborative care**, defined as integrated behavioral health within primary care, improved both depressive symptoms and glycemic control in patients with **comorbid depression and diabetes**.⁹ When an appropriate regimen is not producing expected results, **screen for depression** before increasing the dose.

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Unmeasured patients are unidentified	Clinically stable patients skip visits, outside lab results are not retrieved, and the registry scores all of them as poor control	Continuous maintenance of the unmeasured list of patients , point-of-care testing at every encounter type, and outside-record retrieval
Qualitative documentation in place of a numeric results	Notes such as "A1c stable," "well controlled," or "<8" do not meet specification. Review requires a distinct numeric value with a collection date	A note template that requires the exact value and collection date and rejects ranges or qualitative descriptions. For example, "7.4% on 05/14" meets specification; "doing well" does not ²

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
An early favorable result followed by no further testing	An early result that meets the goal is treated as sufficient, and no further test is scheduled . If control declines later in the year, either no updated value is identified, or a later, worse value overwrites the earlier credit	Testing cadence by status: quarterly above goal, twice yearly at goal, and a fall recheck for anyone whose treatment was escalated ^{2,4}
Late-year lab orders that result after year-end	A test ordered in December returns results after the measurement year closes. The patient scores as untested despite completing the required test	A standing September to November recheck window , and point-of-care testing for any test ordered later in the year
CPT II band codes that fail to process	The result code is submitted on the wrong claim type, such as a laboratory claim, or with a performance-exclusion modifier, so the administrative pathway does not document it	Pair the band code with the visit claim , audit weekly, and use supplemental data feeds where labs don't submit codes ²
Treatment escalation without addressing the underlying barrier	The dose is increased while the patient is rationing the current agent due to cost . The A1c does not improve, and the patient is labeled non-adherent	A pharmacist barrier assessment before intensification, covering affordability, side effects, regimen complexity, and refill logistics. Identify the barrier, then select a therapy that accounts for it ⁵

ABBREVIATIONS: CPT = Current Procedural Terminology



RED FLAG — OVERTREATMENT

In frail older patients, lowering A1c below **7.0%** to meet a tighter target increases the risk of hypoglycemia-related falls and other harm. For these patients, an individualized target of **8.0% to 8.5%** is the appropriate clinical goal, even when it does not align with the measure's 9.0% threshold. Document the reasoning in the note.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Cost trade-offs between food and medication	High out-of-pocket costs lead patients to ration or discontinue effective medications. This presents clinically as treatment failure	Ask about cost directly , prescribe formulary-preferred medications first, use the pharmacist for benefit navigation and assistance programs
Food insecurity	Patients without reliable access to nutritious food cannot follow standard dietary recommendations, which do not reflect what is affordable or available to them	Screen for food insecurity and refer to food-is-medicine resources. Produce prescriptions and medically tailored meals improved HbA1c among food-insecure adults with type 2 diabetes ¹⁰
Regimen complexity	Sliding-scale dosing, carbohydrate counting, and multi-drug schedules exceed what a standard visit can teach. Patients may not fully understand instructions and modify the regimen independently at home	Use teach-back for every self-management instruction ; this method improved adherence and quality of life. ¹¹ Simplify the regimen where possible, and refer to a CDCES for teaching that exceeds visit time
Diabetes distress	Ongoing self-management requires sustained attention and planning. Depression and chronic stress reduce this capacity, and patients often stop tracking their disease before reporting difficulty	Screen for distress and depression , integrate behavioral health through collaborative care, ¹⁰ and reduce the daily task list to a level the patient can sustain

ABBREVIATIONS: CDCES = Certified Diabetes Care and Education Specialist



CLINICAL PEARL — NON-ADHERENCE

A discontinued regimen typically has an **identifiable cause**: cost, an undocumented hypoglycemic episode, a work schedule that does not accommodate a midday dose, or instructions the patient did not retain. Identifying the specific barrier should **precede any treatment escalation**. Increasing medication intensity without first identifying the cause is not standard care, and treats the symptom rather than the underlying problem.⁵

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Outside results not documented in the record	Endocrinology, urgent-care, and emergency department results are recorded in other systems . The practice's registry reads as untested even though a result exists in an outside portal	Standing retrieval workflows, HIE data feeds , supplemental data submission, and manual transcription of the exact collection date and value when only a document is available ²
Patients who do not complete outside lab orders	Patients given an external lab order do not always complete them, and this is often not identified until year-end	Point-of-care testing as the default for anyone due ; order labs ahead of visits so results can be discussed; track open orders weekly
Limited visit time for a condition requiring ongoing management	A single visit cannot accommodate titration, education, diet counseling, and troubleshooting together. Education is most often deprioritized	Distribute these tasks across the care team : pharmacist titration under standing orders, CDCES and MNT referrals, and care-manager follow-up calls at 14 and 30 days after any regimen change ^{5,7}
Emergency department visits not identified until claims processing	A diabetes-related emergency encounter at another facility can change the treatment plan and risk profile, but the practice may not learn of it for weeks	Real-time ADT alerts through the HIE , hospitals are required to send them; routed to same-week outreach and medication reconciliation ¹²

ABBREVIATIONS: ADT = admission, discharge, transfer; CDCES = Certified Diabetes Care and Education Specialist; ED = emergency department; HIE = health information exchange; MNT = medical nutrition therapy

Disparity Gaps Requiring Targeted Action

The contract-level rate does not identify which patient subgroups are underperforming, and this measure includes no case-mix adjustment. At **triple weight**, addressing these disparities is both a **clinical priority** and the largest opportunity to improve the score.¹ Track testing completion and control rates by income, race and ethnicity, housing status, and geography.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Low-income working adults	Inflexible hourly work schedules prevent attendance at daytime visits and care-management calls. Supplies and CGM devices are frequently excluded from insurance coverage	Evening and weekend appointment availability, telephonic care management, 90-day synchronized prescription fills with delivery, and pharmacist-coordinated manufacturer assistance programs
Minoritized racial and ethnic groups	Limited access to healthy food, combined with dietary counseling that discourages culturally significant foods rather than adapting to them, reduces patient engagement	Culturally adapted self-management education and community health worker programs. A randomized trial in Black and Latino adults demonstrated greater HbA1c improvement with culturally tailored education compared with generic education ⁸
Unhoused and housing-insecure patients	Insulin storage, supply security, and monitoring assume a stable living environment , which these patients do not have	Simplified regimens and street-medicine outreach partnerships address this barrier directly ¹³
Older adults living alone, and rural patients	Vision loss, fine-motor impairment, and social isolation contribute to dosing errors and intentional under-dosing due to fear of error . Rural patients face additional travel distance to specialists and educators	Connected insulin pens and adaptive devices with remote caregiver visibility, simplified once-daily regimens where clinically appropriate, telehealth follow-up for titration management, and tele-mentoring models that extend specialist support to the local PCP ¹⁵

ABBREVIATIONS: CGM = continuous glucose monitor; PCP = primary care provider



DOCUMENTATION REMINDER

This measure requires **four documentation elements** for every result: the distinct numeric value, the exact collection date, the test type, and the linked diabetes diagnosis. Patient-reported values, threshold statements, and undated entries copied from prior notes **do not meet this specification**. Document the value in a location the reporting system can identify, or it will need to be located again during the review period.

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Frail older adults	A low A1c carries greater risk in this population. Blunted counter-regulatory response and hypoglycemia unawareness raise the risk of falls, fractures, arrhythmias, and cognitive injury ⁴	Set an individualized target, typically 8.0% to 8.5% . De-prescribe sulfonylureas and intensive insulin regimens where risk outweighs benefit, and document the rationale for the individualized goal in the chart ⁴
Cardiovascular and renal comorbidity	Most patients in the denominator also have hypertension, ASCVD, or CKD . A single visit can address several triple- and standard-weighted measures simultaneously	Select medications with demonstrated cardiorenal benefit where indicated. Combine A1c, blood pressure, and kidney function assessment into a single pre-visit workup ⁴
New or worsening cognitive impairment	Complex regimens can exceed a patient's cognitive capacity. Resulting errors and missed doses may be misattributed to non-adherence	Simplify the regimen , engage a caregiver with the patient's consent, prefer regimens with a low risk profile if missed or duplicated, and reassess cognitive capacity as part of ongoing diabetes management ⁴
After an ED visit or admission	Steroid use, missed doses, new medications , and stress hyperglycemia during a hospitalization can disrupt glycemic control before the practice is aware of the encounter	ADT-triggered outreach with medication reconciliation , and an early recheck rather than waiting for the routine interval ¹²

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CKD = chronic kidney disease; ED = emergency department

Patient Journey

BEAT	CONTENT
Presents as	A patient in his late fifties with type 2 diabetes works hourly retail with no schedule flexibility . His last recorded HbA1c (8.6%) is seven months old, on a metformin dose unchanged for a year. He arrives in October for an unrelated acute visit
What happens	The registry indicates no result for the measurement year. The MA performs a point-of-care HbA1c during intake, returning 8.9% . The pharmacist is notified while the patient is still present and identifies the barrier: he discontinued his second agent several months earlier because of cost. The pharmacist arranges a formulary-appropriate substitution and a synchronized 90-day mail-order fill. The PCP confirms the plan and schedules a fall-window recheck
Outcome	The 14-day follow-up call confirms no hypoglycemia and that the new prescription was filled. The late-November point-of-care recheck returns 8.4% , below the measure threshold, with the exact value and date recorded in structured fields and the band code paired to the visit claim
Follow-up	Sustained improvement takes priority over a single result. Quarterly testing continues until the patient reaches his individualized goal, and the cost barrier is now documented in the record for any clinician reviewing the case
ABBREVIATIONS: MA = medical assistant; PCP = primary care provider Note: Case is illustrative and is not a reported individual case	

Companion Guides - Making Connections

GUIDE	WHEN TO REACH FOR IT
Kidney Health Evaluation QRG (C13)	C12 and C13 both apply to patients with diabetes. Order the kidney panel alongside the A1c at the same visit , rather than scheduling a separate appointment
Diabetes Care Eye Exam QRG (C11)	A related diabetes measure with a similar screening completion requirement
Controlling Blood Pressure QRG (C14)	The other triple-weighted intermediate outcome measure affecting the same patient population, with the same overtreatment caution in frail patients
<u>Medication Adherence for Cholesterol (Statins) QRG (D10)</u>	The pharmacist touchpoint that corrects the fill history supports both the adherence measures and this measure simultaneously

ABBREVIATIONS: QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- **Every glycemic entry requires four elements:** test type, exact collection date, linked diabetes diagnosis, and a distinct numeric result. Reviewers and automated systems reject ranges, thresholds, the term "stable," and undated values. Each rejected entry defaults the patient's status to poor control²
- **Outside results should be documented whenever available:** transcribe the facility name, exact collection date, and value, or submit them through a supplemental data feed²
- **GMI documentation has separate requirements:** the CGM data date range must be documented, with the range's end date serving as the assessment date. Incomplete CGM documentation can result in an otherwise valid numerator not being counted²
- **Document the individualized target and the clinical reasoning behind it,** particularly when the target is intentionally less stringent than standard guidance for a frail patient⁴

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The result	Distinct numeric value, exact collection date, test type (venous, point-of-care, or GMI with date range), and source facility if the result is external
The linked diagnosis	Diabetes type and status connected to the result in the assessment
The individualized goal	The target for this patient and the supporting rationale (age, life expectancy, hypoglycemia risk, comorbidity), reviewed whenever health status changes
The action	What changed at this encounter: titration, new agent, de-prescription, referral (pharmacist, CDCES, or MNT), or CGM initiation. Include the date and the scheduled recheck
The barrier	The specific barrier (cost, side effects, regimen complexity, food insecurity, or transportation), the intervention selected, and the team member responsible.
The claim pairing	The band code (3044F, 3051F, 3052F, or 3046F) paired with the visit claim, and without a performance-exclusion modifier, so the administrative pathway closes without requiring a chart review

ELEMENT	WHAT TO RECORD
ABBREVIATIONS: CDCES = Certified Diabetes Care and Education Specialist; CGM = continuous glucose monitor; GMI = glucose management indicator; MNT = medical nutrition therapy	

Clinical Documentation Optimization - SOAP

S — Subjective

Presents for an **acute complaint**; diabetes review added per registry flag. No glycemic result on file this measurement year. Reports taking metformin consistently; admits he stopped filling his second agent several months ago because of the copay, and did not want to mention it. No hypoglycemia, polyuria, or visual change.

O — Objective

Point-of-care HbA1c performed during rooming: **8.9%**, collected today [date], FDA-cleared device, result interfaced to the structured field.

A — Assessment

Type 2 diabetes with suboptimal glycemic control (**8.9%**), driven primarily by a medication-affordability gap rather than regimen failure. Individualized goal for this patient: below 7.5%, given age, life expectancy and low hypoglycemia risk.

P — Plan

Same-visit pharmacist consultation completed: cost barrier confirmed, formulary-appropriate agent substituted, 90-day synchronized mail-order fill arranged. Metformin continued. Teach-back completed on the new regimen. Recheck scheduled for late November (fall window) by point-of-care test. 14-day pharmacist follow-up call booked for tolerability and fill confirmation. Point-of-care HbA1c billed **83037** with band code **3052F** paired to today's visit claim.

Documentation caution: Complete documentation includes every required element, the value, the date, the diagnosis, the individualized goal, the identified barrier, the action taken, and the scheduled recheck. This level of documentation also protects the patient from an inaccurate "non-adherent" label by recording the actual cause of the gap in care.

Documentation Examples

Complete

"Type 2 diabetes: most recent venous HbA1c collected 05/14 returned a distinct numeric result of 7.4% — at this patient's individualized goal. Continues metformin 1000 mg twice daily; adherence confirmed. Next check scheduled November per twice-yearly cadence at goal."

Complete — external result retrieved

"Endocrinology lab report obtained from [facility]: HbA1c 8.1%, collected [exact date]. Value, date, and source entered in the structured field; report linked. Fall recheck scheduled here; clinical-inertia review at that visit — regimen unchanged for nine months against a drifting value."

Incomplete

"A1c stable." "Blood sugar well-controlled." "A1c <8 per patient, done at her endocrinologist last month." — no numeric value, no collection date, no source document. Each defaults toward poor control at review, and each usually sits on top of a real result nobody retrieved.²



DOCUMENTATION REMINDER — RECORD THE NUMERIC VALUE CONSISTENTLY

This measure depends on a consistent practice: **recording the distinct numeric value** with its collection date, in a location the reporting system identifies, at **every encounter**.

Treatment escalation, barrier resolution, and the fall recheck do not affect the score unless the final result is documented.

One Status, Clearly Stated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Unmeasured	No valid result exists for the measurement year. This scores as poor control by default until a value is obtained. This list should be worked weekly
External result pending	An outside test is known to exist and is being retrieved. Outreach is paused pending retrieval or confirmation that retrieval has failed
Above 9%, escalated	Therapy has been changed and dated. Contacts are scheduled at 14 and 30 days , with a fall-window recheck on the calendar
8-9%, inertia review	The regimen is unchanged despite a drifting value. A barrier discussion is required before intensification. Testing cadence is quarterly
At goal, verified	The most recent value meets the individualized target and is documented in structured fields, with the claim paired correctly. Testing cadence is twice yearly
Recheck due, window closing	Any patient escalated this year without a post-change value as the fall recheck window opens. This list determines outcomes for December
Exclusion validated	Hospice, palliative care, institutional residence, or documented frailty combined with advanced illness. Validated centrally, dated, and reconfirmed annually

KEY TAKEAWAYS

1

Each patient's status is determined by the most recent glycemic result of the year

A result at or below 9.0% is controlled; no result on file scores as poor control.^{1,2}

2 This measure is triple-weighted

A completed test or a retrieved outside-lab result has three times the effect on the health plan rating compared with a standard process measure.¹

3 The last value recorded in the year determines the score

Escalate treatment by summer, recheck between **September and November**, and use point-of-care testing so scoring does not depend on external lab turnaround time in December.²

4 9.0% is the measure threshold, not the treatment target

Below 9.0%, targets are individualized. Tight control in frail older adults increases the risk of falls and hypoglycemia described in Section 6.⁴

5 Document all required elements every time:

Numeric A1c value, collection date, test type, linked diagnosis, and the band code paired with the visit claim. Qualitative notes and mispaired codes do not count toward the measure.

6 A stronger prescription does not resolve a cost barrier, fear of hypoglycemia, or limited food access

A pharmacist barrier assessment should precede treatment intensification.⁵

7 A documented GMI from CGM data can satisfy the numerator without a blood draw, provided it meets specification

The same CGM data supports treatment titration between visits.^{2,6}

Changes to Monitor

Current as of 2026-08-20.

KIND OF CHANGE	GOOD PRACTICE
Measure status and specification	C12 remains an active, triple-weighted Part C intermediate outcome measure using HEDIS MY2024 GSD. NCQA continues to evolve the GSD specification (GMI handling, reporting methodology, and eligible data sources) so reconfirm the current measurement-year rules against the licensed specification before each cycle ^{1,2}
Rating-year methodology	Cut points reset annually through clustering with Tukey outlier deletion; revalidate cut points, Categorical Adjustment Index treatment, and Improvement Measure inclusion (correlation 0.792 for 2026) each cycle. Because Tukey removes extreme contracts before cut points are set, build margin above a published threshold rather than targeting it exactly ¹
Rating-year policy	The CY2027 final rule did not implement the planned health-equity-based reward; the historical reward factor continues. Confirm reward-factor treatment each Advance Notice cycle before adjusting strategy ¹⁵
Clinical guidance	ADA Standards of Care revised annually; individualized targets, older-adult de-intensification guidance, agent selection for cardiorenal benefit, and CGM indications all carry revision risk. Refresh the clinical rows of this guide against the current Standards ⁴
Codes and data pathways	Confirm current CPT and CPT II handling, point-of-care billing and CLIA requirements, GMI documentation rules, and each plan's supplemental-data acceptance before the measurement year ²
Internal tools	Review registry logic (especially the unmeasured list definition), the fall-recheck calendar trigger, note templates, and dashboards annually; do not label retained prior-year cut points as current

ABBREVIATIONS: ADA = American Diabetes Association; CGM = continuous glucose monitor; CLIA = Clinical Laboratory Improvement Amendments; CPT = Current Procedural Terminology; GMI = glucose management indicator; NCQA = National Committee for Quality Assurance

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