Select Health Quality Provider Program

DIABETES CARE: GLYCEMIC STATUS

2026 Quality Measure Reference Guide

What's Inside

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Select Health

This measure is included in the Primary Care and Endocrinology Quality Provider Programs.

Measure Description

Description	The percentage of members ages 18 to 75 with diabetes (type 1 or type 2) who had glycemic status testing in control (GSD)
Denominator	Members ages 18 to 75 who have been identif ed as having diabetes (type 1 or type 2) using claim/encounter data and pharmacy data
Numerator	Members in the denominator who had most recent hemoglobin A1c (HbA1c) or glucose management indicator (GMI) of <8%
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	**Members who:** • Have PCOS (polycystic ovarian syndrome) • Are not diabetic
Correction Allowed	"A1c or GMI results are available."

Allowable Corrections

General Guidance

- Include a copy of the electronic health record (EHR) note, progress note, or screen print signed by MA/RN/MD including member name, DOB, and provider.
- Submit corrections using **this online tool**.
- Wait 6 weeks from the date of service to enter corrections to allow for claim lag.
- Don't attach multiple patient records to a single correction.
- Each date of service for this measure requires separate correction entries.

Glycemic Status Assessment (A1c or GMI)						
Allowable Correction	**Submission Correction Process**				**Additional Required Documentation** (see "General Guidance" for Standard Requirements)	**Notes for Entering Corrections**
	Category	**Measure**	**Component**	**Correction Type(s)**		
Unaccounted for HbA1c or GMI <8.0	Chronic Disease	Comprehensive Diabetes Care	A1c **OR** Glycemic Status	Hemoglobin A1c Result or Glucose Management Indicator: 4.0 – 20.0	A1c or glucose management indicator (GMI) value and resulted date Be sure to USE: • The **resulted date** if available • The **collected date** if only that is listed • The **received date** if multiple dates are listed (collected, resulted, received) • The **last day of the month** (e.g., "3/2026" → enter as 3/31/2026) if the result is recorded as month and year only • The **last date in the range** as the assessment date if the result is based on a date range	**NOTES:** • An HbA1c or GMI <8 will count towards patient compliance. • An HbA1c or GMI ≥ 8 will not count toward compliance, but will be used for HEDIS reporting. • For GMI, use the terminal date (last date in the range) as the report date.
Unaccounted for HbA1c or GMI ≥8.0						

Access guidance for general corrections to demographics.

Frequently Asked Questions

Q: Why does this measure matter?

A: Diabetes affects more than 30 million people in the U.S. and is the 7th leading cause of death.[1] In addition to these human costs, the 2017 estimated total financial cost of diagnosed diabetes in the U.S. was $327 billion.[2]

When managed, we can prevent or delay diabetic complications. However, for about 20% of Americans, their diabetes is undiagnosed.[3]

Another 88 million adults have elevated blood glucose levels, increasing their risk of developing type 2 diabetes in the next few years.[4] Among those whose diabetes is poorly controlled, complications tend to be more common and more severe. Better health outcomes rely on preventive care practices.

Q: What is Select Health doing to help?

A: Outreach to Select Health members includes:

- Hosting a **chronic disease blog** on the Select Health Member Resources webpage.
- Providing care management services that help members manage health conditions, such as diabetes. Members or providers can contact Care Management at **800-442-5305** or via email at **SHTOC@imail.org**.
- Sending a biannual diabetes newsletter to members with diabetes with information about managing diabetes and healthy lifestyle tips.
- Using computer-generated calls to provide diabetes care reminders and education to Medicaid members with diabetes.
- During the 4th quarter of the year, Medicare members receive live diabetes reminder calls about the Nations Beneft reward to close gaps.

Select Health Quality Provider Program provides an up-to-date registry of patients who have diabetes and are included in the glycemic statua, diabetic eye exam, and kidney health evaluations measures. This registry includes compliance status.

Q: What are best practices for this measure?

A: Best practices include:

- Creating workfo w processes that use collaborative, team-based care focused on evidence-based guidelines. Some examples of processes include diabetes care reminders and follow-up appointments.
- Partnering with patients to develop an individualized plan based on medical history, preferences, comorbidities, and individual prognosis and risk.
- Supporting positive lifestyle changes, including using available education for weight loss and nutrition, medication management, or medical visit follow-up.
- Evaluating social determinants of health (SDoH) and available community resources that support diabetes management (e.g., access to food, medications, transportation).
- Using payor or electronic medical record patient registries or reports, decision-support tools, or clinic huddles to identify patients missing screenings or services.[5]
- Measuring progress toward your goals and adjusting process when needed by:
  - — Establishing a baseline screening rate and setting an ambitious goal
  - — Discussing how your screening system is working during staff meetings
  - — Making process adjustments as needed to ensure success

References:

1 U.S. Department of Health and Human Services. *Healthy People 2030: Diabetes.* **HealthyPeople.gov**. Available at: **https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes**. Accessed February 16, 2026.

2 Parker ED, Lin J, Mahoney T, et al. Economic costs of diabetes in the U.S. in 2022. *Diabetes Care* 2024;47(1):26–43.

3 American Diabetes Association. *Statistics About Diabetes.* **diabetes.org**. 2026. Available at: **https://diabetes.org/about-diabetes/statistics/about-diabetes**. Accessed February16, 2026.

4 National Institute of Diabetes and Digestive and Kidney Diseases. *Diabetes Statistics.* **NIDDK.NIH.gov**. Available at: **https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics**. Last reviewed January 2024. Accessed February 16, 2026.

5 American Diabetes Association. Standards of medical care in diabetes—2019 abridged for primary care providers. *Clinical Diabetes.* 2019;37(1):11-34.

Select Health

Working Your Open Gaps List

STEP 1
Create a current gaps-in-care list: 1. Open your Gaps-in-Care-for-Download report: **QPP Report Hub** 2. Apply these filters: — **Super clinic:** Choose your clinic. — **Measure:** Click on "Glycemic Status." — **Status:** Unclick the "Compliant" box. This will filter for only the achievable members. 3. In the drop-down menu on the top right side of the page, change the view from "**Member**" to "**Download.**" 4. Follow the instructions on the screen to export the data to Excel. Refer to **Report Hub Instructions: Basic User**.
STEP 2
Format your Excel export. (Refer to **Formatting a Gaps List in Excel**.)
STEP 3
Review tips for working your Gaps-in-Care List (**page 6**).

Measure Information

The American Diabetes Association (ADA) recommends A1c or GMI testing twice a year if the goals are being met.[1] For this measure, **the treatment goal is set at the most recent result being < 8.0%**. If goals aren't being met or the treatment plan changes, A1c or other GMI testing should be done more often.

For this measure:

- The beginning of the calendar year is the measurement start date.
- The end of the calendar year is the measurement end date. Your gaps in care list has the measurement end date noted in the "Achievable Date" column.
- Any testing completed before or after the measurement year will NOT count as compliance for this measure.

NOTE: Examples used in this document are for instructional purposes only; the dates that appear are only representative of what a user might see.

Measure Name	Status	Status Detail	Achievable Date	Measure Instructions
Diabetes Care: Glycemic Status (<8%) (GSD_8)	Achievable	To be completed.	MM/DD/YYYY	Member needs glycemic status < 8 by MM/DD/YYYY. Schedule testing.
Diabetes Care: Glycemic Status (<8%) (GSD_8)	Achievable	Most recent glycemic status on MM/DD/YYYY is 9.4.	MM/DD/YYYY	Member needs glycemic status < 8 by MM/DD/YYYY. Retesting required.
Diabetes Care: Glycemic Status (<8%) (GSD_8)	Achievable	Most recent glycemic status on MM/DD/YYYY is missing result.	MM/DD/YYYY	Submit glycemic status result of < 8 as correction by 12/31/YYYY.

Continued on page 6...

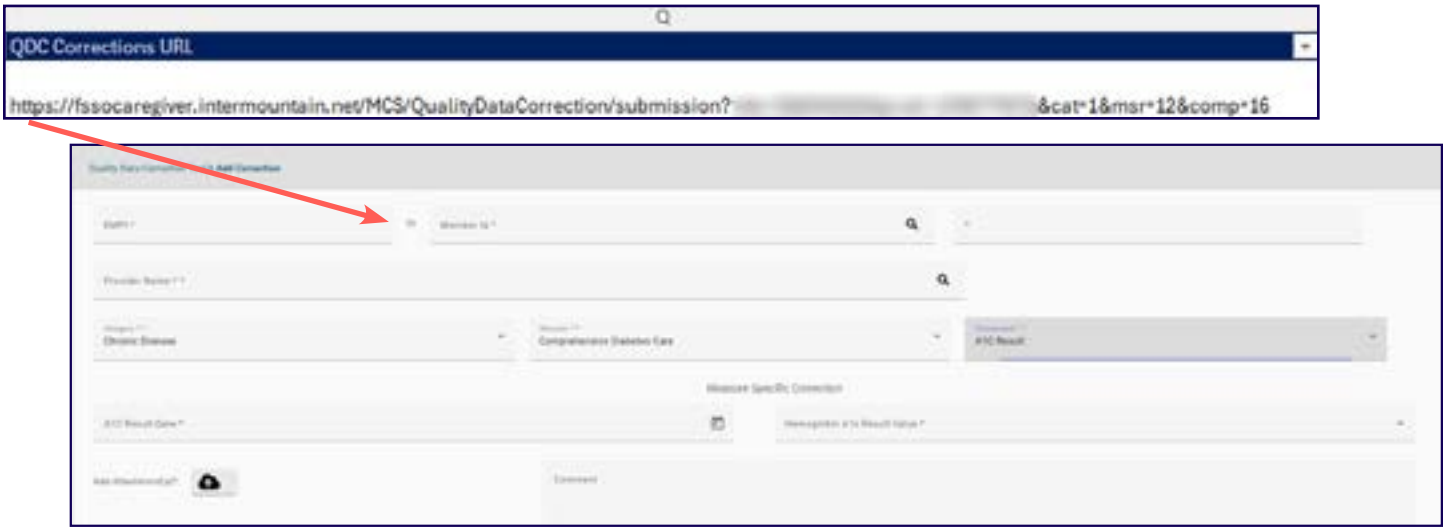
Working Open Gaps List, Continued

Tips for Working your Gaps-in-Care List

1. **Follow the guidance provided in the "Measure Instruction" column.** When working through this list of "achievable" members, you will encounter 3 possible scenarios:

Scenarios	Status Detail Examples	Tips
No A1c testing has been completed this year	To be completed.	Member needs glycemic status <8 by MM/DD/YYYY. Schedule testing.
The A1c result is 8.0% or greater	Most recent glycemic status on MM/DD/YYYY is 9.4.	Member needs glycemic status <8 by MM/DD/YYYY. Retesting required.
The A1c lab was drawn, but the results are missing	Most recent glycemic status on MM/DD/YYYY is missing result.	Submit glycemic status result of <8 as correction by MM/DD/YYYY.

2. **As you review charts and fnd lab values, you can submit these values as corrections by:**
   - **Accessing the Quality Data Corrections (QDC) Tool**
   - Using the link(s) provided in the downloaded Gaps-in-Care Excel fle to have member and measure information prepopulated



Learn More

Refer to the Quality Data Correction (QDC) Tool: Submitting Corrections for more information.

Corrections Pro Tip

Please wait 6 weeks from the date of service before determining if a correction is needed. This allows time for claims to be processed, ultimately ensuring that only needed corrections are submitted.

Reference:

[1] American Diabetes Association. *Understanding A1c: What is the A1C Test?* no date. https://diabetes.org/about-diabetes/a1c. Accessed February 25, 2026.

Best Practices: Closing Gaps in Care

Glycemic Status (< 8% GMI and HbA1c)

To help close gaps in care:

- Target your glycemic status gaps by identifying the members who have had an A1c drawn, but the health plan just needs a value.
- **Implement CPT Category II Codes** to denote results.
- Determine frequency of glycemic status testing based on results.
- Educate patients that many diabetes-related complications can develop without noticeable symptoms.
- Hold daily or weekly huddles to review members with upcoming diabetes care gaps and to plan outreach for those who have missed their appointments.
- Make sure the correct diabetic labs are built into your provider order sets.
- Designate staff to review charts prior to each visit, and send notes to the medical assistant/provider indicating whether the patient is due for an A1c or other glycemic monitoring test, annual eye exam, or kidney health testing (e.g., uACR and eGFR).

Questions about the Quality Provider Program?
Contact us at QualityProvider@selecthealth.org.