C·B·H

a division of DBHIDS

Gaps in Care Guide

Updated January 2026

Community Behavioral Health

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1. INTRODUCTION TO THE GAP IN CARE PROJECT

Community Behavioral Health (CBH) provides quality care to all members within the network. One of the ways that CBH has chosen to monitor member health care quality is by monitoring gaps in care (GIC) reports related to outcome performance measures. GIC reports are used to identify specific instances of member care that is not successfully meeting the performance measure, thus creating a "gap" in the member's care. Providers can then utilize these reports to help members "bridge the gap" to meet the healthcare outcome. When members experience gaps in care, it can be harmful for the patient and costly; additionally, this can lead to serious complications that could have been preventable.

Beginning in 2025, CBH will be sharing GIC reports with the providers in the network so they can assist with ensuring that members are receiving quality care.

1.1. What are GIC reports?

CBH Quality GIC reports are semi-annual reports that identify the discrepancy between standards of care specified in the quality measures and the service that was provided.

There are many reasons why a member may be identified as having a gap in care. These reasons can include but are not limited to the following:

- Recommended care was not provided
- Recommended care was provided but not adequately documented
- Care was provided but not adequately reflected in the claims submitted
- Recommended care was provided prior to the coverage by the current payer
- Recommended care was provided between generation of a GIC report and receipt of the report

CBH receives claims and supplemental data from the provider network and utilizes a certified Healthcare Effectiveness Data and Information Set (HEDIS®) vendor to run HEDIS performance measures and establish network performance. This includes GIC reports with member-level details. CBH monitors gaps in care in the following measures:

- HEDIS SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (Annual LDL-C)

- **HEDIS SMD**: Diabetes Monitoring for People with Diabetes and Schizophrenia (Annual LDL-C and Hba1c)
- **HEDIS SSD**: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Annual fasting blood glucose or HbA1c)
- HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Gaps in the HEDIS measures reflect that the individual did not have the recommended laboratory tests completed in the measurement year. In the HPCMI-AD measure, gaps indicate that the member either did not have the recommended screening (Hgba1c) or that their results reflect poor diabetes management which needs additional clinical attention.

1.1.1. As a provider, how should the GIC reports be utilized?

CBH values the strong relationships that providers have with the members they treat. CBH intends to share this information to facilitate higher quality care, and to support both members and providers in "closing the gaps" whenever possible. When providers receive their gaps in care report, the following steps are recommended to help close the care gaps:

- Learn how to use the GIC reports (see **Section 3**)
- Identify members who have a gap in care
- Develop a plan for the members who are currently active on how to help close the gaps, such as:
  - Discussing the importance of annual screening
  - Assisting with scheduling appointments
  - Alerting the care team and primary care provider
- Utilize the **HEDIS Member Tip Sheets** to share information with members on the importance of closing the care gap.
- To prevent care gaps in the future, learn more about the performance measures via the **HEDIS Provider Tip Sheets** and implement these practices into daily operations.

2. METABOLIC/CARDIOVASCULAR SCREENING MEASURES

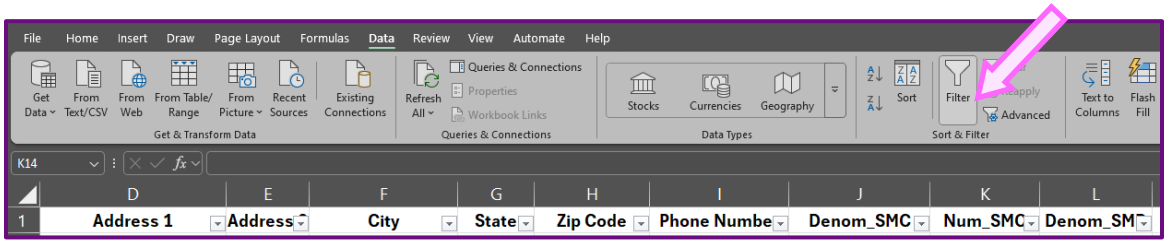
It is best practice to conduct metabolic screening when an individual is taking antipsychotic medications, as they are at greater risk of developing diabetes or cardiovascular disease. Those who have diabetes may be at risk of poor monitoring and need additional support. CBH identifies the following measures for Metabolic and Cardiovascular screening:

- **HEDIS SMC**: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (Annual LDL-C)
- **HEDIS SMD**: Diabetes Monitoring for People with Diabetes and Schizophrenia (Annual LDL-C and Hba1c)
- **HEDIS SSD**: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Annual fasting blood glucose or HbA1c)
- HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

To assist providers in supplying the best metabolic care for members, please see the **CBH Clinical Practice Guidelines (CPG) for the Pharmacologic Treatment of Schizophrenia** and **DBHIDS Bulletin 07-07: Policy Regarding the Screening for and Treatment of the Components of Metabolic Syndrome**.

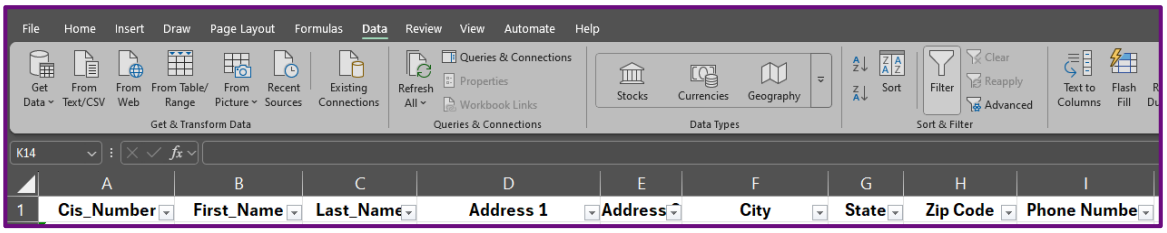
3. USING GIC REPORTS

Below are directions on how to read and manipulate the GIC reports that you will receive from CBH.



1. First, put the filters "on" in the report.

3.1. Demographic Information



2. **Column A (CIS_Number):** The unique member's Medicaid State ID Number
3. **Columns B, C (First_Name, Last_Name):** The unique member's Medicaid State ID Number
4. **Columns D through H (Address 1, Address 2, City, State, ZIP Code):** The unique member's Medicaid-Identified Address
5. **Column I (Phone Number):** The unique member's Medicaid-identified phone number

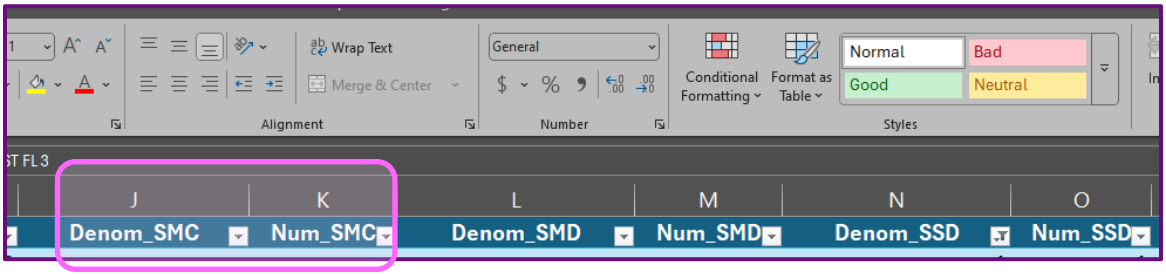
3.2. Instructions for Detailed Data Usage Regarding Measures

You must filter the following columns according to the definitions of what includes/excludes a member from the measure. The Operational Definitions illustrate who is to be included in the denominator and numerator. Apply the measures category filters one at a time.

- Regular diabetes screening (blood glucose or HbA1c) for any member 18 or older taking antipsychotic medication
- Annual monitoring for poor diabetes control (HbA1c level >9.0) for any member 18 and older taking an antipsychotic medication with a history of diabetes

3.2.1. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (Annual LDL-C)

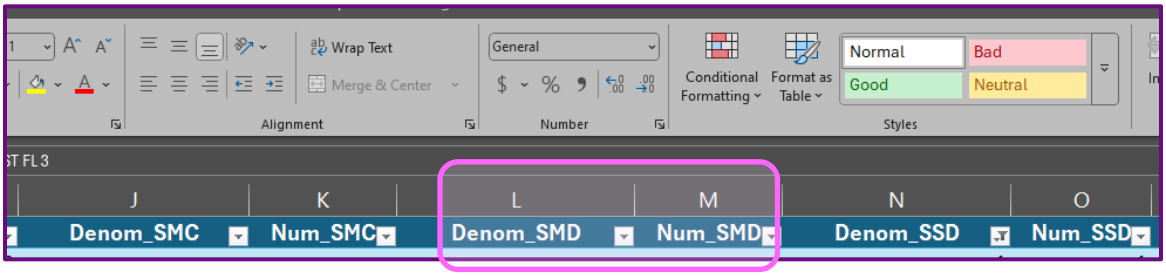
This PA Integrated Care Plan measure assesses the percentage of members ages 18 to 64 years of age with serious mental illness (SMI) and cardiovascular disease who had an LDL-C test during the measurement year (January 1 to December 31).



1. First, filter Colum “J” to “1” to identify members who need to be screened for cardiovascular disease. Ensure that there are no other filters on currently. Then filter Colum “K” to “1” to identify if the member needs to be screened for cardiovascular disease.
2. **Column J (Denom_SMC):** Member is identified to be in the part of the denominator for cardiovascular screening (1= Member should be screened for cardiovascular disease)
3. **Column K (Num_SMC):** Member is identified as needing their cardiovascular screening (0=No, 1= Yes). This column identifies members who need an LDL screening test

3.2.2. Diabetes Monitoring for People with Diabetes and Schizophrenia

This measure assesses adults 18 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and HbA1c test during the measurement year.



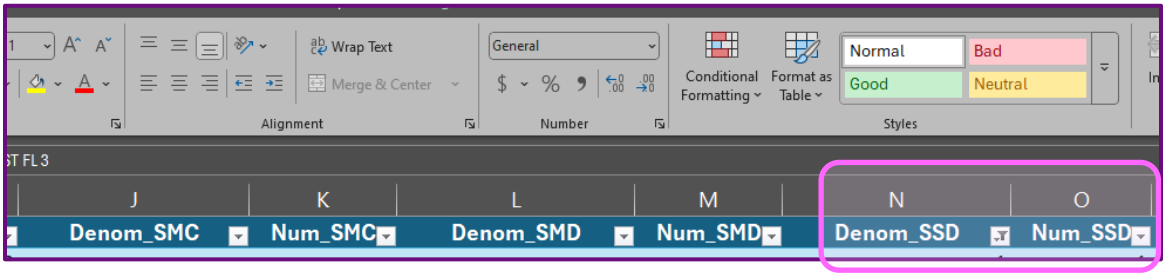
1. First, filter Colum "L" to "1" to identify members who need to be screened for diabetes. Ensure that there are no other filters on currently. Then filter Colum "M" to "1" to identify if the member needs to be screened for diabetes.

2. **Column L (Denom_SMD):** Member is identified to be in the part of the denominator for diabetes screening (1= Member should be screened for diabetes)

3. **Column M (Num_SMD):** Member is identified as needing their diabetes screening (0=No, 1= Yes). This column identifies members who need an A1c screening test or another diabetes screening test.

3.2.3. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

This measure assesses annual diabetes screening for members 18 to 64 years of age who have dispensed an antipsychotic medication for SMI.



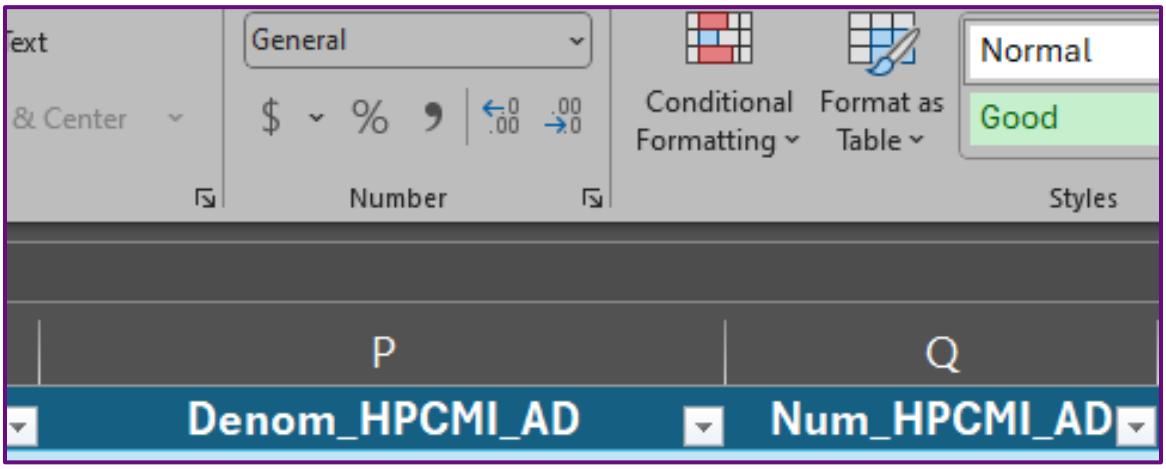
1. First, filter Colum "N" to "1" to identify members who need to be screened for diabetes. Ensure that there are no other filters on currently. Then filter Colum "O" to "1" to identify if the member needs to be screened for diabetes.

2. **Column N (Denom_SSD):** Member is identified to be in the part of the denominator for diabetes screening (1= Member should be screened for diabetes)

3. **Column O (Num_SSD):** Member is identified as needing their diabetes screening (0=No, 1= Yes). This column identifies members who need an A1c screening test or another diabetes screening test.

3.2.4. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

This PA Integrated Care Plan measure assesses diabetes monitoring for members ages 18 to 65 who have a diagnosis of type 1 or type 2 diabetes.

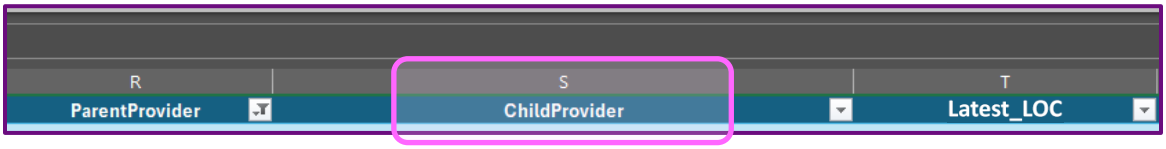


1. First, filter Colum “P” to “1” to identify members who need to be screened for diabetes. Ensure that there are no other filters on currently. Then filter Colum “Q” to “1” to identify if the member needs to be screened for diabetes or if they have hemoglobin A1c (HbA1c) poor control (>9/0%).

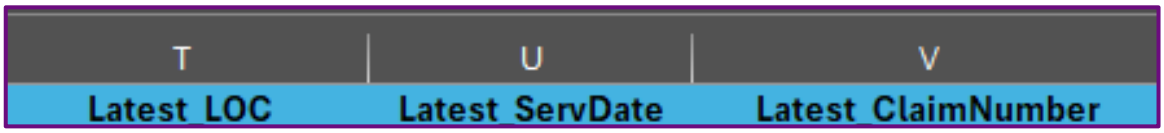
2. **Column P (Denom_HPCMI_AD):** Member is identified to be in the part of the denominator for diabetes screening (1= Member should be screened for diabetes)

3. **Column Q (Num_HPCMI_AD):** Member is identified as needing their diabetes screening (0=No, 1= Yes). This column identifies members who need an A1c screening test or another diabetes screening test or whose A1c test was above 9%.

3.2.5. Provider Information



1. **Column S (ChildProvider):** This filter will allow you to stratify members by which provider location they are connected to.



2. **Column T (Latest_LOC):** This filter will allow providers to see the latest level of care that the members attended with a prescribing practitioner.

3. **Column U (Latest_ServDate):** This filter will allow you to see the last service data that members had with a prescribing practitioner.

4. **Column V (Latest_ClaimNumber):** This filter will allow you to see the number of that member's last claim they had with their prescribing practitioner.

4. RESOURCES FOR PATIENT EDUCATION

CBH expects the providers in our network to help members understand the importance of closing the health gaps that were identified in the GIC reports. CBH has created several tip sheets to help members understand a variety of health conditions and how these conditions may impact behavioral health treatment. These documents were developed in partnership with collaborating providers and the Southeastern Pennsylvania Medicaid MCOs that participate in the HealthChoices and Community HealthChoices programs in both English and Spanish.

4.1. HEDIS Member Tip Sheets

CBH HEDIS Member Tip Sheets can be found on the CBH website on the **Integrated Care Plans** page of the Member Resources section.

4.2. Clinical Practice Guidelines/Provider Tip Sheets

4.2.1. Clinical Practice Guidelines

CBH has developed clinical practice guidelines (CPGs) to outline best practices for treating specific disorders or certain populations. These CPGs reflect evidence-based guidelines from leading expert groups, such as the **Substance Abuse and Mental Health Services Administration (SAMHSA)** and **American Psychiatric Association (APA)**. CPGs are not intended to dictate or control clinical judgment about the proper treatment for a patient in any given case. Still, they should aid providers in tailoring their services and meeting CBH quality expectations. CPGs also include metrics used by CBH to monitor network performance and progress.

CPGs can enhance clinician and patient decision-making by synthesizing vast available medical literature and clearly defining the scientific evidence behind clinical recommendations. CPGs translate complex scientific research findings into recommendations for clinical practices that have the potential to enhance healthcare quality for our members.

CBH's CPG on the pharmacologic treatment of schizophrenia can be found on the CBH website on the **CPG page** of the Provider Manual section.

4.2.2. Provider HEDIS Tip Sheets

Several CPGs utilize **HEDIS®** to monitor quality of care in the provider network, a widely used set of performance measures in the managed care industry. CBH developed Provider HEDIS tip sheets in partnership with collaborating providers and the Southeastern Pennsylvania Medicaid MCOs that participate in the HealthChoices and Community HealthChoices programs as a resource for providers to summarize HEDIS metrics and parameters. The latest versions of these tip sheets can be found at the CBH website on the **CPG page** of the Provider Manual section.