

Diabetes and Obesity Report for the Medicaid Managed Care Program

*Report Prepared in Response to Act 210 of the 2013 Regular Legislative
Session*

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Glossary

Current Procedural Terminology (CPT®) – Current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. LDH has designated the CPT code set as the national coding standard for physicians and other health care professional services and procedures under HIPAA.

Children’s Health Insurance Program (CHIP) – Created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP.

Comprehensive Diabetes Care (CDC) - A performance measure developed by the National Committee for Quality Assurance (NCQA). This measure is designed to assess adults 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9.0%), HbA1c control (<8.0%), Eye exam (retinal) performed, Medical attention for nephropathy, and BP control (<140/90 mm Hg).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible Beneficiaries ages birth through twenty (20), in accordance with 42 U.S.C. §1396d(r). This includes but is not limited to, conditions that are discovered through EPSDT Well Child screening services, whether or not such services are covered under the State Plan. [42 U.S.C. §1396d(r)(5) and the CMS State Medicaid Manual.]

Encounter Data – Includes: (i) All data captured during a single health care encounter that specify the diagnoses, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Enrollee receiving services during the encounter; (ii) the identification of the Enrollee receiving and the provider(s) delivering the health care services during the single encounter; and (iii) a unique, unduplicated, identifier for the single encounter.

Health Equity – Achieved when every person in a community has the opportunity to reach their full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Healthcare Effectiveness Data and Information Set (HEDIS) – A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures are designed to help health care purchasers understand the value of health care purchases and measure plan (e.g. MCO) performance.

Hemoglobin A1C (HbA1c) Test – A blood test that measures average blood sugar levels over the past 3 months. It’s one of the most commonly used tests to diagnose prediabetes and diabetes and the main test to help manage diabetes.

Louisiana Children’s Health Insurance Program (LaCHIP) – Louisiana’s program authorized by Title XXI of the Social Security Act in 1997. Provides health care coverage for uninsured children up to age nineteen (19) through a Medicaid expansion program for children at or below two hundred percent (200%) FPL and a separate State CHIP program for the unborn child option and children with income from two hundred percent (200%) up to and including two hundred fifty percent (250%) FPL.

Managed Care Organization (MCO) – A private entity that contracts with LDH to provide covered healthcare services to Enrollees in exchange for a monthly capitated amount per Enrollee. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Managed Care

Program, be regulated by the LDH.

Managed Care Program – A managed care delivery system wherein covered health care services are provided through MCOs.

Measurement Year – Concerning health care quality measure reporting, measurement year refers to the timeframe during which healthcare services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard Measurement Year. The health care quality measure steward defines the Measurement Year (or period) in the technical specifications for each measure.

National Committee for Quality Assurance (NCQA) – A nonprofit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans. HEDIS and the Quality Compass have registered trademarks of NCQA.

Performance Measures – Tools that quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Value-Added Benefit (VAB) – The additional benefits outside of the MCO Covered Services that are delivered at the Contractor’s discretion and are not included in the Capitation Rate calculations. Value-added benefits do not include in lieu of services.

Value-Based Payment (VBP) – Broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures of quality and/or cost or resource use.

Executive Summary

This report is submitted pursuant to Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2021 paid healthcare claims submitted by each of the five Medicaid managed care organizations (MCOs) to Louisiana Medicaid, and represent the Louisiana Medicaid managed care population only.

Below are some highlights from this year's report:

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity 2022* report, Louisiana was ranked seventh highest in the nation.¹ The following obesity summary was based on 2021 MCO claims data:
 - In 2021, 58,960 Medicaid managed care enrollees under the age of 18 had an obesity diagnosis. This is 8.29% of the managed care child population. Additionally, 12.92% of adult enrollees 18 years of age or older (118,666 enrollees) had an obesity diagnosis in 2021. The overall obesity prevalence was 10.9% of the total managed care population of 1,628,646 enrollees. See Appendix B for a breakdown of obesity prevalence by Louisiana Medicaid region, parish, and age group.
 - The total paid for medical and pharmacy claims with dates of service in 2021 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2021) was 24.41% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2021.
- Louisiana was also ranked seventh highest (tied) in the nation for adult diabetes in 2021.² The following diabetes summary was based on 2021 MCO claims data:
 - In 2021, 9.07% (83,274 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.30% (2,167 enrollees). The total managed care population (1,628,646) had a diabetes prevalence of 5.24% (77,286). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish, and age group.
 - Adult Medicaid managed care enrollees with diabetes during 2021 were associated with 28.46% of the adult total managed care paid claims with dates of service in 2021.
 - Of the 193,711 inpatient discharges in 2021, 2.94% (5,701 discharges) had a primary or secondary diagnosis of diabetes. There were 1,268,718 emergency department visits in 2021 and 2.68% (34,015) had a primary or secondary diagnosis of diabetes.
 - The average cost per enrollee with diabetes in 2021 was \$4,735.

¹*The State of Obesity: Better Policies for a Healthier America 2022*. (September 2022). Retrieved November 14, 2022 from https://www.tfah.org/wp-content/uploads/2022/09/2022ObesityReport_FINAL3923.pdf

² Ibid.

1 Introduction

Obesity and diabetes are two critical and interlinked public health concerns in Louisiana. These two chronic conditions increase the risk of other costly health conditions, such as high blood pressure, heart disease, and stroke. Obesity and diabetes can also decrease the quality and duration of life and result in avoidable healthcare costs.

This report describes the scope of obesity and diabetes in the Medicaid-managed care population by examining costs, complications, and how LDH and its contracted Medicaid partners address obesity and diabetes in the populations they serve. In addition, the report discusses recommendations on how to improve the health of Louisiana residents with, or at risk for developing, obesity and diabetes.

1.1 Report Methodology

1.1.1 Data Sources

Louisiana Medicaid claims and eligibility data were used to produce the prevalence and utilization summaries contained in the Act 210 *Diabetes and Obesity Report*. Each of the five MCOs submitted a standardized diabetes and obesity action plan which provided goals, action steps taken, and results of their efforts to minimize the impact of diabetes and obesity on the Medicaid managed care population. The report also cites widely accepted national diabetes- and obesity-related reports published by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS), and the Robert Wood Johnson Foundation.

1.1.2 Improvements

Changes were made in the production of the 2020 Act 210 *Diabetes and Obesity Report* and were continued for the 2021 and 2022 reports. Modifications made in 2020 streamline data validation and allows prevalence rates to be calculated and reported by Louisiana Medicaid regions, races, and age groups. All diagnosis, procedure, CPT, and HCPCS codes were updated in the 2021 data extraction methodology and continued in 2022 to reflect updates in the respective manuals.

1.2 Obesity Overview

1.2.1 National Prevalence

Although national, state, and local governments, and many private employers and payers have increased their efforts to address obesity since 1998,³ the national prevalence of obesity in adults was 41.9% in 2017-2020; the national prevalence of obesity in children was 19.7% in 2017-2020.⁴

1.2.2 What is Obesity?

Obesity is a complex health issue resulting from a combination of causes and individual factors such as social determinants of health, behavior, and genetics.⁵ For adults, a body mass index (BMI) below 18.5 is considered underweight, between 18.5 and less than 25 is the normal range, 25 to less than 30 is overweight, and 30 or higher is obese. For children, obesity is defined as a BMI at or above the 95th percentile for children and teens of the same age and sex. BMI is calculated by dividing a person's weight in kilograms by the square of their height in meters.⁶

³ Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Aff (Millwood)*. 2009 Sep-Oct;28(5):w822-31. doi: 10.1377/hlthaff.28.5.w822. Epub 2009 Jul 27. PMID: 19635784. Retrieved November 14, 2022 from <https://pubmed.ncbi.nlm.nih.gov/19635784/>

⁴ *The State of Obesity: Better Policies for a Healthier America 2022*. (September 2022). Retrieved November 14, 2022 from https://www.tfah.org/wp-content/uploads/2022/09/2022ObesityReport_FINAL3923.pdf

⁵ *Causes of Obesity* (March 21, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/obesity/adult/causes.html>

⁶ *Overweight and Obesity* (September 27, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/obesity/index.html>

People diagnosed with obesity compared to people in the normal weight range are at an increased risk for serious diseases and health conditions including Type 2 diabetes, coronary heart disease, hypertension, stroke, increased low-density lipoprotein (LDL) cholesterol, decreased high-density lipoprotein (HDL) cholesterol, and high levels of triglycerides, gallbladder disease, osteoarthritis, sleep apnea, and cancer. Obesity is also associated with all-causes of death (mortality).⁷

1.3 Diabetes Overview

1.3.1 National Prevalence

Diabetes is a common disease. The CDC reports that 37.3 million Americans are living with diabetes, and another 96 million are living with prediabetes. In the United States, diabetes was the seventh leading cause of death in 2019.⁸

1.3.2 What is Diabetes?

Diabetes is a disease in which the body either does not make enough insulin or cannot use its insulin as well as it should, causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body including the eyes, heart, blood vessels, kidneys, and nerves. This damage makes diabetes the leading cause of adult blindness and end-stage kidney disease. People with diabetes are also at a greater risk for heart disease, stroke, and amputations of the foot and/or leg.^{9,10}

1.3.3 Types of Diabetes

Type 1 diabetes develops when the body produces little to no insulin due to the destruction of the pancreatic cells that make insulin. To survive, people with Type 1 diabetes must have insulin delivered by injection or through an insulin pump. This form of diabetes usually occurs in children and young adults, although disease onset can occur at any age. In adults, Type 1 diabetes accounts for approximately 5% to 10% of all diagnosed cases of diabetes. There is no known way to prevent Type 1 diabetes.¹¹

Type 2 diabetes develops with “insulin resistance,” a condition in which cells (e.g., liver, muscles) of the body do not use insulin properly.¹² The risk factors for developing this type of diabetes include older age, obesity, family history of diabetes, personal history of gestational diabetes, physical inactivity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, some Asian Americans, and some Pacific Islanders are at a higher risk for the development of Type 2 diabetes and its complications. Type 2 diabetes may be preventable through proven lifestyle changes.¹³

Gestational diabetes is a type of diabetes that is first seen in pregnant people who did not have diabetes before being pregnant.¹⁴ The risk factors for gestational diabetes are similar to those for Type 2 diabetes.¹⁵ Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, and increased risk of Type 2 diabetes for both the mother and the child later in life. Often, gestational diabetes can be controlled through eating healthy foods,

⁷ *Health Effects of Overweight and Obesity* (September 24, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/healthyweight/effects/index.html>.

⁸ *National Diabetes Statistics Report* (June 29, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

⁹ *What is Diabetes?* (July 7, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/basics/diabetes.html>

¹⁰ *National Diabetes Statistics Report* (June 29, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

¹¹ *Type 1 Diabetes*. (March 25, 2021). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/basics/type1.html>

¹² *Type 2 Diabetes*. (December 16, 2021). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/basics/type2.html>

¹³ *Diabetes Risk Factors* (April 5, 2022). Retrieved November 14, 2022 from <http://www.cdc.gov/diabetes/basics/risk-factors.html>

¹⁴ *Gestational Diabetes and Pregnancy* (July 14, 2022). Retrieved November 14, 2022 from <http://www.cdc.gov/pregnancy/diabetes-gestational.html>

¹⁵ *Diabetes Risk Factors*. (April 5, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/basics/risk-factors.html>

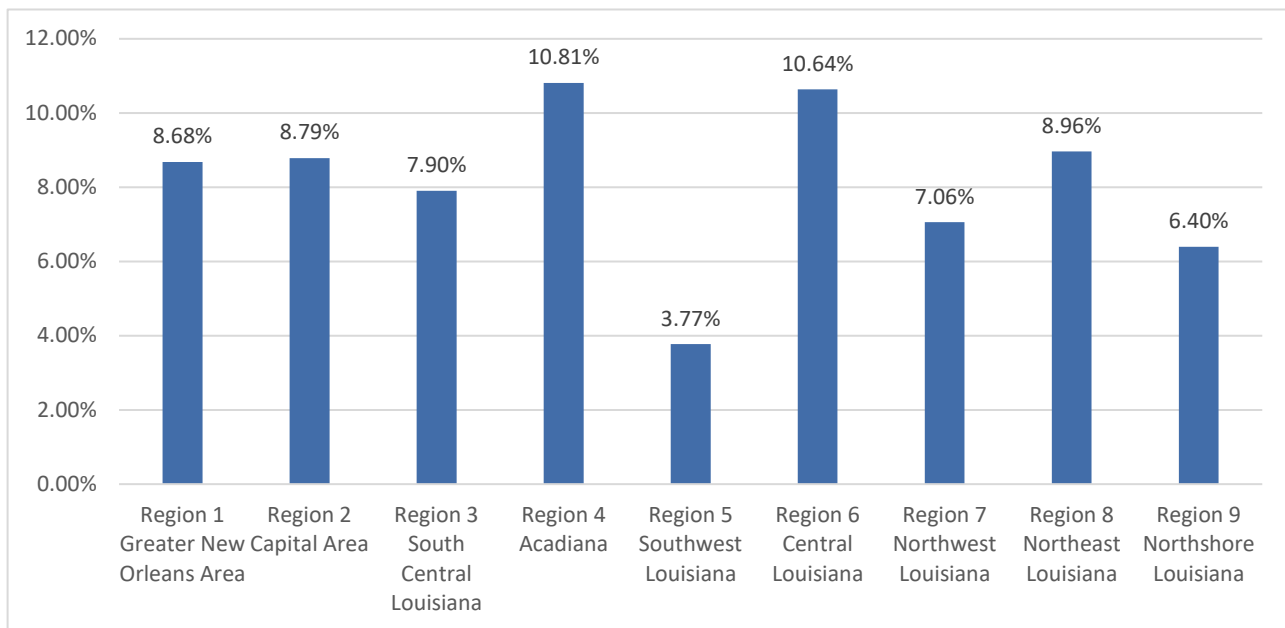
regular exercise, and losing weight if overweight. Sometimes those with gestational diabetes must also take insulin.¹⁶

2 The Scope of Obesity in the Medicaid Managed Care Program

The *State of Obesity* published by the Trust for America’s Health and the Robert Wood Johnson Foundation reports that Louisiana’s adult obesity rate was 38.6% in 2021, which is the seventh-highest adult obesity rate in the United States.¹⁷ Given our reported obesity rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data and yields an artificially low prevalence rate when exclusively using Louisiana Medicaid medical claims data to calculate the rate.

In this report, Medicaid-managed care enrollees with obesity were identified by medical claims with dates of service in 2021 that included a primary or secondary diagnosis of obesity. Based on 2021 claims data, the managed care overall obesity prevalence rate was 10.90% of 1,628,646 MCO enrollees. Figure 2.1 shows that Louisiana Medicaid Region 4 had the highest child obesity prevalence rate (10.81%), followed closely by Louisiana Medicaid Region 6 (10.64%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 4 at 17.11% and was followed closely by Louisiana Medicaid Region 8 at 15.58% (Figure 2.2). When the data were stratified by age, gender, and race, the highest prevalence rates were found in adult females. The female adult obesity prevalence rate by race was 19.41% African-American, 14.48% other races, and 11.62% white (Figure 2.3). The remaining age, gender, and race strata had obesity prevalence rates below 9.90%. For parish-level obesity prevalence rates, please see Appendix B.

Figure 2.1: Medicaid Managed Care Child Obesity Prevalence in 2021 by Medicaid Regions Age < 18 Years



¹⁶ *Gestational Diabetes and Pregnancy*. (July 14, 2022). Retrieved November 16, 2022 from <http://www.cdc.gov/pregnancy/diabetes-gestational.html>

¹⁷ *The State of Obesity: Better Policies for a Healthier America 2022*. (September 2022). Retrieved November 14, 2022 from https://www.tfah.org/wp-content/uploads/2022/09/2022ObesityReport_FINAL3923.pdf

Figure 2.2: Medicaid Managed Care Adult Obesity Prevalence in 2021 by Medicaid Regions Age ≥ 18 Years

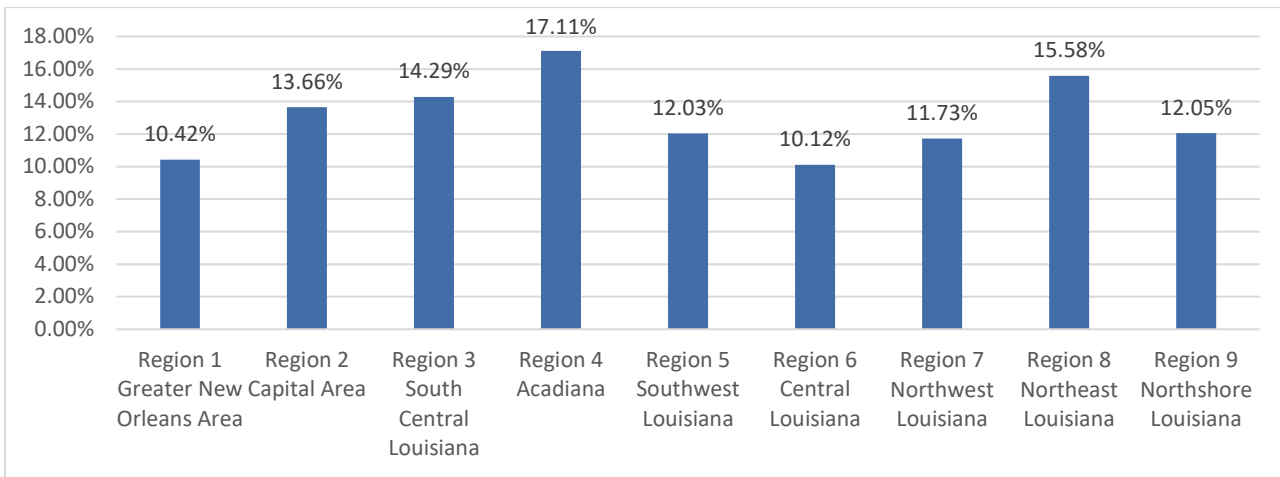
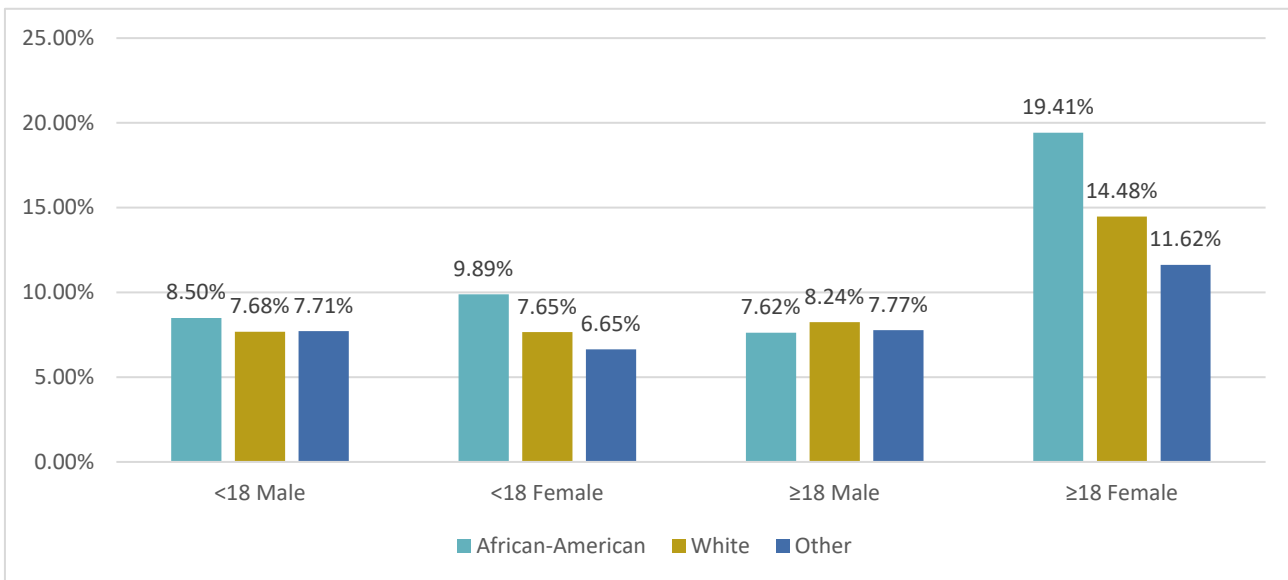


Figure 2.3: Medicaid Managed Care Obesity Prevalence in 2021 by Age Group, Gender, and Race



2.1 The Financial Impact of Obesity and Its Complications

Table 2.1 lists total costs by claim type, age group, and obesity category for healthcare claims with dates of service in 2021 associated with Medicaid-managed care enrollees with and without obesity. All paid claims for enrollees were included and categorized by age and obesity status.

The overall prevalence of obesity in the Medicaid managed care population is 10.90%. Healthcare claim costs for these enrollees totaled \$1,717,143,080 in 2021, which accounts for 24.14% of the total MCO claims payments (\$7,113,466,702). In other words, of the entire Medicaid managed care population, the 10.90% who have a diagnosis of obesity account for 24.14% of the total healthcare claim costs.

Table 2.1: Total Claims Payments in 2021 among Medicaid Managed Care Enrollees By Claim Type, Age Group, and Obesity Category

Claim Type	Total Cost: Children Diagnosed with Obesity*	Total Cost: Non-Obese Children	Total Cost: Adults Diagnosed with Obesity **	Total Cost: Non-Obese Adults	Percent of Total Costs Associated with Enrollees Diagnosed with Obesity
Medical	\$140,758,597	\$1,225,228,439	\$1,018,471,212	\$2,498,962,755	31.13%
Pharmacy	\$41,472,325	\$251,324,564	\$498,978,903	\$1,299,538,508	25.84%
Other***	\$11,034,548	\$88,421,645	\$6,427,495	\$32,847,710	12.59%
Total	\$193,265,470	\$1,564,974,648	\$1,523,877,610	\$3,831,348,974	24.14%

*Includes claims, with dates of service in 2021, for any child MCO enrollee diagnosed with obesity in 2021.

**Includes claims, with dates of service in 2021, for any adult MCO enrollee diagnosed with obesity in 2021.

***Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

3 The Scope of Diabetes in the Medicaid Managed Care Program

This section of the report provides data on the scope of diabetes among children and adults in the Medicaid-managed care population. Data from the BRFSS describe how adult Louisiana residents with diabetes compare nationally in meeting clinical and self-care measures.

The *National Diabetes Statistics Report* published by the CDC states that the overall adult crude prevalence of diagnosed diabetes in the United States was 11.3% for the years 2017-2020 and that 3.4% of adults (age \geq 18 years) who met laboratory criteria for diabetes were unaware or did not report that they had diabetes. The report also indicated that the total direct and indirect costs of diagnosed diabetes in the United States in 2017 were \$327 billion.¹⁸

For the 2022 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2021 that included a primary or secondary diagnosis of diabetes. Based on 2021 claims data, the adult diabetes prevalence was 9.07% of 917,980 unique managed care adults. The child diabetes prevalence was 0.30% of 710,666 enrollees under the age of 18. Louisiana Medicaid Regions 8 and 7 had the highest child prevalence rates, 0.41% and 0.36% respectively (Figure 3.1). Louisiana Medicaid Region 7 had the highest adult prevalence rate, 9.61%, although five of the other eight regions had prevalence rates over 9.0% (Figure 3.2).

¹⁸ *National Diabetes Statistics Report* (June 29, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

Figure 3.1: Medicaid Managed Care Child Diabetes Prevalence in 2021 by Medicaid Regions Age < 18 Years

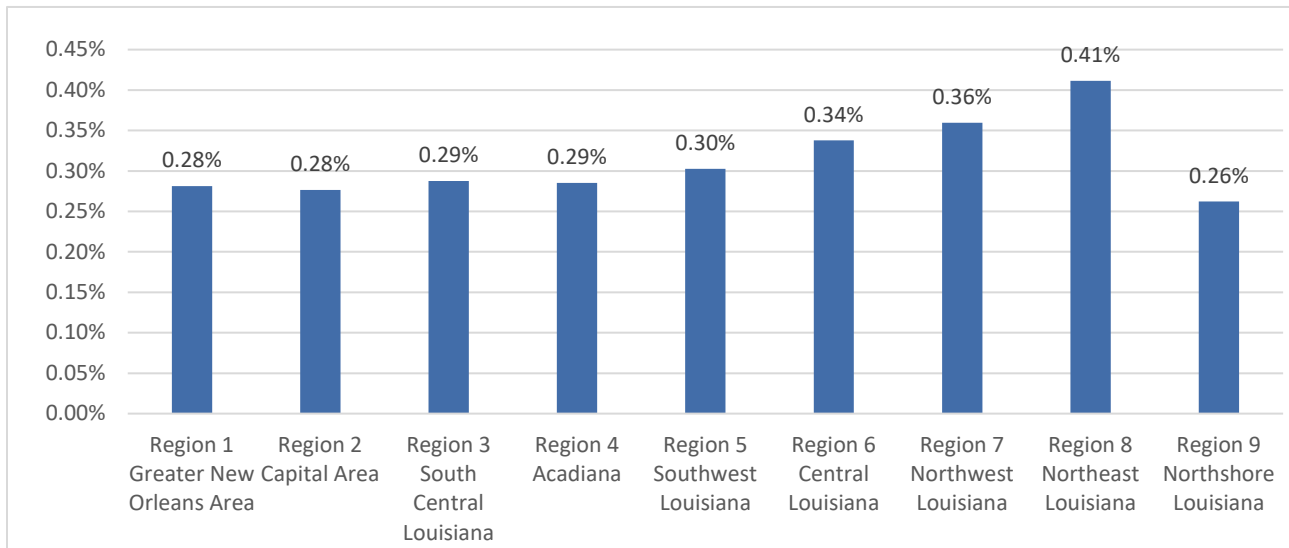


Figure 3.2: Medicaid Managed Care Adult Diabetes Prevalence in 2021 by Medicaid Regions Age ≥ 18 Years

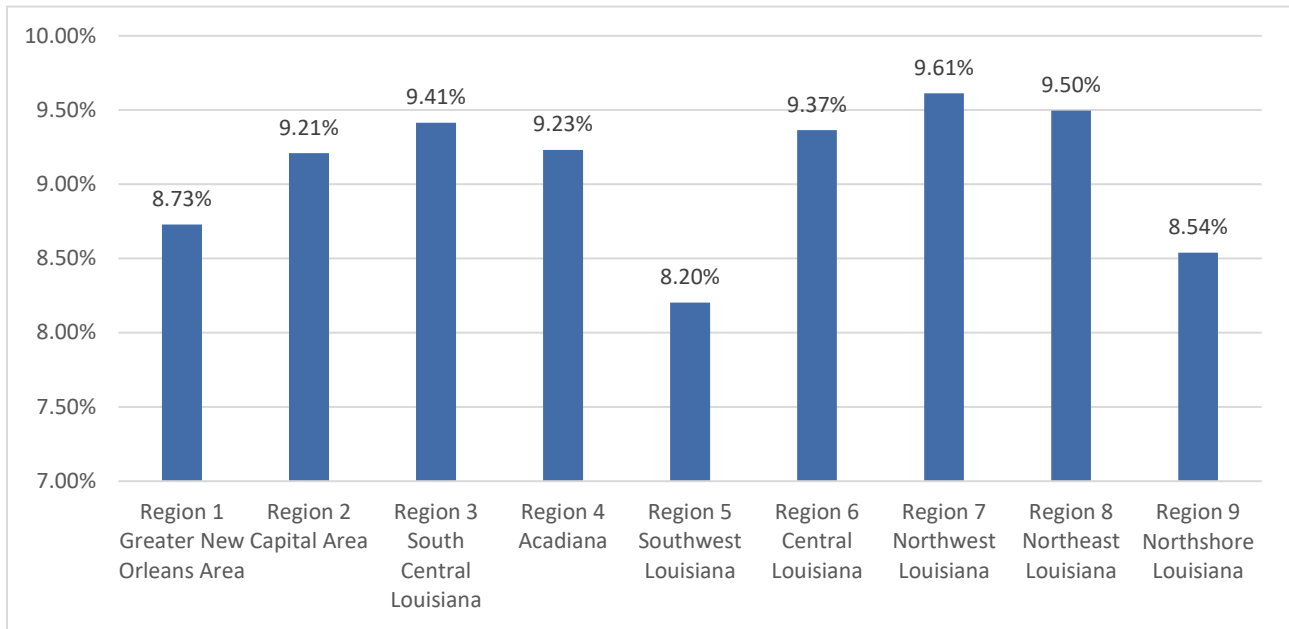


Figure 3.3 shows diabetes prevalence stratified by age group, gender, and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among African-American race adult females (10.95%) and other race adult males (9.53%). These decreased prevalence rates are in agreement with trends reported in the CDC *National Diabetes Statistics Report*. The CDC reports that the prevalence of adult-diagnosed diabetes was highest among non-Hispanic African-Americans (12.7%).¹⁹

¹⁹ *National Diabetes Statistics Report* (June 29, 2022). Retrieved November 14, 2022 from <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

Figure 3.3: Medicaid Managed Care Diabetes Prevalence in 2021 by Age, Gender, and Race

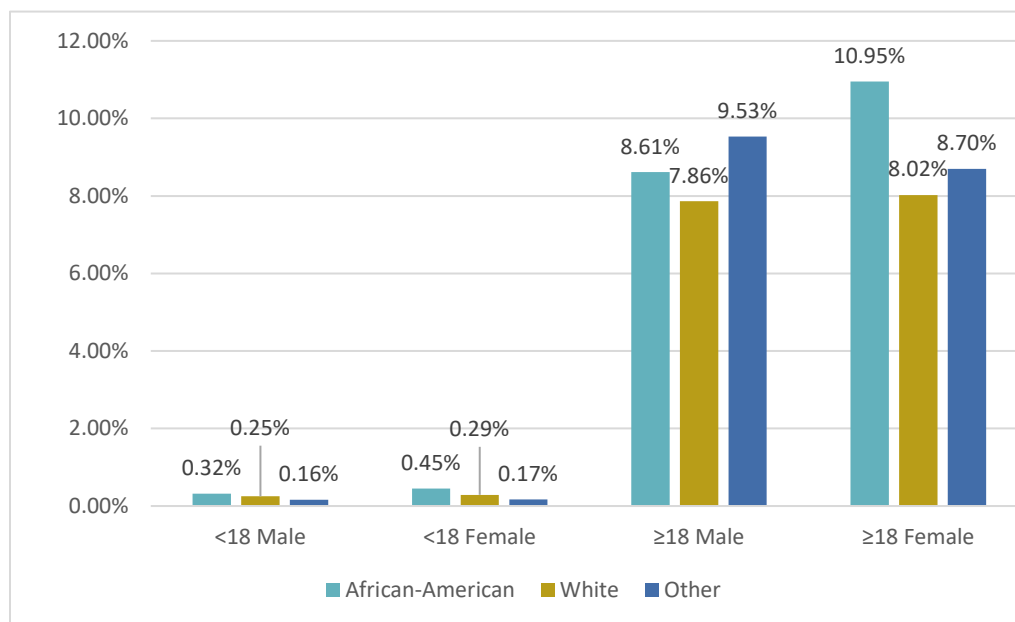


Table 3.1 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes to state and national utilization rates for the same practices. Louisiana’s BRFSS percentages were less than the 2018 national numbers for most of the listed preventive care practices. The managed care dilated eye exam rate was considerably lower than the 2018 national median (39.52% versus 69.0%). For enrollees with diabetes in Medicaid managed care, HbA1c testing was slightly higher than the U.S. median (77.71% versus 75.2%). However, the rate of ever having received self-management education was notably lower in the Medicaid managed care population when compared to the 2018 national median (14.32% versus 52.0%). The distribution of care practices across races in the managed care population is displayed in Figure 3.4. The distribution of care practices is very similar across races except for home blood glucose devices. Higher rates of owning a home glucose monitoring device were found among the African-American (69.53%) and white (59.53%) race categories when compared to the other (51.61%) race category.

Table 3.1: Comparison of Reported Rates of Diabetic Preventive Care Practices Among Adults with Diabetes: Medicaid Managed Care, Louisiana and in the United States

Preventive Care Practice	Medicaid Managed Care (2021 Data)	BRFSS United States (2018 Data) [†]
Received annual dilated eye exam	39.52%	69.0%
Received one or more HbA1c tests during year	77.71%	75.2% ^{††}
Received seasonal influenza vaccine	19.50%*	(Not reported)
Ever received pneumonia vaccine	15.60%*	(Not reported)
Ever had home blood glucose device	63.28%	61.5%**
Ever had self-management education	14.32%	52.0%

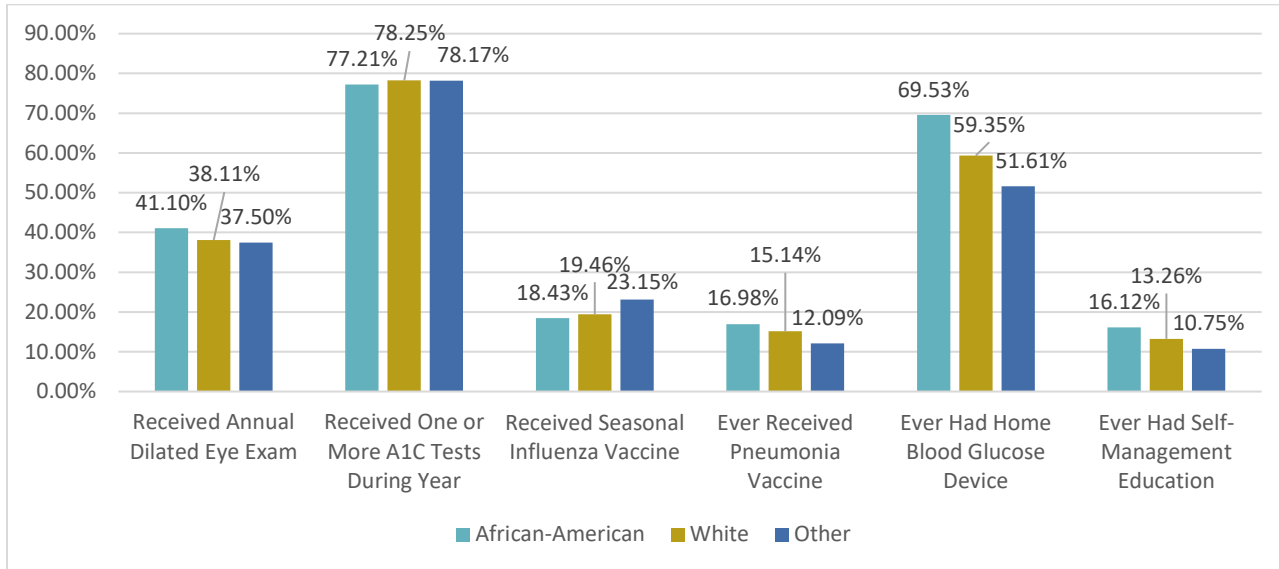
[†]2018 is the most recent year reported in the CDC *Diabetes Report Card*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; Available at: <https://www.cdc.gov/diabetes/library/reports/reportcard.html>.

^{††} Rate reported by BRFSS in the CDC *Diabetes Report Card* reflects two or more HbA1c tests in the last year.

*Because Medicaid managed care enrollees may receive immunizations from organizations outside of the normal healthcare delivery settings and who may offer the vaccines free or nearly free, the claims data will produce artificially low rates for influenza and pneumonia vaccines.

**Rate reported by BRFSS in the CDC *Diabetes Report Card* reflects daily self-monitoring of blood glucose.

**Figure 3.4: Medicaid Managed Care Diabetic Preventive Care Practices in 2021
Among Adults with Diabetes by Race**



3.1 Diabetes and Pregnancy

Table 3.1.1 shows the cost of Medicaid-managed care enrollee pregnancies in 2021 with and without diabetes. The total cost per pregnant enrollees with diabetes was 1.78 times greater than those who did not have a diabetes complication during their pregnancy (\$8,240 vs \$4,619). Of the MCO enrollees who were pregnant during 2021 (51,459), 10.77% had a diagnosis of diabetes.

Table 3.1.1: Medicaid Managed Care Diabetes* and Pregnancies in 2021

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,544	\$45,685,267	\$8,240
Pregnancies without diabetes	45,915	\$212,101,563	\$4,619

*Includes gestational diabetes and diabetes pre-existing in pregnancy.

3.2 The Financial Impact of Diabetes and Its Complications

The estimated total economic cost of diagnosed diabetes in 2017 was \$327 billion. Sixty-seven percent of the cost of diabetes care in the United States is provided by government insurance (including Medicare, Medicaid and the military). The remainder is paid through private insurance (30.7%) or by the uninsured (2%).²⁰

3.2.1 Impact of Diabetes on Total Cost of Care in Adult Medicaid Managed Care

Table 3.2.1 lists total costs by claim type for healthcare claims with dates of service in 2021 associated with managed care adult enrollees with and without diabetes. Managed care adult enrollees with diabetes were identified by medical claims with dates of service in 2021 that included a primary or secondary diagnosis of diabetes. All paid claims for enrollees with diabetes were included in the “Total Cost of MCO Adult

²⁰ Economic Costs of Diabetes in the U.S. in 2017, American Diabetes Association, Diabetes Care Mar 2018, dci180007; DOI: 10.2337/dci18-0007 Retrieved November 16, 2022 from <https://www.diabetes.org/resources/statistics/cost-diabetes>

Enrollees with Diabetes” column. If an enrollee did not meet the criteria to enter the diabetes category, all of their paid claims were included in the “Total Cost of Adult MCO Enrollees without Diabetes” column.

The prevalence of diabetes in the adult Medicaid managed care population is 9.07%. Healthcare claim costs for these enrollees totaled \$1,403,158,801 in 2021 which accounts for 26.20% of the total adult MCO claims payments (\$5,355,226,583) with dates of service in 2021.

Table 3.2.1: Medicaid Managed Care Cost for Adults with and without Diabetes by Claim Type

Claim Type	Total Cost of MCO Adult Enrollees with Diabetes*	Total Cost of MCO Adult Enrollees without Diabetes	Percent Costs for Enrollees with Diabetes
Medical	\$853,543,969	\$2,663,889,999	24.27%
Pharmacy	\$544,801,594	\$1,253,715,817	30.29%
Other**	\$4,813,239	\$34,461,966	12.26%
Total	\$1,403,158,801	\$3,952,067,782	26.20%

*Includes claims, with dates of service in 2021, for any adult MCO enrollee with diabetes in 2021.

**Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

3.2.2 Specific Diabetes Complications

Diabetic complications were identified using medical claims with dates of service in 2021 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows by age group and race the percentage of 2021 Medicaid managed care enrollees with diabetes who also had a diabetic complication.

For enrollees under 18 years of age with diabetes, the most prevalent complication was hyperglycemia (54.96%), followed by ketoacidosis (16.15%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (38.02%) and neurological manifestations (18.52%).

3.2.3 Emergency Department (ED) Visits Due to Diabetes

Table 3.2.3 includes information by race and age group regarding diabetes-related ED visits and the number of these ED visits associated with a diabetic complication. The table also includes the percentage of overall ED visits associated with diabetes and the percentage of diabetes-related ED visits associated with a diabetic complication.

In 2021, for the Medicaid managed care population, 34,015 ED visits were diabetes-related. These diabetes-related visits represented 2.68% of ED visits for managed care enrollees during 2021. Of these diabetes-related visits, 18,835 visits (55.37%) were associated with diabetes-related complications.

Table 3.2.2: Prevalence of Diabetic Complications Among Medicaid Managed Care Enrollees with Diabetes by Race and Age Group*

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total
Ketoacidosis	17.13%	14.44%	15.57%	16.15%	3.19%	2.76%	2.37%	2.92%
Hyperosmolarity	1.24%	0.60%	0.47%	0.97%	1.37%	1.01%	1.08%	1.20%
Coma	0.70%	0.75%	0.47%	0.69%	0.41%	0.42%	0.31%	0.40%
Renal Manifestations	2.02%	1.05%	1.89%	1.71%	11.18%	9.34%	10.16%	10.39%
Ophthalmic Manifestations	1.40%	0.60%	3.77%	1.38%	10.76%	8.92%	10.81%	10.13%
Neurological Manifestations	1.09%	1.05%	1.42%	1.11%	18.18%	20.14%	15.98%	18.52%
Peripheral Circulatory Disorders	0.08%	0.45%	0.00%	0.18%	5.86%	6.39%	5.50%	5.99%
Arthropathy	0.16%	0.00%	0.00%	0.09%	0.46%	0.68%	0.45%	0.53%
Skin Complications	1.32%	0.60%	1.42%	1.11%	3.51%	4.68%	3.46%	3.91%
Oral Complications	0.16%	0.15%	0.00%	0.14%	0.05%	0.03%	0.03%	0.04%
Hypoglycemia	6.36%	10.98%	13.68%	8.49%	3.22%	3.10%	2.51%	3.07%
Hyperglycemia	55.50%	55.34%	50.47%	54.96%	39.13%	37.41%	35.74%	38.02%
Other Specified Complications	9.15%	7.52%	10.38%	8.77%	11.07%	11.10%	11.03%	11.08%
Unspecified Complications	7.60%	6.62%	4.25%	6.97%	8.78%	7.95%	7.52%	8.30%
Count of Enrollees With Any Diabetes Diagnosis	1,290	665	212	2,167	41,789	28,873	12,612	83,274

* An enrollee can be counted in more than one diabetic complication.

Table 3.2.3 Medicaid Managed Care Prevalence of ED Visits with a Diagnosis of Diabetes and Prevalence of Diabetic ED Visits with a Diabetic Complication

Race Age, Group	All ED Visits	Primary or Secondary Diabetes Diagnosis ED Visits*	Percent of ED Visits with Primary or Secondary Diabetes Diagnosis*	Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**	Percent of Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**
African-American, < 18 years	177,087	784	0.44%	577	73.60%
White, < 18 years	103,958	322	0.31%	231	71.74%
Other, < 18 years	73,474	117	0.16%	81	69.23%
Total, < 18 years	354,519	1,223	0.34%	889	72.69%
African-American, ≥ 18 years	488,866	19,070	3.90%	10,475	54.93%
White, ≥ 18 years	334,101	10,466	3.13%	5,693	54.40%
Other, ≥ 18 years	91,232	3,256	3.57%	1,778	54.61%
Total, ≥ 18 years	914,199	32,792	3.59%	17,946	54.73%
Total, All Ages	1,268,718	34,015	2.68%	18,835	55.37%

*Includes ED visits with a diabetes diagnosis in the primary or secondary diagnosis position.

**Includes ED visits with a diabetes diagnosis and a diabetic complication diagnosis in any diagnosis position.

3.2.4 Diabetes and Other Common Chronic Conditions

Table 3.2.4 shows the number of Medicaid managed care enrollees with selected chronic conditions, the total cost paid by the MCOs for these chronic conditions, and the average cost per enrollee. Among

managed care enrollees who were diagnosed with one of the reported chronic conditions in 2021, hypertension (226,778 enrollees) was the most prevalent, followed by asthma (104,953 enrollees) and diabetes (85,441 enrollees). For the reported chronic conditions in 2021, the highest total paid by the MCOs was \$777,255,115 for hypertension. The total paid for diabetes during 2021 was \$404,107,711. In 2021, for the reported chronic conditions, the highest average cost per enrollee was for congestive heart failure (\$9,873). The average cost per enrollee with diabetes was \$4,730.

Table 3.2.4: Medicaid Managed Care 2021 Prevalence of Selected Chronic Conditions and Cost Comparisons among Diabetes and Selected Chronic Conditions

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Hypertension	226,778	13.92%	\$777,255,115	\$3,427
Asthma	104,953	6.44%	\$148,290,655	\$1,413
Diabetes	85,441	5.25%	\$404,107,711	\$4,730
Arthritis	58,981	3.62%	\$80,453,456	\$1,364
COPD	27,624	1.70%	\$126,325,233	\$4,573
Coronary Heart Disease	25,074	1.54%	\$141,852,895	\$5,657
Congestive Heart Failure	18,804	1.15%	\$185,646,305	\$9,873

*A unique enrollee may be included in more than one chronic disease count.

**The prevalence denominator is the 2021 total unique enrollee count in MCOs (1,628,646).

4 LDH and MCO Recommendations

The Department strives to protect and promote health statewide and to ensure access to medical, preventive, and rehabilitative services for all residents. Below are some recommendations from LDH and the MCOs on ways to empower the community, promote self-management training, and monitor health outcomes.

- Promote Well-Ahead Louisiana’s Community Resource Guide as a tool to identify local (by parish) health-related resources. This resource is available at <http://wellaheadla.com/Well-ahead-community/community-resource-guide>.
- Encourage the use of community and faith-based organizations to promote the importance of healthy eating and physical fitness.
- Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those patients with diabetes and obesity.
- Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients with diabetes. DSME programs have been associated with improved health outcomes for patients with diabetes.

5 Conclusion

Managing obesity and diabetes is a complicated endeavor, and the strategies described in this report serve as a foundation for healthier Louisiana residents. Diabetes and obesity are associated with a considerable amount of the total Medicaid managed care healthcare claim expenditures. To lessen the burden of obesity and diabetes, changes must occur in multiple parts of the healthcare system, community settings, and personal behaviors.

Appendix A – Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

A. The Department of Health shall submit an action plan, after consulting with and receiving comments from the medical director of each of its contracted Medicaid partners, to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare no later than February 1 of each year on the following:

(1) The financial impact and reach diabetes of all types is having on the state of Louisiana and its residents. Items in this assessment shall include the number of lives with diabetes covered by Medicaid through the Department of Health and its contracted partners, the number of lives with diabetes impacted by the prevention and diabetes control programs implemented by the Department and its contracted partners, the financial cost diabetes and its complications places on the Department and its contracted partners, and the financial cost diabetes and its complications places on the Department and its contracted partners in comparison to other chronic diseases and conditions.

(2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.

(3) A description of the level of coordination existing between the Department of Health, its contracted partners and other stakeholders on activities, programmatic activities and the level of communication on managing, treating or preventing all forms of diabetes and its complications.

(4) The development of a detailed action plan for battling diabetes with a range of actionable items. The plan shall identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan shall identify expected outcomes of the action steps proposed while establishing benchmarks for controlling and preventing diabetes.

(5) The development of a detailed budget blueprint identifying needs, costs and resources to implement the plan identified in Paragraph 4 of this Subsection.

B. The Department of Health shall include within the annual diabetes action plan the most current editions of the standards of medical care in diabetes by the American Diabetes Association and the American Association of Clinical Endocrinologists.

Acts 2013, No. 210, §1, eff. June 10, 2013; Acts 2014, No. 713, §1.

RS 46:2617

§2617. Obesity annual action plan; submission; content

The Department of Health shall submit an action plan, after consulting with and receiving comments from the medical director of each of its contracted Medicaid partners, to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare no later than February 1 of each year on the following:

- (1) The financial impact and reach obesity is having on the state of Louisiana and its residents. Items included in this assessment shall include the number of lives with obesity covered by Medicaid through the Department of Health and its contracted partners, the number of lives with obesity impacted by the prevention and control programs implemented by the Department of Health and its contracted partners, the financial cost obesity and its complications place on the Department of Health and its contracted partners, and the financial cost obesity and its complications places on the Department of Health and its contracted partners in comparison to other chronic diseases and conditions.
- (2) An assessment of the benefits of implemented programs and activities aimed at controlling obesity and preventing the disease.
- (3) A description of the level of coordination existing between the Department of Health, its contracted partners and other stakeholders on activities, programmatic activities and the level of communication on managing, treating or preventing obesity and its complications.
- (4) The development of a detailed action plan for battling obesity with a range of actionable items. The plan shall identify proposed action steps to reduce the impact of obesity and related obesity complications. The plan shall identify expected outcomes of the action steps proposed while establishing benchmarks for controlling and preventing obesity.
- (5) The development of a detailed budget blueprint identifying needs, costs, and resources to implement the plan identified in Paragraph 4 of this Section.

Acts 2013, No. 210, §1, eff. June 10, 2013.

Appendix B – Prevalence of Obesity among Medicaid Managed Care Enrollees by Region and Parish

Total number of MCO enrollees and their obesity prevalence by Medicaid region, parish, and age group.

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
	Parish	<18 Years	≥ 18 Years	<18 Years
Region 1 Greater New Orleans Area				
Jefferson	66,863	85,328	9.79%	11.34%
Orleans	55,241	93,261	6.95%	9.45%
Plaquemines	2,969	3,780	10.81%	10.71%
St. Bernard	8,888	10,747	10.41%	11.48%
Total – Region 1	133,961	193,116	8.68%	10.42%
Region 2 Capital Area				
Ascension	14,752	16,491	8.40%	16.91%
East Baton Rouge	64,649	80,792	8.78%	12.14%
East Feliciana	2,441	3,721	13.64%	21.10%
Iberville	5,071	6,395	8.44%	16.36%
Pointe Coupee	2,994	3,825	11.72%	13.62%
West Baton Rouge	3,893	4,561	6.55%	18.04%
West Feliciana	1,297	1,557	5.71%	16.44%
Total – Region 2	95,097	117,342	8.79%	13.66%
Region 3 South Central Louisiana				
Assumption	2,548	3,754	11.93%	18.89%
Lafourche	12,253	16,066	11.13%	14.50%
St. Charles	6,393	7,494	8.57%	11.72%
St. James	2,837	3,993	8.64%	14.90%
St. John the Baptist	7,800	9,765	7.69%	12.82%
St. Mary	9,144	12,043	6.73%	15.88%
Terrebonne	18,494	22,946	5.54%	13.92%
Total – Region 3	59,469	76,061	7.90%	14.29%
Region 4 Acadiana				
Acadia	10,671	13,402	5.72%	17.49%
Evangeline	5,952	7,472	10.30%	14.44%
Iberia	13,243	17,165	16.51%	13.68%
Lafayette	33,503	41,688	10.75%	16.94%
St. Landry	17,678	21,718	8.30%	19.91%
St. Martin	8,083	10,103	15.65%	18.92%
Vermilion	9,064	11,503	9.59%	17.28%
Total – Region 4	98,194	123,051	10.81%	17.11%
Region 5 Southwest Louisiana				
Allen	3,491	4,286	5.76%	9.94%
Beauregard	5,895	6,702	3.09%	8.88%
Calcasieu	31,218	37,128	3.16%	12.00%
Cameron	315	467	5.40%	9.64%
Jefferson Davis	5,035	6,242	6.91%	17.22%
Total – Region 5	45,954	54,825	3.77%	12.03%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
	Parish	<18 Years	≥ 18 Years	<18 Years
Avoyelles	7,212	9,014	12.10%	10.10%
Catahoula	1,688	2,534	6.93%	9.51%
Concordia	3,835	5,137	2.40%	7.42%
Grant	3,150	3,986	12.73%	10.56%
LaSalle	2,167	2,804	5.26%	15.19%
Rapides	21,781	26,815	13.82%	10.40%
Vernon	6,017	7,390	2.59%	8.44%
Winn	2,093	2,766	16.10%	11.75%
Total – Region 6	47,943	60,446	10.64%	10.12%
Region 7 Northwest Louisiana				
Bienville	2,401	3,304	6.50%	10.32%
Bossier	16,478	18,168	8.29%	11.86%
Caddo	40,582	51,467	7.78%	13.03%
Claiborne	2,080	2,767	5.72%	9.87%
DeSoto	4,148	5,242	5.01%	12.55%
Natchitoches	6,123	7,663	4.90%	8.44%
Red River	1,592	1,927	3.08%	6.43%
Sabine	3,592	4,865	4.37%	8.26%
Webster	6,426	8,817	5.84%	10.47%
Total – Region 7	83,422	104,220	7.06%	11.73%
Region 8 Northeast Louisiana				
Caldwell	1,768	2,592	3.05%	12.35%
East Carroll	1,488	1,855	9.21%	16.12%
Franklin	3,972	5,410	3.63%	12.53%
Jackson	1,966	2,693	12.87%	15.97%
Lincoln	5,971	8,130	7.79%	14.02%
Madison	2,405	3,026	6.74%	13.81%
Morehouse	5,005	7,348	13.17%	17.65%
Ouachita	27,960	36,395	9.38%	16.30%
Richland	3,682	5,189	11.22%	16.17%
Tensas	727	1,201	4.54%	10.66%
Union	3,691	5,011	9.27%	13.55%
West Carroll	1,879	2,815	7.45%	19.93%
Total – Region 8	60,514	81,665	8.96%	15.58%
Region 9 Northshore Louisiana				
Livingston	20,108	23,438	7.06%	13.19%
St. Helena	1,337	1,728	11.52%	14.35%
St. Tammany	30,427	38,620	5.75%	10.35%
Tangipahoa	25,497	31,791	6.39%	12.40%
Washington	8,743	11,677	6.38%	14.12%
Total – Region 9	86,112	107,254	6.40%	12.05%

Appendix C – Prevalence of Diabetes among Medicaid Managed Care Enrollees by Region and Parish

Total number of MCO enrollees and their diabetes prevalence by Medicaid region, parish, and age group.

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
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Grant	3,150	3,986	0.22%	9.45%
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Natchitoches	6,123	7,663	0.38%	10.20%
Red River	1,592	1,927	0.19%	9.65%
Sabine	3,592	4,865	0.42%	9.31%
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Lincoln	5,971	8,130	0.57%	8.75%
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Morehouse	5,005	7,348	0.38%	9.09%
Ouachita	27,960	36,395	0.38%	8.71%
Richland	3,682	5,189	0.54%	10.50%
Tensas	727	1,201	0.28%	12.74%
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Total – Region 8	60,514	81,665	0.41%	9.50%
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St. Helena	1,337	1,728	0.30%	10.59%
St. Tammany	30,427	38,620	0.26%	7.29%
Tangipahoa	25,497	31,791	0.25%	9.42%
Washington	8,743	11,677	0.30%	11.18%

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
	Parish	<18 Years	≥ 18 Years	<18 Years
Total – Region 9	86,112	107,254	0.26%	8.54%

Appendix D – 2021 Diabetes and Obesity Action Plans Submitted by Each MCO

This section contains action plans submitted by each MCO. The action plans describe MCO initiatives to address diabetes and obesity in the managed care enrollee population.

Links to Each MCO Action Plan

Appendix D1	Aetna Better Health of Louisiana 2021 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2021 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2021 Diabetes and Obesity Action Plan
Appendix D4	Louisiana Healthcare Connections 2021 Diabetes and Obesity Action Plan
Appendix D5	United Healthcare 2021 Diabetes and Obesity Action Plan

Appendix D1

Aetna Better Health of Louisiana

2021 Diabetes and Obesity Action Plan

Diabetes Goals 2021

- **Goal 1: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an HbA1c (estimated average glucose) test and medical attention for nephropathy by at least 2% year-over-year (YOY) as compared to baseline. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the HealthCrowd integrated voice response (IVR) programs.
 - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools in through the HealthCrowd nanosite. The program is used to motivate and help members better track and manage their condition, engage in preventive actions, and share valuable information with their care teams.
 - **Expected Outcome:** Increase in HbA1c testing and medical attention to nephropathy among members age 18-75 with a diabetes diagnosis.
 - **Action Measurement:** Use HEDIS Gaps in Care reports.
- **Goal 2: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an HbA1c (estimated average glucose) test and eye exam by at least 2% year-over-year (YOY) as compared to baseline. Start Date: January 1, 2021 End Date December 31, 2021**
 - **Action Step:** Contact identified members to enroll in HealPros, and provide each enrolled member with an in-home dilated eye exam and, if needed, an HbA1c test.
 - **Action Description:** Provide our vendor, HealPros, HEDIS Gaps in Care reports to identify members with a gap in care for dilated eye exam. HealPros will schedule appointments and complete eye exam in a convenient location to the member.
 - **Expected Outcome:** Increase in eye exam and HbA1c testing among members age 18-75 with a diabetes diagnosis.
 - **Action Measurement:** Use HEDIS Gaps in Care reports.
- **Goal 3: Increase access to care for this metric through value-based agreements with providers. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Review provider contracts to align with diabetes goals and support providers through value-based incentives.
 - **Action Description:** Distribute patient-specific data to providers to enhance the necessary care delivered in an effort to align with value-based goals.
 - **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.

- **Action Measurement:** Use value-based reports.

Diabetes Results 2021

Goal	Benchmark	Results
1	Average rates in 2020: HbA1c Testing: 82.97% Nephropathy Monitoring: 26.60%	Average rates in 2020: HbA1c Testing: 85.64% Nephropathy Monitoring: 29.41%
2	Average rates in 2020: HbA1c Testing: 82.97% Eye Exam: 53.04%	Average rates in 2021: HbA1c Testing: 85.64% Eye Exam: 51.58%
3	Average overall rates in 2021: HbA1c <8%: 22.10% Eye Exam: 45.23%	Average value-based agreements rates in 2021: HbA1C <8%: 24.85% Eye Exam: 45.65%

Diabetes Goals 2022

- **Goal 1: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an HbA1c (estimated average glucose) test by at least 2% year-over-year (YOY) as compared to baseline. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the HealthCrowd integrated voice response (IVR) programs.
 - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools in through the HealthCrowd nanosite. The program is used to motivate and help members better track and manage their condition, engage in preventive actions, and share valuable information with their care teams.
 - **Expected Outcome:** Increase in HbA1c testing among members age 18-75 with a diabetes diagnosis.
 - **Action Measurement:** Use HEDIS Gaps in Care reports.
- **Goal 2: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an eye exam by at least 2% year-over-year (YOY) as compared to baseline. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the mPulse integrated voice response (IVR) programs.
 - **Action Description:** Provide our vendor, HealPros, HEDIS Gaps in Care reports to identify members with a gap in care for dilated eye exam. HealPros will schedule appointments and complete eye exam in a convenient location to the member.

- **Expected Outcome:** Increase in eye exam and HbA1c testing among members age 18-75 with a diabetes diagnosis.
 - **Action Measurement:** Use HEDIS Gaps in Care reports.
- **Goal 3: Increase access to care for this metric through value-based agreements with providers. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Review provider contracts to align with diabetes goals and support providers through value-based incentives.
 - **Action Description:** Distribute patient-specific data to providers to enhance the necessary care delivered in an effort to align with value-based goals.
 - **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.
 - **Action Measurement:** Use value-based reports.

Obesity Goals 2021

- **Goal 1: Host community events across Louisiana and provide education about obesity to attendees. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Work with community outreach to understand where they are hosting events and ensure that there is education about obesity, healthy eating, and physical activity available at those events.
 - **Action Description:** Track the number of materials that were distributed at the events.
 - **Expected Outcome:** Members will increase their knowledge about obesity, healthy eating, and physical activity.
 - **Action Measurement:** Internal reports tracking distributed materials.
- **Goal 2: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Through our health equity director, work to expand partnerships across the state to address obesity education.
 - **Action Description:** Gather information about what our partners are doing to combat obesity and how we can best support their work.
 - **Expected Outcome:** Expand our partnerships and support across the state to address obesity.
 - **Action Measurement:** Track number of new partnerships and support provided around obesity initiatives.
- **Goal 3: Increase awareness of After School Value-Added Benefit and support those after school programs that provide safe physical activity to participants. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Train teams that regularly talk to members to educate members on the value-added benefits (VABs) that are available to them, such as the after school program. Track participating after-school programs and ensure they are able to provide safe physical activity to participants.

- **Action Description:** Inform departments about VABs available to our members to ensure that our members are aware of those benefits and support VABs.
- **Expected Outcome:** Increase utilization of VABs and further support of participating organizations/vendors.
- **Action Measurement:** VAB reports

Obesity Results 2021

Goal	Benchmark	Results
1	Calendar year 2020: 33 community outreach events (limited due to COVID-19 pandemic)	Calendar year 2021: 415 community outreach events 14,015 materials distributed in English 6,515 materials distributed in Spanish
2	Calendar year 2020: 0 health equity partnerships and events (limited due to COVID-19 pandemic)	Calendar year 2021: 31 health equity partnerships/events
3	Calendar year 2020: 1,682 value added benefits gift cards claimed	Calendar year 2021: 5,615 value added benefits gift cards claimed

Obesity Goals 2022

- **Goal 1: Host community events across Louisiana and provide education about obesity to attendees. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Work with community outreach to understand where they are hosting events and ensure that there is education about obesity, healthy eating, and physical activity available at those events.
 - **Action Description:** Track the number of materials that were distributed at the events.
 - **Expected Outcome:** Members will increase their knowledge about obesity, healthy eating, and physical activity.
 - **Action Measurement:** Internal reports tracking distributed materials.
- **Goal 2: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Through our health equity director, work to expand partnerships across the state to address obesity education.
 - **Action Description:** Gather information about what our partners are doing to combat obesity and how we can best support their work.
 - **Expected Outcome:** Expand our partnerships and support across the state to address obesity.
 - **Action Measurement:** Track number of new partnerships and support provided around obesity initiatives.

- **Goal 3: Increase awareness of After School Value-Added Benefit and support those after school programs that provide safe physical activity to participants. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Train teams that regularly talk to members to educate members on the value-added benefits (VABs) that are available to them, such as the after school program. Track participating after-school programs and ensure they are able to provide safe physical activity to participants.
 - **Action Description:** Inform departments about VABs available to our members to ensure that our members are aware of those benefits and support VABs.
 - **Expected Outcome:** Increase utilization of VABs and further support of participating organizations/vendors.
 - **Action Measurement:** VAB reports

Appendix D2

AmeriHealth Caritas Louisiana (ACLA) 2021 Diabetes and Obesity Action Plan

Diabetes Goals 2021

- **Goal 1: ACLA will increase provider participation in its Data Exchange Program and increase provider use of CPT CAT II codes for member diabetic test results by December 2021, to identify necessary clinical data for closing gaps in care for diabetic members to ensure members receive the best healthcare achievable. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** ACLA will analyze claims data to identify provider groups who will benefit from Data Exchange program participation.
 - **Action Description:** ACLA will outreach to engage providers in the Data Exchange Program or use of CPT CAT II codes by sharing benefits of both participation and usage through multidisciplinary provider education.
 - **Expected Outcome:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes for member diabetic test results or participate in the Data Exchange Program.
 - **Action Measurement:** The percentage of diabetic member results received for 2021 compared to results received in 2020.
- **Goal 2: ACLA will increase member compliance percentage for diabetic members linked to providers participating in value-based care (VBC) who selected Comprehensive Diabetes Care (CDC) submeasure HbA1c >9.0% as a measureable outcome or Quality-Educated Provider Groups by December 2021. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Continue process for assisting providers participating in VBC who selected CDC sub-measure HbA1c >9.0% as a measureable outcome or quality-educated provider groups to continually improve member compliance rates in CDC sub-measure HbA1c >9.0% via multi-disciplinary provider education.
 - **Action Description:** ACLA will identify and target providers participating in VBC who selected CDC sub-measure HbA1c >9.0% as a measureable outcome or quality-educated provider groups to assist in improving their CDC member compliance rates through CDC compliance education, application access, real-time member data, and care gap resolution.
 - **Expected Outcome:** Increased member compliance rates of CDC sub-measure HbA1c >9.0% used as a measurable outcome for providers participating in VBC or quality-educated provider groups.
 - **Action Measurement:** The percentage of CDC sub-measure HbA1c >9.0% used as a measurable outcome in providers participating in VBC or quality-educated provider groups with an increase in member compliance as compared to those non-participating provider groups.

- **Goal 3: ACLA will meet and/or exceed the LDH goal of the 2020 Medicaid Quality Compass (QC) 50th percentile or 2% decrease goal for CDC submeasure HbA1c >9.0% for 2021, with a special focus on our diabetic members who are most likely to experience health disparities by December 2021. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** ACLA will utilize program evaluation data to implement new pilot programs, continue and/or modify current programs, or discontinue programs.
 - **Action Description:** Evaluated programs/interventions will include ACLA Community Center access, member Care Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, diabetic text messaging campaign, Vheda Health for chronic disease monitoring, and Care Meals NourishCare, United We Feed pilot.
 - **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2020 Medicaid QC 50th percentile or 2% increase goal for CDC sub measure HbA1c >9.0% for 2021.
 - **Action Measurement:** The percentage of increase in CDC sub measure HbA1c >9.0% rates in 2021 compared to 2020 and/or the 2020 Medicaid QC 50th percentile.

Diabetes Results 2021

Goal	Benchmark	Results
1	An increase in the percentage of diabetic member results received for 2021, compared to results received in 2020.	In 2021, the MCO met its goal by demonstrating a 55.12% increase in the amount of diabetic test results received for members linked to providers who submit CPT CAT II codes for member diabetic results, compared to those received in 2020.
2	An increase in member compliance percentage for CDC submeasure HBA1c >9.0% for members linked to providers participating in VBC or quality-educated provider groups, compared to those non-participating provider groups in 2021.	Providers participating in value-based contracting (VBC) who selected CDC submeasure HBA1c >9.0% as a measureable outcome demonstrated increased member compliance, as evidenced by an overall 8.86% decrease in submeasure HBA1c >9.0% rates from 2020 to 2021.
3	The 2020 Medicaid QC 50th percentile or 2% increase for CDC submeasure HBA1c >9.0% in 2021.	In 2021, the MCO exceeded the 2% improvement goal for the CDC HBA1c>9.0% submeasure, experiencing a 4.86% rate decrease in 2021, with a special focus on our diabetic members who are most likely to experience health disparities.

Diabetes Goals 2022

- Goal 1: ACLA will increase provider use of CPT CAT II codes for member diabetic test results by December 2022, to identify necessary clinical data for closing gaps in care for diabetic members to ensure members receive the best health care achievable. Start Date: January 1, 2022 End Date: December 31, 2022**

 - **Action Step:** ACLA will analyze claims data to identify diabetic members attributed to their practice, and will benefit from billing CPT CAT II codes.
 - **Action Description:** ACLA will outreach to engage providers in usage of CPT CAT II codes by sharing benefits of usage through multidisciplinary provider education, quarterly provider trainings, projects involving specialized file sharing with identified provider groups, and report card in provider portal.
 - **Expected Outcome:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes for member diabetic test results.
 - **Action Measurement:** The percentage of diabetic member results received for 2022 compared to results received in 2021.

- Goal 2: ACLA will increase member compliance percentage for diabetic members linked to providers participating in VBC who selected HBA1c >9.0% as a measureable outcome or Quality-Educated Provider Groups by December 2022. Start Date: January 1, 2022 End Date: December 31, 2022**

 - **Action Step:** Continue process for assisting providers participating in VBC who selected HbA1c >9.0% as a measureable outcome or quality-educated provider groups to continually improve member compliance rates in HBA1c >9.0% via multi-disciplinary provider education, quarterly trainings, etc.
 - **Action Description:** ACLA will identify and target providers participating in VBC who selected HBA1c >9.0% as a measureable outcome or quality-educated provider groups to assist in improving their member compliance rates through diabetes compliance education, application access, real time member data, and care gap resolution.
 - **Expected Outcome:** Increased member compliance rates of HBA1c >9.0% used as a measurable outcome for providers participating in VBC or quality-educated provider groups.
 - **Action Measurement:** Increased member compliance rates of HBA1c >9.0% used as a measurable outcome for providers participating in VBC or quality-educated provider groups.

- Goal 3: ACLA will meet and/or exceed the LDH goal of the 2021 Medicaid QC 50th percentile or 2% decrease goal for HBA1c >9.0%, with a special focus on our diabetic members who are most likely to experience health disparities by December 2022. Start Date: January 1, 2022 End Date: December 31, 2022**

 - **Action Step:** ACLA will utilize program evaluation data to implement new pilot programs, continue and/or modify current programs, or discontinue programs.
 - **Action Description:** Evaluated programs/interventions will include: ACLA Community Center access (multi-departmental coverage and intervention input) with plans to erect a new wellness center in Metropolitan Baton Rouge area and a mobile wellness unit,

community center exercise programs and cooking classes, member Care Card benefits, updated web content, member portal access, 24/7 nurse helpline, transportation program, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, diabetic text messaging campaign, Vheda Health for chronic disease monitoring, Heart Healthy program, Care meals, ACLA Nutrition pilot, faith-based organizations presentation, Make Every Calorie Count program, Member Advisory Council, member surveys.

- **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2022 Medicaid QC 50th percentile or 2% decrease goal for HBD measure HBA1c >9.0% for 2022.
- **Action Measurement:** The percentage of decrease in HBD measure HBA1c >9.0% rates in 2022 compared to 2021 and/or the 2021 Medicaid QC 50th percentile.

Obesity Goals 2021

- **Goal 1: ACLA will develop and implement program to promote a basic needs and healthy living initiative for members with a diagnosis of obesity and other comorbid conditions. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Target population will consist of ACLA members living in Baton Rouge and surrounding parishes linked to a specific provider group.
 - **Action Description:** This program will aim to improve health outcomes for members, such as reduced blood pressure, BMI and blood glucose levels, along with increased exercise, energy, and knowledge of disease self-management.
 - **Expected Outcome:** Engagement of at least 25% of targeted population engaged in pilot program.
 - **Action Measurement:** The percentage of members engaged in the United We Feed pilot program by December 2021.
- **Goal 2: ACLA will improve the health outcomes of obese members with comorbid conditions who are most likely to experience health disparities in 2021. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming with the purpose of promoting self-management of obesity and other comorbid conditions.
 - **Action Description:** ACLA will determine effective ways to support equitable access for obese members, address social determinants of health (SDOH) where possible, and increase compliance in HEDIS measures associated with obesity.
 - **Expected Outcome:** Lowered BMI percentile for obese population engaged in the Make Every Calorie Count program by December 2021.
 - **Action Measurement:** The percentage of members with a diagnosis of obesity engaged in the Make Every Calorie Count program with a decreased BMI percentile by December 2021.
- **Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2021 to reduce the impact of obesity by providing obese members with**

education including self-management, treatment, and benefits. Start Date: January 1, 2021 End Date: December 31, 2021

- **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help obese members with comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.
- **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to obese members, and discussion of programs for members with obesity during bi-monthly member advisory council meetings.
- **Expected Outcome:** Increased engagement of high-risk obese members in ACLA's Population Health Management programs.
- **Action Measurement:** The percentage of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2021 compared to those engaged in 2020.

Obesity Results 2021

Goal	Benchmark	Results
1	At least 25% of targeted population engaged in ACLA Nutrition pilot program by December 2021	ACLA was unable to reach its goal in 2021 due to program launch delay and recognizes that there continue to be opportunities to develop and implement a program to promote a basic needs and healthy living initiative for members with a diagnosis of obesity and other comorbid conditions. The MCO developed the ACLA Nutrition pilot program during 2021 through a partnership with a target provider group. Implementation of the pilot was postponed to 2022 due to closures, restrictions, and recovery efforts from the COVID-19 pandemic, which had a negative effect on access to wellness care for our members.
2	A decreased BMI percentile for at least 25% of obese members engaged in the Make Every Calorie Count program with by December 2021.	In 2021, the MCO exceeded its goal with 50% of participants of the Make Every Calorie Count program experiencing a decrease in BMI.
3	At least the same number of high-risk members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2021.	ACLA did not reach its goal and recognizes that there continue to be opportunities to engage members with a primary or secondary diagnosis of obesity in a Population Health Management program and educate members on the importance of healthy behaviors. The plan also realizes that closures, restrictions, and the overall alarm of

		society due to the COVID-19 pandemic had a negative effect on access to wellness care for our members.
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Obesity Goals 2022

- **Goal 1: ACLA will develop and implement program to promote a basic needs and healthy living initiative for members with a diagnosis of obesity and other comorbid conditions. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Target population will consist of ACLA members living in Baton Rouge and surrounding parishes linked to a specific provider group.
 - **Action Description:** This program will aim to improve health outcomes for members, such as reduced blood pressure, BMI and blood glucose levels, along with increased exercise, energy, and knowledge of disease self-management.
 - **Expected Outcome:** Engagement of at least 10% of targeted population engaged in pilot program.
 - **Action Measurement:** The percentage of members engaged in the ACLA Nutrition pilot program by December 2022.
- **Goal 2: ACLA will improve the health outcomes of obese members with comorbid conditions who are most likely to experience health disparities in 2022. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming with the purpose of promoting self-management of obesity and other comorbid conditions through early intervention.
 - **Action Description:** ACLA will determine effective ways to support equitable access for obese members, address social determinants of health (SDOH) where possible, and increase compliance in Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with obesity. Re-evaluate program criteria for ACLA's Make Every Calorie Count program to allow obese members with lower BMIs to participate.
 - **Expected Outcome:** Increased engagement of obese members in ACLA's Make Every Calorie Count program by December 2022.
 - **Action Measurement:** The percentage of members with a diagnosis of obesity engaged in the Make Every Calorie Count program by December 2022 compared to that of members engaged by December 2021.
- **Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2022 to reduce the impact of obesity by providing obese members with education including self-management, treatment, and benefits. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help obese members with comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.

- **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to obese members, and discussion of programs for members with obesity during bi-monthly member advisory council meetings.
- **Expected Outcome:** Increased engagement of high-risk obese members in ACLA's Population Health Management programs.
- **Action Measurement:** The percentage of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2022 compared to those engaged in 2021.

Appendix D3 Healthy Blue 2021 Diabetes and Obesity Action Plan

Diabetes Goals 2021

- **Goal 1: Improved YOY HEDIS Rates associated with diabetes by at least 2%, ultimately reaching NCQA's 50th percentile. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Expanded provider education and outreach from previous year.
 - **Action Description:** Provider education program on documentation and coding best practices, action plan development by patient-centered care consultants, and provider summits/webinars offering educational credits.
 - **Expected Outcome:** Increased provider awareness of quality metrics, documentation, and coding requirements and overall improved outcomes for the members we serve.
 - **Action Measurement:** Improved YOY rates by achieving at least a **2%** increase in the following measures:
 - Comprehensive Diabetes Care HbA1c Testing
 - Comprehensive Diabetes Care Eye Exams
 - Comprehensive Diabetes Care Poor Control (>9.0%)
 - Comprehensive Diabetes Care Good Control (<8.0%)
 - Diabetes Short-term Complication
 - Diabetes Monitoring for People with Diabetes and Schizophrenia
 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

- **Goal 2: Improve diabetes preventive care practices YOY among adults with diabetes. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Expanded member outreach and engagement from previous year.
 - **Action Description:** Engaged and educated members through: diabetes classes, outreach calls, text campaigns, collaboration with Pennington Research Center, collaboration with BioTel Remote Patient Monitoring Program, case management, new incentive platform, community events, and HbA1c home test kits.
 - **Expected Outcome:** Improved diabetes preventative care practices YOY among adults with diabetes including:
 - Annual dilated eye exam
 - One or more HbA1cs (current reporting period)
 - An influenza vaccine (current reporting period)
 - A pneumonia vaccine (ever received)
 - Daily self-blood glucose monitoring
 - Diabetes self-management education (ever received)
 - **Action Measurement:** Improved diabetes preventative care practices YOY among adults with diabetes including:
 - Annual dilated eye exam

- One or more HbA1cs (current reporting period)
- An influenza vaccine (current reporting period)
- A pneumonia vaccine (ever received)
- Daily self-blood glucose monitoring
- Diabetes self-management education (ever received)

• **Goal 3: Increased Provider Incentive Programs YOY aligning with Healthy Blue's strategy to improve diabetes outcomes for the members served. Start Date: January 1, 2021 End Date: December 31, 2021**

- **Action Step:** Increase provider alternative payment model (APM) agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
- **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
- **Expected Outcome:** Increase in APM programs will result in improved outcomes related to diabetes and obesity.
- **Action Measurement:** Number of providers enrolled in APM programs aligned with diabetes measures.

Diabetes Results 2021

Goal	Benchmark	Results
1	Diabetes-Related HEDIS® Rates	Comprehensive Diabetes Care Poor Control >9% (CDC) = 42.09% (5.01% YOY improvement), Comprehensive Diabetes Care Good Control <8% (HBD) = 50.85% (5.06% YOY improvement), Eye Exam for Patients with Diabetes (EED) = 48.66% (-0.88% YOY), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) = 83.39% (-0.63% YOY), Comprehensive Diabetes Care Hba1c Testing (CDCHBa1cCTL) = 26.6% (5.78% YOY increase), Diabetes Monitoring for People with Diabetes & Schizophrenia (SMD) = 60.8% (1.01% YOY increase)
2	Diabetes Preventative Care Practices	Comprehensive Diabetes Care Poor Control >9% (CDC) = 42.09% (5.01% YOY improvement), Eye Exam for Patients with Diabetes (EED) = 48.66%, Making Fitness Fun initiative grew to serve over 1500 Healthy Blue members, encompassing 13 communities in various regions of Louisiana **NOTE** FVA Flu Vaccinations for Adults Ages 18-64 and PNU measure for pneumonia vaccine ever received have been retired - through a claims-based evaluation, 14% of adults with diabetes received a flu vaccination in 2021; Daily self-blood glucose monitoring is tracked as part of the CDC measure, which has increased over 5% YOY; Diabetes Self-Management Program & Education Programs are handled by our nurses and case management, though there is no HEDIS measure result that can be provided
3	# of Providers in Value-Based Programs	Total provider counts raised by 32% from 2020 to 2021 for a total of 104 providers enrolled in the programs in 2021

Diabetes Goals 2022

- **Goal 1: Improved diabetes preventative care practices with a focus on decreasing racial disparities. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Decrease Black/White disparity in rate of diabetic control.
 - **Action Description:** Targeted outreach to members and their attributed providers with uncontrolled diabetes (engagement with disease management, complex case management, care coordination) using geographic and racial information, identify and increase engagement with providers who have a high number of black patients with HbA1c >9%, monitor diabetes drug adherence and target outreach members with poor adherence.
 - **Expected Outcome:** Increased provider awareness of disparities and mitigation strategies to improve quality metrics and overall outcomes for the members we serve with an increased awareness on health equity.
 - **Action Measurement:** Increase percentage of Black members with HbA1c >9% (engaged in case management programs). Increase percentage of drug adherent members.
- **Goal 2: Improved YOY HEDIS rates as they relate to Diabetes by at least 2%. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Expand provider outreach and education from prior year.
 - **Action Description:** Increased collaboration and guidance between Health Plan and Providers on programs/summits/educational offerings available to improve documentation and coding to improve overall HEDIS and STARS rates.
 - **Expected Outcome:** Increased provider awareness of quality goals and metrics, coding and documentation expectations, and requirements for overall improved outcomes and health for the members we serve.
 - **Action Measurement:** Improve YOY rates by 2% or greater for HEDIS measures: Comprehensive Diabetes Care HbA1c >9% (CDC), Hemoglobin HbA1c Control for Patients with Diabetes (HBD), Eye Exam for Patients with Diabetes (EED), Blood Pressure Control for Patients with Diabetes (BPD), Statin Therapy for Patients with Diabetes, received therapy (SPD).
- **Goal 3: Increased provider engagement within value-based agreements to improve diabetes outcomes for Healthy Blue members. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Increase provider engagement in value-based programs that align with diabetes and overall Health Plan strategy.
 - **Action Description:** Revise and expand value-based offerings to align with Health Plan strategy to close disparity gaps and improve outcomes overall.
 - **Expected Outcome:** Increased and targeted programs will result in improved outcomes related to diabetes and close disparity gaps.
 - **Action Measurement:** Total number of providers enrolled in value-based programs aligned with diabetes measures and health equity strategies.

Obesity Goals 2021

- **Goal 1: Improve YOY HEDIS rates associated with obesity by at least 2% , ultimately reaching QC for Medicaid 50th percentile for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (Age 3-17) and Adult BMI Screening (ABA) (Age 18-64). Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Provider education and outreach.
 - **Action Description:** Provider education program on EPSDT requirements, documentation and coding, action plan development by patient-centered care consultants and provider summits/webinars offering educational credits.
 - **Expected Outcome:** Increased provider awareness of quality metrics, documentation and coding requirements, and overall improved outcomes for the members we serve.
 - **Action Measurement:** Review HEDIS Weight Assess and Counseling for Nutrition and Physical Activity Members 3-17 and Well-Child measure rates.
- **Goal 2: Improved EPSDT screening and participation rates YOY. Start Date: January 1,2021 End Date: December 31, 2021**
 - **Action Step:** Member education and outreach, specifically targeting children under 21 to promote prevention of obesity
 - **Action Description:** Engage and educate members through Zumba fitness classes, outreach calls, text campaigns, member incentives, collaboration with Pennington Biomedical Research Center, case management, and community events.
 - **Expected Outcome:** Increased member awareness of importance of preventative care, follow-ups with provider and management of obesity.
 - **Action Measurement:** Review EPSDT screening and participation rates.
- **Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to prevent and manage obesity for the members served. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Increase provider APM agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
 - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
 - **Expected Outcome:** See improved diabetes-related and obesity-related outcomes associated with an increase in APM programs.
 - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate obesity and prevention measures.

Obesity Results 2021

Goal	Benchmark	Results	
1	HEDIS Measures	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile Total = 75.18% (0.47% YOY increase); Well-child visits in the first 30 months of life (W30) = 55.9% (No change, though NCQA 50th Percentile is 54.96%) **Note Adult BMI Assessment (ABA) was retired for measurement year (MY) 2020.	
2	EPSDT Screening and Participation Ratio	EPSDT Rates: Screening Ratio/Participation Ratio	
		<ul style="list-style-type: none"> • January 30, 2020 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75% 	January 30, 2021 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75%
		<ul style="list-style-type: none"> • April 30, 2020 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75% 	April 30, 2021 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75%
		<ul style="list-style-type: none"> • July 30, 2020 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75% 	July 30, 2021 <ul style="list-style-type: none"> o Medicaid 91%/100% o CHIP 62%/75%
		<ul style="list-style-type: none"> • October 30, 2020 <ul style="list-style-type: none"> o Medicaid 91%/62% o CHIP 100%/75% 	October 30, 2020 <ul style="list-style-type: none"> o Medicaid 91%/100% o CHIP 62%/75%
3	Providers in Value-Based Programs	Total provider counts raised by 32% from 2020 to 2021 for a total of 104 providers enrolled in the programs in 2021.	

Obesity Goals 2022

- **Goal 1: Improve YOY HEDIS rates associated with obesity by 2% or greater and/or reach the 50th percentile for Medicaid set by NCQA. Start Date: January 1, 2022 End Date: December 31, 2022**
 - o **Action Step:** Expand provider outreach and education from prior year.
 - o **Action Description:** Increased collaboration and guidance between Health Plan and providers on programs/summits/educational offerings available to improve documentation and coding to improve overall HEDIS and STARS rates.
 - o **Expected Outcome:** Increased provider awareness of quality metrics, documentation and coding requirements, and improve member awareness of health care management.
 - o **Action Measurement:** Improve YOY rates by 2% or greater for HEDIS measures: Weight Assessment and Counseling for Nutrition and Physical Activity for children/adolescents (WCC, separate measures for BMI, Counseling for Nutrition, Counseling for Physical Activity), Statin Therapy for Patients with Cardiovascular Disease (SPC, received)

- **Goal 2: Increase engagement in EPSDT screening and participation. Start Date: January 1, 2022
End Date: December 31, 2022**
 - **Action Step:** Expand member education and outreach specific to preventative options for obesity.
 - **Action Description:** Increase engagement in the Zumba Making Fitness Fun program, wellness campaigns run by case management and quality, community events, and outreach campaigns related to wellness.
 - **Expected Outcome:** Increased participation in and awareness of preventative care activities and weight management.
 - **Action Measurement:** Continued and increased participation in EPSDT screening rates.

- **Goal 3: Increase provider engagement within value-based agreements to improve health outcomes related to weight management for Healthy Blue members. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Increase provider engagement in value-based programs that align with obesity and overall Health Plan strategy.
 - **Action Description:** Revise and expand value-based offerings to align with Health Plan strategy to improve outcomes in alignment with NCQA strategy.
 - **Expected Outcome:** Increased and targeted programs will result in improved outcomes related to obesity and physical health.
 - **Action Measurement:** Total number of providers enrolled in value-based programs aligned with weight control strategies.

Appendix D4

Louisiana Healthcare Connections 2021 Diabetes and Obesity Action Plan

Diabetes Goals 2021

- **Goal 1: LHCC will maintain or exceed an enrollment rate of 75% for the Diabetes Program for 2021. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Certified diabetetic educators will be provided member engagement skills training within the first quarter of employment.
 - **Action Description:** Training will ensure staff knowledge and promote optimal member engagement opportunity through provision of effective program descriptions and awareness of program benefits during member encounters.
 - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
 - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which indicates enrollment into the disease management program.
- **Goal 2: LHCC will improve provider engagement in comprehensive diabetes care outcomes through revised provider incentives aligned with LDH HEDIS priority measures, including comprehensive diabetes care HEDIS metrics. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Revise provider performance incentive program to promote provider engagement in improving diabetes outcomes through inclusion of targeted performance thresholds for HEDIS CDC sub-measures.
 - **Action Description:** Realign LHCC's provider performance incentive program to include improvement thresholds for HEDIS Comprehensive Diabetes Care sub measures, including provider education and resources to support improved performance and member outcomes.
 - **Expected Outcome:** Improvement in diabetetic member outcomes as evidenced by improvement in selected HEDIS CDC performance metrics YOY.
 - **Action Measurement:** Improvement in HEDIS CDC sub measures CDC-HbA1c Poor Control and CDC-Eye Exam by at least **2%** over prior year.
- **Goal 3: LHCC will optimize member risk identification and engagement in diabetes care by increasing the percentage of diabetetic members who complete annual HbA1c testing. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Promote diabetes management and clinical monitoring recommendations via targeted outreach to diabetetic members identified as noncompliant with annual HbA1c testing.

- **Action Description:** Member engagement in diabetes management will be facilitated through member outreach, promoting access to diabetes education and resources, as well as promotion of available member incentives for completing health and wellness milestones for diabetes care.
- **Expected Outcome:** These efforts are expected to increase annual HbA1c testing for diabetic members as evidenced by improved HEDIS CDC A1c testing rates.
- **Action Measurement:** Improvement in HEDIS CDC annual HbA1c testing rates by at least 2% over prior year.

Diabetes Results 2021

Goal	Benchmark	Results
1	Annual Enrollments in Diabetes Disease Management Programs	LHCC achieved goal of increasing health risk assessment identifications and enrollments into Diabetes disease management program. In 2021, 321 members with diabetes risk identified on HRA's were successfully enrolled out of 437 referrals received, indicating an enrollment rate of 74% (1% short of the 75% goal).
2	HbA1c >9.0% (Poor Control) and Eye Exam Rates	LHCC demonstrated improvements in Comprehensive Diabetes Care measures, exceeding established goals for the following: <ul style="list-style-type: none"> • CDC HbA1c poor control*: 2021 rate 52.8, improved 8.27%over prior year, which was 61.07 (*lower rates indicate improved performance) • Eye Exam: 2021 rate 61.31, increased 3.4%over prior year, which was 57.91
3	HbA1c Testing Rate	LHCC demonstrated improvements in A1C testing over prior year, exceeding established goals for the following: <ul style="list-style-type: none"> • HbA1c testing: 2021 rate 84.97, increased 4.37%over prior year, which was 80.54

Diabetes Goals 2022

- **Goal 1: LHCC will maintain or exceed an enrollment rate of 75% for the Diabetes Program for 2022. Start Date: January 1, 2022 End Date: December 31, 2022**

- **Action Step:** Update program curriculum. Health coaches will attend motivational interviewing and member engagement skills training with annual refreshers. New hire health coaches will be provided these trainings within the first quarter of employment.
 - **Action Description:** Training will ensure staff knowledge and promote optimal member engagement opportunity through provision of effective program descriptions and awareness of program benefits during member encounters. The call curriculum was updated to align with updated clinical practice guidelines and standards of care. The curriculum focuses on key interventions that are covered with the members in a more frequent cadence.
 - **Expected Outcome:** This action is expected to improve member engagement and program enrollments/completions through enhanced engagement techniques.
 - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which indicates enrollment into the disease management program.
- **Goal 2: LHCC will improve member outcomes as reflected by 2% improvement or meeting/exceeding national 50th percentile rates in the following HEDIS Comprehensive Diabetes Care (CDC) submeasures: HbA1c >9.0% (Poor Control), Eye Exam, HbA1c Control <8.0%, and BP Control (>140/90 mm Hg). Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** LHCC will expand member engagement in diabetes care through targeted outreach, education, and expanded member incentives for completing recommended diabetes testing for optimal health.
 - **Action Description:** Member engagement in diabetes management will be facilitated through direct member outreach, multimodal access to diabetes education and resources, as well as promotion of \$50 member incentive through our My Health Pays rewards program for completing health and wellness milestones for diabetes care.
 - **Expected Outcome:** Improvement in diabetic member outcomes as evidenced by improvement in selected HEDIS CDC performance metrics YOY.
 - **Action Measurement:** Improvement of 2% over prior year or meeting/exceeding national 50th percentile for the following HEDIS Comprehensive Diabetes Care (CDC) submeasures: HbA1c >9.0% (Poor Control), Eye Exam, HbA1c Control <8.0%, and BP Control (>140/90 mm Hg).
- **Goal 3: LHCC will optimize member risk identification and engagement in diabetes care by increasing the percentage of diabetic members who complete annual HbA1c testing. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** LHCC will risk-stratify non-engaged diabetic members for targeted outreach and alternative care options to encourage annual screenings and clinical monitoring.
 - **Action Description:** Member engagement in diabetes management will be facilitated through targeted outreach promoting HbA1c home testing options for targeted populations, providing an alternative means of clinical screening and opportunity to re-engage members with no recent PCP visits.

- **Expected Outcome:** Improvement in HbA1c testing in identified non-engaged member population targeted for home testing pilot. Identification of members with uncontrolled or at risk HbA1C results, allowing for outreach and linkage to care and resources.
- **Action Measurement:** Improvement in annual HbA1c testing rates by at least 2% over prior year and/or HbA1c home testing kit return rates >5% .

Obesity Goals 2021

- **Goal 1: LHCC will maintain an enrollment rate above 50% for Obesity Disease Management Programs for 2021. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Health coaches will be provided member engagement skills training within the first quarter of employment.
 - **Action Description:** Training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
 - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
 - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which will indicate enrollment into the disease management program.
- **Goal 2: LHCC will increase member referrals to case management over prior year baseline for those identified as at risk for obesity-related comorbidities. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Improve Case Management identification of members at risk for obesity-related adverse outcomes through health risk assessments (HRA).
 - **Action Description:** Enhanced case management training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
 - **Expected Outcome:** The expected outcome would be increased HRA completions that would facilitate case management identification and referral for members with identified obesity risks.
 - **Action Measurement:** Increase identification of members with obesity risks through HRA completions.
- **Goal 3: Improve HEDIS outcomes for pediatric obesity related measures (WCC) by at least 2% over prior year. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Promote obesity management and improved member health behaviors through member and provider outreach, education, and access to weight and nutrition management resources.

- **Action Description:** Promote obesity management and improved member health behaviors through member and provider outreach, education, and access to weight and nutrition management resources.
- **Expected Outcome:** Improvement in member obesity-related outcomes as evidenced by improvement in selected HEDIS CDC performance metrics YOY.
- **Action Measurement:** Improve HEDIS outcomes for pediatric obesity related measures (WCC) by at least 2% over prior year. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:
 - BMI percentile (> 59.42)
 - Counseling for Nutrition (> 58.45)
 - Counseling for Physical Activity (> 47.74)

Obesity Results 2021

Goal	Benchmark	Results
1	Annual Enrollments in Obesity Disease Management Programs	LHCC successfully met goal of increasing health risk assessment identifications and enrollments into Obesity disease management program. In 2021, 397 members with obesity risk identified on HRA's were successfully enrolled out of 738 referrals received, indicating an enrollment rate of 54% (exceeding goal of 50%).
2	HRA Completions with Obesity Risks Identified	Identification of members with obesity risks through HRA completions was 22% for 2021; this was a baseline measurement due to transition to new disease management platform prior year.
3	BMI Percentile Assessment Rate Counseling for Nutrition Rate Counseling for Physical Activity Rate	BMI percentile (2021 rate 63.3) improved 5.9%over prior year (57.4) Counseling for Nutrition (2021 rate 55.0) declined 1.5%over prior year (56.5). Counseling for Physical Activity (2021 rate 47.7) improved 2%over prior year (45.7).

Obesity Goals 2022

- **Goal 1: LHCC will maintain an enrollment rate above 50% for Obesity Disease Management Programs for 2022. Start Date: January 1, 2022 End Date: December 31, 2022**

 - **Action Step:** Update program curriculum. Health coaches will attend motivational interviewing and member engagement skills training with annual refreshers. New hire health coaches will be provided these trainings within the first quarter of employment.
 - **Action Description:** Training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters. The call curriculum was updated to align with updated clinical practice guidelines and standards of care. The curriculum focuses on key interventions that are covered with the members in a more frequent cadence.
 - **Expected Outcome:** This action is expected to improve member engagement and program enrollments/completions through enhanced engagement techniques.
 - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which will indicate enrollment into the disease management program.

- **Goal 2: Improve member awareness and skill development to promote healthy lifestyle and nutrition management through the following initiatives: SNAP match programs with farmers markets, nutrition education partnership with LSU Ag Center EFNEP (Expanded Food and Nutrition Program), LHCC collaboration to support LSU's healthy meals skill building videos and educational programs. These resources are promoted to LHCC members and videos are shared through multiple channels including the SNAP-Ed and EFNEP web and social media sites. Start Date: January 1, End Date: December 31, 2022**

 - **Action Step:** Increase member awareness, self-management skill development, and promote healthy lifestyle and nutrition management through community partnerships and expanding member access to healthy foods and meal planning on a limited budget.
 - **Action Description:** Improve member awareness and skill development to promote healthy lifestyle and nutrition management through the following initiatives: SNAP match programs with farmers markets, nutrition education partnership with LSU Ag EFNEP (Expanded Food and Nutrition Program), LHCC collaboration to support LSU's healthy meals skill building videos and educational programs. These resources are promoted to LHCC members via social media, member websites, and available on demand online.
Expected Outcome: Expand member engagement in local community programs, increase access to healthy foods, and support members with purchasing, planning and preparing healthy meals with limited food dollars.
 - **Action Measurement:** Success will be measured through individual engagement/participation at LHCC sponsored events/programs, increased SNAP match benefits/investments, and video collaborations and distributions throughout the year.

- **Goal 3: LHCC will improve HEDIS outcomes for pediatric obesity related measures (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents) BMI**

Percentile, Counseling for Nutrition, and Counseling for Physical Activity by at least 2% over prior year: Start Date: January 1, 2022 End Date: December 31, 2022

- **Action Step:** LHCC will increase provider engagement and awareness of obesity related programs, resources, and HEDIS improvement opportunities.
- **Action Description:** LHCC will expand EPSDT outreach to enhance provider support and increase focus on pediatric obesity resources, documentation best practices, and highlight HEDIS/WCC care gap opportunities for collaborative approach to improving member outcomes.
- **Expected Outcome:** Improvement in member obesity-related outcomes as evidenced by improvement in selected HEDIS CDC performance metrics YOY.
- **Action Measurement:** LHCC will improve HEDIS outcomes for pediatric obesity related measures (WCC) by 2% over prior year or meeting/exceeding national 50th percentile in the following measures:
 - BMI percentile (> 63.3)
 - Counseling for Nutrition (> 55.0)
 - Counseling for Physical Activity (> 47.7)

Appendix D5

UnitedHealthcare of Louisiana

2021 Diabetes and Obesity Action Plan

Diabetes Goals 2021

- **Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2% YOY. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Increase the use of HRAs for new members.
 - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
 - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
 - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- **Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
 - **Action Description:** Utilize the Healthy First Steps program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
 - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
 - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- **Goal 3: Increase engagement with providers by at least 2% YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results. Educate members in understanding their HbA1c and lipid panel and need to complete HbA1c, eye exams, and medical attention for nephropathy.
 - **Action Description:** Clinical consultants engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS measure targets.

The HEDIS guidelines and tip sheets are also distributed by clinical consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the clinical consultants educate providers on the importance of HbA1c (estimated average glucose) testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, clinical consultants ensure the providers are aware of the vision vendor MARCH Vision Care. Qualified providers are incentivized through our CP-PCPi Program for members with good HbA1c control <or = 9. Implemented Diabetic Wellness days pilot as an opportunity for members to receive diabetic education.

- **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS CDC rate and to see an upward trend in the monthly rates.
- **Action Measurement:** Increase engagement with providers by at least **2%** YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurements.

Diabetes Results 2021

Goal	Benchmark	2019 Results
1	2020 HRAs completed: 18,819	2021 HRAs completed: 14,058
	2021 # Members reached: 55,873	2021 # Members reached: 54,306
2	2020 # Members identified: 13,154	2021 # Members identified: 15,513
	2020 # Members qualified: 10,843	2020 # Members qualified: 13,604
3	HEDIS CDC MY2020: <ul style="list-style-type: none"> • Eye Exams: 60.58% • HbA1c Testing: 82.73% 	HEDIS CDC MY2020: <ul style="list-style-type: none"> • Eye Exams: 54.75% • HbA1c Testing: 81.32%

Diabetes Goals 2022

- **Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2% YOY. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Increase the use of HRAs for new members.
 - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
 - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
 - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- **Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
 - **Action Description:** Utilize the Healthy First Steps program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
 - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
 - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- **Goal 3: Increase engagement with providers by at least 3% YOY to ensure familiarity with current clinical practice guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) measurements. Start Date: January 1, 2022 End Date: December 2022**
 - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results. Educate members in understanding their HbA1c and lipid panel and need to complete HbA1c, eye exams and medical attention for nephropathy.
 - **Action Description:** Clinical consultants engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS measure targets. The HEDIS guidelines and tip sheets are also distributed by clinical consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the clinical consultants educate providers on the importance of HbA1c (estimated average glucose) testing, retinal eye exams, and blood pressure control. In the case of retinal exams, clinical consultants ensure the providers are aware of the vision vendor MARCH® Vision Care. Qualified providers are incentivized through our CP-PCPi Program for members with good HbA1c control < or = 9. Implemented Diabetic Wellness Days pilot as an opportunity for members to receive diabetic education.
 - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS® HBD (Comprehensive Diabetes Care HbA1c <8.0%) and EED (Eye Exam for patients with Diabetes) and to see an upward trend in the monthly rates.
 - **Action Measurement:** The indicators used to measure this goal include claims/encounter data and medical/treatment record abstractions.

Obesity Goals 2021

- **Goal 1: Increase member awareness of healthy lifestyles by 2% YOY. Start Date: January 1, 2021 End Date: December 31, 2021**

- **Action Step:** Educate members using weight management education materials.
 - **Action Description:** Members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended dietary intake, monitoring, and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
 - **Expected Outcome:** The expected outcome is to see an improvement in the number of members who are provided with weight management education materials.
 - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and in reports.
- **Goal 2: Facilitate healthy lifestyles by increasing the number of members engaged in community-based programs reached by 2% YOY. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Continue and build partnerships with community based organizations. Continue offering Weight Watchers® program information.
 - **Action Description:** There are a number of community-based organizations that can empower members to make positive changes in their lifestyles. For example, Heart Smart Sisters educates women about the causes of heart disease, the benefits of healthy diet, and the importance of regular exercise. Weight Watchers is available to all enrollees as a value added benefit.
 - **Expected Outcome:** The expected outcome is to see an improvement in the number of members contacted to educate on healthy nutrition and lifestyle.
 - **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and in the UHC database/report.
- **Goal 3: Increase engagement with providers by 2% YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: January 1, 2021 End Date: December 31, 2021**
 - **Action Step:** Educate providers by distributing resources including obesity toolkits.
 - **Action Description:** Consultants engage in educating providers about HEDIS. Consultants distribute HEDIS guidelines and HEDIS tips sheets to providers. Diabetes and obesity toolkits are also distributed to providers.
 - **Expected Outcome:** The expected outcome is to see an increase in the number of providers educated, an improvement in the final measurement year WCC percentile rate and upward trend in the monthly rate.
 - **Action Measurement:** The indicators used to measure this goal include information in the UHC database, information in claims/encounter data, and medical/treatment record abstractions.
 - **Action Measurement:** The indicators used to measure this goal include information in the UHC database, information in claims/encounter data, and medical/treatment record abstractions.

Obesity Results 2021

Goal	Benchmark	Results
1	2020 # of mailings to members: 12,272	2021 # of mailings to members: 14,624
2	2020 # of members reached: 1,226	2021 # of members reached: 3,770
	2020 # of events: 33	2021 # of events: 61
3	HEDIS MY2019 Adult BMI Assessment (ABA): 91.97%	HEDIS MY2020 Adult BMI Assessment (ABA): Retired measure
	HEDIS MY2020 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total) (WCC): 81.02%	HEDIS MY2021 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total) (WCC): 79.81%

Obesity Goals 2022

- **Goal 1: Increase member awareness of healthy lifestyles by 2% YOY. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Educate members using weight management education materials.
 - **Action Description:** Members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended dietary intake, monitoring, and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
 - **Expected Outcome:** The expected outcome is to see and improvement in the number of members sent weight management education materials.
 - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and in reports.

- **Goal 2: Facilitate healthy lifestyles by increasing the number of members engaged in community-based programs reached by 2% YOY. Start Date: January 1, 2022 End Date: December 31, 2022**
 - **Action Step:** Continue and build partnerships with community based organizations. Continue offering Weight Watchers® program information.
 - **Action Description:** There are a number of community-based organizations that can empower members to make positive changes in their lifestyles. For example, Heart Smart

Sisters® educates women about the causes of heart disease, the benefits of a healthy diet, and the importance of regular exercise. Weight Watchers is available to all enrollees as a value added benefit.

- **Expected Outcome:** The expected outcome is to see an improvement in the number of members contacted to educate on healthy nutrition and lifestyle.
- **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and the UHC database/report.

- **Goal 3: Increase engagement with providers by 2% YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: January 1, 2022 End Date: December 31, 2022**

- **Action Step:** Educate providers by distributing resources including obesity toolkits.
- **Action Description:** Consultants engage in educating providers about HEDIS. Consultants distribute HEDIS guidelines and HEDIS tips sheets to providers. Diabetes and obesity toolkits are also distributed to providers.
- **Expected Outcome:** The expected outcome is to see an increase in the number of providers educated, an improvement in the final measurement year WCC percentile rate, and upward trend in the monthly rate.
- **Action Measurement:** The indicators used to measure this goal include information in the UHC database, information in claims/encounter data, and medical/treatment record abstractions.

Appendix E – Standards of Diabetes Care

American Diabetes Association

Standards of Medical Care in Diabetes - 2022

https://diabetesjournals.org/care/issue/45/Supplement_1

Consensus Statement by the American Association of Clinical Endocrinologist and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm – 2020

<https://pubmed.ncbi.nlm.nih.gov/32022600/>

American Association of Clinical Endocrinologists and American College of Endocrinology – Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan – 2015

<https://www.aace.com/files/dm-guidelines-ccp.pdf>

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