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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January 2024

LOUISIANA DEPARTMENT OF HEALTH

Contents

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 the Health Insurance Portability and Accountability Act (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 was 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). Effective measurement year 2022, this measure was retired and replaced the following stand-alone measures: Hemoglobin A1c Control for Patients with Diabetes, Blood Pressure Control for Patients with Diabetes, and Eye Exam for Patients with Diabetes.

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), per 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 three 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 200% of the Federal Poverty Level 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 not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans. HEDIS and the Quality Compass are 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) – A 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 under 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 2022 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* 2023 report, Louisiana was ranked second highest in the nation.[1] The following obesity summary was based on 2022 MCO claims data:
    - In 2022, 58,853 Medicaid managed care enrollees under the age of 18 years had an obesity diagnosis. This is 8.24% of the managed care child population. Additionally, 12.80% of adult enrollees 18 years of age or older (123,217) had an obesity diagnosis in 2022. The overall obesity prevalence was 10.86% of the total managed care population of 1,676,070 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 2022 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2022) was 24.01% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2022.

- Louisiana was also ranked seventh highest in the nation for adult diabetes in 2022.[2] The following diabetes summary was based on 2022 MCO claims data:
    - In 2022, 9.07% (87,220 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.31% (2,183 enrollees). The total managed care population (1,676,070) had a diabetes prevalence of 5.33% (89,403). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish and age group.
    - While adults with diabetes make up 9.07% of the total managed care population, they accounted for 36.37% of total claim payments for all adults enrolled in managed care dates of service in 2022.
    - Of the 188,168 inpatient discharges in 2022, 2.88% (5,426 discharges) had a primary or secondary diagnosis of diabetes. There were 1,322,541 emergency department visits in 2022 for all Medicaid managed care enrollees and 2.36% (31,220) of those visits had a primary or secondary diagnosis of diabetes.

[1] *The State of Obesity: Better Policies for a Healthier America 2023.* (September 21, 2023). Retrieved October 31, 2023 from https://www.tfah.org/report-details/state-of-obesity-2023/

[2] Ibid.

- The average cost per enrollee with diabetes in 2022 was $17,390 and the average cost per member without diabetes in 2022 was $4,834.

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 contracted with Louisiana in 2022 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 future reports. Modifications made in 2020 streamline data validation and allow 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 2022 data extraction methodology and continued in 2023 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

[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 October 31, 2023 from https://pubmed.ncbi.nlm.nih.gov/19635784/

[4] *The State of Obesity: Better Policies for a Healthier America 2023.* (September 21, 2023). Retrieved October 31, 2023 from https://www.tfah.org/report-details/state-of-obesity-2023/

[5] *Causes of Obesity* (March 21, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/obesity/basics/causes.html

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]

People diagnosed with obesity compared to people in the healthy 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 38.4 million Americans are living with diabetes, and another 97.6 million are living with prediabetes. In the United States, diabetes was the eighth leading cause of death in 2021.[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]

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[6] *Overweight and Obesity* (September 21, 2023). Retrieved October 31, 2023 from https://www.cdc.gov/obesity/index.html
[7] *Health Effects of Overweight and Obesity* (September 24, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/healthyweight/effects/index.html.
[8] *National Diabetes Statistics Report* (June 29, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/data/statistics-report/index.html
[9] *What is Diabetes?* (September 5, 2023). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/basics/diabetes.html
[10] *National Diabetes Statistics Report* (November 29, 2023). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/data/statistics-report/index.html
[11] *Type 1 Diabetes.* (March 25, 2021). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/basics/type1.html
[12] *Type 2 Diabetes.* (April 18, 2023). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/basics/type2.html
[13] *Diabetes Risk Factors* (April 5, 2022). Retrieved October 31, 2023 from http://www.cdc.gov/diabetes/basics/risk-factors.html
[14] *Gestational Diabetes and Pregnancy* (July 14, 2022). Retrieved October 31, 2023 from http://www.cdc.gov/pregnancy/diabetes-gestational.html
[15] *Diabetes Risk Factors.* (April 5, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/basics/risk-factors.html

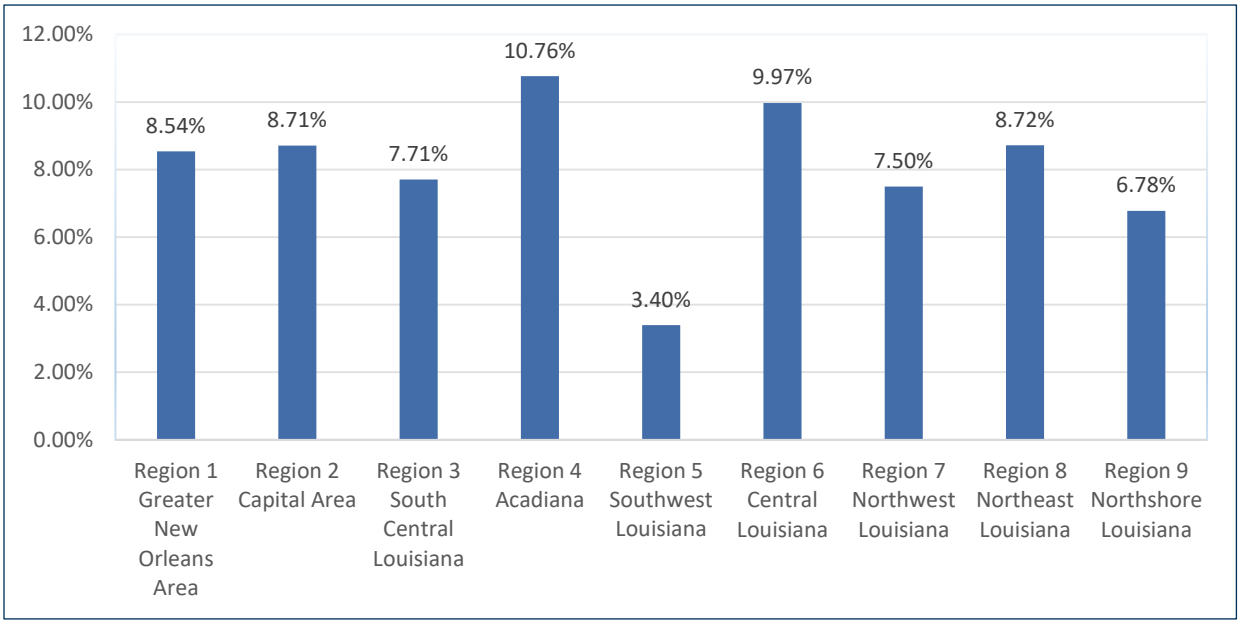
Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, and increased risk of Type 2 diabetes for both the mother and the child later in life. Often, gestational diabetes can be controlled through eating healthy foods, regular exercise, and losing weight if overweight. Sometimes those with gestational diabetes must also take insulin.[16]

2 The Scope of Obesity in the Louisiana 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 40.1% in 2022, which is the second-highest adult obesity rate in the United States.[17] In comparison, the rate of obesity for the Medicaid Managed Care population calculated using claims data was 10.86% for 2022. The discrepancy between rates indicates 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 2022 that included a primary or secondary diagnosis of obesity. Based on 2022 claims data, the managed care overall obesity prevalence rate was 10.86% of 1,676,070 managed care organization (MCO) enrollees. Figure 2.1 shows that Louisiana Medicaid Region 4 had the highest child obesity prevalence rate (10.76%), followed closely by Louisiana Medicaid Region 6 (9.97%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 4 at 15.26% and was followed closely by Louisiana Medicaid Region 8 at 15.07% and Louisiana Medicaid Region 3 at 14.90% (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 19.48% African-American, 12.31% other races, and 14.45% white (Figure 2.3). The remaining age, gender, and race strata had obesity prevalence rates below 9.93%. For parish-level obesity prevalence rates, please see Appendix B.

Figure 2.1: Louisiana Medicaid Managed Care - Prevalence of Obesity in Children (Age <18) in 2022 by Region



[16] *Gestational Diabetes and Pregnancy.* (July 14, 2022). Retrieved October 31, 2023 from http://www.cdc.gov/pregnancy/diabetes-gestational.html

[17] *The State of Obesity: Better Policies for a Healthier America 2023.* (September 21, 2023). Retrieved October 31, 2023 from https://www.tfah.org/report-details/state-of-obesity-2023/

Figure 2.2: Louisiana Medicaid Managed Care - Prevalence of Obesity in Adults (Age ≥18) in 2022 by Region

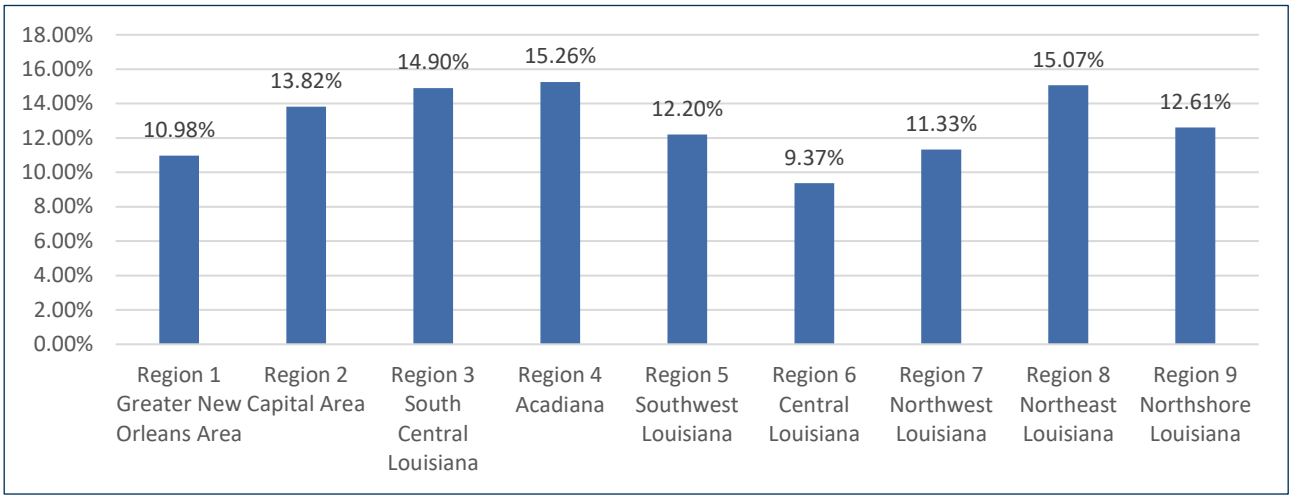
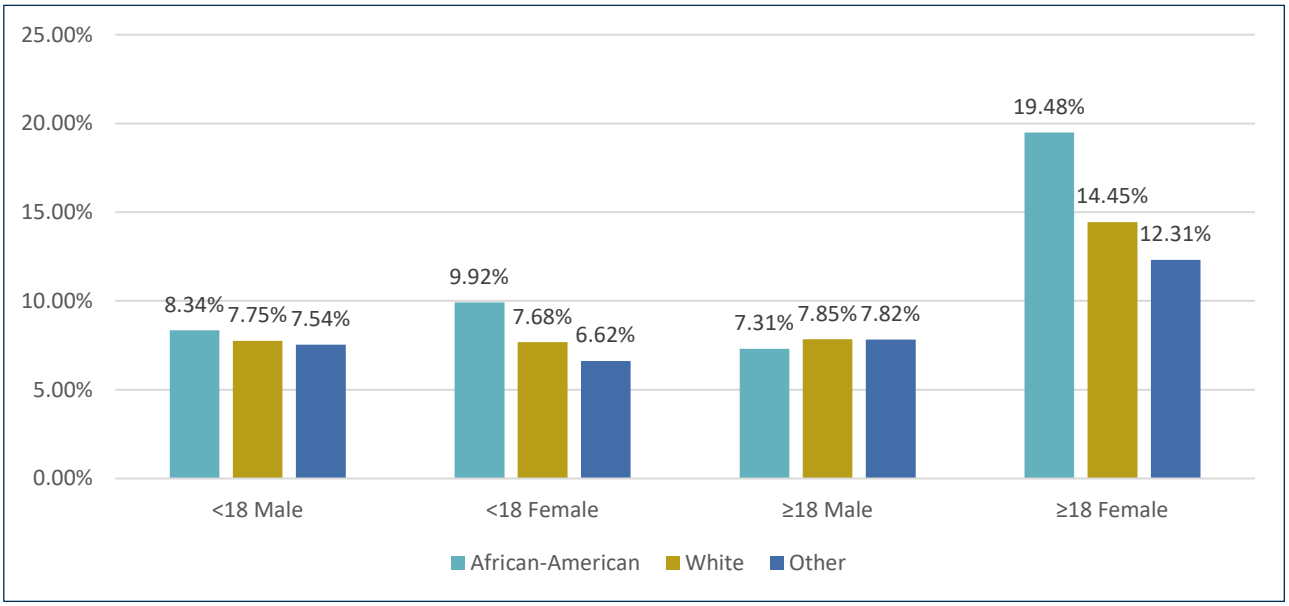


Figure 2.3: Louisiana Medicaid Managed Care – Prevalence of Obesity in 2022 by Age Group, Gender, and Race



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 2022 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 10.86%. Healthcare claim costs for these enrollees totaled $1,853,074,701 in 2022, which accounts for 24.01% of the total MCO claims payments ($7,718,462,298). In other words, of the entire Medicaid managed care population, the 10.86% who have a diagnosis of obesity account for 24.01% of the total healthcare claim costs.

Table 2.1: Total Cost of Obesity in 2022 among Medicaid Managed Care Enrollees By Claim Type, Age Group, and Obesity Category

Claim Type	Total Cost: Children Diagnosed with Obesity*	Total Cost: Children Without an Obesity Diagnosis	Total Cost: Adults Diagnosed with Obesity **	Total Cost: Adults Without an Obesity Diagnosis	Percent of Total Costs Associated with Enrollees Diagnosed with Obesity
Medical	$155,675,734	$1,327,330,072	$1,024,627,065	$2,577,954,300	23.21%
Pharmacy	$52,980,335	$303,095,732	$597,952,017	$1,512,322,086	26.39%
Other***	$12,387,411	$99,993,458	$9,452,140	$44,691,952	13.11%
Total	$221,043,480	$1,730,419,260	$1,632,031,221	$4,134,968,337	24.01%

*Includes claims, with dates of service in 2022, for any child MCO enrollee diagnosed with obesity in 2022.
**Includes claims, with dates of service in 2022, for any adult MCO enrollee diagnosed with obesity in 2022.
***Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

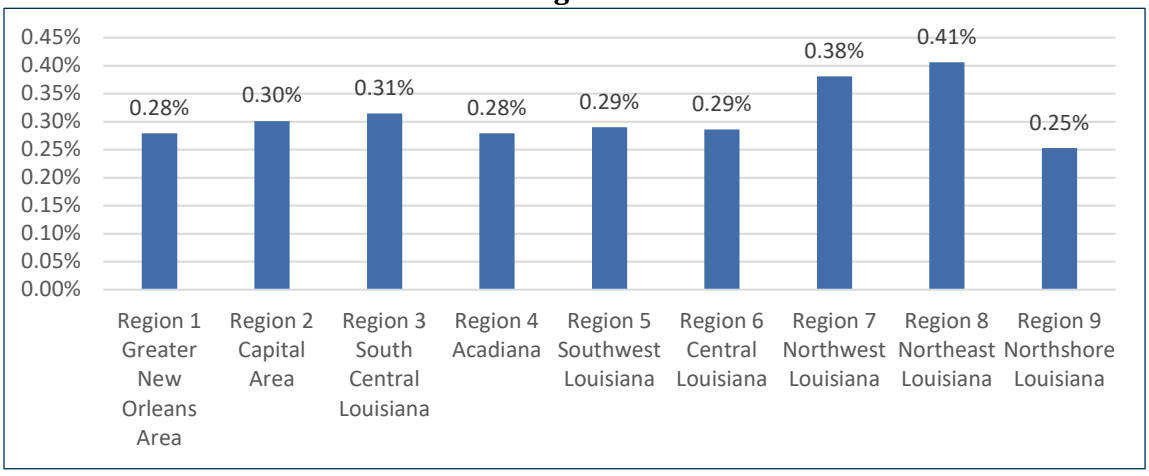
3 The Scope of Diabetes in the Medicaid Managed Care Program

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 ≥ 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 2022 was $413 billion.[18]

For the 2023 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2022 that included a primary or secondary diagnosis of diabetes. Based on 2022 claims data, the adult diabetes prevalence was 9.07% of 962,029 unique managed care adults. The child diabetes prevalence was 0.31% of 714,041 enrollees under the age of 18 years. Louisiana Medicaid Regions 8 and 7 had the highest child prevalence rates, 0.41% and 0.38% respectively (Figure 3.1). Louisiana Medicaid Region 3 had the highest adult prevalence rate, 9.84%, although all other regions had prevalence rates over 8.00% (Figure 3.2).

Figure 3.1: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Children (Age <18) in 2022 by Region



[18] *National Diabetes Statistics Report* (June 29, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/data/statistics-report/index.html

Figure 3.2: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Adults (Age ≥ 18) in 2022 by Region

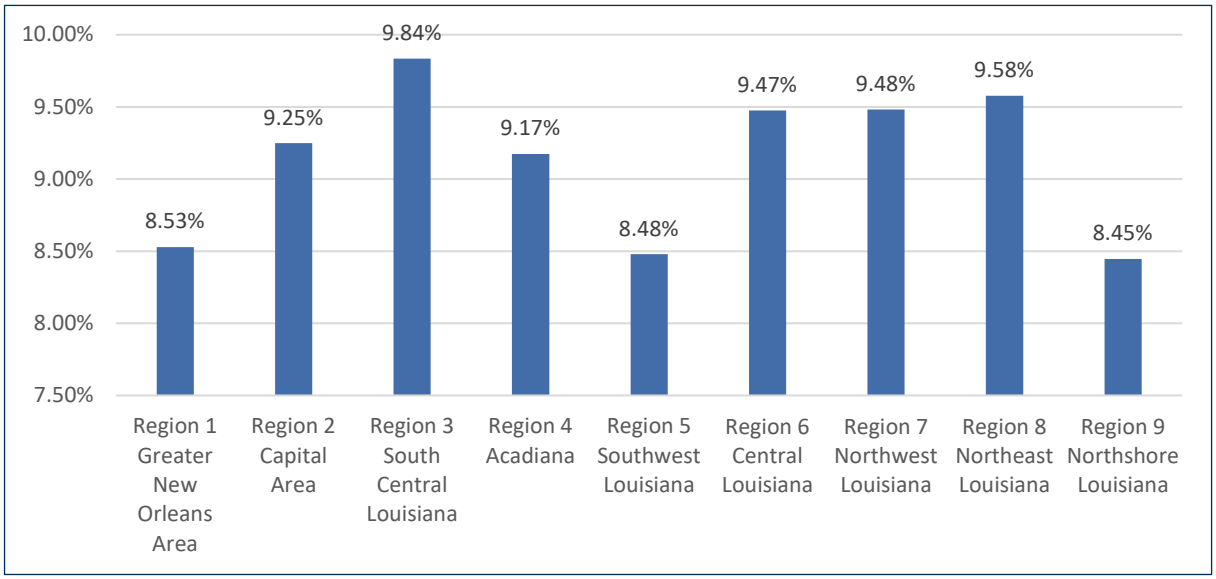


Figure 3.3 shows diabetes prevalence stratified by age group, gender and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among African-American race adult females (11.05%) and other race adult males (9.83%). CDC *National Diabetes Statistics Report* states that the prevalence of adult-diagnosed diabetes was highest among non-Hispanic African-Americans (12.7%).[19]

Figure 3.3: Louisiana Medicaid Managed Care –Prevalence of Diabetes in 2022 by Age, Gender, and Race

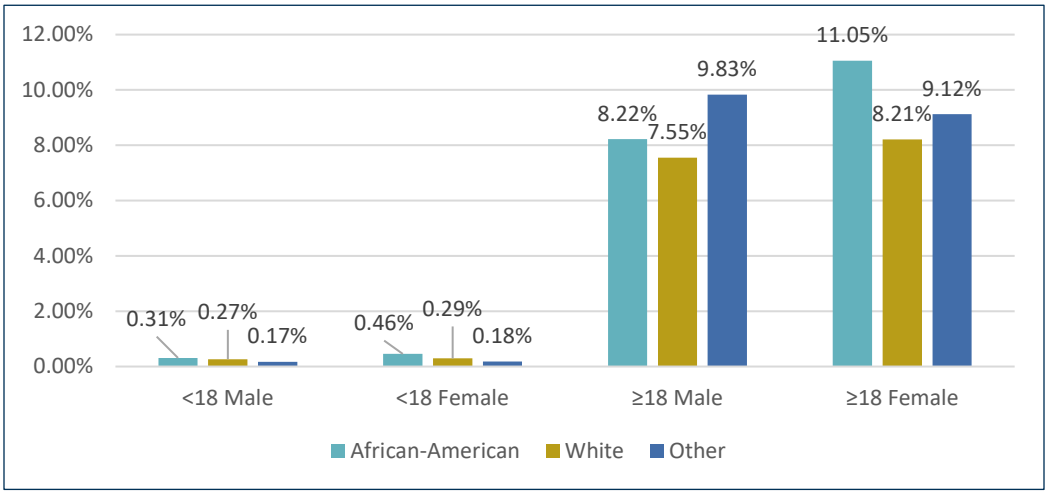


Table 3.1 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes to state and national utilization rates for the same practices. Louisiana's BRFSS percentages were less than the 2016 national numbers for most of the listed preventive care practices. The managed care dilated eye exam rate was considerably lower than the 2016 national median (40.55% versus 69.0%). For enrollees with diabetes in Medicaid managed care, HbA1c testing was slightly higher than the U.S. median

[19] *National Diabetes Statistics Report* (June 29, 2022). Retrieved October 31, 2023 from https://www.cdc.gov/diabetes/data/statistics-report/index.html

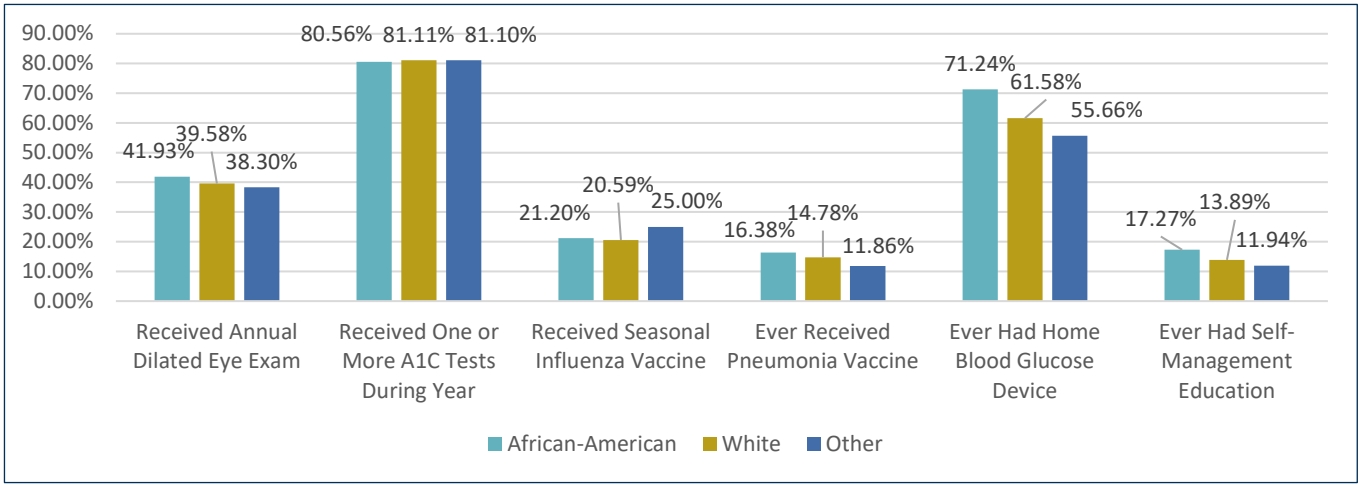
(80.84% versus 75.2%). However, the rate of ever having received self-management education was notably lower in the Medicaid managed care population when compared to the 2016 national median (15.27% versus 52.0%). The distribution of care practices across races in the managed care population is displayed 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 (71.24%) and white (61.58%) race categories when compared to the other (55.66%) race category.

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

Preventive Care Practice	Louisiana Medicaid Managed Care (2022 Data)	BRFSS United States (2016 Data)†
Received annual dilated eye exam	40.55%	69.0%
Received one or more HbA1c tests during the year	80.84%	75.2%††
Received seasonal influenza vaccine	21.59%*	(Not reported)
Ever received the pneumonia vaccine	15.12%*	(Not reported)
Ever had a home blood glucose device	65.46%	61.5%**
Ever had self-management education	15.27%	52.0%

†2016 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/pdfs/library/Diabetes-Report-Card-2019-508.pdf.
†† 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: Louisiana Medicaid Managed Care – Diabetic Preventive Care Practices in 2022 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 2022 with and without diabetes. The total cost per pregnant enrollees with diabetes was 1.79 times greater than those who did not have a diabetes complication during their pregnancy ($8,475 vs $4,736). Of the MCO enrollees who were pregnant during 2022 (51,234), 11.08% had a diagnosis of diabetes.

Table 3.1.1: Louisiana Medicaid Managed Care – Diabetes* and Pregnancies in 2022

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,676	$48,105,512	$8,475
Pregnancies without diabetes	45,558	$215,741,537	$4,736

*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 the U.S for 2022 was $413 billion.[20]

3.2.1 Impact of Diabetes on Total Cost of Care for Adults in Louisiana Medicaid Managed Care

Table 3.2.1 lists total costs, by claim type, for healthcare claims with dates of service in 2022 associated with Louisiana Medicaid managed care adult enrollees with and without diabetes. Managed care adult enrollees with diabetes were identified by medical claims with dates of service in 2022 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 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 MCO Adult 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 $1,538,095,102 in 2022 which accounts for 26.67% of the total adult MCO claims payments ($5,766,999,557) with dates of service in 2022.

[20] Economic Costs of Diabetes in the U.S. in 2022, American Diabetes Association, Diabetes Care 2023, dci230085; Retrieved November 16, 2023 from https://doi.org/10.2337/dci23-0085

Table 3.2.1: Louisiana Medicaid Managed Care – Cost of Adults with Diabetes in 2022 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	$873,377,041	$2,729,204,322	24.24%
Pharmacy	$658,020,765	$1,452,253,337	31.18%
Other**	$6,697,296	$47,446,796	12.37%
Total	$1,538,095,102	$4,228,904,455	26.67%

*Includes claims, with dates of service in 2022, for any adult MCO enrollee with diabetes in 2022.
**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 2022 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows, by age group and race, the percentage of 2022 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 (55.38%), followed by ketoacidosis (15.25%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (37.80%) and neurological manifestations (18.08%).

3.2.3 Emergency Department (ED) Visits Due to Diabetes

Table 3.2.3 includes, by race and age group, information 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 2022, for the Medicaid managed care population, 31,220 ED visits were diabetes-related. These diabetes-related visits represented 2.36% of ED visits for managed care enrollees during 2022. Of these diabetes-related visits, 17,720 visits (56.76%) were associated with diabetes-related complications.

Table 3.2.2: Louisiana Medicaid Managed Care - Prevalence of Diabetic Complications Among Enrollees with Diabetes in 2022 by Race and Age Group*

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total
Ketoacidosis	14.18%	16.22%	18.07%	15.25%	2.66%	2.43%	1.96%	2.47%
Hyperosmolarity	1.19%	0.74%	1.61%	1.10%	1.36%	1.13%	1.08%	1.24%
Coma	0.24%	0.60%	1.20%	0.46%	0.38%	0.43%	0.23%	0.37%
Renal Manifestations	1.58%	1.34%	1.20%	1.47%	11.37%	9.46%	10.34%	10.55%
Ophthalmic Manifestations	1.90%	1.49%	2.01%	1.79%	10.98%	8.91%	10.63%	10.21%
Neurological Manifestations	0.63%	0.45%	1.20%	0.64%	17.98%	19.43%	15.40%	18.08%
Peripheral Circulatory Disorders	0.08%	0.30%	0.00%	0.14%	6.37%	6.56%	5.83%	6.35%
Arthropathy	0.16%	0.00%	0.00%	0.09%	0.47%	0.51%	0.38%	0.47%
Skin Complications	1.19%	0.89%	0.40%	1.01%	3.88%	4.90%	3.65%	4.20%
Oral Complications	0.00%	0.00%	0.00%	0.00%	0.05%	0.06%	0.05%	0.05%
Hypoglycemia	6.66%	8.78%	11.65%	7.88%	3.05%	3.25%	2.45%	3.02%
Hyperglycemia	56.74%	55.06%	49.40%	55.38%	39.21%	36.89%	35.36%	37.80%

Other Specified Complications	7.84%	5.80%	10.84%	7.56%	11.92%	12.07%	12.04%	11.99%
Unspecified Complications	6.18%	5.65%	3.21%	5.68%	8.65%	7.99%	7.75%	8.28%
Count of Enrollees With Any Diabetes Diagnosis	1,262	672	249	2,183	43,353	30,221	13,646	87,220

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

Table 3.2.3: Louisiana Medicaid Managed Care – Prevalence of ED Visits with a Diagnosis of Diabetes and Prevalence of Diabetic ED Visits with a Diabetic Complication in 2022

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	200,037	686	0.34%	484	70.55%
White, < 18 years	115,083	348	0.30%	250	71.84%
Other, < 18 years	95,044	131	0.14%	101	77.10%
Total, < 18 years	410,164	1,165	0.28%	835	71.67%
African-American, ≥ 18 years	486,162	17,067	3.51%	9,558	56.00%
White, ≥ 18 years	330,801	9,604	2.90%	5,427	56.51%
Other, ≥ 18 years	95,414	3,384	3.55%	1,900	56.15%
Total, ≥ 18 years	912,377	30,055	3.29%	16,885	56.18%
Total, All Ages	1,322,541	31,220	2.36%	17,720	56.76%

***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. In 2022, among managed care enrollees who were diagnosed with one of the reported chronic conditions, hypertension (233,353 enrollees) was the most prevalent, followed by asthma (106,290 enrollees) and diabetes (89,403 enrollees). In 2022, for the reported chronic conditions, the highest total paid by the MCOs was $764,464,585 for hypertension. The total paid for diabetes during 2022 was $390,156,141. In 2022, for the reported chronic conditions, the highest average cost per enrollee was for congestive heart failure ($9,744). The average cost per enrollee with diabetes was $4,364.

Table 3.2.4: Louisiana Medicaid Managed Care – Prevalence of Selected Chronic Conditions and Cost Comparisons among Diabetes and Selected Chronic Conditions in 2022

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Hypertension	233,353	13.92%	$764,464,585	$3,276
Asthma	106,290	6.34%	$148,879,004	$1,401
Diabetes	89,403	5.33%	$390,156,141	$4,364

Arthritis	61,722	3.68%	$83,470,828	$1,352
COPD	26,508	1.58%	$123,534,618	$4,660
Coronary Heart Disease	25,244	1.51%	$138,290,436	$5,478
Congestive Heart Failure	18,824	1.12%	$183,413,353	$9,744

*A unique enrollee may be included in more than one chronic disease count.
**The prevalence denominator is the 2022 total unique enrollee count in MCOs (1,676,070).

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 in 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**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	67,152	88,834	9.16%	11.44%
Orleans	54,606	95,843	7.33%	10.46%
Plaquemines	2,964	3,961	8.57%	10.65%
St. Bernard	8,933	11,411	11.28%	11.86%
Total – Region 1	133,655	200,049	8.54%	10.98%
Region 2 Capital Area				
Ascension	15,280	17,810	8.26%	17.66%
East Baton Rouge	65,650	85,663	8.64%	12.34%
East Feliciana	2,455	3,977	12.91%	18.48%
Iberville	5,058	6,725	8.66%	16.45%
Pointe Coupee	2,959	4,068	11.73%	14.26%
West Baton Rouge	3,928	4,837	7.61%	16.87%
West Feliciana	1,307	1,655	6.12%	16.62%
Total – Region 2	96,637	124,735	8.71%	13.82%
Region 3 South Central Louisiana				
Assumption	2,483	3,851	10.43%	20.41%
Lafourche	12,176	16,674	11.06%	15.56%
St. Charles	6,287	7,774	7.84%	11.96%
St. James	2,813	4,217	7.15%	16.58%
St. John the Baptist	7,656	10,172	7.89%	13.01%
St. Mary	9,203	12,410	6.04%	15.91%
Terrebonne	18,180	23,507	5.90%	14.50%
Total – Region 3	58,798	78,605	7.71%	14.90%
Region 4 Acadiana				
Acadia	10,787	14,045	6.26%	15.27%
Evangeline	5,833	7,757	10.06%	13.67%
Iberia	13,103	17,904	15.55%	12.85%
Lafayette	34,133	44,167	10.98%	14.57%
St. Landry	17,680	23,008	8.04%	17.64%
St. Martin	8,220	10,609	14.88%	16.38%
Vermilion	9,098	12,054	10.36%	16.78%
Total – Region 4	98,854	129,544	10.76%	15.26%
Region 5 Southwest Louisiana				
Allen	3,516	4,458	5.75%	9.89%
Beauregard	5,976	7,112	3.58%	9.87%
Calcasieu	31,332	39,013	2.69%	12.31%
Cameron	296	459	6.42%	11.76%
Jefferson Davis	5,061	6,403	5.77%	15.77%
Total – Region 5	46,181	57,445	3.40%	12.20%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Avoyelles	7,174	9,323	10.61%	8.72%
Catahoula	1,636	2,633	7.70%	8.85%
Concordia	3,911	5,354	1.99%	7.42%
Grant	3,188	4,096	12.08%	8.86%
LaSalle	2,128	2,915	4.09%	12.42%
Rapides	21,718	28,011	13.12%	10.11%
Vernon	6,059	7,857	2.81%	7.37%
Winn	2,041	2,863	15.38%	11.56%
Total – Region 6	47,855	63,052	9.97%	9.37%
Region 7 Northwest Louisiana				
Bienville	2,385	3,399	5.95%	9.06%
Bossier	16,822	19,299	7.86%	11.67%
Caddo	40,246	53,663	8.45%	12.03%
Claiborne	2,085	2,870	5.32%	11.22%
DeSoto	4,271	5,516	7.16%	14.00%
Natchitoches	6,113	8,115	5.33%	8.19%
Red River	1,586	2,029	3.22%	7.05%
Sabine	3,512	5,036	3.62%	9.87%
Webster	6,422	9,219	7.27%	10.38%
Total – Region 7	83,442	109,146	7.50%	11.33%
Region 8 Northeast Louisiana				
Caldwell	1,741	2,739	2.64%	13.29%
East Carroll	1,470	1,931	7.89%	17.71%
Franklin	3,961	5,677	3.81%	11.96%
Jackson	1,920	2,820	8.49%	14.79%
Lincoln	6,141	8,550	7.52%	11.20%
Madison	2,374	3,164	6.02%	12.99%
Morehouse	4,937	7,606	14.32%	20.59%
Ouachita	28,213	38,156	9.41%	15.45%
Richland	3,748	5,416	9.42%	14.81%
Tensas	704	1,265	4.40%	12.09%
Union	3,724	5,304	9.53%	13.69%
West Carroll	1,863	2,953	6.28%	19.74%
Total – Region 8	60,796	85,581	8.72%	15.07%
Region 9 Northshore Louisiana				
Livingston	20,755	25,121	6.62%	13.12%
St. Helena	1,316	1,803	12.84%	17.08%
St. Tammany	30,983	41,030	6.23%	10.77%
Tangipahoa	25,931	33,720	6.70%	12.98%
Washington	8,838	12,198	8.42%	16.07%
Total – Region 9	87,823	113,872	6.78%	12.61%

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	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	67,152	88,834	0.26%	9.01%
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Total – Region 1	133,655	200,049	0.28%	8.53%
Region 2 Capital Area				
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Pointe Coupee	2,959	4,068	0.27%	12.29%
West Baton Rouge	3,928	4,837	0.28%	11.21%
West Feliciana	1,307	1,655	0.15%	9.85%
Total – Region 2	96,637	124,735	0.30%	9.25%
Region 3 South Central Louisiana				
Assumption	2,483	3,851	0.28%	13.14%
Lafourche	12,176	16,674	0.32%	9.73%
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St. Landry	17,680	23,008	0.27%	9.88%
St. Martin	8,220	10,609	0.33%	9.28%
Vermilion	9,098	12,054	0.27%	9.54%
Total – Region 4	98,854	129,544	0.28%	9.17%
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Beauregard	5,976	7,112	0.18%	10.12%
Calcasieu	31,332	39,013	0.31%	7.83%
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Jefferson Davis	5,061	6,403	0.28%	9.29%
Total – Region 5	46,181	57,445	0.29%	8.48%

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
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Catahoula	1,636	2,633	0.24%	10.03%
Concordia	3,911	5,354	0.28%	9.64%
Grant	3,188	4,096	0.19%	9.96%
LaSalle	2,128	2,915	0.38%	10.70%
Rapides	21,718	28,011	0.30%	8.79%
Vernon	6,059	7,857	0.21%	9.61%
Winn	2,041	2,863	0.24%	11.32%
Total – Region 6	47,855	63,052	0.29%	9.47%
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Bienville	2,385	3,399	0.63%	11.62%
Bossier	16,822	19,299	0.24%	9.02%
Caddo	40,246	53,663	0.41%	9.20%
Claiborne	2,085	2,870	0.86%	11.67%
DeSoto	4,271	5,516	0.42%	10.12%
Natchitoches	6,113	8,115	0.38%	9.80%
Red River	1,586	2,029	0.32%	8.58%
Sabine	3,512	5,036	0.26%	9.93%
Webster	6,422	9,219	0.36%	9.90%
Total – Region 7	83,442	109,146	0.38%	9.48%
Region 8 Northeast Louisiana				
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Franklin	3,961	5,677	0.33%	10.87%
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Lincoln	6,141	8,550	0.49%	8.92%
Madison	2,374	3,164	0.42%	9.29%
Morehouse	4,937	7,606	0.49%	9.51%
Ouachita	28,213	38,156	0.34%	8.62%
Richland	3,748	5,416	0.59%	10.89%
Tensas	704	1,265	0.57%	12.41%
Union	3,724	5,304	0.27%	10.16%
West Carroll	1,863	2,953	0.54%	11.51%
Total – Region 8	60,796	85,581	0.41%	9.58%
Region 9 Northshore Louisiana				
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St. Helena	1,316	1,803	0.15%	9.60%
St. Tammany	30,983	41,030	0.26%	7.08%
Tangipahoa	25,931	33,720	0.25%	9.49%
Washington	8,838	12,198	0.31%	10.67%

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Total – Region 9	87,823	113,872	0.25%	8.45%

Appendix D – 2022 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 2022 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2022 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2022 Diabetes and Obesity Action Plan
Appendix D4	Louisiana Healthcare Connections 2022 Diabetes and Obesity Action Plan
Appendix D5	United Healthcare 2022 Diabetes and Obesity Action Plan
Appendix D6	Humana Healthy Horizons in Louisiana 2022 Diabetes and Obesity Action Plan

Appendix D1
Aetna Better Health of Louisiana
2022 Diabetes and Obesity Action Plan

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 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 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 aged 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 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 exams. HealPros will schedule appointments and complete eye exams in a convenient location for the member.
    - **Expected Outcome:** Increase in eye exams and HbA1c testing among members aged 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: 1/1/2022 End Date: 12/31/2022***
    - **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 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 2022

Goal	Benchmark	Results
1	Diabetes-specific HEDIS outreach appts baseline (2021) compared to 2022)	2021 HEDIS Outreach: 285; 2022 HEDIS Outreach 340
2	Diabetes-specific IVR calls with baseline (2021) compared to 2022	2021 Diabetes IVR Calls: 4,353 2021 Diabetes IVR Calls: 4,601
3	HEDIS Administrative Rate Comparison of Plan to VBS	HbA1c >8% ABHLA Final 2022: 45.26%; VBS Final: 46.85% Eye Exam ABHLA Final 2022 47.93%; VBS final: 48.62%

Diabetes Goals 2023

- ***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 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **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 users with a broad range of personalized educational content and evidence-based tools through the mPulse 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 aged 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 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **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 (CDC). HealPros will schedule appointments and complete eye exams in a convenient location for the member.
- **Expected Outcome:** Increase in eye exams and HbA1c testing among members aged 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: 1/1/2023 End Date: 12/31/2023***
  - **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 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 contracts.

Obesity Goals 2022

- ***Goal 1: Host community events across Louisiana and provide education about obesity to attendees. Start Date: 1/1/2022 End Date: 12/31/2022***
  - **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: 1/1/2022 End Date: 12/31/2022***
  - **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 the number of new partnerships and support provided around obesity initiatives.

- ***Goal 3: Increase awareness of After-School Value Added Benefits and support after-school programs that provide safe physical activity to participants. Start Date: 1/1/2022 End Date: 12/31/2022***

- **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 can 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 2022

Goal	Benchmark	Results
1	Events held by community outreach team	2022 calendar year - community outreach: 430 events 15,025 – materials in English distributed 6,515 – materials in Spanish distributed
2	Events held by community outreach team	2022 calendar year - community outreach: 430 events 15,025 – materials in English distributed 6,515 – materials in Spanish distributed
3	Number of staff trained in VABs across the plan	8 community outreach coordinators in 2022 3 HEDIS outreach coordinators, 5 in Quality Management total Member services staff: 20

Obesity Goals 2023

- ***Goal 1: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Work with community-based organizations 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 obesity program support capacity.
  - **Action Measurement:** Track the number of new partnerships and support provided around obesity initiatives.

- ***Goal 2: Hire a Health Coach and begin active health coaching for adult members with obesity. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Hire a Health Coach with a focus on Diabetes and Obesity.

- **Action Description:** Expanding internal capacity for obesity program function and support.
- **Expected Outcome:** Enrolling members in health coaching that promotes a healthy lifestyle and addresses obesity.
- **Action Measurement:** Increase the number of members receiving health coaching.

- ***Goal 3: Host community events across Louisiana and provide education about obesity to attendees. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Partner with community development to provide educational material around obesity, healthy eating, and physical activity at community events.
  - **Action Description:** Track the number of materials that were distributed at the events.
  - **Expected Outcome:** Increased member knowledge about obesity, healthy eating, and physical activity.
  - **Action Measurement:** Internal reports tracking distributed materials.

Appendix D2
AmeriHealth Caritas Louisiana (ACLA)
2022 Diabetes and Obesity Action Plan

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 members with diabetes to ensure members receive the best health care achievable. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** ACLA will analyze claims data to identify members with diabetes attributed to their practice, and will benefit from billing CPT CAT II codes.
    - **Action Description:** ACLA will reach out to engage providers in the usage of CPT CAT II codes by sharing the benefits of usage through multidisciplinary provider education, quarterly provider training, projects involving specialized file sharing with identified provider groups, and report cards in the 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 member with diabetes results received for 2022, compared to results received in 2021.

- ***Goal 2: ACLA will increase member compliance percentage for members with diabetes linked to providers participating in VBC who selected HbA1c >9.0% as a measurable outcome or Quality-Educated Provider Groups by December 2022. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** Continue the process for assisting providers participating in VBC who selected HbA1c >9.0% as a measurable 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 measurable 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% will be 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 Quality Compass (QC) 50th percentile or 2% decrease goal for HbA1c >9.0%, with a special focus on our members with diabetes who are most likely to experience health disparities by December 2022. Start Date: 1/1/2022 End Date: 12/31/2022***

- **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 Hemoglobin A1c Control for Patients With Diabetes (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.

Diabetes Results 2022

Goal	Benchmark	Results
1	An increase in the percentage of members with diabetes results received for 2022 compared to 2021.	In 2022, the MCO exceeded its goal by demonstrating an increase of over 100% in the number of diabetic test results received for members linked to providers who submit CPT CAT II codes, compared to those received in 2021.
2	Members linked to providers participating in VBC or quality-educated provider groups who demonstrated glycemic control - quantify those HEDIS rates for HBD Poor Control for both 2022 and 2021.	ACLA Quality-educated provider groups and groups participating in Value-Based Contracting (VBC) who selected HBD Poor Control as a measurable outcome demonstrated increased member compliance, as evidenced by an overall 14.72% decrease in rates from 2021 to 2022.
3	The 2021 Medicaid QC 50th percentile or 2% decrease for HBD Poor Control measure in 2022.	The MCO exceeded the 2% improvement goal for the HBD Poor Control measure, experiencing a 4.14% rate decrease in 2022 compared to 2021.

Diabetes Goals 2023

- ***Goal 1: ACLA will increase provider use of CPT CAT II codes for member diabetic test results by December 2023, to identify necessary clinical data for closing gaps in care for members with diabetes to ensure members receive the best health care achievable. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** ACLA will analyze claims data to identify members with diabetes attributed to their practice, and will benefit from billing CPT CAT II codes.
    - **Action Description:** ACLA will reach out to engage providers in the usage of CPT CAT II codes by sharing benefits of usage through multidisciplinary provider education, projects involving specialized file sharing with identified provider groups (i.e. EPIC) and, Comprehensive CPT CAT II Provider flyer web posting.
    - **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:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes.

- ***Goal 2: ACLA will increase member compliance for members with diabetes linked to quality-educated provider groups, including VBC groups who selected HBD as a measurable outcome, by December 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Continue the process of educating provider groups to continually improve member compliance rates for the HBD measure via multi-disciplinary provider education, quarterly trainings, and ad hoc provider trainings.
    - **Action Description:** ACLA will identify and target providers with paneled members with diabetes 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, as evidenced by improved rates for HBD measures for quality-educated and VBC groups who selected HBD as a measurable outcome.
    - **Action Measurement:** The percentage of improvement shown for HBD measures for both quality-educated and VBC provider groups who selected HBD as a measurable outcome in 2023 compared to 2022.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2022 Medicaid QC 50th percentile or 2% decrease goal for HBD Poor Control, with a special focus on our members with diabetes who are most likely to experience health disparities by December 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **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 and Mobile Wellness units (with multi-departmental initiatives), Community Center Exercise Programs and cooking classes, Diabetic Retinopathy (DR) eye

examinations at Wellness Center with an educational component, HELS "We're Here for You" proactive member education campaign aimed at newly-diagnosed African American and Spanish speaking enrollees in rural areas, Make Every Calorie Count program (MECC), gym membership, fitness kit if qualify, Member Care Card Benefits, updated web content, member portal access, 24/7 Nurse Helpline, Transportation program, Automated Reminder Calls (Call Blasts), Emergency Room follow-up visits, educational mailings, member newsletter, social media posts and invitations, RROT working with high PICS population in Transition to Care, member mobile apps, diabetic text messaging campaign, voice mail messaging, Vheda Health for chronic disease monitoring, Heart Healthy program, Care Meals, ACLA Nutrition Pilot, PHM outreach to HbA1c >8%, faith-based organizations presentations, 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 Poor Control measure for 2023.
- **Action Measurement:** The percentage decrease in HBD Poor Control measure rates in 2023 compared to 2022 and/or the 2022 Medicaid QC 50th percentile.

Obesity Goals 2022

- ***Goal 1: ACLA will 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. Start Date: 1/1/2022 End Date: 12/31/2022***
  - **Action Step:** The 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 the targeted population engaged in the 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 members with a diagnosis of obesity with comorbid conditions who are most likely to experience health disparities in 2022. Start Date: 1/1/2022 End Date: 12/31/2022***
  - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming to promote self-management of obesity and other comorbid conditions through early intervention.
  - **Action Description:** ACLA will determine effective ways to support equitable access for members with an obesity diagnosis, address social determinants of health (SDOH) where possible, and increase compliance with 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 members with an obesity diagnosis with lower BMIs to participate.
  - **Expected Outcome:** Increased engagement of members with obesity 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 members with obesity with education including self-management, treatment, and benefits. Start Date: 1/1/2022 End Date: 12/31/2022***
  - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help members with obesity 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 members with obesity, and discussion of programs for members with obesity during bi-monthly Member Advisory Council meetings.
  - **Expected Outcome:** Increased engagement of high-risk members with obesity 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.

Obesity Results 2022

Goal	Benchmark	Results
1	At least 10% of targeted population engaged in ACLA Nutrition pilot program by December 2022.	In 2022, ACLA did not meet its goal, with enrollment of only 6.2% of the targeted members into our nutrition program pilot. ACLA recognizes that there continue to be opportunities to improve the program to promote basic needs and healthy living initiatives for members with a diagnosis of obesity and other comorbid conditions. The MCO developed the ACLA Nutritional Pilot program in 2022 through a partnership with a target provider group. Implementation of the pilot was started in March of 2022 but involved multiple steps that had to be completed by the member and our plan before enrollment and receipt of nutrition packages, which harmed access to healthy food delivery for our members. In 2023, the program is being restructured to involve a less complex regimen.
2	An increase of at least 2% of members with obesity engaged	The MCO did not meet its Make Every Calorie Count (MECC) program goal. In 2022 there were

	in the Make Every Calorie Count program by December 2022 compared to the number of members engaged by December 2021.	214 members engaged as compared to 252 members engaged in 2021, resulting in a 0.85% reduction.
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 2022, compared to 2021.	ACLA met the goal set for 2022. The percentage of ACLA members engaged in Population Health Management programs with a primary or secondary diagnosis of obesity was 0.25% in both 2021 and 2022. ACLA recognizes that there continue to be opportunities to engage and educate members on the importance of healthy behaviors. The plan also realizes that the implementation of face-to-face visits in 2022 created challenges in the distribution of resources as we continue to provide access to case management for our members.

Obesity Goals 2023

- ***Goal 1: ACLA will develop and implement programs to promote basic needs and healthy living initiatives for members with a diagnosis of obesity and other comorbid conditions. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** The target population will consist of ACLA members living in East Baton Rouge and surrounding parishes linked to specific provider groups.
    - **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 the targeted population in the pilot program.
    - **Action Measurement:** The percentage of members engaged in the ACLA Nutrition pilot program by December 2023.

- ***Goal 2: ACLA will improve the health outcomes of members with obesity with comorbid conditions who are most likely to experience health disparities in 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Focus on member populations with historic disparate health outcomes through the use of tailored programming to promote self-management of obesity and other comorbid conditions through early intervention.
    - **Action Description:** ACLA will determine effective ways to support equitable access for African American members with obesity, address social determinants of health (SDOH) where possible, and increase compliance with Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with obesity.

- **Expected Outcome:** Increased engagement of African American members with obesity in ACLA's Make Every Calorie Count (MECC) program by December 2023.
- **Action Measurement:** The percentage of African American members with a diagnosis of obesity engaged in the Make Every Calorie Count program by December 2023 compared to that of members engaged in 2022.

- ***Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2023 to reduce the impact of obesity by providing members who are obese with education including self-management, treatment, and benefits. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help members with obesity 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 members with obesity, and discussion of programs for members with obesity during Member Advisory Council and Provider Advisory Council meetings.
  - **Expected Outcome:** Increased engagement of members who are at high risk for obesity 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 2023 compared to those engaged in 2022.

Appendix D3
Healthy Blue
2022 Diabetes and Obesity Action Plan

Diabetes Goals 2022

- ***Goal 1: Improved Diabetes Preventative Care Practices with a focus on decreasing racial disparities. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** Decrease Black/white disparity in the 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 of health equity.
    - **Action Measurement:** Increase the percentage of Black members with HbA1c >9% (engaged in case management programs). Increase the percentage of drug-adherent members.

- ***Goal 2: Improved YoY HEDIS rates as they relate to diabetes by at least 2%. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** Expand provider outreach and education from the 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 Medicaid Quality Rating System 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: 1/1/2022 End Date: 12/31/2022***
    - **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.

Diabetes Results 2022

Goal	Benchmark	Results
1	HEDIS rates for HBD by race	Hemoglobin A1c Control for Patients With Diabetes Good Control <8% (HBD) = 80.00% American Indian and Alaska Native, 53.70% Asian, 52.66% Black, 54.84% white Hemoglobin A1c Control for Patients With Diabetes Poor Control >9% (HBD) = 20.00% American Indian and Alaska Native, 35.19% Asian, 37.77% Black, 37.42% white,
2	HEDIS rates for HBD, BPD, EED, SPD	Hemoglobin A1c Control for Patients With Diabetes Poor Control >9% (HBD) = 37.47% (4.62% YOY improvement), Hemoglobin A1c Control for Patients With Diabetes Good Control <8% (HBD) = 53.77% (2.97% YOY improvement), Blood Pressure Control for Patients With Diabetes (BPD) = 64.48% (8.58% YOY improvement), Eye Exam for Patients with Diabetes (EED) = 55.23% (6.63% YOY improvement), Statin Therapy for Patients with Diabetes-Received Statin Therapy (SPD) = 65.52 (-2.58% YOY)
3	LA Request for Proposals (RFP) Medicaid Data Provider Counts for Value-Based Programs	Total provider counts raised by 66% from 2021-2022 for a total of 173 primary care providers, including specialists enrolled in value-based programs for year 2022

Diabetes Goals 2023

- ***Goal 1: Improve YoY HEDIS rates associated with Diabetes by at least 2% and/or 50th percentile based on NCQA benchmark. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Expand provider outreach and education from the prior year.
  - **Action Description:** Increase collaboration between health plan and providers on programs and educational offerings available to improve documentation and coding as well as gap in care reports and practice consultants to improve overall HEDIS and Medicaid Quality Rating System rates.

- **Expected Outcome:** Increased provider awareness of quality goals and metrics, coding and documentation requirements, and overall improved outcomes for Healthy Blue members.
- **Action Measurement:** Improved YoY rates by 2% and/or 50th percentile for the following HEDIS measures: Hemoglobin A1c Control for Patients with Diabetes, Good Control <8% (HBD); Hemoglobin A1c Control for Patients with Diabetes, Poor Control >9% (HBD); Blood Pressure Control for Patients with Diabetes (BPD); Eye Exam for Patients with Diabetes (EED); Kidney Health Evaluation for Patients with Diabetes (KED); Statin Therapy for Patients with Diabetes, received therapy (SPD); Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD); Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).

- ***Goal 2: Improve Diabetes Preventative Care Practices with a focus on decreasing racial disparities. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Decrease Black/white disparity rate in diabetes control.
  - **Action Description:** Outreach to members and their attributed providers with uncontrolled diabetes 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 to members with poor adherence.
  - **Expected Outcome:** Increased provider awareness of disparities and strategies to improve quality metrics and overall outcomes for the members we serve with an increased awareness of health equity
  - **Action Measurement:** Increased percentage of Black members with HbA1c >9% engaged in case management programs and increased percentage of drug adherent members

- ***Goal 3: Increase provider enrollment within Value-Based Programs to improve diabetes outcomes for members served. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Increase provider engagement in Value-Based Programs that align with diabetes outcomes.
  - **Action Description:** Expand Value-Based offerings for providers that align with health plan strategy to improve outcomes overall.
  - **Expected Outcome:** Increased provider enrollment will result in an increased number of members receiving diabetic care and improved outcomes related to diabetes.
  - **Action Measurement:** Total number of providers enrolled in Value-Based programs aligned with diabetes measures.

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: 1/1/2022 End Date: 12/31/2022***
  - **Action Step:** Expand provider outreach and education from the 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 Medicaid Quality Rating System rates.

- **Expected Outcome:** Increased provider awareness of quality metrics, documentation, and coding requirements and improved member awareness of health care management.
- **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: 1/1/2022 End Date: 12/31/2022***
  - **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: 1/1/2022 End Date: 12/31/2022***
  - **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 the 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.

Obesity Results 2022

Goal	Benchmark	Results
1	HEDIS rates for WCC, SPC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile Total (WCC) = 77.13% (1.95% YOY increase), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (WCC) = 62.53% (-5.11% YOY), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (WCC) = 55.96% (-1.70% YOY),

		Statin Therapy for Patients with Cardiovascular Disease - Received Therapy (SPC)= 80.54 (-0.46% YOY)
2	EPSDT Screening and Participation Rates	EPSDT Rates 2022: January 30th Medicaid: Screening Ratio = 91%, Participant Ratio = 62% CHIP: Screening Ratio = 100%, Participant Ratio = 75%, April 30th Medicaid: Screening Ratio = 91%, Participant Ratio = 62% CHIP: Screening Ratio = 100%, Participant Ratio = 75%, July 30th Medicaid: Screening Ratio = 91%, Participant Ratio = 62% CHIP: Screening Ratio = 100%, Participant Ratio = 75%, October 30th Medicaid: Screening Ratio = 91%, Participant Ratio = 62% CHIP: Screening Ratio = 100%, Participant Ratio = 75%
3	LA RFP Medicaid Data Provider Counts for Value-Based Programs	Total provider counts raised by 66% from 2021-2022 for a total of 173 primary care providers, including specialists enrolled in value-based programs for year 2022

Obesity Goals 2023

- ***Goal 1: Improve YoY HEDIS rates associated with obesity by 2% or greater and/or reach the 50th percentile NCQA benchmark for Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Expand provider outreach and education from the prior year.
    - **Action Description:** Increase collaboration between health plan and providers on programs and educational offerings available to improve documentation and coding as well as gap in care reports and practice consultants to improve overall HEDIS and Medicaid Quality Rating System rates.
    - **Expected Outcome:** Increase provider awareness of quality metrics, documentation & coding requirements, and improve member awareness of healthcare management.
    - **Action Measurement:** Review and monitor HEDIS rates for Weight Assessment and Counseling for Nutrition and Physical Activity for children/adolescents (WCC).

- ***Goal 2: Increase engagement in EPSDT screening and participation. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Member education and outreach on preventative options for obesity and promoting healthy lifestyle choices.
    - **Action Description:** Increase member engagement through outreach and text campaigns, incentives, and wellness campaigns run by case management and quality.
    - **Expected Outcome:** Increase member participation and awareness of preventative care activities and weight management.
    - **Action Measurement:** Review and monitor participation in EPSDT screening rates.

- ***Goal 3: Increase provider enrollment within Value-Based Programs to prevent and manage obesity for Healthy Blue members. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Increase provider engagement in Value-Based Programs that align with obesity and overall Health Plan strategy.

- **Action Description:** Expand Value-Based offerings for providers that align with health plan strategy to improve outcomes overall.
- **Expected Outcome:** Increased provider enrollment will result in improved outcomes related to obesity and physical health.
- **Action Measurement:** Total number of providers enrolled in Value-Based programs that incorporate obesity and prevention measures.

Appendix D4
Louisiana Healthcare Connections
2022 Diabetes and Obesity Action Plan

Diabetes Goals 2022

- ***Goal 1: LHCC will maintain or exceed an enrollment rate of 75% for the Diabetes Program for 2022. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 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 indicate 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: 1/1/2022 End Date: 12/31/2022***
    - **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 a $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 the prior year or meeting/exceeding the 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 members with diabetes who complete annual HbA1c testing. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** LHCC will risk-stratify non-engaged members with diabetes 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 an 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% points over the prior year and/or HbA1c home testing kit return rates >5%.

Diabetes Results 2022

Goal	Benchmark	Results
1	Annual Enrollments in Diabetes Disease Management Programs > 75%	LHCC achieved the goal of increasing health risk assessment identifications and enrollments into the diabetes disease management program. In 2022, 173 members with diabetes risk identified on HRA's were successfully enrolled out of 254 referrals received, indicating an enrollment rate of 68% (below the 75% goal). *Centene's Disease Management program is undergoing evaluation and transition for operational efficiency; as a result, this indicator is being retired.
2	NCQA Quality Compass 50th percentile or 2% improvement over prior year performance.	LHCC demonstrated improvements in 2022 Diabetes Care HEDIS measures, exceeding established goals for the following: - HbA1c poor control (HBD) 45.99%, >2% improvement over the prior year (52.8%) - Retinal Eye Exams (EED) 53.04%, exceeding the national 50th percentile (51.09%) - HbA1c control (<8.0%) 44.77%, >2% improvement over prior year (40.88%) - BP control (<140/90 mm Hg) 50.61%, >2% improvement over the prior year (42.34%)

3	HbA1c testing - 2% improvement over the prior year and/or HbA1c Home Test Kit return rate > 5%	LHCC exceeded established goals for the following: - Diabetes home testing kit return rates were 6.5%, exceeding the goal of 5% LHCC did not meet the benchmark for HbA1c testing however it is significant to note that NCQA removed the HbA1c test as a HEDIS indicator in 2022. LHCC continued to measure this rate internally - the 2022 rate was 80.65%, 4.26% lower than the prior year (84.91%)

Diabetes Goals 2023

- ***Goal 1: Improve outreach and engagement in preventive care for members with diabetes as reflected by improved health outcomes evidenced by HEDIS diabetes measure performance. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Expand member and provider engagement in diabetes care through targeted outreach, education, and expanding 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, expanded screenings through community events, as well as promotion of $50 member incentive through our My Health Pays rewards program for completing health and wellness milestones for diabetes care. Provider incentives will be promoted to expand awareness of available resources and support to facilitate care gap closures and improvement of health outcomes.
    - **Expected Outcome:** Improvement in member diabetes care outcomes as evidenced by improvement in selected HEDIS performance associated with diabetes.
    - **Action Measurement:** Improvement in the following HEDIS diabetes measures by 2% over the prior year: Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control < 8.0%, HbA1c Poor Control > 9.0%; BP control (<140/90 mm Hg)

- ***Goal 2: Optimize member risk identification in targeted areas for referral and linkage to clinical partner organizations for diabetes preventive care and engagement. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Identify members through health risk assessments and claims analysis who may benefit from referral to local community and clinical partner programs in targeted areas supporting diabetes preventive care and self-management resources.
    - **Action Description:** Member referral to Pennington Biomedical Research Center's education and wrap-around supports to improve member awareness of disease process, impact of food intake and physical activity, and lifestyle modification.

- **Expected Outcome:** Increase member referrals to Pennington's diabetes treatment program that helps people to lose weight and develop long-term lifestyle changes through in-person sessions, meal replacement/calorie control, and medication management when clinically indicated.
- **Action Measurement:** Outcomes will be reflected by increased member referrals to Pennington's diabetes program from the prior year.

- ***Goal 3: Increase community awareness, access to screenings, and member engagement in diabetes preventive care related to eye health. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Improve early detection, timely treatment, and appropriate follow-up care to reduce diabetic member's risk for severe vision loss from diabetic eye disease by promoting community screening events for retinal eye exams.
  - **Action Description:** Member engagement in diabetic eye exams will be facilitated through direct member outreach and linkage to eye screening events, including the promotion of a $50 member incentive through our My Health Pays rewards program for completing health and wellness milestones for diabetes care.
  - **Expected Outcome:** Improvement in member diabetes care outcomes as evidenced by improvement in HEDIS Diabetes Eye Exam measure performance.
  - **Action Measurement:** Improvement in the following HEDIS diabetes measures by 2% over the prior year: Eye Exam for Patients With Diabetes

Obesity Goals 2022

- ***Goal 1: LHCC will maintain an enrollment rate above 50% for Obesity Disease Management Programs for 2022. Start Date: 1/1/2022 End Date: 12/31/2022***
  - **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: 1/1/2022 End Date: 12/31/2022

- **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 are 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 the prior year: Start Date: 1/1/2022 End Date: 12/31/2022***
  - **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 the prior year or meeting/exceeding the national 50th percentile in the following measures:
    - BMI percentile (> 63.3)
    - Counseling for Nutrition (> 55.0)
    - Counseling for Physical Activity (> 47.7)

Obesity Results 2022

Goal	Benchmark	Results

1	Annual Enrollments in Obesity Disease Management Programs > 50%	LHCC successfully met the goal of maintaining >50% enrollments in the Obesity disease management program. In 2022, 237 members with obesity risk identified on HRA's were successfully enrolled out of 296 referrals received, indicating an enrollment rate of 80% (exceeding the goal of 50%).
2	Individual engagement - participation at LHCC-sponsored events/programs, increased SNAP match benefits/investments, and video collaborations and distributions throughout the year	LHCC continued its partnership with LSU Ag Center SNAP-Ed and EFNEP program to produce quick and easy dollar-store recipes to help Medicaid families make healthier food choices. In 2022, focused on diabetic-friendly and heart-healthy meals, producing eight additional videos (>29 over the four-year partnership) that received over 20,000 YouTube views cumulatively. Grants and SNAP Match • $192,000 in grants and funding targeting food insecurity and nutrition • Supported SNAP match farmers market programs in five locations (Shreveport, Baton Rouge, St. Helena, New Orleans, Natchitoches) o Urban Garden grant produced 836.5 lbs of produce and served 1,684 individuals o At the St. Helena Farmers Market, 75% of customers shop at the market for SNAP • Funded approx. $80,000 for SNAP match which doubles the fresh food purchasing power of 8,000 families. Additionally, LHCC provided over $62,000 in funding for wellness / physical activity/obesity education initiatives, including the following: • 41 community programs and events across every region in the state with over 6,000 attendees • Active participation in numerous Healthy Community coalitions across the

		state, collaborating to advance community health and wellness.
3	NCQA Quality Compass 50th percentile or 2% improvement over prior year performance	LHCC demonstrated improvements in the 2022 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS measures, exceeding established goals for the following: - WCC Counseling for Nutrition 2022 rate 57.18%, >2% improvement over the prior year (55.0%) - WCC Counselling for Exercise/Physical Activity 2022 rate 51.58%, >2% improvement over the prior year (47.7%) WCC BMI percentile rate declined in 2022 to 60.58%, lower than the prior year (63.3%).

Obesity Goals 2023

- ***Goal 1: Maintain and/or improve member identification and enrollment in Centene disease management program for Obesity above 80% in 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Promotion of Disease Management resources for members including linkage to certified health coaching for weight management.
    - **Action Description:** Promotion of Disease Management resources and support. Members will be identified through health risk screenings and claims analysis for potential engagement in available Lifestyle Management programs that include weight management. Member-facing resources will also encourage member self-referral options in LHCC's Member Handbook, Website, and referral link through LHCC's member portal.
    - **Expected Outcome:** This action is expected to improve member engagement and program enrollments/completions, ultimately yielding improved nutrition and lifestyle modifications resulting in improved health outcomes.
    - **Action Measurement:** Action measurement/outcomes will be monitored via increased successful enrollments into the weight (lifestyle) management program.

- ***Goal 2 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 the prior year. Start Date: 1/1/2023 End Date: 12/31/2023***

- **Action Step:** Increase provider engagement and awareness of obesity-related programs, resources, and HEDIS improvement opportunities.
- **Action Description:** Offer and promote EPSDT support and resources to providers for increased focus on pediatric obesity intervention, improving capture of clinical documentation to support clinical efforts, highlighting HEDIS/WCC practices, and communicating care gap opportunities for a 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 the prior year or meeting/exceeding the national 50th percentile in the following measures: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI percentile, Counseling for Nutrition, Counseling for Physical Activity

- ***Goal 3: Improve member awareness and skill development to promote healthy lifestyle and nutrition management through member engagement in nutrition resource programs and investment in community programs/partnerships. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Increase community partnerships and member initiatives to support nutritional awareness, access to healthy foods/resources, and healthy lifestyle promotion.
  - **Action Description:** Increase member engagement in local community programs, increase access to nutritious foods, and support Medicaid families with making healthier food choices with limited food dollars through the following initiatives: SNAP match programs with farmers markets, Nutrition education partnership with LSU Ag EFNEP (expanded food and nutrition program), collaboration and support of LSU's healthy meals skill building videos and educational programs with promoted via social media, member websites, and on-demand access online.
  - **Expected Outcome:** Increased member engagement in local community programs, increased access to nutritious foods, and improved healthy food choices for individual and family wellness.
  - **Action Measurement:** Success will be measured through member and community engagement/participation at LHCC-sponsored events/programs, increased SNAP match benefits/investments, and community coalition events advancing health and wellness.

Appendix D5
UnitedHealthcare of Louisiana
2022 Diabetes and Obesity Action Plan

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% year over year. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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: 1/1/2022 End Date: 12/31/2022***
    - **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 percentage points YOY to ensure familiarity with current clinical practice guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) measurements. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 the 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 to 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 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.

Diabetes Results 2022

Goals	Benchmark	2019 Results
1	2021 #HRA's completed 14,058 #members reached 54,306	2022 #HRA's completed 15,780 members reached
2	2021- 15,513 members identified 13,604 qualified	2022- 16,107 members were identified and of those 14,124 qualified. While the goal of a 2% increase was not met, the number of identified and qualified members did increase.
3	2021 CDC eye exams 54.75% CDC HbA1c testing 81.32%	2022 EED eye exams 55.72% HBD (Comprehensive Diabetes Care HbA1c<8%) 57.91%

Diabetes Goals 2023

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2 percentage points year-over-year (YOY). Start Date: 1/1/2023 End Date: 12/31/2023***
  - **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 at least 2 percentage points YOY. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **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 percentage points YOY to ensure familiarity with current clinical practice guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) measurements. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **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 the need to complete HbA1c and eye exams.
  - **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 to 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 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.
  - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS (HBD) Hemoglobin A1c control for patients with diabetes and (EED) eye exam for patients with diabetes rate and to see an upward trend in the monthly rates.
  - **Action Measurement:** Increase engagement with providers by at least 2 percentage points YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurements.

Obesity Goals 2022

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% year over year. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 an 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 reports.

- ***Goal 2: Facilitate healthy lifestyles by increasing the number of members engaged in community-based programs reached by 2% year over year. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **Action Step:** Continue and build partnerships with community-based organizations. Continue offering Weight Watchers® program information.
    - **Action Description:** There are several 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% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2022 End Date: 12/31/2022***
    - **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 tip 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 an 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.

Obesity Results 2022

Goal	Benchmark	Results
1	2021 # of mailings to members 14,624	2022 # of mailings/ emails sent to members 25,647
2	2021 #members reached 3,770 #events 61	2022: Weight Watcher vouchers were distributed and continued to be offered
3	2021 WCC BMI percentile 79.81%	2022 WCC BMI percentile 83.21%

Obesity Goals 2023

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% year over year. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **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 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 reports.

- ***Goal 2: Facilitate healthy lifestyles early in life by targeting children and adolescents on the importance of appropriate EPSDT screenings with a 2% increase year over year. Start Date: 1/1/2023 End Date: 12/31/2023***

- **Action Step:** Send monthly preventive letters to all eligible and new members to educate and convey the importance of receiving/scheduling appropriate screenings/well visits. Continue Weight Watchers vouchers.
- **Action Description:** Our EPSDT coordinator continues to work with providers on current EPDST recommendations using toolkits. Live agents make outbound calls to members and assist them with appointment scheduling through a 3-way call with clinic scheduling staff. 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% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **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 an 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 D6
Humana Healthy Horizons in Louisiana
2022 Diabetes and Obesity Action Plan

Please note that Humana Healthy Horizons in Louisiana became a Healthy Louisiana MCO effective 1/1/23, so this appendix does not include 2022 goals and results.

Diabetes Goals 2023

- ***Goal 1: Improve the HEDIS measure performance rate to ultimately achieve the NCQA 50th percentile compared to baseline data (CY 2023), for HbA1c Poor Control (HBD) for members 18-75 years of age with diabetes. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Provide a Gap in Care Report to providers for their members with diabetes whose HbA1c is >9.0% during the calendar year (HBD).
    - **Action Description:** The Gap in Care Report will help the providers identify those members with diabetes whose HbA1c is >9.0% so they may conduct member outreach to schedule an appointment for their diabetes monitoring and routine testing.
    - **Expected Outcome:** Improve the HEDIS (HBD) measure performance rate (a lower rate indicates better performance for HbA1c poor control).
    - **Action Measurement:** Gap in Care Reports accessed by providers via the Compass platform. When we meet with providers, will gauge their knowledge and verify their use of Compass to access the Gap in Care Reports. And, the Provider Profile report will also be used to analyze the HbA1c Poor Control Incentive Measure (HBD) performance rate.

- ***Goal 2: Increase the number of members with diabetes enrolled in disease management and/or care management programs, by 2% compared to baseline data (CY 2023). Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** The number of members with diabetes participating in the Ochsner Digital Medicine Remote Patient Monitoring (RPM) Pilot Project and/or members actively engaged in Care Management (CM).
    - **Action Description:** The Ochsner Remote Patient Monitoring program will enroll up to 1,000 members with Type 2 diabetes and they will receive a glucometer, diabetic testing supplies, personalized care plans from licensed clinicians, and lifestyle support from professional health coaches from their smartphones.
    - **Expected Outcome:** Increase members with diabetes enrollment, by 2%, in either the Ochsner RPM program and/or active Care Management.
    - **Action Measurement:** Reports from the Ochsner RPM program to track member enrollment and reports from Guiding Care to track members with diabetes who are actively engaged in CM.

- ***Goal 3: Increase utilization of Go365 Incentives and Value-Added Benefits (VAB) offered for Diabetes care and management, for those members with diabetes, by 2% compared to baseline data (CY 2023). Start Date: 1/1/2023 End Date: 12/31/2023***

- **Action Step:** Educate and promote awareness for members with diabetes on the resources (i.e., Go365 Incentives & Value-Added Benefits) offered to assist with their care and management of diabetes.
- **Action Description:** Go365 member incentives for diabetes include $25 in rewards for completing a retinal eye exam and $50 in rewards for completing an annual diabetic screening. The VAB includes up to $25 per calendar month for OTC diabetes medications and supplies. Members are provided education on the Go365 incentives and Value-Added benefits with their new member welcome packets and new member welcome calls. Members are encouraged to download the Go 365 App and the My Humana App. Humana is also planning a text campaign to send to members educating them about the Go365 incentives, and how to earn and redeem their rewards.
- **Expected Outcome:** Increase utilization by 2% of any of the Go365 incentives and/or VAB offered for members with diabetes.
- **Action Measurement:** Review and analyze the member usage reports for the Go 365 Incentives and VAB and the Sharepoint site for the Go365 Incentives.

Obesity Goals 2023

- ***Goal 1: Offer community grants, community engagement and expand partnerships around Louisiana that will provide nutrition education, help promote physical activity, and improve overall health. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Work with community outreach to identify where they are hosting events and ensure that there is education about obesity, healthy eating, and physical activity available at those events.
  - **Action Description:** In support of the Louisiana Healthy Child Task Force, Humana has partnered with various organizations across Louisiana including the Boys & Girls Club of Metro Louisiana; Healthy Start; Eat Move Grow; Three O'Clock Project; and Tensas Community Health Coalition to provide nutrition education, access to healthy, nutritious food and physical activity to adolescents and children. There are also KidsHealth education links available on the HHH website that offers educational videos and articles. In addition, the community engagement team hosts regular health and resources events to help bring access, promote healthy habits, and identify resources in local communities.
  - **Expected Outcome:** Members will increase their knowledge about obesity, healthy eating, and physical activity. And, increase awareness of Value-Added Benefits and community partnerships that provide safe physical activity to participants.
  - **Action Measurement:** Use Quickbase internal reports to track the number of community events hosted.

- ***Goal 2: Improve HEDIS measure (WCC) performance rate to ultimately achieve the NCQA 50th percentile, compared to baseline data (CY 2023), for members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN during the MY and who had evidence of BMI percentile documentation, and counseling for both nutrition and physical activity. Start Date: 1/1/2023 End Date: 12/31/2023***

- **Action Step:** Provide a Gap in Care Report to providers for their members diagnosed with obesity during the calendar year and who do not have evidence of BMI percentile documentation, and counseling for both nutrition and physical activity (WCC).
- **Action Description:** The Gap in Care Report will help the providers identify those members with obesity and no evidence of their weight assessment and counseling, so they may conduct member outreach to schedule an appointment for their BMI monitoring, and to provide counseling for nutrition and physical activity.
- **Expected Outcome:** Improve HEDIS measure (WCC) performance rate for Weight Assessment (BMI) and Counseling for Nutrition and Physical Activity for Children/Adolescents.
- **Action Measurement:** Gap in Care Reports accessed by providers via the Compass platform. When we meet with Providers, will gauge their knowledge and verify their use of Compass to access their Gap in Care Reports.

- ***Goal 3: Increase utilization of Go365 Incentives and Value-Added Benefits (VABs), offered for members with a diagnosis of obesity, by 2% compared to baseline data (CY 2023). Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Educate and promote awareness for members with obesity on the resources (i.e., Go365 Incentives & Value-Added Benefits) offered to assist with their care and management of obesity.
  - **Action Description:** Go365 member incentives for obesity include up to $50 in rewards for participating in the Weight Management Program and $25 in rewards for completing one annual wellness child visit that includes a BMI assessment. The VAB includes a free one-year gym membership at a participating YMCA and adolescent members are eligible for one annual sports physical that includes an assessment of height and weight. Members are provided education on the Go365 incentives and Value-Added benefits with their new member welcome packets and new member welcome calls. Members are encouraged to download the Go 365 App and the My Humana App. Humana is also planning a text campaign to send to members educating them about the Go365 incentives, and how to earn and redeem their rewards.
  - **Expected Outcome:** Increase utilization by 2% of any of the Go365 incentives and/or VAB offered for members with obesity.
  - **Action Measurement:** Review and analyze the member usage reports for the Go 365 Incentives and VAB and the Sharepoint site for the Go365 Incentives.

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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