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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Contents

Glossary 2

Executive Summary 4

1 Introduction 5

1.1 Report Methodology 5

1.2 Obesity Overview 5

1.3 Diabetes Overview 6

2 The Scope of Obesity in the Louisiana Medicaid Managed Care Program 7

2.1 The Financial Impact of Obesity and Its Complications 8

3 The Scope of Diabetes in the Medicaid Managed Care Program 10

3.1 Diabetes and Pregnancy 12

3.2 The Financial Impact of Diabetes and Its Complications 12

4 LDH and MCO Recommendations 16

5 Conclusion 17

Appendix A – Act 210 of the 2013 Regular Legislative Session 18

Appendix B – Prevalence of Obesity among Medicaid Managed Care Enrollees by Region and Parish 20

Appendix C – Prevalence of Diabetes among Medicaid Managed Care Enrollees by Region and Parish 22

Appendix D – 2024 Diabetes and Obesity Action Plans Submitted by Each MCO 24

Aetna Better Health of Louisiana 25

AmeriHealth Caritas Louisiana (ACLA) 33

Healthy Blue 40

Humana Healthy Horizons in Louisiana 45

Louisiana Healthcare Connections 53

UnitedHealthcare of Louisiana 62

Appendix E – Standards of Diabetes Care 69

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. The Louisiana Department of Health (LDH) has designated the CPT code set as the national coding standard for physicians and other healthcare 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.

Early and Periodic Screening, Diagnostic, 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 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 healthcare 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 healthcare 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 healthcare purchasers understand the value of healthcare 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 healthcare coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% of the Federal Poverty Level (FPL), and a separate state CHIP program for the unborn child option and children with income from 200% up to and including 250% of the 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 LDH.

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

Measurement Year (MY) – Concerning healthcare 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 healthcare 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 (QC) 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 healthcare and/or that relate to one or more quality goals for healthcare.

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 on prevalence, utilization, and costs of obesity and diabetes are based on 2024 paid healthcare claims submitted by each of the six Medicaid MCOs to Louisiana Medicaid and represent the Louisiana Medicaid managed care population only.

Below are some highlights from this year's report:

- 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 2025 report, Louisiana was ranked third highest in the nation, up from fourth in 2024.[1] The following obesity summary was based on 2024 MCO claims data:
    - In 2024, 58,789 Medicaid managed care enrollees under the age of 18 years had an obesity diagnosis. This is 8.82% of the managed care child population. Additionally, 13.89% of adult enrollees 18 years of age or older (119,211) had an obesity diagnosis in 2024. The overall obesity prevalence was 11.67% of the total managed care population of 1,525,060 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 2024 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2024) was 32.29% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2024.

- Louisiana was also ranked third highest in the nation for adult diabetes in 2025, maintaining the same rank as 2024.[2] The following diabetes summary was based on 2024 MCO claims data:
    - In 2024, 9.52% (81,712 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.33% (2,210 enrollees). The managed care population (1,525,060) had a diabetes prevalence of 5.50% (83,922). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish, and age group.
    - While adults with diabetes make up 9.52% of the total managed care population, they accounted for 41.03% of total claim payments for all adults enrolled in managed care dates of service in 2024.
    - Of the 163,308 inpatient discharges in 2024, 3.03% (4,948 discharges) had a primary or secondary diagnosis of diabetes. There were 1,107,217 emergency department visits in 2024 for all Medicaid managed care enrollees and 2.20% (24,362) of those visits had a primary or secondary diagnosis of diabetes.
    - The average cost per enrollee with diabetes in 2024 was $20,993 and the average cost per member without diabetes in 2024 was $4,348.

[1] *State of Obesity 2025: Better Policies for a Healthier America*. (October 2025). Retrieved December 8, 2025 from https://www.tfah.org/report-details/state-of-obesity-report-2025/

[2] Ibid.

Introduction

Obesity and diabetes are 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 improving the health of Louisiana residents with or at risk for developing obesity and diabetes.

Report Methodology

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 six MCOs contracted with Louisiana in 2024 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 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.

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 through 2025 to reflect updates in the respective manuals.

Obesity Overview

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 40.3% from 2021-2023; the national prevalence of obesity in children was 21.1% from 2021 to 2023.[4]

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 healthy weight range, 25 to less than 30 is overweight, and 30 or higher is obese.[6] For children and teens ages 2 through 19, obesity is defined as a BMI at or above

[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 December 8, 2025 from https://pubmed.ncbi.nlm.nih.gov/19635784/

[4] *State of Obesity 2025: Better Policies for a Healthier America.* (October 2025). Retrieved December 8, 2025 from https://www.tfah.org/report-details/state-of-obesity-report-2025/

[5] *Risk Factors for Obesity* (November 14, 2025). Retrieved December 8, 2025 from https://www.cdc.gov/obesity/risk-factors/risk-factors.html

[6] *Adult BMI Categories* (March 19, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html

the 95th percentile for children and teens of the same age and sex.[7] BMI is calculated by dividing a person's weight in kilograms by the square of their height in meters.[8]

People diagnosed with obesity, are at an increased risk for serious diseases and health conditions, including type 2 diabetes, heart disease, and some types of cancer.[9]

Diabetes Overview

National Prevalence

Diabetes is a common disease. The CDC reports that 38.4 million people are living with diabetes in the U.S., and another 97.6 million have prediabetes. In the U.S., diabetes was the eighth leading cause of death in 2021.[10]

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.[11]

Types of Diabetes

Type 1 diabetes develops when the pancreas 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.[12]

Type 2 diabetes develops with insulin resistance, a condition in which cells (e.g., liver, muscles) do not use insulin properly. The risk factors for developing this type of diabetes include older age, obesity, family history of type 2 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 can develop during pregnancy in people who did not have diabetes before being pregnant.[14] The risk factors for gestational diabetes are similar to those for type 2 diabetes.[15] Gestational diabetes requires treatment. Often, gestational diabetes can be controlled through eating healthy foods, regular exercise, and monitoring blood sugar levels. Sometimes, those with gestational diabetes must also take insulin.[16]

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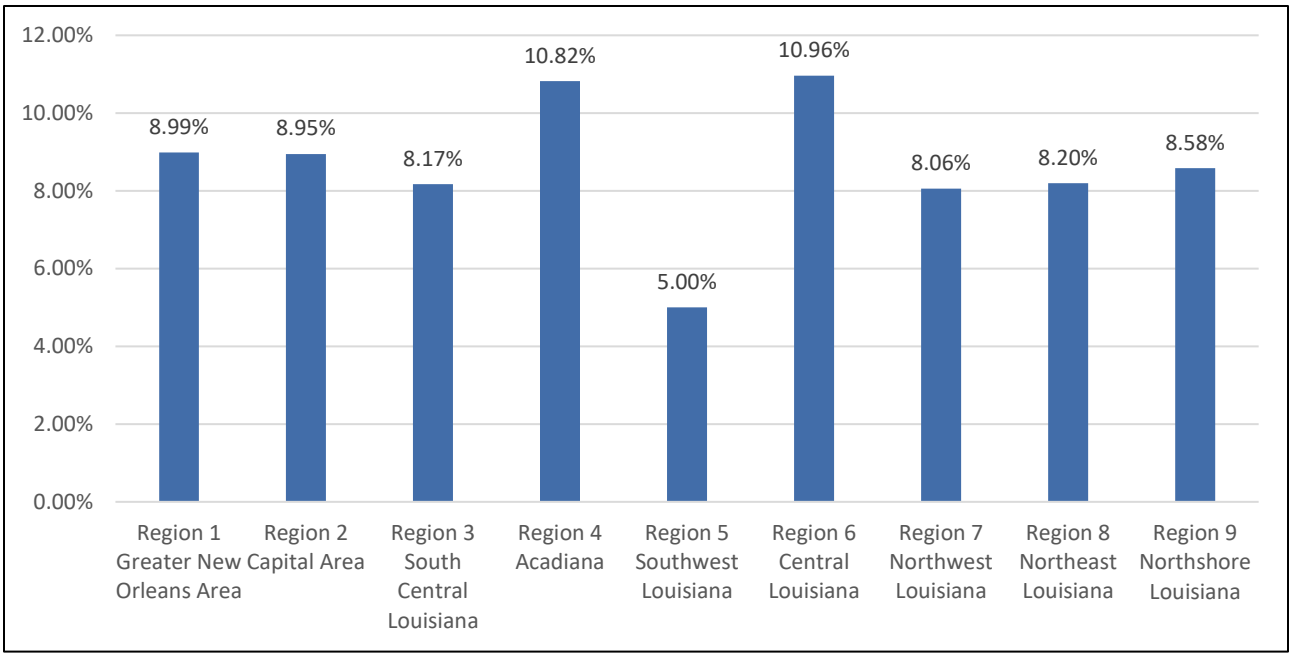
[7] *Child and Teen BMI Categories* (June 28, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/bmi/child-teen-calculator/bmi-categories.html
[8] *About Body Mass Index (BMI)* (May 20, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/bmi/about/index.html
[9] *About Obesity* (January 23, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/obesity/php/about/index.html.
[10] *National Diabetes Statistics Report* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/php/data-research/index.html
[11] *Diabetes Basics* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/about/index.html
[12] *Type 1 Diabetes*. (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/about/about-type-1-diabetes.html
[13] *Type 2 Diabetes.* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html
[14] *Gestational Diabetes* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/about/gestational-diabetes.html
[15] *Diabetes Risk Factors* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/risk-factors/index.html
[16] *Gestational Diabetes* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/about/gestational-diabetes.html

The Scope of Obesity in the Louisiana Medicaid Managed Care Program

The State of Obesity report published by the Trust for America's Health and the Robert Wood Johnson Foundation reports that Louisiana's adult obesity rate was 39.2% in 2024, the third-highest adult obesity rate in the U.S.[17] In comparison, the obesity rate for the Medicaid managed care adult population calculated using claims data was 13.89% for 2024. 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 2024 that included a primary or secondary diagnosis of obesity. Based on 2024 claims data, the managed care overall obesity prevalence rate was 11.67% of 1,525,060 MCO enrollees. Figure 2.1 shows that Louisiana Medicaid Region 6 had the highest child obesity prevalence rate (10.96%), followed closely by Louisiana Medicaid Region 4 (10.82%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 3 at 16.69%, followed closely by Louisiana Medicaid Region 4 at 16.12% (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 20.59% African American, 16.44% white, and 13.68% other races (Figure 2.3). The remaining age, gender, and race strata had obesity prevalence rates below 10.42%. 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 2024 by Region



[17] *State of Obesity 2025: Better Policies for a Healthier America*. (October 2025). Retrieved December 8, 2025 from https://www.tfah.org/report-details/state-of-obesity-report-2025/

Figure 2.2: Louisiana Medicaid Managed Care – Prevalence of Obesity in Adults (Age ≥18) in 2024 by Region

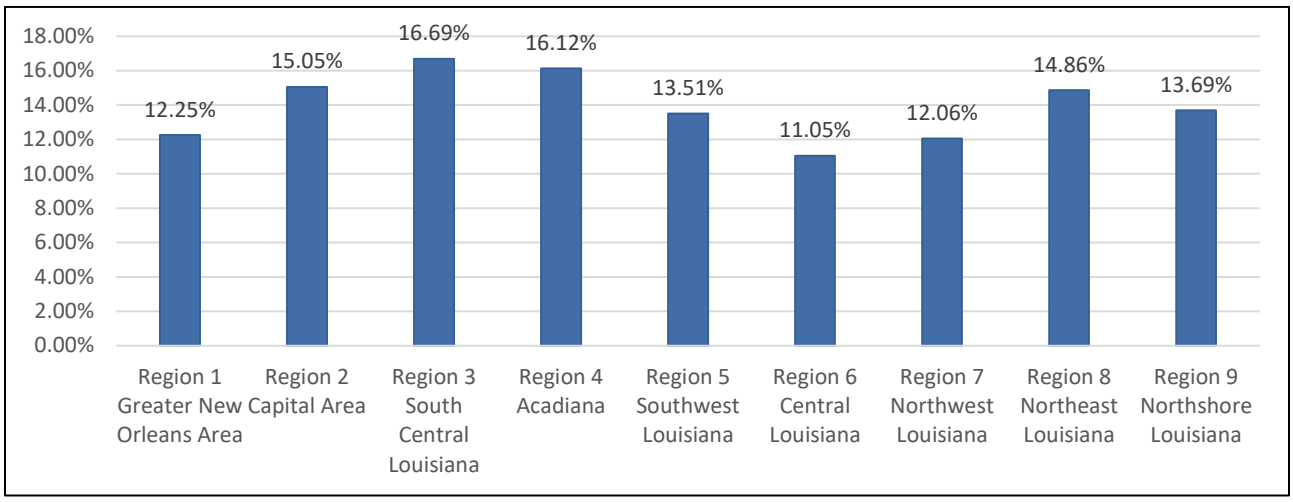
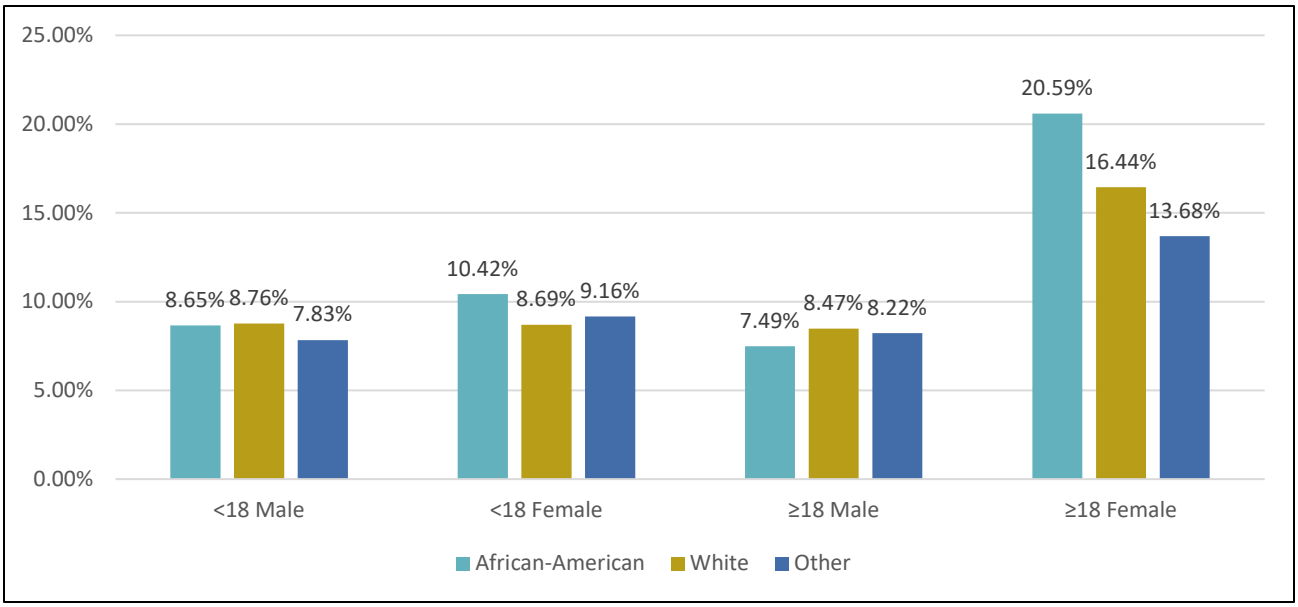


Figure 2.3: Louisiana Medicaid Managed Care – Prevalence of Obesity in 2024 by Age Group, Gender, and Race



The Financial Impact of Obesity and Its Complications

Table 2.5 lists total costs, by claim type, age group, and obesity category, for healthcare claims with dates of service in 2024 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 11.67%. Healthcare claim costs for these enrollees totaled $2,560,527,183 in 2024, which accounts for 31.90% of the total MCO claims payments ($8,027,601,225). In other words, of the entire Medicaid managed care population, the 11.67% who have a diagnosis of obesity account for 31.90% of the total healthcare claim costs.

Table 2.5: Total Cost of Obesity in 2024 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	$221,234,709	$1,343,039,446	$1,299,540,811	$2,279,693,231	29.57%
Pharmacy	$79,626,506	$307,757,495	$921,944,507	$1,359,161,593	37.53%
Other* **	$25,577,363	$136,960,737	$12,603,286	$40,461,541	17.71%
Total	$326,438,579	$1,787,757,677	$2,234,088,604	$3,679,316,365	31.90%

*Includes claims, with dates of service in 2024, for any child MCO enrollee diagnosed with obesity in 2024.

**Includes claims, with dates of service in 2024, for any adult MCO enrollee diagnosed with obesity in 2024.

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

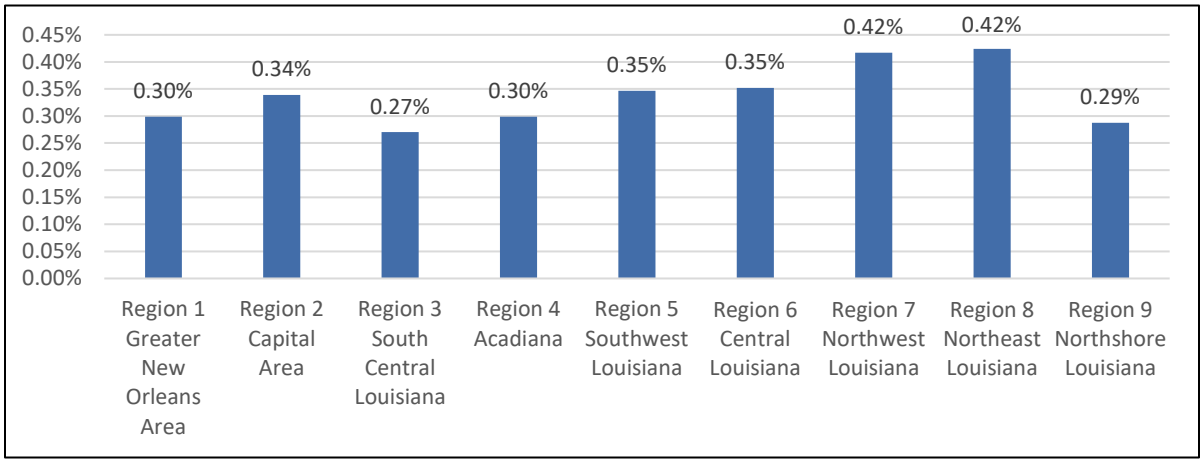
The Scope of Diabetes in the Medicaid Managed Care Program

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 U.S. was 11.3% for the years 2017 to 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 U.S. in 2022 were $413 billion.[18]

For the 2025 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2024 that included a primary or secondary diagnosis of diabetes. Based on 2024 claims data, the adult diabetes prevalence was 9.52% of 858,548 unique managed care adults. The child diabetes prevalence was 0.33% of 666,512 enrollees under the age of 18 years. Louisiana Medicaid Regions 7 and 8 had the highest child prevalence rates, both rounded to 0.42% (Figure 3.1). Louisiana Medicaid Region 3 had the highest adult prevalence rate, 10.78%, although all other regions had prevalence rates of over 8.65% (Figure 3.2).

Figure 3.1: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Children (Age <18) in 2024 by Region



[18] *National Diabetes Statistics Report* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/php/data-research/index.html

Figure 3.2: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Adults (Age ≥ 18) in 2024 by Region

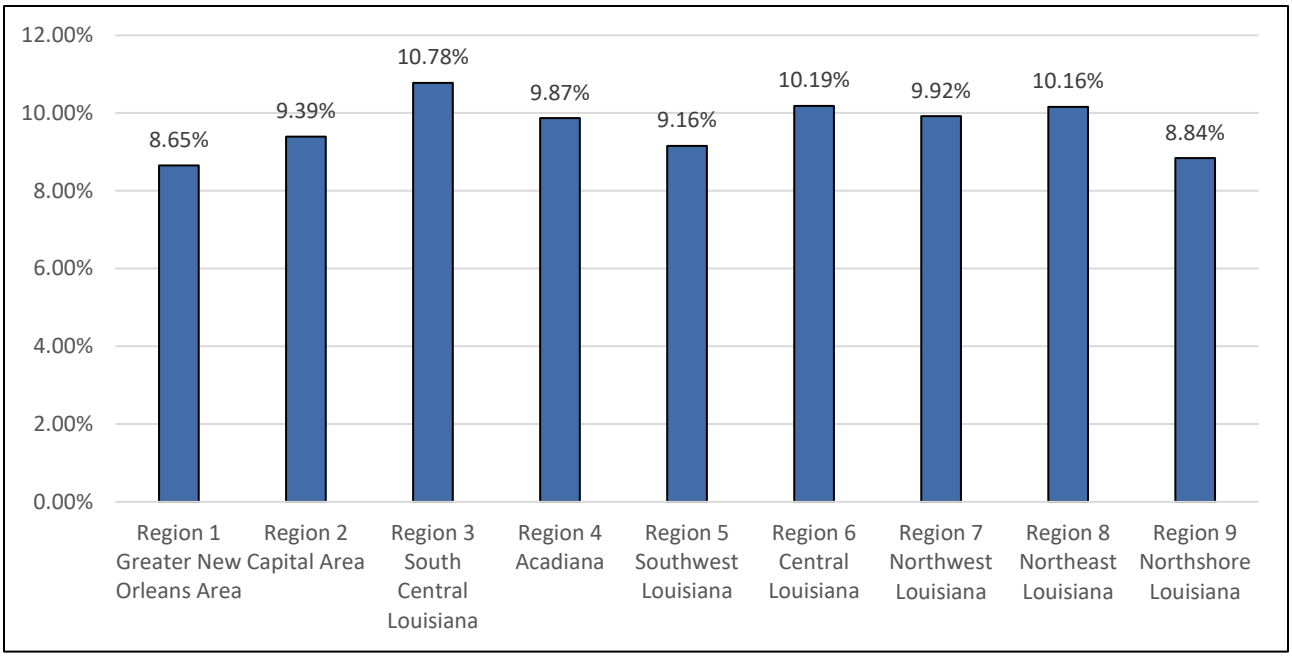
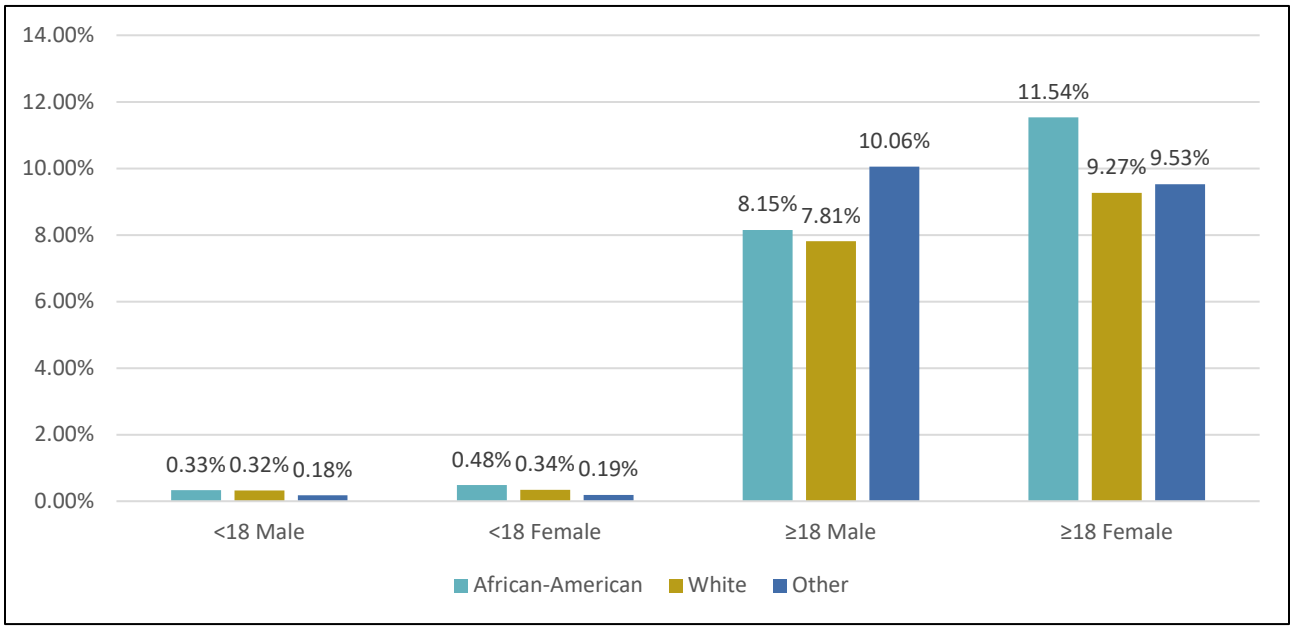


Figure 3.3 shows diabetes prevalence stratified by age group, gender, and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among African American adult females (11.54%) and other race adult males (10.06%). The CDC's National Diabetes Statistics Report states that the prevalence of adult-diagnosed diabetes was highest among non-Hispanic African Americans (12.7%).[19]

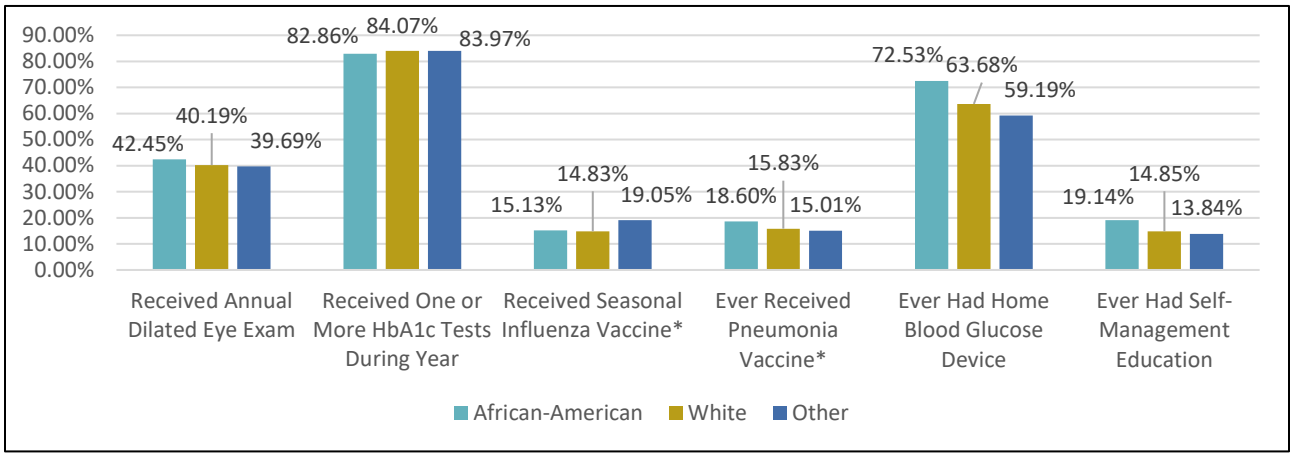
Figure 3.3: Louisiana Medicaid Managed Care – Prevalence of Diabetes in 2024 by Age, Gender, and Race



[19] *National Diabetes Statistics Report* (May 15, 2024). Retrieved December 8, 2025 from https://www.cdc.gov/diabetes/php/data-research/index.html

Figure 3.4 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes across races. 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 African Americans (72.53%) when compared to whites (63.68%) and other races (59.19%).

Figure 3.4: Louisiana Medicaid Managed Care – Diabetic Preventive Care Practices in 2024 Among Adults with Diabetes by Race



*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.

Diabetes and Pregnancy

Table 3.1.1 shows the cost of Medicaid managed care enrollee pregnancies in 2024 with and without diabetes. The average total cost per pregnant enrollees with diabetes was 1.60 times greater than those who did not have a diabetes diagnosis during their pregnancy ($9,047 vs $5,668). Of the MCO enrollees who were pregnant during 2024 (44,618), 13.12% had a diagnosis of diabetes.

Table 3.1.1: Louisiana Medicaid Managed Care – Diabetes* and Pregnancies in 2024

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Average Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,856	$52,978,523	$9,047
Pregnancies without diabetes	38,762	$219,699,599	$5,668

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

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]

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 2024 associated with Louisiana Medicaid managed care adult enrollees with and without diabetes. Managed care adult enrollees

[20] Economic Costs of Diabetes in the U.S. in 2022, American Diabetes Association, Diabetes Care 2024, dci230085; Retrieved December 8, 2025 from https://doi.org/10.2337/dci23-0085

with diabetes were identified by medical claims with dates of service in 2024 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 9.52%. Healthcare claim costs for these enrollees totaled $1,720,382,831 in 2024, which accounts for 29.09% of the total adult MCO claims payments ($5,913,404,969) with dates of service in 2024.

Table 3.2.1: Louisiana Medicaid Managed Care – Cost of Adults with Diabetes in 2024 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	$897,112,649	$2,682,121,393	25.06%
Pharmacy	$817,607,669	$1,463,498,431	35.84%
Other**	$5,662,514	$47,402,314	10.67%
Total	$1,720,382,831	$4,193,022,138	29.09%

*Includes claims, with dates of service in 2024, for any adult MCO enrollee with diabetes in 2024.
**Includes dental, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and adult daycare.

Specific Diabetes Complications

Diabetic complications were identified using medical claims with dates of service in 2024 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows, by age group and race, the percentage of 2024 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 (52.37%), followed by ketoacidosis (13.61%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (36.93%) and neurological manifestations (17.13%).

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 related to diabetes and the percentage of diabetes-related ED visits associated with a diabetic complication.

In 2024, for the Medicaid managed care population, 24,362 ED visits were diabetes-related. These diabetes-related visits represented 2.20% of ED visits for managed care enrollees during 2024. Of these diabetes-related visits, 15,146 visits (62.17%) were associated with diabetes-related complications.

Table 3.2.2: Louisiana Medicaid Managed Care - Prevalence of Diabetic Complications Among Enrollees with Diabetes in 2024 by Race and Age Group*

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total

Ketoacidosis	13.66%	13.35 %	11.27 %	13.26 %	2.53%	2.29%	1.97%	2.36%
Hyperosmolarity	0.57%	0.44%	0.35%	0.50%	1.17%	0.91%	1.29%	1.09%
Coma	1.05%	1.16%	0.35%	1.00%	0.40%	0.41%	0.36%	0.40%
Renal Manifestations	1.13%	2.18%	0.70%	1.40%	12.32%	9.90%	12.05 %	11.40 %
Ophthalmic Manifestations	1.70%	1.31%	1.06%	1.49%	10.40%	8.47%	10.57 %	9.72%
Neurological Manifestations	0.65%	1.16%	0.70%	0.81%	17.17%	19.26 %	15.93 %	17.75 %
Peripheral Circulatory Disorders	0.40%	0.87%	0.35%	0.54%	6.55%	6.91%	6.23%	6.63%
Arthropathy	0.00%	0.15%	0.00%	0.05%	0.44%	0.56%	0.46%	0.49%
Skin Complications	1.05%	2.03%	0.70%	1.31%	3.68%	4.58%	3.93%	4.04%
Oral Complications	0.00%	0.00%	0.00%	0.00%	0.13%	0.14%	0.09%	0.13%
Hypoglycemia	4.28%	5.37%	7.75%	5.07%	3.33%	3.30%	2.66%	3.22%
Hyperglycemia	53.35%	53.56 %	51.06 %	53.12 %	37.96%	36.36 %	34.72 %	36.92 %
Other Specified Complications	7.60%	7.40%	6.34%	7.38%	14.31%	14.84 %	13.54 %	14.39 %
Unspecified Complications	5.17%	4.50%	2.46%	4.62%	7.11%	6.26%	6.35%	6.69%
Count of Enrollees with Any Diabetes Diagnosis	1,237	689	284	2,210	40,267	29,783	11,662	81,712

* 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 2024

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	166,253	647	0.39%	484	74.81%
White, < 18 years	96,569	297	0.31%	215	72.39%
Other, < 18 years	94,659	121	0.13%	88	72.73%
Total, < 18 years	357,481	1,065	0.30%	787	73.90%
African American, ≥ 18 years	396,384	12,856	3.24%	7,978	62.06%
White, ≥ 18 years	277,249	7,898	2.85%	4,758	60.24%
Other, ≥ 18 years	76,103	2,543	3.34%	1,623	63.82%
Total, ≥ 18 years	749,736	23,297	3.11%	14,359	61.63%
Total, All Ages	1,107,217	24,362	2.20%	15,146	62.17%

*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.

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 2024, among managed care enrollees who were diagnosed with one of the reported chronic conditions, hypertension (202,386 enrollees) was the most prevalent, followed by asthma (94,295 enrollees) and diabetes (83,922 enrollees). In 2024, for the reported chronic conditions, the highest total paid by the MCOs was $716,396,098 for hypertension. The total paid for diabetes during 2024 was $356,589,045. In 2024, the highest average cost per enrollee for the reported chronic conditions was for congestive heart failure ($9,947). The average cost paid for diabetes per enrollee was $4,249.

Table 3.2.4: Louisiana Medicaid Managed Care – Prevalence of Selected Chronic Conditions and Cost Comparisons among Diabetes and Selected Chronic Conditions in 2024

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Diabetes	83,922	5.50%	$356,589,045	$4,249
Hypertension	202,386	13.27%	$716,396,098	$3,540
Asthma	94,295	6.18%	$151,662,346	$1,608
Arthritis	53,563	3.51%	$82,601,370	$1,542
Congestive Heart Failure	17,430	1.14%	$173,367,749	$9,947
Chronic Obstructive Pulmonary Disease (COPD)	22,659	1.49%	$116,576,829	$5,145
Coronary Heart Disease	23,035	1.51%	$123,067,252	$5,343

*A unique enrollee may be included in more than one chronic disease count.
**The prevalence denominator is the 2024 total unique enrollee count in MCOs (1,525,060).

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 empowering the community, promoting self-management training, and monitoring 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 wellaheadla.com/Well-ahead-community/community-resource-guide.
- Encourage community and faith-based organizations to promote the importance of healthy eating and physical fitness.
- Encourage 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.
- Prioritize performance on the Optimal Diabetes Care incentive measure by supporting care coordination and population health strategies that improve glycemic control, blood pressure management, tobacco-free status, and appropriate cardiovascular risk reduction for Medicaid members ages 18-75 with diabetes.

Conclusion

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

Appendix A – Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

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

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

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	62,583	78,648	9.68%	12.13%
Orleans	49,834	81,312	7.78%	12.28%
Plaquemines	2,607	3,500	8.52%	13.03%
St. Bernard	8,252	10,176	11.10%	12.74%
Total – Region 1	123,276	173,636	8.99%	12.25%
Region 2 Capital Area				
Ascension	14,552	16,454	8.74%	18.05%
East Baton Rouge	62,395	78,994	8.44%	13.49%
East Feliciana	2,132	3,469	15.15%	17.84%
Iberville	4,665	6,054	11.36%	18.62%
Pointe Coupee	2,667	3,730	12.67%	23.22%
West Baton Rouge	3,643	4,386	9.47%	17.81%
West Feliciana	1,145	1,410	7.51%	15.11%
Total – Region 2	91,199	114,497	8.95%	15.05%
Region 3 South Central Louisiana				
Assumption	2,203	3,367	11.39%	21.50%
Lafourche	11,137	14,885	11.14%	17.71%
St. Charles	5,661	6,794	8.46%	13.66%
St. James	2,533	3,488	6.20%	16.00%
St. John the Baptist	7,266	9,080	7.78%	13.88%
St. Mary	8,660	10,777	7.37%	17.60%
Terrebonne	16,570	20,793	6.54%	17.05%
Total – Region 3	54,030	69,184	8.17%	16.69%
Region 4 Acadiana				
Acadia	9,923	12,556	7.32%	14.21%
Evangeline	5,284	6,945	9.12%	16.65%
Iberia	12,141	15,603	14.10%	13.31%
Lafayette	32,779	40,001	11.06%	14.69%
St. Landry	16,527	20,431	9.24%	19.54%
St. Martin	7,768	9,264	13.80%	17.63%
Vermilion	8,694	10,793	10.69%	19.67%
Total – Region 4	93,116	115,593	10.82%	16.12%
Region 5 Southwest Louisiana				
Allen	3,181	4,097	6.70%	13.18%
Beauregard	5,413	6,464	4.12%	13.12%
Calcasieu	29,352	35,756	5.12%	13.13%
Cameron	267	413	4.87%	15.01%
Jefferson Davis	4,515	5,627	4.10%	16.47%
Total – Region 5	42,728	52,357	5.00%	13.51%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Avoyelles	6,641	8,479	9.74%	9.35%
Catahoula	1,463	2,252	9.36%	10.66%
Concordia	3,681	4,822	2.66%	9.37%
Grant	2,868	3,672	12.90%	10.70%
LaSalle	1,983	2,513	7.11%	13.73%
Rapides	20,097	24,512	15.19%	11.52%
Vernon	5,687	7,035	2.51%	11.64%
Winn	1,883	2,578	14.18%	12.02%
Total – Region 6	44,303	55,863	10.96%	11.05%
Region 7 Northwest Louisiana				
Bienville	2,200	3,031	7.41%	10.76%
Bossier	16,031	17,925	7.88%	11.98%
Caddo	37,557	47,682	9.17%	12.51%
Claiborne	1,984	2,566	4.89%	9.59%
DeSoto	4,054	5,022	8.16%	11.99%
Natchitoches	5,559	7,142	6.94%	10.92%
Red River	1,428	1,846	4.06%	7.96%
Sabine	3,245	4,494	4.22%	11.82%
Webster	5,878	8,101	6.82%	12.99%
Total – Region 7	77,936	97,809	8.06%	12.06%
Region 8 Northeast Louisiana				
Caldwell	1,621	2,392	3.15%	11.79%
East Carroll	1,322	1,730	4.69%	15.66%
Franklin	3,653	5,131	4.38%	13.86%
Jackson	1,754	2,542	8.78%	13.61%
Lincoln	5,767	7,783	10.18%	11.47%
Madison	2,196	2,781	6.24%	13.05%
Morehouse	4,548	6,521	7.32%	21.98%
Ouachita	26,677	34,361	8.92%	14.55%
Richland	3,498	4,703	11.81%	14.97%
Tensas	649	1,055	4.31%	16.97%
Union	3,419	4,792	7.75%	14.13%
West Carroll	1,694	2,573	5.19%	18.81%
Total – Region 8	56,798	76,364	8.20%	14.86%
Region 9 Northshore Louisiana				
Livingston	20,080	23,029	8.39%	14.52%
St. Helena	1,291	1,669	10.69%	15.88%
St. Tammany	28,590	37,150	7.83%	11.51%
Tangipahoa	24,791	30,081	9.35%	14.67%
Washington	8,374	11,316	9.06%	16.19%
Total – Region 9	83,126	103,245	8.58%	13.69%

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	62,583	78,648	0.28%	9.16%
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Ascension	14,552	16,454	0.32%	9.38%
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Pointe Coupee	2,667	3,730	0.45%	12.49%
West Baton Rouge	3,643	4,386	0.44%	11.54%
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St. Mary	8,660	10,777	0.18%	11.41%
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Total – Region 5	42,728	52,357	0.35%	9.16%
				Region 6 Central Louisiana

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
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Grant	2,868	3,672	0.24%	10.70%
LaSalle	1,983	2,513	0.40%	13.45%
Rapides	20,097	24,512	0.34%	9.53%
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Winn	1,883	2,578	0.48%	11.48%
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Morehouse	4,548	6,521	0.53%	10.08%
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St. Tammany	28,590	37,150	0.26%	7.34%
Tangipahoa	24,791	30,081	0.26%	9.83%
Washington	8,374	11,316	0.27%	11.21%
Total – Region 9	83,126	103,245	0.29%	8.84%

Appendix D – 2024 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 2024 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2024 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2024 Diabetes and Obesity Action Plan
Appendix D4	Humana Healthy Horizons 2024 Diabetes and Obesity Action Plan
Appendix D5	Louisiana Healthcare Connections 2024 Diabetes and Obesity Action Plan
Appendix D6	UnitedHealthcare 2024 Diabetes and Obesity Action Plan

Appendix D1
Aetna Better Health of Louisiana
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***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: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Aetna Better Health of Louisiana (ABHLA) will initiate a culturally appropriate nutritional intervention program with the company, GA Foods, through our value-added benefits offered to adult members. Eligible member criteria are adult and non-compliant with Controlling High Blood Pressure (CBP) and Hemoglobin A1c Control for Patients with Diabetes (HBD) HEDIS measures.
    - **Action Description:** ABHLA will offer home-delivered, culturally appropriate, and dietary-specific meals, ensuring accessibility for low income, rural, and ethnically diverse members. Our strategy in partnering with this organization is to reduce food and nutrition insecurities of members with chronic conditions through targeted efforts. We introduce members to the knowledge and skills needed to make healthy food choices. The GA Foods vendor cooks and delivers nutritious, medically appropriate meals to enrollees (e.g., non-specialty, breakfast, vegetarian, puree, renal, kosher, shelf stable, medically tailored meals). Eligible member criteria are adult and non-compliant with CBP and HBD HEDIS measures. Members can participate in this program every quarter (if they are still not compliant with CBP and HBD). They are provided two meals per day for 14 days, for a total of 28 meals quarterly. When approved for the service, members will be notified through outreach within 24-72 hours of receiving authorization. GA Foods provides a welcome call to discuss the program's value and services offered. GA Foods also completes/confirms referrals and the delivery of meals. Members are also notified about each status update: "referral received, member reached, accepted meals and delivery, refused meals and unable to reach" Although our goal is to help with providing nutritionally appropriate meals, there are limitations or barriers, such as the inability to reach members to set up their meal service. Inactive or inaccurate phone numbers would be the top challenge. In this instance, we continue to work with our members, GA Foods, and our provider partner to attain accurate contact information to ensure members are given the opportunity to receive the meals they deserve. Additionally, ABHLA has operationalized efforts with our RN health coach to facilitate outreach to the members who received food boxes from this program "members who received food and accepted outreach engagement from the RN health coach."
    - **Expected Outcome:** Increase compliant adult members 18-75 with diabetes (Type 1 and Type 2).
    - **Action Measurement:** Enrollee files, or HEDIS data and claims data, are used to identify eligible members. GA Foods Referral received, member reached, accepted meals and delivery, refused meals and unable to reach.

- ***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: 1/1/2024 End Date: 12/31/2024***
    - **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. Send screening reminder through vendor mPulse SMS program.
    - **Action Description:** As part of ABHLA's HEDIS Outreach team's on-going outreach to members, the HEDIS Outreach team contacts members with identified gaps in care to remind the members of screenings due and works with the member to schedule an appointment with their primary care provider. The SMS mPulse campaigns are strategically designed to enhance enrollee awareness of health services and foster improved connections to care and local community resources.
    - **Expected Outcome:** Increase in eye exams among members aged 18-75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 3: Increase the percentage of members 20 years of age or older that completed an annual wellness exam ((Adults' Access to Preventative/Ambulatory Health Services, AAP). Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Develop and share provider plan of action reports.
    - **Action Description:** Similar to a gap-in-care report, mid-year data will be pulled for members who are non-compliant with specified HEDIS measures. The reports will be sent by ABHLA's Quality Provider Liaisons (QPL's) to the top ten providers ranked by those with the most non-compliant members. The reports include if the members have already had their yearly recommended wellness exam completed or not.
    - **Expected Outcome:** The inclusion of the wellness exam aims to highlight the opportunity to screen a member during this appointment for HBD and Eye Exam for Patients with Diabetes (EED).
    - **Action Measurement:** Gap care closure reports

Diabetes Results 2024

Goal	Benchmark	Results
1	HbA1c (estimated average glucose) test performance measure, 2024 compared to 2023	2023: 59.61% 2023: 67.40% Did meet goal
2	Eye exams for members with diabetes performance measure, 2024 compared to 2023	2023: 46.96% 2024: 58.64% Did meet goal
3	Adults' Access to Preventative/Ambulatory Health Services (AAP), 2024 compared to 2023	2023: 72.59% 2024: 78.03% Did meet goal

Diabetes Goals 2025

- ***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: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Aetna Better Health of Louisiana (ABHLA) will initiate a culturally appropriate nutritional intervention program with the company, GA Foods, through our value-added benefits offered to adult members. Eligible member criteria are adult and noncompliant with Controlling High Blood Pressure (CBP) and Glycemic Status Assessment (GSD, formerly HBD) HEDIS measures.
    - **Action Description:** ABHLA will offer home-delivered, culturally appropriate, and dietary-specific meals, ensuring accessibility for low income, rural, and ethnically diverse members. Our strategy in partnering with this organization is to reduce food and nutrition insecurities of members with chronic conditions through targeted efforts. We introduce members to the knowledge and skills needed to make healthy food choices. The GA Foods vendor cooks and delivers nutritious, medically appropriate meals to enrollees (e.g., non-specialty, breakfast, vegetarian, puree, renal, kosher, shelf stable, medically tailored meals). Eligible member criteria are adult and noncompliant with CBP and GSD (formerly HBD) HEDIS measures. Members can participate in this program every quarter (if they are still not compliant with CBP and GSD (formerly HBD). They are provided with 2 meals per day for 14 days, for a total of 28 meals quarterly. When approved for the service, members will be notified through outreach within 24 to72 hours of receiving authorization. GA Foods provides a welcome call to discuss the program's value and services offered. GA Foods also completes/confirms referrals and the delivery of meals. Members are also notified about each status update: "referral received, member reached, accepted meals & delivery, refused meals & unable to reach" Although our goal is to help with providing nutritionally appropriate meals, there are limitations or barriers, such as the inability to reach members to set up their meal service. Inactive or inaccurate phone numbers would be the top challenge. In this instance, we continue to work with our members, GA Foods, and our provider partner to attain accurate contact information to ensure members are given the opportunity to receive the meals they deserve. Additionally, ABHLA has operationalized efforts with our RN Health Coach to facilitate outreach to the members who received food boxes from this program and "members who received food and accepted outreach engagement from RN Health Coach."
    - **Expected Outcome:** Increase compliant adult members 18-75 with diabetes (Type 1 and Type 2).
    - **Action Measurement:** Enrollee files, or HEDIS data and claims data, are used to identify eligible members. GA Foods Referral received, member reached, accepted meals and delivery, refused meals and unable to reach.

- ***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: 1/1/2025 End Date: 12/31/2025***
    - **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. Send screening reminder through vendor mPulse SMS program.
    - **Action Description:** As part of ABHLA's HEDIS Outreach team's ongoing outreach to members, the HEDIS Outreach team contacts members with identified gaps in care to remind the members of screenings due and works with the member to schedule an appointment with their primary care provider. The SMS mPulse campaigns are strategically designed to enhance enrollee awareness of health services and foster improved connections to care and local community resources.
    - **Expected Outcome:** Increase in eye exams among members aged 18-75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 3: Increase the percentage of members 20 years of age or older that completed an annual wellness exam (Adults' Access to Preventative/Ambulatory Health Services, AAP). Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Develop and share provider plan of action reports.
    - **Action Description:** Similar to a gap-in-care report, mid-year data will be pulled for members who are non-compliant with specified HEDIS measures. The reports will be sent by ABHLA's Quality Provider Liaisons (QPL's) to the top ten providers ranked by those with the most non-compliant members. The reports include if the members have already had their yearly recommended wellness exam completed or not.
    - **Expected Outcome:** The inclusion of the wellness exam aims to highlight the opportunity to screen a member during this appointment for HBD and Eye Exam for Patients with Diabetes (EED).
    - **Action Measurement:** Gap care closure reports

Obesity Goals 2024

- ***Goal 1: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Work with partners to increase access to healthy fruits and veggies and education to address obesity.
    - **Action Description:** Healthy Families Produce Rx (HFPRx) is an innovative food access program, developed in partnership with Aetna Better Health of Louisiana, Share Our Strength's No Kid Hungry campaign, Vouchers for Veggies, and LSU Ag Center, with funding from the USDA's Gus Schumacher Nutrition Incentive Grant Program (GusNIP). The program will provide eligible families with $40 per month to purchase fresh fruits and vegetables at select local farmers markets and grocery retailers. Eligible families receive up to $240 to purchase fruits and vegetables over six months and eligible members are enrolled in SNAP and WIC. Program Eligibility: Households with a child aged 3-17 who is

currently enrolled in any Medicaid health plan. The child lives in or has a primary health care provider in: Northshore region: Washington, Tangipahoa, or St. Helena parish or Acadiana region: St. Landry, Acadia or Lafayette parish. Communication with the enrollees begins as soon as the card/vouchers is mailed – they do an introduction welcome call and then after, if the enrollees opt in, they do a monthly reminder via SMS or phone call to remind the enrollee to use the benefit and if they aren't using it they get additional reminders to encourage and more of a follow-up call to address any issues, then at the end of the six months they do a final outreach

  - **Expected Outcome:** Increase access to healthy fruits and veggies and education Region 4 and Region 9. Improve dietary health and food security for families in rural Louisiana who are disproportionately impacted by poor nutrition and related health outcomes.
  - **Action Measurement:** Vouchers received.

- ***Goal 2: Promote physical activity in the school system in support of Louisiana State Act 84 resolution. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Support playground equipment sponsorship through collaboration with a school board.
  - **Action Description:** ABHLA to approve $5,000 sponsorship to fund playground equipment for Evangeline Parish School Board.
  - **Expected Outcome:** Promote childhood physical activity in support of healthy lifestyle and weight management.
  - **Action Measurement:** Evangeline Parish School reported outcomes.

- ***Goal 3: Increase access to healthy food. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Develop and support partnership with Second Harvest Mobile Market
  - **Action Description:** ABHLA provides $10 vouchers for mobile market programs in regions 1, 3, 4 and 5
  - **Expected Outcome:** Increase access to healthy food and increase food security
  - **Action Measurement:** Number of food vouchers distributed

Obesity Results 2024

Goal	Benchmark	Results
1	Expand partnerships	2023, first year of grant: 86 brick and mortar pantry partners with 14.5 million pounds of food 2024: The Makin' Groceries Mobile Market's objective is to address the inequity in access to healthy food in Acadiana and Southwest Louisiana, and the health inequities that are associated

		with food insecurity, with a particular emphasis on diet-related chronic disease. With support from Aetna, the Mobile Market makes approximately 20 stops per month across 8 parishes throughout the year. This includes the sale of nutritious food at reduced rates, nutrition education activities emphasizing the connection between diet and overall health, SNAP outreach, and partnerships with healthcare organizations which will provide a wide range of resources and services to shoppers. With Aetna's support, we achieved the following outcomes in the 2024-2025 fiscal year: • 202 stops made by the Makin' Groceries Mobile Market in 8 parishes: Acadia, Calcasieu, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion. • 10,115 transactions completed by shoppers at the Makin' Groceries Mobile Market. • 165,425 pounds of fresh, nutritious food sold at discounted rates at the Makin' Groceries Mobile Market, the equivalent of 137,854 meal
2	Support playground equipment sponsorship	On March 6th 2024, the ABHLA Community Development Team presented Evangeline Parish School Board with a $5,000.00 check to fund playground equipment in support of the Louisiana State Act 84 Resolution and ABHLA Building Activities to Address Childhood Obesity. The focus aligned with early education and the prevention of chronic diseases (diabetes, hypertension, obesity, etc.) while instilling lifelong healthy habitats.
3	Number of food vouchers distributed, 2024 compared to 2023	Cumulative 2023: 1,576 households (108 Aetna member households) Cumulative 2024: More than 1,700 households; more than $167,000 in vouchers redeemed (48 Aetna member

		households; e.g., $37,400 in produce prescription benefits to Aetna members in 2023-2024).

Obesity Goals 2025

- ***Goal 1: Work with partners to increase access to healthy fruits and vegetables and education to address obesity by providing healthy food vouchers. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Work with partners to increase access to healthy fruits and veggies and education to address obesity.
    - **Action Description:** Healthy Families Produce Rx (HFPRx) is an innovative food access program, developed in partnership with Aetna Better Health of Louisiana, Share Our Strength's No Kid Hungry campaign, Vouchers for Veggies, and LSU Ag Center, with funding from the USDA's Gus Schumacher Nutrition Incentive Grant Program (GusNIP). The program provides eligible families with $40 per month to purchase fresh fruits and vegetables at select local farmers markets and grocery retailers. Eligible families receive up to $240 to purchase fruits and vegetables over 6 months and eligible members are enrolled in SNAP and WIC. T Program Eligibility: Households with a child aged 3 to 17 who is currently enrolled in any Medicaid Health Plan in LA. The child lives in or has a primary health care provider in the Northshore region (Washington, Tangipahoa, or St. Helena parish) or the Acadiana region (St. Landry, Acadia or Lafayette parish). Communication with the enrollees begins as soon as the card/vouchers is mailed. Program partners do an introduction welcome call and then, if the enrollees opt in, do a monthly reminder via SMS or phone call to remind the enrollee to use the benefit. If the enrollees aren't using the benefit, they will receive additional reminders to encourage them, as well as a follow-up call to address any issues. At the end of the six months, program partners do a final outreach.

    - **Expected Outcome:** Increase access to healthy fruits and vegetables, as well as education in Regions 4 and 9. Improve dietary health and food security for families in rural Louisiana who are disproportionately impacted by poor nutrition and related health outcomes.
    - **Action Measurement:** Vouchers received.

- ***Goal 2: Partnership with Cajun Nation commUNITY focusing on educating the community at large and specifically children about health and wellness. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Develop and support a partnership with Cajun Nation commUNITY
    - **Action Description:** Focuses on educating children about health and wellness through the use of a mascot. The partnership serves as a fun and interactive learning tool for children. This Mascot is designed to capture their attention and make health and wellness topics engaging and enjoyable. These materials will cover a wide range of topics such as nutrition, exercise, personal hygiene, mental health, and more actively engage with the community through partnerships with local organizations and schools. Enable us to reach a larger audience and have a greater impact on children's health and wellbeing.
    - The mascot will be accompanied by a comprehensive educational program that includes age-appropriate materials and activities.

- **Expected Outcome:** A positive impact on the health and wellbeing of our younger generation.
- **Action Measurement:** Number of Interactive presentations and community events, where engaging sessions on health and wellness topics and providing health related materials. These presentations and or materials will be designed to be both educational and entertaining, ensuring maximum participation and learning. Ensure the accuracy and relevance of our educational content. This will help us provide the most up-to-date and evidence-based information to children and their families.

- ***Goal 3: Support partnership with Second Harvest Mobile Market. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Support partnership with Second Harvest Mobile Market
  - **Action Description:** Aetna will support Makin' Groceries Mobile Market. Designed to enhance the quality of life in under-resourced communities in existing food deserts, the Makin' Groceries Mobile Market serves as an access point for healthy and affordable food, a resource to increase food literacy, and a conduit to connect people to health information and interventions, as well as SNAP outreach. The Market sells fresh produce, often from local growers, at wholesale rates, and also offers proteins, cheese, eggs, and milk when available. Customers may pay with cash, credit, debit, or use SNAP benefits. The Mobile Market hosts nutrition education activities to teach people about the items available at the market, does cooking demonstrations to illustrate ways to prepare foods that may be less familiar, conducts SNAP outreach, and partners with healthcare organizations to provide additional services at select locations. The Mobile Market currently serves locations throughout Acadiana and Southwest Louisiana, and will expand to Southeast Louisiana, beginning in Jefferson Parish.
  - **Expected Outcome:** With support from Aetna, Second Harvest work to fill gaps in food access in rural areas through our brick and mortar pantries and mobile pantries.
  - **Action Measurement:** Number of filled and mobile pantries and number of pounds of food.

Appendix D2
AmeriHealth Caritas Louisiana (ACLA)
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***Goal 1: ACLA will increase provider use of CPT Category (CAT) II codes for member diabetic test results by December 2024, 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: 1/1/2024 End Date: 12/31/2024***
    - **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:** The percentage of diabetic member results received for 2024 compared to results received in 2023.

- ***Goal 2: ACLA will increase member compliance for members with diabetes linked to quality-educated provider groups, including value-based care (VBC) groups who selected GSD as a measurable outcome, by December 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Continue the process of educating provider groups to continually improve member compliance rates for the GSD 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 GSD measures for quality-educated and VBC groups who selected GSD as a measurable outcome.
    - **Action Measurement:** The percentage of improvement shown for GSD measures for both quality-educated and VBC provider groups who selected GSD as a measurable outcome in 2024 compared to 2023.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2023 Medicaid QC 50th percentile or 2% decrease goal for GSD > 9.0%, with a special focus on our members with diabetes who are most likely to experience health disparities by December 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **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, Wellness Center events in English and Spanish, members offered a translator for provider visits, Make Every Calorie Count program (MECC), fitness kit for those who 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, Rapid Response Team (RROT) working with high Predicting Impact for Case Management Services (PICS) population in Transition to Care, member mobile apps, diabetic text messaging campaign, voice messaging campaign, remote monitoring program for chronic disease monitoring, Heart Healthy program, Care Meals, Population Health Management (PHM) outreach for members with HbA1c >8%, faith-based organizations presentations, Member Advisory Council, member surveys.

- **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2023 Medicaid QC 50th percentile or 2% decrease goal for the measure GSD >9.0% for 2024.
- **Action Measurement:** The percentage decrease in GSD >9.0% measure rates in 2024 compared to 2023 and/or the 2023 Medicaid QC 50th percentile.

Diabetes Results 2024

Goal	Benchmark	Results
1	An increase in the percentage of diabetic member results received for 2024 compared to results received in 2023	In 2024, CPT CAT II codes saw a 4.19% decrease in total billing, yet their utilization by provider groups rose by 6.17%. Plan membership decreased by 17.20% in 2024, with the number of members dropping from 188,312 in 2023 to 155,962. The decrease in codes billed corresponds to the 25.73% decrease in the diabetes measure population from 2023 to 2024.
2	Improved rates for Glycemic Status Assessment for Patients with Diabetes (GSD) measures for providers participating in VBC who selected GSD measure(s) or quality-educated provider groups in 2024 compared to compliance in 2023.	ACLA Quality-educated provider groups and groups participating in VBC who selected GSD as a measurable outcome demonstrated increased member compliance, as evidenced by an overall rate of 57.60% in 2024 when compared to the 2023 rate of 33.77%.
3	The 2023 Medicaid QC 50th percentile or 2% decrease for GSD measure HBA1c >9.0% in 2024.	ACLA achieved greater than HEDIS Quality Compass 2023 Medicaid 90th percentile, 29.44% with a final rate of 28.22% in 2024. The plan's 2024 2% annual decrease goal, 31.09%, was met. The 2024 LDH Goal QC

		2023 Medicaid 50th percentile, 37.96%, was met.

Diabetes Goals 2025

- ***Goal 1: ACLA will increase provider use of CPT CAT II codes for member diabetic test results by December 2025, 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: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** ACLA will analyze claims data to identify provider groups who have diabetic members attributed to their practice and will benefit from billing CPT CAT II codes.
    - **Action Description:** ACLA will outreach to engage providers in usage of CPT CAT II codes by sharing benefits of usage through multidisciplinary provider education, projects involving specialized file sharing with identified provider groups, Comprehensive CPT CAT II Provider flyer for distribution (web posting) and quarterly provider alerts on incentives.
    - **Expected Outcome:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes for member diabetic test results.
    - **Action Measurement:** The percentage of diabetic member results received for 2025, compared to results received in 2024.

- ***Goal 2: By December 2025, ACLA will improve diabetic health outcomes for members in rural areas through enhanced access to care. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** ACLA will target diabetic populations within rural regions to provide opportunities to close diabetic care gaps.
    - **Action Description:** ACLA will leverage the mobile wellness bus, contracted retinal screening labs, federally qualified health centers (FQHCs), and other providers, along with faith based organizations to deliver on-site, at home diabetic screenings and education in rural areas, increasing access and member compliance with diabetic care measures in rural areas.
    - **Expected Outcome:** Increased member compliance in rural areas, as evidenced by improved rates for GSD, EED, Kidney Health Evaluation for Patients with Diabetes (KED), and Blood Pressure Control for Patients with Diabetes (BPD) measures in 2025.
    - **Action Measurement:** The percentage of improvement shown for GSD <8.0% and BPD measures in rural areas as measurable outcome in 2025 compared to 2024.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2024 Medicaid QC 50th percentile or 2% decrease goal for GSD >9.0% for 2025, with a special focus on improving health outcomes for diabetic members exhibiting poor glycemic control. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **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, Wellness Center events in English and Spanish, members offered a translator for provider visits, Make Every Calorie Count program (MECC), fitness kit for those who 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, Rapid Response Team (RROT) working with high PICS population in Transition to Care, member mobile apps, diabetic text messaging campaign, voice messaging campaign, remote monitoring program for chronic disease monitoring, Heart Healthy program, Care Meals, PHM outreach for members with HbA1c >8%, faith-based organizations presentations, Member Advisory Council, member surveys.

- **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2024 Medicaid QC 50th percentile or 2% decrease goal for the measure GSD >9.0% for 2025.
- **Action Measurement:** The percentage decrease in measure GSD >9.0% rates in 2025 compared to 2024 and/or the 2023 Medicaid QC 50th percentile.

Obesity Goals 2024

- ***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: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Target population will consist of ACLA members living in Orleans and Jefferson 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 2024.

- ***Goal 2: ACLA will improve the health outcomes of members with obesity with comorbid conditions who are most likely to experience health disparities in 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming with the purpose of promoting self-management of obesity and other comorbid conditions through early intervention.
  - **Action Description:** ACLA will determine effective ways to support equitable access for African Americans obese members assisted with identification by HELS/collaborative intervention to outreach, address social determinants of health (SDOH) where possible, and increase compliance in Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with obesity.
  - **Expected Outcome:** Increased African Americans engagement of obese members in ACLA's Make Every Calorie Count (MECC) program by December 2024.

- **Action Measurement:** The percentage of members with a diagnosis of obesity engaged in the Make Every Calorie Count program by December 2024 compared to that of members engaged by December 2023.

- ***Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2024 to reduce the impact of obesity by providing obese members with education including self-management, treatment, and benefits. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help obese members with comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.
  - **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to obese members, and discussion of programs for members with obesity during Member Advisory Council and Provider Advisory Council meetings.
  - **Expected Outcome:** Increased engagement of high-risk obese members in ACLA's Population Health Management programs.
  - **Action Measurement:** The percentage of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2024 compared to those engaged in 2023.

Obesity Results 2024

Goal	Benchmark	Results
1	At least 10% of targeted population engaged in ACLA Nutrition pilot program by December 2024.	Eighteen (18) percent of the targeted population engaged in the ACLA Nutrition pilot program by December 2024.
2	An increase of at least 2% of African American members with obesity engaged in the Make Every Calorie Count program by December 2024 compared to the number of members engaged by December 2023.	ACLA exceeded its goal by realizing a 48% increase of African American members with obesity engaged in the Make Every Calorie Count program by December 2024.
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 2024.	ACLA exceeded the goal by increasing the number of high-risk members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2024 by 32.1%.

Obesity Goals 2025

- ***Goal 1: ACLA will promote healthy weight by decreasing the adult obesity rate and the percentage of adults reporting no exercise. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Target population will consist of adult members with obesity with a BMI greater than 28 kg/m^2.
    - **Action Description:** ACLA 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 through interventions including Make Every Calorie Count (MECC), the Gym Membership Incentive, healthy eating, cooking and exercise classes at Wellness Centers, Food Bank partnership at ACLA Wellness Centers, and Family Engagement Night occurring monthly at Wellness Centers.
    - **Expected Outcome:** 2% increase in targeted population engaged in Make Every Calorie Count and a 2025 baseline measurement for the gym membership incentive.
    - **Action Measurement:** The percentage of members engaged in the Make Every Calorie Count by December 2025.

- ***Goal 2: ACLA will improve the health outcomes of members with obesity and comorbid conditions who are most likely to experience health disparities by increasing the number of well screenings in 2025. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming with the purpose of promoting self-management of obesity and other comorbid conditions through early intervention.
    - **Action Description:** ACLA will determine effective ways to support equitable access for African Americans members with obesity assisted with identification by HELS/collaborative intervention to outreach, address social determinants of health (SDOH) where possible, and increase compliance in HEDIS measures associated with obesity.
    - **Expected Outcome:** Improve engagement in annual well visits among African American adults identified as obese.
    - **Action Measurement:** An increase of at least 2% of African American members with obesity completing a well visit by December 2025 compared to those completing a well visit in 2024.

- ***Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2025 to reduce the impact of obesity by providing members with obesity with education including self-management, treatment, and benefits. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help members with obesity and comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.
    - **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to obese members, and discussion of programs for members with obesity during Member Advisory Council and Provider Advisory Council meetings, Wellness Centers' monthly Member and Family

Engagement Night and Member Orientation to the Ochsner Remote Patient Monitoring (RPM) Program, community partnership with Nest Health, Caritas on the Move, and Grocery Give Away events.

- **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 2025 compared to those engaged in 2024.

Appendix D3
Healthy Blue
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***Goal 1: Improve YoY HEDIS rates associated with diabetes by at least 2% and or the 66.67th percentile based in NCQA. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase the use of effective programs that increase the monitoring of diabetes management
    - **Action Description:** Collaborate with providers and with existing programs with an emphasis on diabetes management control
    - **Expected Outcome:** Education to members and providers with consistent monitoring will improve the management of diabetes and improve the HEDIS measures with a direct correlation to diabetes management
    - **Action Measurement:** Improved YoY rates by 2% and/or 66.67th percentile for the following HEDIS measures:
        - Glycemic Status Assessment for Patients with Diabetes, Good Control <8% (GSD)
        - Glycemic Status Assessment for Patients with Diabetes, Poor Control >9% (GSD)
        - 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)

- ***Goal 2: Improve Diabetes Preventive Care Practices. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase the amount of members enrolled in case management with HbA1c >9%
    - **Action Description:** Outreach to members and their attributed providers with uncontrolled diabetes using gap-in-care reports, identify and increase engagement with providers who have a high number of patients with HbA1c >9%, monitor diabetes drug adherence and target outreach to members with poor adherence
    - **Expected Outcome:** Increase member and provider awareness of strategies to improve diabetes control and overall outcomes
    - **Action Measurement:** Increase the percentage of members with an HbA1c >9% engaged in case management programs

- ***Goal 3: Increase the number of providers within VBP programs aligned to diabetes management. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **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:** Increase the total number of providers enrolled in value-based programs aligned with diabetes measures by adding an additional 15 providers.

Diabetes Results 2024

Goal	Benchmark	Results
1	HEDIS rates for GSD <8% and >9%, BPD, EED, KED, and SPD	2023: HBD <8%: 62.29% HBD >9%: 30.66% (lower is better) BPD: 63.50% EED: 55.47% KED: 28.62% SPD (Received Statin Therapy): 64.53% SPD (Statin Adherence 80%): 50.45% 2024: GSD (formerly HBD) <8%: 63.75% GSD (formerly HBD) >9%: 30.66% (lower is better) BPD: 67.64% EED: 58.39% KED: 36.52% SPD (Received Statin Therapy): 67.83% SPD (Statin Adherence 80%): 55.51%
2	Case management	Engaged 4,158 members using the "Healthy Lifestyle" campaign. Seen YoY improvement in all above measures ranging from 1.46% to 7.95% with the exception of GSD >9% staying flat.
3	Number of providers added to VBP and total VBP providers	A total of 22 new VBP providers were added to focus on measures specific to diabetes for a total of 123 providers.

Diabetes Goals 2025

- ***Goal 1: Improve YoY HEDIS rates associated with diabetes by at least 2% and or the 66.67th percentile based on NCQA benchmark. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Increase the use of effective programs that increase the monitoring of diabetes management
  - **Action Description:** Collaborate with providers and with existing programs with an emphasis on diabetes management control

- **Expected Outcome:** Education to members and providers with consistent monitoring will improve the management of diabetes and improve the HEDIS measures with a direct correlation to diabetes management
- **Action Measurement:** Improved YoY rates by 2% and/or 66.67th percentile for the following HEDIS measures:
  - Glycemic Status Assessment for Patients with Diabetes, Good Control <8% (GSD)
  - Glycemic Status Assessment for Patients with Diabetes, Poor Control >9% (GSD)
  - 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)

- ***Goal 2: Improve Diabetes Preventive Care Practices. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Increase the amount of members enrolled in case management with HbA1c >9%
  - **Action Description:** Outreach to members and their attributed providers with uncontrolled diabetes using gap-in-care reports, identify and increase engagement with providers who have a high number of patients with HbA1c >9%
  - **Expected Outcome:** Increase member and provider awareness of strategies to improve diabetes control and overall outcomes
  - **Action Measurement:** Increase the percentage of members with an HbA1c >9% engaged in case management programs

- ***Goal 3: Increase the number of providers within VBP programs aligned to diabetes management. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **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:** Increase the total number of providers enrolled in value-based programs aligned with diabetes measures by an additional 15 providers.

Obesity Goals 2024

- ***Goal 1: Improve YoY HEDIS rates associated with obesity by 2% or greater and/or reach the 66.67th percentile NCQA benchmark for Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Expand provider outreach and education from the prior year.
  - **Action Description:** Increase collaboration between health plan and providers as well as communities and schools to provide programs and education on the need for physical activity and the appropriate documentation to improve obesity rates and HEDIS rates

- **Expected Outcome:** Increase provider awareness and education of quality metrics, appropriate documentation and coding requirements, and provide member education on how to improve physical activity through strategic partnerships within the community.
- **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: 1/1/2024 End Date: 12/31/2024***
  - **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: 1/1/2024 End Date: 12/31/2024***
  - **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.
  - **Expected Outcome:** Increased provider enrollment will result in improved outcomes related to obesity and physical health.
  - **Action Measurement:** Increase total number of providers enrolled in value-based programs that incorporate obesity and prevention measures with an additional 15 providers.

Obesity Results 2024

Goal	Benchmark	Results
1	HEDIS rates for WCC	Ensured providers received the necessary materials regarding HEDIS documentation and coding for the WCC measure. Additional opportunity to provide education regarding BMI. WCC (BMI Percentile): 83.7%
2	EPDST engagement	Campaigns were conducted for members to encourage the completion of well-visits as well as back to school events which encouraged the need to complete necessary screenings.
3	VBP providers added to program with focus on obesity	A total of 22 new VBP providers were added to focus on measures specific to diabetes for a total of 123 providers.

Obesity Goals 2025

- ***Goal 1: Improve YoY HEDIS rates associated with obesity by 2% or greater and/or reach the 66.67th percentile NCQA benchmark for Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Expand provider outreach and education.
    - **Action Description:** Increase collaboration between health plan and providers as well as communities and schools to provide programs and education on the need for physical activity and the appropriate documentation to improve obesity rates and HEDIS rates
    - **Expected Outcome:** Increase provider awareness and education of quality metrics, appropriate documentation and coding requirements, and provide member education on how to improve physical activity through strategic partnerships within the community.
    - **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: 1/1/2025 End Date: 12/31/2025***
    - **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: 1/1/2025 End Date: 12/31/2025***
    - **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.
    - **Expected Outcome:** Increased provider enrollment will result in improved outcomes related to obesity and physical health.
    - **Action Measurement:** Increase total number of providers enrolled in value-based programs that incorporate obesity and prevention measures by 15 providers.

Appendix D4
Humana Healthy Horizons in Louisiana
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***Goal 1: Improve the HEDIS GSD HbA1c Poor Control (> 9.0%) measure performance rate by July 2025 to ultimately achieve the NCQA 50th percentile, compared to baseline data July 2024, for members 18-75 years of age with diabetes. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Review the Gap in Care (GIC) report for the GSD Poor Control measure performance rate in Compass with individual provider groups during our recurring meetings. Share best practices for closing the care gaps, resources, identify any barriers providers are having and assist them with closing the care gaps. Request a feature in Compass for a dashboard to show month over month measure performance rates to track and trend results to share with the providers. Upload monthly Provider Performance Rollup report in Availity for providers to access and the quality team liaisons will review the report results during our recurring provider group meetings. Monitor GSD Poor Control measure performance rate trends in the Medicaid HEDIS BI suite. Send a Go365 Diabetic Member Preventive Care Marketing Campaign to members via multiple modalities that includes information about screenings for A1c, diabetic eye exam, blood pressure and kidney health. Planning and initial development is underway to include care gap alerts in Guiding Care for diabetic members to engage them in CM.
    - **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 GSD HbA1c Poor Control (> 9.0%) measure performance rate (a lower rate indicates better performance for HbA1c poor control).
    - **Action Measurement:** Review and track provider performance rates in Compass. Analyze GSD Poor Control measure performance rate in the Medicaid HEDIS BI suite. Evaluate member response results from the Go365 Diabetic Preventive Care Marketing Campaign. Monitor the status of implementing care gap alerts in Guiding Care and if successfully implemented, request a report to determine if those members engaged in a CM program related to treatment of their diabetes.

- ***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 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase outreach efforts to members with diabetes to enroll in the Ochsner Digital Medicine Remote Patient Monitoring (RPM) Pilot Project and/or Humana care management (CM) program.
    - **Action Description:** The Ochsner RPM program will enroll up to 1,000 members with Type 2 diabetes and they will receive a glucometer, diabetic testing supplies, and personalized care plans from licensed clinicians, and lifestyle support from professional health coaches

from their smart phones. Case managers will continue outreach to members with Type 2 diabetes to enroll in CM program.

- **Expected Outcome:** Increase members with diabetes enrollment, by 2%, in either the Ochsner RPM program and/or active CM.
- **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 member 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 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate and promote awareness for diabetic members on the resources (i.e., Go365 incentives and value-added benefits) offered to assist with their care and management of diabetes.
  - **Action Description:** Go365 member incentives for diabetes include a $20 in rewards for completing an annual diabetic screening and $25 in rewards for completing a retinal eye exam. The VAB include 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 call. 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, 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 Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits.

Diabetes Results 2024

Goal	Benchmark	Results
1	Our Medicaid HEDIS dashboard that measures monthly performance of the GSD measure	The baseline performance for the HEDIS GSD HbA1c Poor Control (>9.0%) measure in July of Measurement Year (MY) 2024 was 46.7%. As of July 2025, the rate has improved to 43.2%, reflecting a 3.5 percentage point reduction in the proportion of members with poor glycemic control. This trend demonstrates meaningful progress toward achieving the NCQA 50th percentile benchmark.

2	Monthly reporting from Ochsner on membership	The Ochsner Digital Medicine program launched in February 2024 with an initial cohort of 37 members enrolled in the diabetes management program. By December 2024, enrollment nearly doubled to 73 members, reflecting a 97% growth and growing engagement and adoption of the program within the target population.
3	Go365 and Value Added Benefits Reporting for Diabetic Screening in 2024	In 2024, baseline utilization data for the Complete Diabetes Health Screening offered through Go365 and Value-Added Benefits indicated that 11,110 members successfully completed the screening. Ongoing monitoring of enrollment will continue to ensure consistent growth and sustained engagement.

Diabetes Goals 2025

- ***Goal 1: By December 31, 2025, proactively conduct telephonic outreach to at least 75% of eligible members using the Member Services team to educate them about the Ochsner Digital Medicine Program, with the aim of increasing program enrollment by 20%. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Develop and implement a telephonic outreach campaign for the Member Services team to call at least 3,000 eligible members for the Ochsner Digital Medicine Program by December 31, 2025.
    - **Action Description:** Develop a segmented outreach list based on eligibility criteria for the Ochsner Digital Medicine Program. Provide targeted training to the Member Services team on program benefits, enrollment procedures, and effective communication strategies. Launch and manage a telephonic outreach campaign using a centralized dashboard to monitor call activity, member engagement, and progress toward outreach targets.
    - **Expected Outcome:** Increased member awareness and understanding of the Ochsner Digital Medicine Program, leading to a 20% increase in diabetic program enrollment compared to the 2024 baseline.
    - **Action Measurement:** Outreach Completion Rate: Percentage of eligible members successfully contacted by December 31, 2025. Enrollment Growth: Percentage increase in the diabetic program enrollment compared to 2024 baseline.

- ***Goal 2: By December 31, 2025, increase utilization of the Go365 member incentive program for the Complete Diabetes Health Screening by 10% from 11,110 completions in 2024 to at least 12,221. Start Date: 1/1/2025 End Date: 12/31/2025***

- **Action Step:** Launch a targeted outreach campaign through the Go365 mobile app and text messaging platform by July 2025, aimed at increasing awareness and participation of our members to complete the Complete Diabetes Health Screening.
- **Action Description:** The campaign will include personalized reminders for eligible members, incentive highlights to encourage engagement, and educational content on the importance of diabetes screening.
- **Expected Outcome:** We expect to see growth in the completion rate for the Complete Diabetes Health Screening amongst our eligible members to reduce the impact of diabetes, prediabetes and diabetes related conditions.
- **Action Measurement:** Success will be measured by tracking the number of screenings completed monthly, with a target of reaching at least 1,018 additional completions by December 31, 2025 to meet the 10% growth goal.

- ***Goal 3: By December 31, 2025, improve the HEDIS GSD HbA1c Poor Control (>9%) measure performance rate by at least 2 percentage points through provider participation in Value-Based Programs, supported by targeted incentives and performance feedback. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Implement performance-based incentives for providers who successfully close care gaps on the GSD measure, with a target of increasing gap closure rate during the measurement year.
  - **Action Description:** Providers are incentivized through performance based payments aiming to improve glucose control. We provide monthly performance rates and conduct education on improving rates for our diabetic members. This approach ensures providers have both the data and the tools needed to drive measurable improvements in care quality.
  - **Expected Outcome:** As a result of incentivizing providers through Value-Based Programs, we expect to see a measurable reduction in the HEDIS GSD rate by December 31, 2025.
  - **Action Measurement:** We will monitor the GSD HbA1c Poor Control (>9%) performance rate through the Medicaid HEDIS performance dashboard.

Obesity Goals 2024

- ***Goal 1: Improve the HEDIS measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) performance rate to ultimately achieve the NCQA 50th percentile by July 2025, compared to baseline data, July 2024. Measure description is the percentage of enrolled members 3-17 years old 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: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Review the Gap in Care report in Compass with the providers to show their members aged 3-17 years old during the measurement year who do not have evidence of BMI percentile documentation, and counseling for both nutrition and physical activity (WCC). Identify any barriers providers are having and assist them with closing the care gaps. Request a feature in Compass for a dashboard to show month over month measure performance rates to track and trend results to share with the providers. Review the appropriate coding that supports the WCC measure, proper electronic medical record

(EMR) workflows and documentation, and provide the HEDIS WCC measure specifications flyer as a resource if needed. Will also create a brief article, on the WCC measure specifications and best practices for closing the care gaps, to publish in the Humana Healthy Horizons Provider Newsletter for Quarter 1 of 2025 for education and awareness.

- **Action Description:** The Gap in Care report will help the providers identify those members who are non-compliant with the measure 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 the HEDIS WCC measure performance rate to ultimately achieve the NCQA 50th percentile.
- **Action Measurement:** Review and track provider performance rates in Compass. Analyze WCC measure performance rate in the HEDIS BI suite.

- ***Goal 2: Continue to offer community grants, community engagement and expand partnerships around Louisiana that will provide nutrition education, help promote physical activity and improved overall health to prevent and combat obesity. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Continue to 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: Boys & Girls Club of Metro Louisiana; American Heart Association; Healthy BR; Healthy Start; Eat Move Grow; Three O'Clock Project ; and Tensas Healthy Communities 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 resource and safe physical activity to participants.
  - **Action Measurement:** Use Quickbase internal reports to track the number of community events hosted.

- ***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 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate and promote awareness for members with obesity on the resources (i.e., Go365 incentives and 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 call. 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, 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 Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits.

Obesity Results 2024

Goal	Benchmark	Results
1	Our Medicaid HEDIS dashboard for 2023 & 2024 results for WCC measure	While we did not meet the NCQA 50th percentile benchmark, we observed meaningful improvements across all components of the Well-Child Visit (WCC) measure, indicating positive momentum in provider engagement and documentation practices. The BMI (WCC-B) rate increased from 41.14% in 2023 to 43.6% in 2024, reflecting a 2.46 percentage point improvement. This indicates enhanced provider adherence to documentation standards during well-child visits. The nutrition counseling (WCC-N) rate rose from 22% in 2023 to 28.7% in 2024, a 6.7 percentage point increase. This improvement suggests greater provider engagement in preventive education and counseling on healthy eating habits. The WCC Physical Activity Counseling (WCC-P) rate improved from 21% in 2023 to 27.4% in 2024, marking a 6.4 percentage point increase. This reflects expanded efforts to promote physical activity discussions during pediatric visits.

2	Community Engagement Activity Tracking through calendar events	HHH participated in over 15 community events focused on improving health literacy around obesity and nutrition. These events aimed to raise awareness of local resources and opportunities available to support healthier lifestyles and reduce obesity-related risks.
3	Member Services Dashboard Reporting Go365 incentive usage	At the close of 2024, we established a baseline for the Weight Management Program with 90 members enrolled. This initial cohort will serve as the foundation for measuring future growth and program impact.

Obesity Goals 2025

- ***Goal 1: By December 2025, invest in an organization to host a CME-accredited provider education event focused on childhood obesity, engaging at least 150 providers across both the pre-conference workshop and full-day sessions. The event will deliver CMEs, equip providers with actionable tools, and foster collaboration to improve child health outcomes in Louisiana. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Fund community based organizations that will host a CME-accredited provider education events on childhood obesity by December 2025, with a target of engaging at least 150 providers through both a pre-conference workshop and full-day sessions.
    - **Action Description:** The events will deliver continuing medical education (CME) credits, provide evidence-based tools and resources for obesity prevention and management, and facilitate interdisciplinary collaboration among providers across Louisiana.
    - **Expected Outcome:** Providers will leave the event better equipped to identify, manage, and prevent childhood obesity, leading to increased screenings, more referrals to nutritional counseling, and improved coordination for pediatric patients.
    - **Action Measurement:** We will gather information from CBO on attendance, CME completions, and follow up engagements.

- ***Goal 2: Increase member participation in the Weight Management Program by 20% through targeted outreach and incentives offered via the Go365 platform, reaching the goal by December 31, 2025. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Members 12 and older are offered incentives to enroll and participate in the Weight Management coaching program.
    - **Action Description:** Members are encouraged to enroll and actively participate in the Weight Management Coaching Program through incentives offered via the Go365 platform. Awareness of the program is also promoted through Health Needs Assessments and referrals from Care Management, ensuring eligible members are informed and supported in accessing weight management resources.

- **Expected Outcome:** Increased awareness, interest, and motivation to participate in the program.
- **Action Measurement:** We will track the Weight Management program enrollment rates and compare to baseline data from 2024 to determine growth.

- ***Goal 3: Increase member enrollment in the gym membership Value-Added Benefit by 20% by December 31, 2025, through targeted outreach and incentives delivered via the Go365 platform. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Humana will provide a 1 year YMCA gym membership for members at no cost.
  - **Action Description:** Humana will offer eligible members a one-year YMCA gym membership at no cost, as part of a broader initiative to promote physical activity and support obesity prevention and management. This benefit is designed to reduce barriers to exercise by providing access to safe, community-based fitness facilities. The program will be tracked through member enrollment and utilization data, with the goal of increasing physical activity engagement among targeted populations.
  - **Expected Outcome:** Increase awareness and perceived value of the gym VAB, leading to an increase in enrollments by the end of Q4 2025.
  - **Action Measurement:** Value added benefit reporting from 2025 of YMCA gym benefit utilization amongst members.

Appendix D5

Louisiana Healthcare Connections
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***Goal 1: Increase the use of home- based remote technology to assist members with improving glycemic control. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Identify members with poor glycemic control through risk stratification and claims data who may benefit from support to manage their diabetes and achieve A1c control.
    - **Action Description:** Collaborate with Ochsner's Digital Medicine Program to utilize digital devices and 1:1 licensed clinician and professional health coaching to clinically manage members with Type 2 diabetes.
    - **Expected Outcome:** Member enrollment in a remote digital monitoring program to assist with effective chronic diabetes management.
    - **Action Measurement:** For 2024, success will be measured by establishment of baseline enrollment and HEDIS rates for members referred to Ochsner Digital Medicine Program, with long term measurement to include trending of diabetes and blood pressure HEDIS outcomes for enrolled members across the continuum of digital medicine program.

- ***Goal 2: Expand referral and collaboration with clinical partner organization to engage members at risk or diagnosed with Type 2 diabetes in self-care management activities. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Use risk stratification data to identify members with or at risk for Type 2 diabetes who may benefit from support and education to develop long-term lifestyle changes to prevent or control diabetes.
    - **Action Description:** Refer identified members to Pennington's Diabetes Treatment Program that offers one-on-one coaching, individualized meal plans, and medication management (if indicated) to lose weight and develop long-term lifestyle changes to help keep weight off.
    - **Expected Outcome:** Increased member awareness and engagement in available resources that assist with lifestyle changes to prevent or control diabetes as evidenced by an increase in the number of referrals to Pennington Diabetes Treatment Program.
    - **Action Measurement:** Increase in member referrals to Pennington's Diabetes Treatment Program from the prior year.

- ***Goal 3: Increase member engagement in recommended diabetes screenings and self-care activities as demonstrated by an improvement in related diabetes HEDIS measures. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Promote member and provider engagement in diabetes management through outreach, education, and incentives for completing recommended diabetes screenings/testing.
    - **Action Description:** Provide member and provider outreach using a variety of approaches (mailers, direct calls, community screening events, in person visits, webinars, incentives,

etc.) to encourage participation in diabetes screenings and testing to improve outcomes and prevent diabetes complications.

- **Expected Outcome:** Improvement in clinical measure of diabetes control as evidenced by improvement in selected HEDIS performance measures associated with diabetes.
- **Action Measurement:** Improvement in the following HEDIS diabetes measures by 2% over prior year:
  - Hemoglobin A1c Control for Patients With Diabetes:
  - HbA1C Control < 8.0%
  - HbA1C Poor Control > 9.0%
  - Eye Exam for Patients With Diabetes
  - BP control (<140/90 mm Hg)

Diabetes Results 2024

Goal	Benchmark	Results
1	Baseline member enrollment and HEDIS rates for members referred for remote digital diabetes monitoring.	LHCC established 2024 baseline enrollment and MY2024 HEDIS rates for members enrolled in Ochsner's Digital Medicine Program as follows: -Enrollment: 259 members received care via Ochsner's Digital Medicine Diabetes Program in 2024 -Baseline HEDIS rates for enrolled members: HbA1c Control (< 8.0%) 70.13%, BPD 69.68%, KED 66.05%, EED 86.87%
2	Increase in member referrals to Pennington's Diabetes Treatment program over prior year	LHCC saw a decrease in referral and enrollment to the Pennington Biomedical Diabetes Program for 2024. For 2023, 162 LHCC members were referred and 26 enrolled. For 2024, 95 LHCC members were referred and 7 enrolled. As the program's personalized medical and behavioral in-person sessions were only available in the Baton Rouge area, geographical distance was a barrier to member recruitment and participation.
3	2% improvement over prior year performance in Diabetes related HEDIS rates	LHCC demonstrated improvements in 2024 Diabetes Care HEDIS measures. Hemoglobin A1c Control for Patients With Diabetes: - HbA1C Control < 8.0%: 63.02%, <2% improvement over prior year rate 61.56%

		(+1.46) and exceeding national 50th percentile rate of 60.58% - HbA1C Poor Control* > 9.0%: 29.68% (lower is better), <2% improvement over prior year rate of 31.63% (-1.95) exceeded the national 50th percentile rate of 30.41% *lower is better Eye Exam for Patients with Diabetes: 66.42%, >2% improvement over prior year rate of 59.37% (+7.05) and exceeding national 50th percentile rate of 56.39% BP control (<140/90 mm Hg): 69.10%, >2% improvement over prior year rate of 63.02% (+6.08)

Diabetes Goals 2025

- ***Goal 1: Improve member outcomes through targeted provider partnerships to address higher acuity members with diagnoses including diabetes and hypertension. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Implement focused interventions including member outreach, engagement, and care coordination/support for diabetic members through targeted provider partnerships.
    - **Action Description:** Identify a target population subset of members with diagnoses including diabetes/hypertension for focused outreach, engagement, and care coordination by select provider partners to address diabetes management including member education/support (i.e. nutrition, medication adherence, lifestyle modification) and monitoring of diabetes related clinical measurements for optimal health outcomes (i.e., HbA1c, blood pressure, and kidney health monitoring and retinal eye exams).
    - **Expected Outcome:** Members engaged through targeted provider partnership will demonstrate improved outcomes in diabetes and blood pressure HEDIS metrics.
    - **Action Measurement:** Improvement in the following HEDIS diabetes measures for the target population by 2% over prior year:
      - Hemoglobin A1c Control for Patients With Diabetes:
        - HbA1C Control < 8.0%
        - HbA1C Poor Control > 9.0%
      -Eye Exam for Patients With Diabetes
      - BP control (<140/90 mm Hg)

- ***Goal 2: Expand use of home-based remote technology to assist members with diabetes in improving glycemic control. Start Date: 1/1/2025 End Date: 12/31/2025***

- **Action Step:** Expand efforts to increase member participation in remote monitoring program to assist with blood glucose control.
- **Action Description:** Continue to identify and refer members who may benefit from using digital devices and 1:1 licensed clinician and professional health coaching to clinically manage members their Type 2 diabetes.
- **Expected Outcome:** Increase in the use of home based remote monitoring to assist members with effective chronic diabetes management.
- **Action Measurement:** Increase in member enrollment in remote diabetes digital monitoring program by 30% over prior year.

- ***Goal 3: Improve outcomes for members with diabetes through increased member engagement in diabetes screenings and activities aimed at maintaining blood glucose levels within a safe range to prevent complications and improve overall health. Start Date: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Promote member engagement in diabetes management through outreach, education, and incentives for completing recommended diabetes screenings/testing.
  - **Action Description:** Expand member outreach using a variety of approaches (mailers, direct calls, emails, social media, community events, incentives, etc.) to encourage participation in diabetes screenings, activities, and use of available resources aimed at controlling blood glucose levels.
  - **Expected Outcome:** Members engaged in diabetes screenings and activities aimed at maintaining blood glucose levels will demonstrate improved clinical outcomes in diabetes related HEDIS metrics.
  - **Action Measurement:** Improvement in the following HEDIS diabetes measures by 2% over prior year:
    - Hemoglobin A1c Control for Patients With Diabetes:
      - HbA1C Control < 8.0%
      - HbA1C Poor Control > 9.0%
    -Eye Exam for Patients With Diabetes
    - BP control (<140/90 mm Hg)

Obesity Goals 2024

- ***Goal 1: Expand member identification and enrollment in Centene's Weight (lifestyle) Management Program to engage members in actions to manage weight and minimize health risk factors associated with obesity. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Identify members through health risk screenings and claims analysis that may benefit from outreach, education, and support to improve nutrition and exercise patterns to manage weight and minimize health risk factors.
  - **Action Description:** Refer identified members to Centene's Weight (lifestyle) Management Program to receive health coaching, nutritional counseling, and education that focuses on ways to improve nutrition, hydration, physical activity, and lifestyle patterns to manage weight. Member-facing resources (LHCC website, member portal, and member handbook) will also encourage self-referral options.

- **Expected Outcome:** Increase in the number of member enrollments into the Weight (lifestyle) Management Program, ultimately yielding improved nutrition and lifestyle modifications that lead to improved health outcomes.
- **Action Measurement:** Increase in member enrollments to Centene's Weight (lifestyle) Management Program from the prior year.

- ***Goal 2: Improve health outcomes for pediatric members with obesity as evidenced by improvement in the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS measure. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Encourage provider engagement in evidenced based practices related to weight management including BMI percentile measurement, counseling for nutrition, and counseling for physical activity during patient encounters.
  - **Action Description:** Offer support and resources to providers assist in managing members with obesity including education, clinical practice guidelines, care gap reports, obesity program referrals, and BMI measurement incentives.
  - **Expected Outcome:** Improvement in member outcomes related to pediatric obesity as evidenced by improvement in selected HEDIS performance measures.
  - **Action Measurement:** Increase in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS obesity related measure including BMI percentile, Counseling for Nutrition, Counseling for Physical Activity by at least 2% over prior year.
- ***Goal 3: Increase member engagement in activities and resources that promote healthy lifestyle and nutrition management through resource programs and investment in community programs/partnerships. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Develop and expand community partnerships and member initiatives that encourage nutritional awareness, increase access to healthy foods/resources, and promote healthy lifestyle choices.
  - **Action Description:** Support and/or sponsor the following initiatives that increase member access and engagement to healthier food choices including:
    - Promotion of Greaux the Good SNAP match farmers' market programs
    - 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.
    - School-based wellness and nutrition events
  - **Expected Outcome:** Increased member engagement in local community programs, increased access to nutritious foods, and improved healthy food choices.
  - **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.

Obesity Results 2024

Goal	Benchmark	Results
1	Increase in member enrollments in Centene's Weight (lifestyle) Management Program	LHCC did not achieve the goal of increasing member enrollments to the Weight (lifestyle) Management Program. In 2024, 231 members with obesity were successfully enrolled representing a decrease over the prior year (384 enrollments in 2023).
2	2% improvement over prior year performance in Obesity related HEDIS rates	LHCC demonstrated improvement in the following Pediatric Obesity related HEDIS measures: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents; - BMI percentile: 89.29%, >2% improvement over prior year rate of 81.5% (+7.78) and exceeding the national 50th percentile rate of 84.18% - Counseling for Nutrition: 69.34%, < 2% improvement over prior year rate of 70.56% (-1.22) - Counseling for Physical Activity: 64.72%, >2% improvement over prior year rate of 59.12% (+5.60)
3	Member and Community Engagement/Participation at LHCC sponsored events/programs, SNAP Benefit Investments, and Community Coalition Events	Nutrition Education -LHCC continued its partnership with LSU Ag Center SNAP-Ed and EFNEP's programs to create quick and easy recipes to help Medicaid families make healthier food choices. In 2024, LHCC focused on budget and kid friendly recipes producing 5 additional videos (in total 33 over the 6-year partnership) that have received over 33,560 YouTube views cumulatively. - Low-salt and low-sugar Build a Healthy Meal resources were shared with 49 providers via webinar during National Nutrition Month. -LHCC promoted education to its members around the statewide Greaux the Good program via community events

		and on its website and Facebook page, resulting in 58,706 total impressions and 7,083 likes, shares or comments. Greaux the Good was also promoted to 49 providers via webinar during National Nutrition Month. Community Grants Program -As part of its 2024 Community Grants Program, LHCC awarded a total of $105,000 to three organizations for initiatives aimed at increasing access to healthy foods: 1) Second Harvest Food Bank to expand the Makin' Groceries Mobile Market in the Acadiana and Southwest Louisiana regions. 2) HGM Community Development Corporation to enhance the effectiveness of its food distribution program in DeSoto Parish by installing a commercial, energy-efficient freezer. 3) Food Bank of Northeast Louisiana to expand its Feeding Seniors food distribution programs. School-Based and Community Wellness and Nutrition Events In 2024, LHCC sponsored and/or participated in both school- based and community events focused on wellness, nutrition, physical fitness, and combatting childhood obesity as follows: -44 school-based events including Get Moving, Get Healthy events, Jags on the Bluff, Louisiana Farm to School Program's Seeds to Success Conference, Louisiana Elementary Fitness Meet, and a preschool playground enhancement in partnership with LSU AgCenter. -37community events including Red Stick Farmers Market Kids Day, Wisner Wins Community Garden, the Mayor's Healthy

		City Initiative, and Market Umbrella's Moonlight Market.

Obesity Goals 2025

- ***Goal 1: Improve member outcomes by expanding access to evidence-based childhood obesity prevention and treatment resources. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Implement evidence based interventions to achieve weight reduction in children with obesity through targeted clinical partnerships among obesity researchers and select and home health providers.
    - **Action Description:** Identify members with childhood obesity for referral to a family weight management program for evidenced based interventions including weekly lesson plans, psychological assessments, education, health coaching, and monitoring of obesity related clinical measurements for optimal health outcomes (i.e. BMI, BP, Eating Patterns, and Quality of Life).
    - **Expected Outcome:** Members engaged in the family weight management program will demonstrate improved knowledge of nutritional and lifestyle modification needs and obesity related clinical outcomes.
    - **Action Measurement:** Success will be measured by establishment of baseline enrollment numbers and review of initial clinical outcomes of members enrolled in the family weight management program.

- ***Goal 2: Improve health outcomes for members with obesity by increasing provider engagement in evidenced-based practices related to weight management. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Offer incentives and tools to providers that encourage the use of evidenced based practices to improve health outcomes for members with obesity.
    - **Action Description:** Provide resources including BMI measurement incentives, clinical practice guidelines, care gap reports, obesity program referrals, coding guidelines, and member wellness appointment reminders to assist providers with the management and treatment of members with obesity.
    - **Expected Outcome:** Improvement in member outcomes related to pediatric obesity as evidenced by improvement in selected HEDIS performance measures.
    - **Action Measurement:** Increase in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS obesity related measure including BMI percentile, Counseling for Nutrition, Counseling for Physical Activity by at least 2% over prior year.
- ***Goal 3: Increase member engagement in activities and resources that promote healthy lifestyle and weight management through resource programs and investment in community programs/partnerships. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Increase community partnerships and member initiatives to support nutritional awareness, access to healthy foods/resources, and healthy lifestyle promotion.

- **Action Description:** Promote 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:
    - Nutrition education partnership with LSU Ag SNAP-Ed and EFNEP (Expanded Food and Nutrition Program)
    - Support the continued development of LSU AG Center's Build a Healthy Meal skill-building video series and promote resources to members via web, social media, and community events.
    - Offering Community Impact Grants for initiatives aimed at increasing access to healthy foods.
    - Community Sponsored Events focused on wellness, nutrition, physical fitness, and expansion of healthy food access.
- **Expected Outcome:** Members engaged in community programs that increase access to and provide awareness of nutritious foods/resources will be better equipped to make lifestyle choices that support a healthy weight.
- **Action Measurement:** Increase in member and community engagement and participation at LHCC sponsored events/programs that promote healthy lifestyle and nutrition management.

Appendix D6
UnitedHealthcare of Louisiana
2024 Diabetes and Obesity Action Plan

Diabetes Goals 2024

- ***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: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase the number of members participating in and completing their HRAs.
    - **Action Description:** Deploying Health Assessment and Research Communities (HARC) and case management to conduct HRAs for new members within 90 days of enrolling and for those beyond 90 days who need to close their assessment gaps focusing on diabetes. Additionally UHC increased the Health Needs Assessments (HNA) rewards to incentivize participation.
    - **Expected Outcome:** The expected outcome should show an increase in the number of members completing their HRAs.
    - **Action Measurement:** The indicators used to measure this goal include telephonic outreach, increased incentives, targeted engagement and comprehensive communication.

- ***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: 1/1/2024 End Date: 12/31/2024***
    - **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: 1/1/2024 End Date: 12/31/2024***
    - **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 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 for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute

provider scorecards that indicate whether the providers have met HEDIS measure targets. The HEDIS guidelines and tip sheets are also distributed by clinical consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the clinical consultants educate providers on the importance of HbA1c (estimated average glucose) testing, retinal eye exams, and blood pressure control. In the case of retinal exams, clinical consultants ensure the providers are aware of the vision vendor MARCH® Vision Care. Qualified Providers are incentivized through our CP-PCPi Program for members with good HbA1c control < or = 9.

- **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS (GSD) HbA1C 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.

Diabetes Results 2024

Goals	Benchmark	2019 Results
1	Completed HRAs	2023 HRAs completed: 6,075 2024 HRAs completed: 7,949 which shows a successful outcome with 1,874 more HRAs completed than the previous year.
2	Case management referral of identified and qualified pregnant members	2023- 17,943 members were identified and 15,676 qualified. 2024- 16,386 members were identified and 13,275 qualified while we didn't have an increase in our benchmark our overall membership has declined due to redetermination efforts.
3	EED and GSD rates	2023: EED 54.74%, HBD (now GSD) <8% 70.07% 2024: EED 55.47%, GSD <8% 65.94%

Diabetes Goals 2025

- ***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: 1/1/2025 End Date: 12/31/2025***
  - **Action Step:** Increase the number of members participating in and completing their HRAs.
  - **Action Description:** Deploying Health Assessment and Research Communities (HARC) and case management to conduct HRAs for new members within 90 days of enrolling and for those beyond 90 days who need to close their assessment gaps focusing on diabetes. Additionally UHC increased the Health Needs Assessments (HNA) rewards to incentivize participation.
  - **Expected Outcome:** The expected outcome should show an increase in the number of members completing their HRAs.

- **Action Measurement:** The indicators used to measure this goal include telephonic outreach, increased incentives, targeted engagement and comprehensive communication.

- ***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: 1/1/2025 End Date: 12/31/2025***
  - **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: 1/1/2025 End Date: 12/31/2025***
  - **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 for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS measure targets. The HEDIS guidelines and tip sheets are also distributed by clinical consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the clinical consultants educate providers on the importance of HbA1c (estimated average glucose) testing, retinal eye exams, and blood pressure control. In the case of retinal exams, clinical consultants ensure the providers are aware of the vision vendor MARCH® Vision Care. Qualified Providers are incentivized through our CP-PCPi Program for members with good HbA1c control < or = 9.
  - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS (HBD) HbA1C 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 2024

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% YOY. 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 ***Goal 1: Increase member awareness of healthy lifestyles by 2% YOY. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **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 YOY. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **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% YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **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.

Obesity Results 2024

Goal	Benchmark	Results
1	Mailings/emails sent to members	2023 # of mailings/emails sent to members 28,668 2024 # of mailings/emails sent to members 24, 211 (7,062 direct mail and 17,149 email)
2	Distributed Weight Watchers vouchers	2023: 20 Weight Watchers vouchers were distributed and UHC participated in approximately 87 events attracting an estimated 21,844 attendees. These events focused on obesity, nutrition, and chronic disease prevention. 2024: 5 Weight Watchers (WW) vouchers were distributed; while WW does offer in-person meetings in bigger cities, there are very limited if any offerings in rural towns making access difficult for members to attend. In 2024 we had a total of 99 unique members with a BMI of 30+ that we offered One Pass membership to. Of those, 75 members (62%) accessed the digital gym membership and 38 members (24%) participated in in-persons gyms with 14% of members engaged in both digital and in-person activities at least once.
3	WCC rate	2022 WCC BMI percentile 83.21% 2024 WCC BMI percentile 87.10% which shows a successful outcome of trending 3.89 points higher than the previous year. We partnered with community stakeholders and participated in 13 community events focused on obesity prevention, nutrition education, and wellness promotion. Across the state, seven Population Health Consultants

		collectively conducted 496 provider-facing visits—both in-person and virtual— and emailed 147 providers to address gaps in care related to diabetes and obesity. During these engagements, consultants distributed Opportunity Reports (PCORs) and Path Guides as supportive resources to enhance provider awareness and promote evidence-based interventions.

Obesity Goals 2025

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% YOY. Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Educate members using personalized communication (calls, texts, emails) to educate members about wellness benefits like OnePass Weight Watchers, and nutrition support.
    - **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 targeting not only adults but also children and adolescents. UnitedHealthcare Community Plan of Louisiana can adapt a multi-generational, community-driven approach that emphasizes obesity prevention, nutrition education, and wellness promotion through strategic partnerships Start Date: 1/1/2025 End Date: 12/31/2025***
    - **Action Step:** Implement a comprehensive strategy to increase member utilization of value-added benefits our efforts will include distributing collateral and providing information at community events, as well as enhancing visibility through our websites and member portals.
    - **Action Description:** Continue to strengthen its commitment to preventative care through the EPSDT program. Our EPSDT coordinator actively collaborates with providers to ensure alignment with current EPSDT recommendations utilizing standardized toolkits that support early identification and intervention for obesity and diabetes. By combining clinical guidance with community outreach we hope to empower families to take proactive steps towards wellness especially in populations at higher risk.
    - **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: 1/1/2025 End Date: 12/31/2025***
  - **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 E – Standards of Diabetes Care

American Diabetes Association
Standards of Care in Diabetes - 2025
https://diabetesjournals.org/care/issue/48/Supplement_1

American Association of Clinical Endocrinology Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm – 2023 Update
https://www.endocrinepractice.org/article/S1530-891X(23)00034-4/fulltext

American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan-2022 Update
https://pubmed.ncbi.nlm.nih.gov/35963508/

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