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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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

This report is submitted pursuant to Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2020 paid healthcare claims submitted by each of the five Medicaid managed care organizations (MCOs) to Louisiana Medicaid, and represent the Louisiana Medicaid managed care population only.

Below are some highlights from this year's report:

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity* 2021 report, Louisiana was ranked fourth highest in the nation.[1] The following obesity summary was based on 2020 MCO claims data:
    - In 2020, 51,386 Medicaid managed care enrollees under the age of 18 years had an obesity diagnosis. This is 7.33% of the managed care child population. Additionally, 11.81% of adult enrollees 18 years of age or older (100,004 enrollees) had an obesity diagnosis in 2020. The overall obesity prevalence was 9.78% of the total managed care population of 1,547,113 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 2020 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2020) was 27.29% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2020.

- Louisiana was also ranked fourth highest in the nation for adult diabetes in 2020.[2] The following diabetes summary was based on 2020 MCO claims data:
    - In 2020, 8.91% (75,428 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.26% (1,858 enrollees). The total managed care population (1,547,113 enrollees) had a diabetes prevalence of 4.99% (77,286). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish and age group.
    - Adult Medicaid managed care enrollees with diabetes during 2020 were associated with 25.51% of the adult total managed care paid claims with dates of service in 2020.
    - Of the 192,153 inpatient discharges in 2020, 2.94% (5,657 discharges) had a primary or secondary diagnosis of diabetes. There were 1,073,864 emergency department visits in 2020 and 2.95% (31,685) had a primary or secondary diagnosis of diabetes.
    - The average cost per enrollee with diabetes in 2020 was $4,518.

[1] *The State of Obesity: Better Policies for a Healthier America 2021*. (September 2021). Retrieved October 11, 2021 from https://www.tfah.org/wp-content/uploads/2021/09/2021ObesityReport_Fnl.pdf
[2] Ibid.

1 Introduction

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

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

1.1 Report Methodology

1.1.1 Data Sources

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

1.1.2 Improvements

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

1.2 Obesity Overview

1.2.1 National Prevalence

Although national, state and local governments, and many private employers and payers have increased their efforts to address obesity since 1998,[3] the age-adjusted national prevalence of obesity in adults has continued to increase and was 42.4% in 2017-2018.[4]

1.2.2 What is Obesity?

Obesity is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics.[5] For adults, a body mass index (BMI) below 18.5 is considered underweight, between 18.5 and less than 25 is the normal range, 25 to less than 30 is overweight, and 30 or higher is obese. For children, obesity is defined as a BMI at or above the 95th percentile for children and teens of

[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 17, 2020 from https://pubmed.ncbi.nlm.nih.gov/19635784/

[4] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018. NCHS data brief, no 360 Hyattsville, MD: National Center for Health Statistics. 2020. Retrieved October 11, 2021 from https://www.cdc.gov/nchs/data/databriefs/db360-h.pdf

[5] *Adult Obesity Causes and Consequences* (September 2020). Retrieved October 12, 2021 from https://www.cdc.gov/obesity/adult/causes.html

the same age and sex. BMI is calculated by dividing a person's weight in kilograms by the square of their height in meters.[6]

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

1.3 Diabetes Overview

1.3.1 National Prevalence

Diabetes is a common disease. The CDC reports that 34.2 million Americans are living with diabetes, and another 88 million are living with prediabetes; further, about 90% to 95% of diagnosed cases are Type 2. In the United States, diabetes was the seventh leading cause of death in 2017.[8]

1.3.2 What is Diabetes?

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

1.3.3 Types of Diabetes

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

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

Gestational diabetes is a type of diabetes that is first seen in pregnant women who did not have diabetes before being pregnant.[14] The risk factors for gestational diabetes are similar to those for Type 2 diabetes.[15]

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[6] *Overweight and Obesity.* Retrieved October 12, 2021 from https://www.cdc.gov/obesity/index.html
[7] *The Health Effects of Overweight and Obesity.* Retrieved October 12, 2021 from https://www.cdc.gov/healthyweight/effects/index.html.
[8] *National Diabetes Statistics Report, 2020* (2020). Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[9] *What is Diabetes?* (June 11, 2020). Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/basics/diabetes.html
[10] *National Diabetes Statistics Report, 2020.* Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.
[11] *Type 1 Diabetes.* (March 11, 2020). Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/basics/type1.html
[12] *Type 2 Diabetes.* (May 30, 2019). Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/basics/type2.html
[13] *Diabetes Risk Factors* (March, 24, 2020). Retrieved October 12, 2021 from http://www.cdc.gov/diabetes/basics/risk-factors.html
[14] *Gestational Diabetes and Pregnancy.* (July 14, 2020). Retrieved October 12, 2021 from http://www.cdc.gov/pregnancy/diabetes-gestational.html
[15] *Diabetes Risk Factors.* (March 24, 2020). Retrieved December 16, 2020 from https://www.cdc.gov/diabetes/basics/risk-factors.html

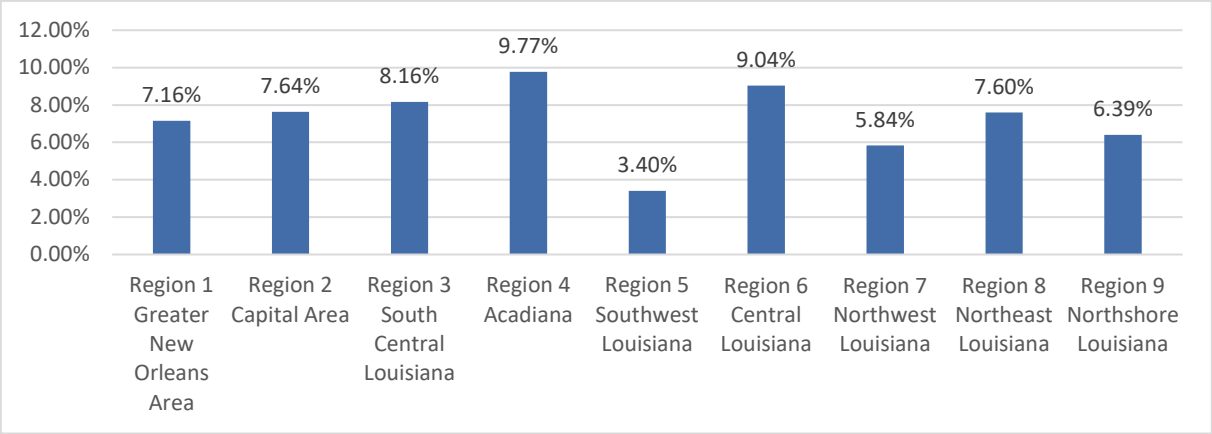
Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, and increased risk of Type 2 diabetes for both the mother and the child later in life. Often, gestational diabetes can be controlled through eating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

2 The Scope of Obesity in the Medicaid Managed Care Program

The *State of Obesity* published by the Trust for America's Health and the Robert Wood Johnson Foundation reports that Louisiana's adult obesity rate was 38.1% in 2020, which is the fourth highest adult obesity rate in the United States.[17] Given our reported obesity rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data and yields an artificially low prevalence rate when exclusively using Louisiana Medicaid medical claims data to calculate the rate.

In this report, Medicaid managed care enrollees with obesity were identified by medical claims with dates of service in 2020 that included a primary or secondary diagnosis of obesity. Based on 2020 claims data, the managed care overall obesity prevalence rate was 9.78% of 1,547,113 MCO enrollees. Figure 2.1 shows that Louisiana Medicaid Region 4 had the highest child obesity prevalence rate (9.77%), followed closely by Louisiana Medicaid Region 6 (9.04%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 4 at 15.80% and was again followed closely by Louisiana Medicaid Region 6 at 14.90% (Figure 2.2). When the data were stratified by age, gender and race, the highest prevalence rates were found in adult females. The female adult obesity prevalence rate by race was 17.40% African-American, 16.03% other race, and 11.65% white (Figure 2.3). The remaining age, gender and race strata had obesity prevalence rates below 9.10%. For parish-level obesity prevalence rates, please see Appendix B.

Figure 2.1: Medicaid Managed Care Child Obesity Prevalence in 2020 by Medicaid Regions Age < 18 Years



[16] *Gestational Diabetes and Pregnancy.* (July 14, 2020). Retrieved October 12, 2021 from http://www.cdc.gov/pregnancy/diabetes-gestational.html

[17] *The State of Obesity: Better Policies for a Healthier America 2021.* (September 2021). Retrieved October 11, 2021 from https://www.tfah.org/wp-content/uploads/2021/09/2021ObesityReport_Fnl.pdf

Figure 2.2: Medicaid Managed Care Adult Obesity Prevalence in 2020 by Medicaid Regions Age ≥ 18 Years

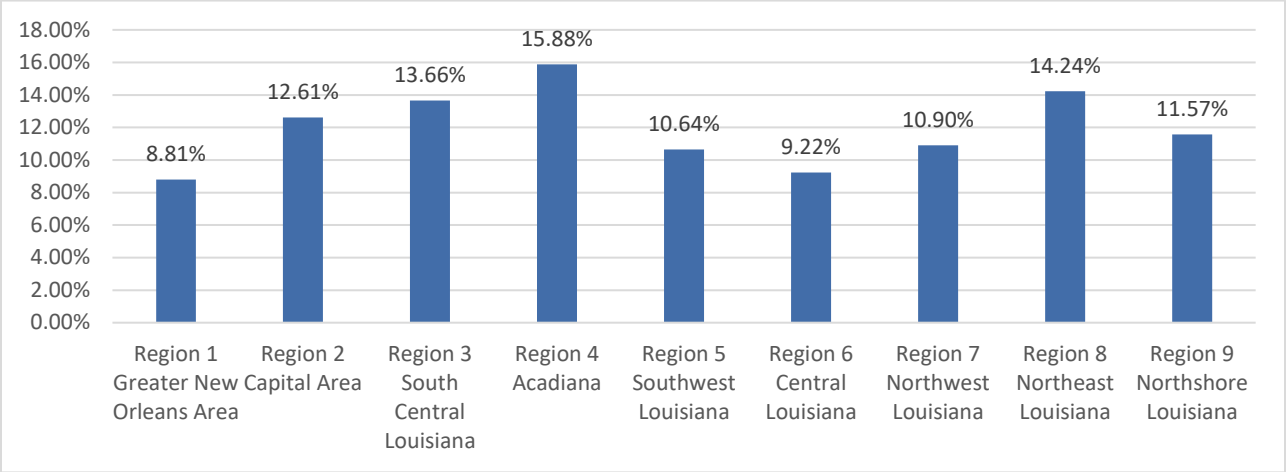
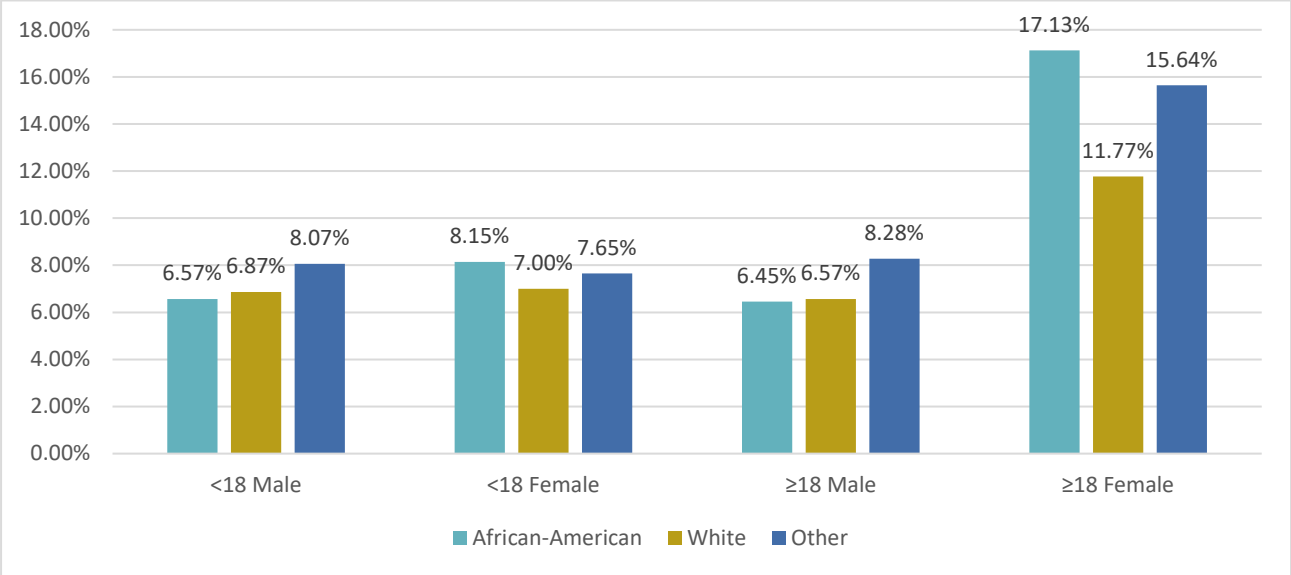


Figure 2.3: Medicaid Managed Care Obesity Prevalence in 2020 by Age Group, Gender and Race



2.1 The Financial Impact of Obesity and Its Complications

Table 2.1 lists total costs, by claim type, age group and obesity category, for healthcare claims with dates of service in 2020 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 9.78%. Healthcare claim costs for these enrollees totaled $1,682,442,325 in 2020, which accounts for 27.29% of the total MCO claims payments ($6,165,779,985). In other words, of the entire Medicaid managed care population, the 9.78% who have a diagnosis of obesity account for 27.29% of the total healthcare claim costs.

Table 2.1: Total Cost of Obesity in 2020 among Medicaid Managed Care Enrollees By Claim Type, Age Group and Obesity Category

Claim Type	Total Cost: Children Diagnosed with Obesity*	Total Cost: Non-Obese Children	Total Cost: Adults Diagnosed with Obesity **	Total Cost: Non-Obese Adults	Percent of Total Costs Associated with Enrollees Diagnosed with Obesity
Medical	$146,869,359	$1,015,992,030	$981,067,816	$2,109,744,516	26.52%
Pharmacy	$44,901,211	$224,344,928	$492,146,068	$1,038,623,660	29.84%
Other***	$13,011,819	$77,493,595	$4,446,052	$17,138,931	15.57%
Total	$204,782,389	$1,317,830,553	$1,477,659,936	$3,165,507,107	27.29%

*Includes claims, with dates of service in 2020, for any child MCO enrollee diagnosed with obesity in 2020.
**Includes claims, with dates of service in 2020, for any adult MCO enrollee diagnosed with obesity in 2020.
***Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

3 The Scope of Diabetes in the Medicaid Managed Care Program

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

The *National Diabetes Statistics Report 2020* published by the CDC states that the overall adult crude prevalence of diagnosed diabetes in the United States was 10.2% for the years 2013-2016, and that 2.8% of adults (age $\geq$ 18 years), who met laboratory criteria for diabetes, were unaware or did not report that they had diabetes. The report also indicated that the total direct and indirect costs of diagnosed diabetes in the United States in 2017 was $327 billion.[18]

For the 2021 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2020 that included a primary or secondary diagnosis of diabetes. Based on 2020 claims data, the adult diabetes prevalence was 8.91% of 846,696 unique managed care adults. The child diabetes prevalence was 0.26% of 700,417 enrollees under the age of 18 years. Louisiana Medicaid Regions 7 and 8 had the highest child prevalence rates, 0.38% and 0.36% respectively (Figure 3.1). The same regions led in adult diabetes prevalence (Figure 3.2) with Region 7 at 10.6% and Region 8 at 9.72%.

[18] *National Diabetes Statistics Report, 2020* (2020). Retrieved October 12, 2021 from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Figure 3.1: Medicaid Managed Care Child Diabetes Prevalence in 2020 by Medicaid Regions Age < 18 Years

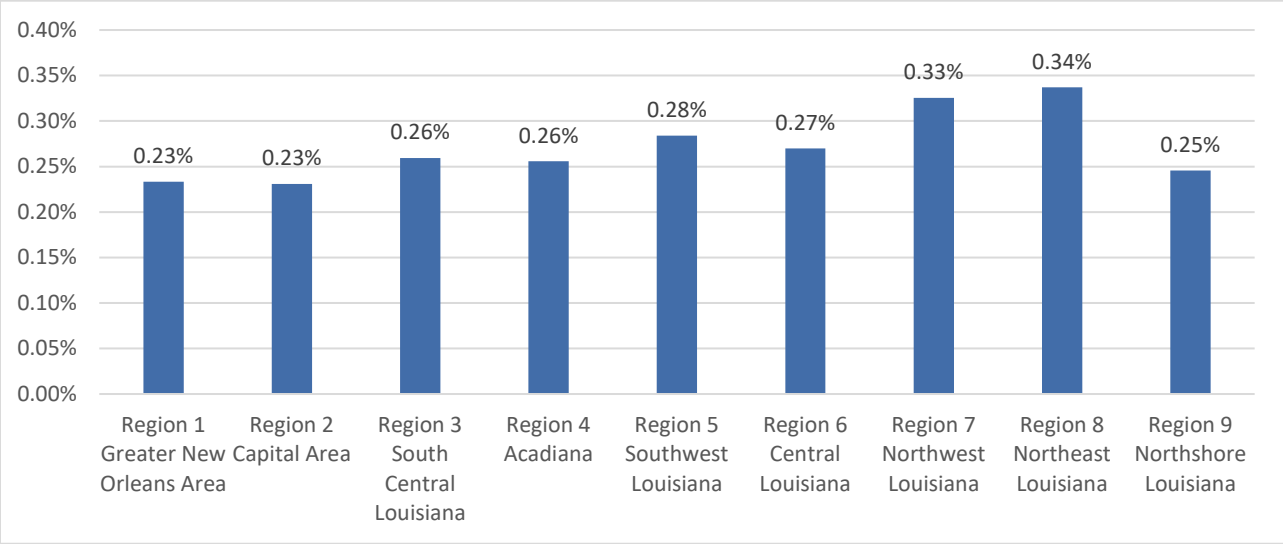


Figure 3.2: Medicaid Managed Care Adult Diabetes Prevalence in 2020 by Medicaid Regions Age ≥ 18 Years

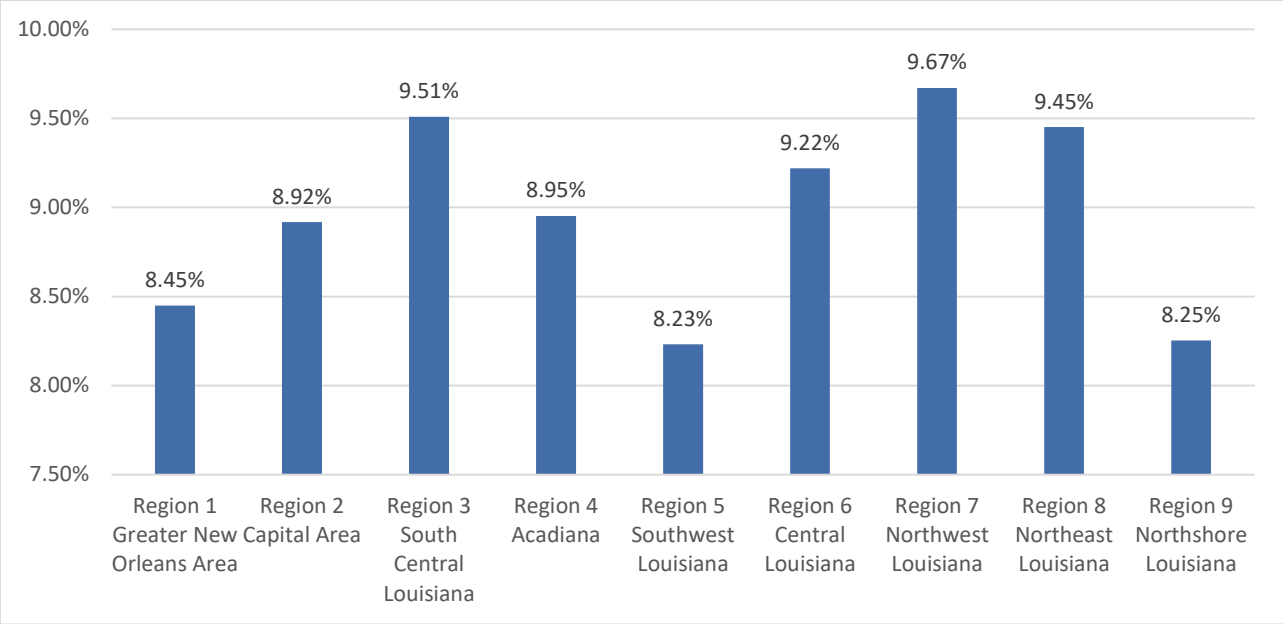


Figure 3.3 shows diabetes prevalence stratified by age group, gender and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among other race adult females (13.48%) and other race adult males (11.61%). These increased prevalence rates are in agreement with trends reported in the CDC *National Diabetes Statistics Report 2020*. The CDC reports that the prevalence of adult-diagnosed diabetes was highest among American Indians/Alaska Natives (14.7%) and people of Hispanic origin (12.5%).[19]

[19] Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2020.* Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services; 2020.

Figure 3.3: Medicaid Managed Care Diabetes Prevalence in 2020 by Age, Gender and Race

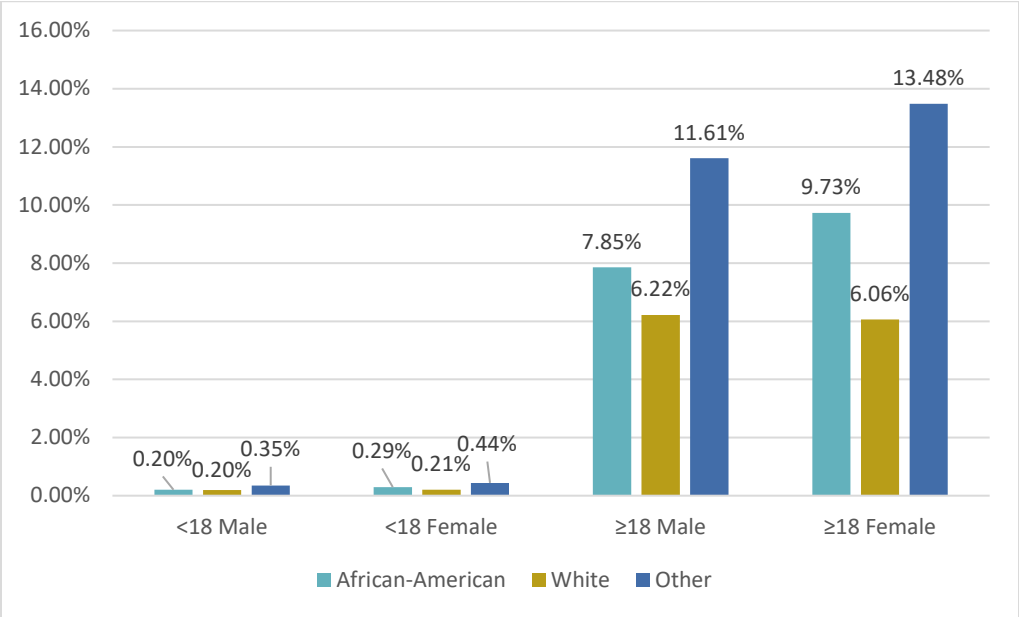


Table 3.1 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes to state and national utilization rates for the same practices. Louisiana's BRFSS percentages were slightly less than the 2016 national numbers for most of the listed preventive care practices. The managed care dilated eye exam rate was considerably lower than the 2016 national median (35.63% versus 62.2%). For enrollees with diabetes in Medicaid managed care, A1c testing was slightly higher than the U.S. median (74.05% versus 69.7%). However, the rate of ever having received self-management education was notably lower in the Medicaid managed care population when compared to the 2016 national median (13.66% versus 55.3%). The distribution of care practices across race in the managed care population is displayed in Figure 3.4. The distribution of care practices is very similar across race with the exception of home blood glucose devices. Higher rates of owning a home glucose monitoring device were found among the African-American (67.39%) and other (63.37%) race categories when compared to the white (53.24%) race category.

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

Preventive Care Practice	Medicaid Managed Care (2020 Data)	BRFSS Louisiana (2016 Data) †	BRFSS United States (2016 Data)†
Received annual dilated eye exam	35.63%	55.8%	62.2%
Received one or more A1c tests during year	74.05%	56.0%††	69.7%††
Received seasonal influenza vaccine	26.56%	(Not reported)	(Not reported)
Ever received pneumonia vaccine	16.07%	(Not reported)	(Not reported)
Ever had home blood glucose device	62.67%	49.6%**	60.9%**
Ever had self-management education	13.66%	47.2%	55.3%

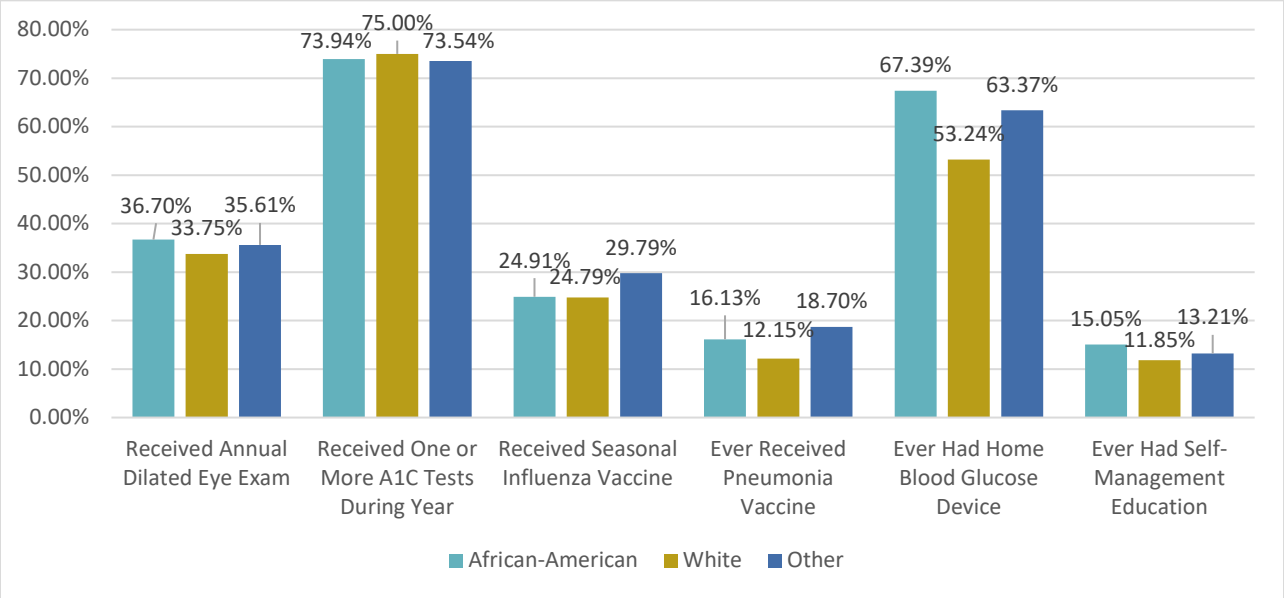
†2016 is the most recent year reported in the CDC *Diabetes Report Card 2019*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020 Available at: www.cdc.gov/diabetes/pdfs/library/Diabetes-Report-Card-2019-508.pdf.

†† Rate reported by BRFSS in the CDC *Diabetes Report Card 2019* reflects two or more A1c tests in the last year.

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

**Rate reported by BRFSS in the CDC *Diabetes Report Card 2019* reflects daily self-monitoring of blood glucose.

Figure 3.4: Medicaid Managed Care Diabetic Preventive Care Practices in 2020 Among Adults with Diabetes by Race



3.1 Diabetes and Pregnancy

Table 3.1.1 shows the cost of Medicaid managed care enrollee pregnancies in 2020 with and without diabetes. The total cost per pregnant enrollees with diabetes was 1.65 times greater than those who did not have a diabetes complication during their pregnancy ($7,735 vs $4,688). Of the MCO enrollees who were pregnant during 2020 (50,666), 11.47% had a diagnosis of diabetes.

Table 3.1.1: Medicaid Managed Care Diabetes* and Pregnancies in 2020

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,809	$44,933,596	$7,735.17
Pregnancies without diabetes	44,857	$210,275,752	$4,687.69

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

3.2 The Financial Impact of Diabetes and Its Complications

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

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

Table 3.2.1 lists total costs, by claim type, for healthcare claims with dates of service in 2020 associated with managed care adult enrollees with and without diabetes. Managed care adult enrollees with diabetes were identified by medical claims with dates of service in 2020 that included a primary or secondary diagnosis of diabetes. All paid claims for enrollees with diabetes were included in the "Total Cost of MCO

[20] Economic Costs of Diabetes in the U.S. in 2017, American Diabetes Association, Diabetes Care Mar 2018, dci180007; **DOI:** 10.2337/dci18-0007 Retrieved December 14, 2020 from https://www.diabetes.org/resources/statistics/cost-diabetes

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 Adult MCO Enrollees without Diabetes" column.

The prevalence of diabetes in the adult Medicaid managed care population is 8.91%. Healthcare claim costs for these enrollees totaled $1,184,432,851 in 2020 which accounts for 25.51% of the total adult MCO claims payments ($4,643,167,043) with dates of service in 2020.

Table 3.2.1: Medicaid Managed Care Cost of Adult Diabetes by Claim Type

Claim Type	Total Cost of MCO Adult Enrollees with Diabetes*	Total Cost of MCO Adult Enrollees without Diabetes	Percent Costs for Enrollees with Diabetes
Medical	$734,170,236	$2,356,642,095	23.75%
Pharmacy	$447,978,201	$1,082,791,527	29.26%
Other**	$2,284,414	$19,300,570	10.58%
Total	$1,184,432,851	$3,458,734,192	25.51%

*Includes claims, with dates of service in 2020, for any adult MCO enrollee with diabetes in 2020.
**Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

3.2.2 Specific Diabetes Complications

Diabetic complications were identified using medical claims with dates of service in 2020 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows, by age group and race, the percentage of 2020 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 (57.27%), followed by ketoacidosis (18.19%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (37.36%) and neurological manifestations (18.70%).

3.2.3 Emergency Department (ED) Visits Due to Diabetes

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

In 2020, for the Medicaid managed care population, 31,685 ED visits were diabetes-related. These diabetes-related visits represented 2.95% of ED visits for managed care enrollees during 2020. Of these diabetes-related visits, 17,823 visits (56.25%) were associated with diabetes-related complications.

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

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total
Ketoacidosis	18.67%	15.24%	19.90%	18.19%	2.91%	2.54%	2.92%	2.83%
Hyperosmolarity	1.31%	0.42%	0.82%	0.91%	1.19%	0.88%	1.33%	1.17%
Coma	0.91%	0.84%	1.47%	1.08%	0.47%	0.40%	0.60%	0.50%
Renal Manifestations	1.44%	1.67%	0.98%	1.35%	10.32%	7.31%	13.05%	10.55%
Ophthalmic Manifestations	1.70%	1.88%	1.79%	1.78%	9.91%	7.82%	10.77%	9.71%
Neurological Manifestations	1.17%	1.25%	0.98%	1.13%	16.95%	16.52%	22.31%	18.70%
Peripheral Circulatory Disorders	0.39%	0.21%	0.49%	0.38%	5.07%	4.73%	7.22%	5.73%
Arthropathy	0.00%	0.21%	0.16%	0.11%	0.56%	0.57%	0.71%	0.61%
Skin Complications	1.31%	0.84%	0.65%	0.97%	3.08%	3.49%	4.74%	3.75%
Oral Complications	0.00%	0.21%	0.00%	0.05%	0.05%	0.04%	0.06%	0.05%
Hypoglycemia	7.44%	8.77%	10.11%	8.67%	2.82%	2.56%	3.36%	2.94%
Hyperglycemia	57.05%	53.03%	60.85%	57.27%	38.14%	34.76%	38.20%	37.36%
Other Specified Complications	8.22%	6.89%	8.81%	8.07%	9.63%	9.47%	10.89%	10.03%
Unspecified Complications	4.18%	3.76%	5.06%	4.36%	8.41%	7.37%	9.51%	8.54%
Count of Enrollees With Any Diabetes Diagnosis	766	479	613	1,858	31,639	17,807	25,982	75,428

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

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

Race Age, Group	All ED Visits	Primary or Secondary Diabetes Diagnosis ED Visits*	Percent of ED Visits with Primary or Secondary Diabetes Diagnosis*	Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**	Percent of Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**
African-American, < 18 years	116,419	426	0.37%	322	75.59%
White, < 18 years	78,028	217	0.28%	151	69.59%
Other, < 18 years	65,641	431	0.66%	334	77.49%
Total, < 18 years	260,088	1,074	0.41%	807	75.14%
African-American, ≥ 18 years	363,772	13,647	3.75%	7,471	54.74%
White, ≥ 18 years	228,925	5,699	2.49%	2,920	51.24%
Other, ≥ 18 years	221,079	11,265	5.10%	6,625	58.81%
Total, ≥ 18 years	813,776	30,611	3.76%	17,016	55.59%
Total, All Ages	1,073,864	31,685	2.95%	17,823	56.25%

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

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

3.2.4 Diabetes and Other Common Chronic Conditions

Table 3.2.4 shows the number of Medicaid managed care enrollees with selected chronic conditions, the total cost paid by the MCOs for these chronic conditions, and the average cost per enrollee. In 2020, among

managed care enrollees who were diagnosed with one of the reported chronic conditions, hypertension (205,521 enrollees) was the most prevalent, followed by asthma (95,025 enrollees) and diabetes (77,286 enrollees). In 2020, for the reported chronic conditions, the highest total paid by the MCOs was $679,482,484 for hypertension. The total paid for diabetes during 2020 was $349,205,471. In 2020, for the reported chronic conditions, the highest average cost per enrollee was for congestive heart failure ($9,386.15). The average cost per enrollee with diabetes was $4,518.35.

Table 3.2.4: Medicaid Managed Care 2020 Prevalence of Selected Chronic Conditions and Cost Comparisons among Diabetes and Selected Chronic Conditions

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Hypertension	205,521	13.28%	$679,482,484	$3,306.15
Asthma	95,025	6.14%	$124,031,747	$1,305.25
Diabetes	77,286	5.00%	$349,205,471	$4,518.35
Arthritis	52,454	3.39%	$68,683,809	$1,309.41
COPD	26,973	1.74%	$121,272,241	$4,496.06
Coronary Heart Disease	23,585	1.52%	$131,485,035	$5,574.94
Congestive Heart Failure	17,199	1.11%	$161,432,430	$9,386.15

*A unique enrollee may be included in more than one chronic disease count.
**The prevalence denominator is the 2020 total unique enrollee count, in MCOs (1,547,113).

4 LDH and MCO Recommendations

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

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

5 Conclusion

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

Appendix A – Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

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

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

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	66,065	79,134	8.51%	9.32%
Orleans	55,943	87,686	5.29%	8.08%
Plaquemines	2,913	3,480	9.10%	9.25%
St. Bernard	8,810	9,942	8.22%	10.94%
Total – Region 1	133,731	180,242	7.16%	8.81%
Region 2 Capital Area				
Ascension	14,217	14,757	7.54%	15.15%
East Baton Rouge	63,485	73,442	7.50%	10.89%
East Feliciana	2,455	3,469	14.01%	21.88%
Iberville	5,100	5,974	7.22%	16.47%
Pointe Coupee	2,971	3,599	9.02%	13.36%
West Baton Rouge	3,658	4,026	6.37%	19.20%
West Feliciana	1,266	1,434	5.37%	15.27%
Total – Region 2	93,152	106,701	7.64%	12.61%
Region 3 South Central Louisiana				
Assumption	2,559	3,458	10.98%	18.68%
Lafourche	12,069	14,899	11.56%	14.56%
St. Charles	6,352	6,944	8.86%	9.63%
St. James	2,848	3,665	8.81%	14.08%
St. John the Baptist	7,798	9,019	7.50%	10.68%
St. Mary	9,106	11,370	7.17%	14.68%
Terrebonne	18,255	21,403	5.96%	14.16%
Total – Region 3	58,987	70,758	8.16%	13.66%
Region 4 Acadiana				
Acadia	10,538	12,377	6.98%	15.71%
Evangeline	5,866	6,937	8.40%	12.82%
Iberia	13,187	15,746	14.93%	11.86%
Lafayette	32,084	37,288	9.75%	15.73%
St. Landry	17,428	20,147	6.47%	18.90%
St. Martin	7,814	9,203	13.82%	18.99%
Vermilion	8,840	10,644	9.32%	16.16%
Total – Region 4	95,757	112,342	9.77%	15.88%
Region 5 Southwest Louisiana				
Allen	3,529	3,954	4.17%	9.53%
Beauregard	5,617	6,100	3.47%	7.25%
Calcasieu	31,780	34,798	2.61%	10.88%
Cameron	341	478	0.59%	9.41%
Jefferson Davis	4,879	5,688	8.10%	13.68%
Total – Region 5	46,146	51,018	3.40%	10.64%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Avoyelles	7,169	8,532	10.49%	7.96%
Catahoula	1,655	2,396	6.34%	8.14%
Concordia	3,839	4,769	2.14%	7.57%
Grant	3,107	3,645	11.30%	9.38%
LaSalle	2,061	2,599	2.57%	13.35%
Rapides	21,609	24,798	11.78%	10.15%
Vernon	5,926	6,748	1.48%	6.56%
Winn	2,061	2,608	14.99%	11.16%
Total – Region 6	47,427	56,095	9.04%	9.22%
Region 7 Northwest Louisiana				
Bienville	2,345	3,084	5.33%	9.14%
Bossier	15,996	16,539	7.51%	10.87%
Caddo	40,287	47,520	6.24%	11.58%
Claiborne	2,052	2,604	4.73%	10.22%
DeSoto	4,068	4,831	5.16%	16.79%
Natchitoches	6,130	7,220	4.00%	7.30%
Red River	1,576	1,807	1.97%	6.75%
Sabine	3,530	4,515	4.33%	9.44%
Webster	6,361	8,202	3.60%	9.25%
Total – Region 7	82,345	96,322	5.84%	10.90%
Region 8 Northeast Louisiana				
Caldwell	1,755	2,443	2.05%	9.66%
East Carroll	1,561	1,793	10.76%	12.66%
Franklin	3,957	5,048	2.93%	11.45%
Jackson	1,962	2,489	10.30%	16.95%
Lincoln	5,803	7,580	8.05%	13.35%
Madison	2,467	2,910	4.90%	11.55%
Morehouse	5,023	6,894	12.78%	16.03%
Ouachita	27,640	33,937	7.39%	15.25%
Richland	3,706	4,889	8.74%	14.30%
Tensas	759	1,140	7.11%	9.47%
Union	3,744	4,614	7.08%	12.68%
West Carroll	1,874	2,622	7.47%	14.76%
Total – Region 8	60,251	76,359	7.60%	14.24%
Region 9 Northshore Louisiana				
Livingston	18,814	20,888	7.38%	13.10%
St. Helena	1,329	1,597	8.80%	13.02%
St. Tammany	28,927	34,557	5.68%	8.94%
Tangipahoa	24,915	28,978	6.28%	12.75%
Washington	8,636	10,839	6.60%	13.61%
Total – Region 9	82,621	96,859	6.39%	11.57%

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	66,065	79,134	0.21%	8.85%
Orleans	55,943	87,686	0.27%	8.13%
Plaquemines	2,913	3,480	0.14%	8.56%
St. Bernard	8,810	9,942	0.23%	8.00%
Total – Region 1	133,731	180,242	0.23%	8.45%
Region 2 Capital Area				
Ascension	14,217	14,757	0.16%	8.46%
East Baton Rouge	63,485	73,442	0.24%	8.41%
East Feliciana	2,455	3,469	0.37%	10.58%
Iberville	5,100	5,974	0.35%	11.58%
Pointe Coupee	2,971	3,599	0.10%	12.03%
West Baton Rouge	3,658	4,026	0.30%	11.40%
West Feliciana	1,266	1,434	0.08%	9.62%
Total – Region 2	93,152	106,701	0.23%	8.92%
Region 3 South Central Louisiana				
Assumption	2,559	3,458	0.31%	12.00%
Lafourche	12,069	14,899	0.23%	9.73%
St. Charles	6,352	6,944	0.20%	8.76%
St. James	2,848	3,665	0.35%	9.96%
St. John The Baptist	7,798	9,019	0.28%	9.61%
St. Mary	9,106	11,370	0.29%	9.99%
Terrebonne	18,255	21,403	0.25%	8.83%
Total – Region 3	58,987	70,758	0.26%	9.51%
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Acadia	10,538	12,377	0.25%	9.98%
Evangeline	5,866	6,937	0.24%	9.92%
Iberia	13,187	15,746	0.25%	9.43%
Lafayette	32,084	37,288	0.21%	7.66%
St. Landry	17,428	20,147	0.27%	9.60%
St. Martin	7,814	9,203	0.36%	9.88%
Vermilion	8,840	10,644	0.33%	8.91%
Total – Region 4	95,757	112,342	0.26%	8.95%
Region 5 Southwest Louisiana				
Allen	3,529	3,954	0.23%	9.26%
Beauregard	5,617	6,100	0.20%	8.44%
Calcasieu	31,780	34,798	0.32%	7.94%
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Jefferson Davis	4,879	5,688	0.20%	9.09%
Total – Region 5	46,146	51,018	0.28%	8.23%

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 6 Central Louisiana				
Avoyelles	7,236	8,319	0.28%	9.67%
Catahoula	1,661	2,286	0.36%	8.93%
Concordia	3,964	4,598	0.26%	9.12%
Grant	3,159	3,620	0.26%	8.97%
LaSalle	1,980	2,401	0.24%	10.93%
Rapides	22,142	24,277	0.28%	8.88%
Vernon	5,927	6,501	0.22%	8.88%
Winn	2,123	2,583	0.24%	10.93%
Total – Region 6	48,192	54,585	0.27%	9.22%
Region 7 Northwest Louisiana				
Bienville	2,345	3,084	0.51%	11.25%
Bossier	15,996	16,539	0.30%	9.72%
Caddo	40,287	47,520	0.31%	9.54%
Claiborne	2,052	2,604	0.34%	10.60%
DeSoto	4,068	4,831	0.42%	10.29%
Natchitoches	6,130	7,220	0.38%	9.43%
Red River	1,576	1,807	0.13%	9.13%
Sabine	3,530	4,515	0.34%	8.77%
Webster	6,361	8,202	0.35%	9.92%
Total – Region 7	82,345	96,322	0.33%	9.67%
Region 8 Northeast Louisiana				
Caldwell	1,755	2,443	0.06%	9.37%
East Carroll	1,561	1,793	0.45%	13.16%
Franklin	3,957	5,048	0.38%	10.56%
Jackson	1,962	2,489	0.61%	15.07%
Lincoln	5,803	7,580	0.48%	8.39%
Madison	2,467	2,910	0.32%	9.00%
Morehouse	5,023	6,894	0.26%	9.43%
Ouachita	27,640	33,937	0.31%	8.52%
Richland	3,706	4,889	0.35%	10.33%
Tensas	759	1,140	0.00%	11.40%
Union	3,744	4,614	0.29%	10.51%
West Carroll	1,874	2,622	0.53%	10.79%
Total – Region 8	60,251	76,359	0.34%	9.45%
Region 9 Northshore Louisiana				
Livingston	18,814	20,888	0.26%	7.46%
St. Helena	1,329	1,597	0.30%	10.39%
St. Tammany	28,927	34,557	0.23%	6.83%
Tangipahoa	24,915	28,978	0.23%	9.57%
Washington	8,636	10,839	0.30%	10.49%
Total – Region 9	82,621	96,859	0.25%	8.25%

Appendix D – 2020 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 2020 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2020 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2020 Diabetes and Obesity Action Plan
Appendix D4	Louisiana Healthcare Connections 2020 Diabetes and Obesity Action Plan
Appendix D5	United Healthcare 2020 Diabetes and Obesity Action Plan

Appendix D1
Aetna Better Health of Louisiana
2020 Diabetes and Obesity Action Plan

Diabetes Goals 2020

- ***Goal 1: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an A1c test, eye exam, and medical attention for nephropathy by 2% year-over-year (YOY) as compared to baseline. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Utilize the HEDIS® outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the Care4Life® and IVR programs.
    - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools in the Care4Life® program. The program is used to motivate and help members track and manage their condition, engage in preventive actions, and share valuable information with their care teams. Additionally, the IVR call campaign, completed quarterly, focuses on the importance of receiving evidence-based health services aimed at reducing mortality and morbidity associated with diabetes.
    - **Expected Outcome:** Increase in A1c testing, retinal screenings and medical attention to nephropathy among members age 18-75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS® Gaps in Care reports.

- ***Goal 2: Increase the number of members 18-75 years of age with diabetes (Type 1 and Type 2) with A1c control (<8%) and with BP control (<140/90 mm Hg) by 2% YOY as compared to baseline. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Contact identified members to enroll in a remote patient monitoring program, and provide each enrolled member with a Bluetooth®-enabled tablet.
    - **Action Description:** Prompt each member to test blood sugar and/or blood pressure daily. If a measurement is outside of an established threshold, the member is contacted to retake and resubmit the measurement. If the second (or third) reading is still outside the established threshold, the member's primary care physician (PCP) is contacted by a clinician health coach to obtain further direction. The PCP direction may include re-monitoring, scheduling a PCP office visit, sending the member to emergency department (ED) or urgent care, ordering a medication change, or suggesting other appropriate actions. If the PCP is unavailable, the clinician health coach may advise the member to access the ED or urgent care as warranted. Also, the Bluetooth®-enabled tablet will provide member education and quizzes to increase knowledge of diabetes.
    - **Expected Outcome:** Show improved control of diabetes and blood pressure among members with diabetes.
    - **Action Measurement:** Use Remote Patient Monitoring report.

- ***Goal 3: Increase access to care for this metric through Value-Based Agreements with providers. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Review provider contracts to align with diabetes goals and support providers through value-based incentives.
    - **Action Description:** Distribute patient-specific data to providers to enhance the necessary care delivered in an effort to align with value-based goals.
    - **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.
    - **Action Measurement:** Use value-based reports.

Diabetes Results 2020

Goal	Benchmark	Results
1	MY2019 HEDIS® HbA1c (estimated average glucose) testing: 87.83% (hybrid rate) *(2018 rate reported due to COVID-19)*	MY2020 HEDIS® HbA1c testing: 82.97% (hybrid rate)
2	MY2019 HEDIS® BP Control: 45.74% (hybrid rate)	MY2020 HEDIS® BP Control: 47.93% (hybrid rate)
3	Average rates in 2019: HbA1c: 85.67% Eye Exam: 49.77% Nephropathy: 89.60%	10 VBS providers selected at least one CDC measure (HbA1c, eye exam, and/or nephropathy), which made up 19 total measures that were tracked. Average rates in 2020: HbA1c: 79.42% - Goal Met: No Eye Exam: 42.93% - Goal Met: No Nephropathy: 85.54% - Goal Met: No

Diabetes Goals 2021

- ***Goal 1: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an A1c (estimated average glucose) test and medical attention for nephropathy by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the HealthCrowd integrated voice response (IVR) programs.
    - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools in through the HealthCrowd nanosite. The program is used to motivate and help members better track and manage their condition, engage in preventive actions, and share valuable information with their care teams.

- **Expected Outcome:** Increase in A1c testing and medical attention to nephropathy among members age 18-75 with a diabetes diagnosis.
- **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 2: Increase the percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) with an A1c (estimated average glucose) test and eye exam by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Contact identified members to enroll in HealPros, and provide each enrolled member with an in-home dilated eye exam and if needed an A1c test.
  - **Action Description:** Provide our vendor, HealPros, HEDIS Gaps in Care reports to identify members with a gap in care for dilated eye exam (CDC). HealPros will schedule appointments and complete eye exam in a convenient location to the member.
  - **Expected Outcome:** Increase in eye exam and A1c testing among members age 18-75 with a diabetes diagnosis.
  - **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 3: Increase access to care for this metric through Value-Based Agreements with providers. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Review provider contracts to align with diabetes goals and support providers through value-based incentives.
  - **Action Description:** Distribute patient-specific data to providers to enhance the necessary care delivered in an effort to align with value-based goals.
  - **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.
  - **Action Measurement:** Use value-based reports.

Obesity Goals 2020

- ***Goal 1: Increase the enrollment in the Ted E. Bear, M.D. Weight Management Program. Members 5-20 years of age who have been screened by a PCP and meet the BMI definition for being overweight or obese. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Send eligible members educational materials about the Ted E. Bear, M.D. Weight Management Program and the incentives available to members enrolled in the program.
  - **Action Description:** Provide innovative mailers and invitations to wellness events, Ted E. Bear Picnics and Ted E. Bear Gardens to members who are enrolled in the Ted E. Bear, M.D. Weight Management Program. Members may also receive healthy diet recipe cards, a vegetable garden starter kit, pedometer, jump rope, basketball, and hopscotch kit.
  - **Expected Outcome:** See a decrease in BMI for enrolled members who use the information provided by the program.
  - **Action Measurement:** Use provider-submitted reports that indicate changes in BMI for participating members.

- ***Goal 2: Increase obesity awareness and obesity-related knowledge through Well-Ahead Louisiana's Diabetes and Obesity Collaborative workgroup. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Participate in the Louisiana Diabetes and Obesity Collaborative Awareness/Education Work Group, which is part of the Well-Ahead Louisiana Program.
    - **Action Description:** Increase diabetes and obesity awareness and education through collaboration with the Well-Ahead Louisiana's Diabetes and Obesity Collaborative Awareness/Education Work Group.
    - **Expected Outcome:** See increased knowledge of diabetes and obesity as well as an improvement in healthy living.
    - **Action Measurement:** Use Well-Ahead Louisiana annual reports.

- ***Goal 3: [Increase member participation in exercise and diet challenges through Welltok Text4Health and Text4Kids campaigns.]. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Send text messages to members through the Text4Health and Text4Kids Welltok® campaigns.
    - **Action Description:** Through the Welltok Text4Health and Text4Kids campaigns, Aetna Better Health sends members text messages that provide encouragement to make smart food choices and gives members an opportunity to participate in exercise challenges.
    - **Expected Outcome:** See an increase in member participation in exercise challenges and improvements in member healthy lifestyle choices.
    - **Action Measurement:** Use Welltok reports.

Obesity Results 2020

Goal	Benchmark	Results
1	MY2019 HEDIS WCC/BMI: 65.45% (hybrid rate)	MY2020 HEDIS WCC/BMI: 71.78% (hybrid rate)
2	New workgroup starting in 2021	There were no activities coming out of this workgroup in 2021
3	Text4Health: Diet: 689 Members; Exercise 514 Members Care4Life: Diet/Exercise: 37 Members with Diabetes	Through Text4Health Campaign, 656 members enrolled in an exercise challenge and 442 enrolled in a diet challenge. Through Care4Life Campaign, 56 members with diabetes set a weight/exercise goal.

Obesity Goals 2021

- ***Goal 1: Host community events across Louisiana and provide education about obesity to attendees. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Work with community outreach to understand where they are hosting events and ensure that there is education about obesity, healthy eating and physical activity available at those events.
    - **Action Description:** Track the number of materials that were distributed at the events.

- **Expected Outcome:** Members will increase their knowledge about obesity, healthy eating and physical activity.
- **Action Measurement:** Internal reports tracking distributed materials.

- ***Goal 2: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Through our Health Equity Director, work to expand partnerships across the state to address obesity education.
  - **Action Description:** Gather information about what our partners are doing to combat obesity and how we can best support their work.
  - **Expected Outcome:** Expand our partnerships and support across the state to address obesity.
  - **Action Measurement:** Track number of new partnerships and support provided around obesity initiatives.

- ***Goal 3: Increase awareness of After School Value Added Benefit and support those after school programs that provide safe physical activity to participants. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Train teams that regularly talk to members to educate members on the value added benefits (VABs) that are available to them, such as the after school program. Track participating after-school programs and ensure they are able to provide safe physical activity to participants.
  - **Action Description:** Inform departments about VABs available to our members to ensure that our members are aware of those benefits and support VABs.
  - **Expected Outcome:** Increase utilization of VABs and further support of participating organizations/vendors.
  - **Action Measurement:** VAB reports

Appendix D2
AmeriHealth Caritas Louisiana (ACLA)
2020 Diabetes and Obesity Action Plan

Diabetes Goals 2020

- ***Goal 1: ACLA will increase member engagement in its Population Health Management programs by December 2020 to reduce the impact of diabetes by providing diabetic members with education including self-management, treatment, and benefits. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** ACLA will utilize program-evaluation data to implement new pilot programs, continue and/or modify current programs, or to discontinue programs.
    - **Action Description:** Several mechanisms will be used to identify the success of current programs and the need for modifications. These mechanisms include review of numerical data, results of member satisfaction surveys, engagement rate in current programs, and the degree of provider "buy-in."
    - **Expected Outcome:** Increased member engagement of diabetic members in ACLA's Population Health Management programs.
    - **Action Measurement:** The percentage of members with a primary or secondary diagnosis of diabetes who are engaged in a population health management program in 2020 compared to the percentage engaged in 2019.

- ***Goal 2: ACLA will increase the focus on HEDIS CDC sub-measures as a measurable outcome in provider groups participating in VBC by December 2020 to improve diabetic health, reduce unnecessary costs and promote accountable care. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Develop a process for assisting provider groups that participate in VBC to continually improve member compliance rates in HEDIS® CDC sub-measures.
    - **Action Description:** ACLA will identify and target provider groups that participated in VBC with a focus on HEDIS CDC sub-measures as a measurable outcome to assist in improving their HEDIS CDC member compliance rates through HEDIS CDC compliance education, application access, real-time member data, and care gap resolution.
    - **Expected Outcome:** Increased member compliance rates of HEDIS CDC sub-measures used as a measurable outcome for providers participating in VBC.
    - **Action Measurement:** The percentage of HEDIS CDC sub-measures used as a measurable outcome in providers participating in VBC with an increase in member compliance in 2020 compared to those participating in 2019.

- ***Goal 3: ACLA will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two HEDIS CDC sub-measures for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **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 and interventions will include ACLA Community Center access, member CARE Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, diabetic text messaging campaign, Vheda Health chronic disease monitoring, and Mom's Meals NourishCare®.
- **Expected Outcome:** ACLA will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two HEDIS CDC sub-measures for 2020.
- **Action Measurement:** The percentage of increase in HEDIS CDC sub-measure rates in 2020 compared to 2019 and/or the 2019 QC for Medicaid 50th percentile.

Diabetes Results 2020

Goal	Benchmark	Results
1	At least the same number of members engaged in a Population Health Management program with a primary or secondary diagnosis of diabetes in 2020.	In 2020, there was a 3.85% increase in the number of members engaged in a Population Health Management program with a primary or secondary diagnosis of diabetes compared to those engaged in 2019.
2	At least the same number of CDC sub-measures used as a measurable outcome in 2020 for providers participating in VBC.	In 2020, the MCO met its goal with a 9.1% increase in the number of CDC sub-measures used as a measurable outcome for providers participating in VBC compared to those participating in 2019.
3	The 2019 Medicaid QC 50th percentile or 2% increase for at least two CDC sub-measures in 2020.	ACLA did not reach its goal and recognizes that there continue to be opportunities to educate both members and providers on the importance of recommended diabetic tests and screenings. The plan also realizes that closures, restrictions and the overall alarm of society due to the COVID-19 pandemic had a negative effect on access to wellness care for our members.

Diabetes Goals 2021

- ***Goal 1: ACLA will increase provider participation in its Data Exchange Program and increase provider use of CPT CAT II codes for member diabetic test results by December 2021, to identify necessary clinical data for closing gaps in care for diabetic members to ensure members receive the best healthcare achievable. Start Date: 1/1/2021 End Date: 12/31/2021***

- **Action Step:** ACLA will analyze claims data to identify provider groups who will benefit from Data Exchange program participation.
- **Action Description:** ACLA will outreach to engage providers in the Data Exchange Program or use of CPT CAT II codes by sharing benefits of both participation and usage through multidisciplinary provider education.
- **Expected Outcome:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes for member diabetic test results or participate in the Data Exchange Program.
- **Action Measurement:** The percentage of diabetic member results received for 2021, compared to results received in 2020.

- ***Goal 2: ACLA will increase member compliance percentage for diabetic members linked to providers participating in VBC who selected CDC sub measure HbA1c >9.0% as a measureable outcome or Quality-Educated Provider Groups by December 2021. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Continue process for assisting providers participating in VBC who selected CDC sub-measure HbA1c >9.0% as a measureable outcome or Quality-Educated Provider Groups to continually improve member compliance rates in CDC sub-measure HbA1c >9.0% via multi-disciplinary provider education.
  - **Action Description:** ACLA will identify and target providers participating in VBC who selected CDC sub-measure HbA1c >9.0% as a measureable outcome or Quality-Educated Provider Groups to assist in improving their CDC member compliance rates through CDC compliance education, application access, real-time member data, and care gap resolution.
  - **Expected Outcome:** Increased member compliance rates of CDC sub-measure HbA1c >9.0% used as a measurable outcome for providers participating in VBC or Quality-Educated Provider Groups.
  - **Action Measurement:** The percentage of CDC sub-measure HbA1c >9.0% used as a measurable outcome in providers participating in VBC or Quality-Educated Provider Groups with an increase in member compliance as compared to those non-participating provider groups.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2020 Medicaid Quality Compass (QC) 50th percentile or 2% decrease goal for CDC sub measure HbA1c >9.0% for 2021, with a special focus on our diabetic members who are most likely to experience health disparities by December 2021. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** ACLA will utilize program evaluation data to implement new pilot programs, continue and/or modify current programs, or discontinue programs.
  - **Action Description:** Evaluated programs/interventions will include ACLA Community Center access, Member Care Card Benefits, updated web content, member portal access, 24/7 Nurse Helpline, Automated Reminder Calls, Emergency Room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, diabetic text messaging campaign, Vheda Health for chronic disease monitoring, and Care Meals NourishCare, United We Feed Pilot.

- **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2020 Medicaid QC 50th percentile or 2% increase goal for CDC sub measure HbA1c >9.0% for 2021.
- **Action Measurement:** The percentage of increase in CDC sub measure HbA1c >9.0% rates in 2021 compared to 2020 and/or the 2020 Medicaid QC 50th percentile.

Obesity Goals 2020

- ***Goal 1: ACLA will increase member engagement in its Population Health Management programs by December 2020 to reduce the impact of obesity by providing education (including self-management, treatment and benefits) to members diagnosed with obesity. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** ACLA will utilize program-evaluation data to implement new pilot programs, continue and/or modify current programs, or to discontinue programs.
  - **Action Description:** Several mechanisms will be used to identify the success of current programs and the need for modifications. These mechanisms include review of numerical data, results of member satisfaction surveys, engagement rate in current programs, and the degree of provider "buy-in."
  - **Expected Outcome:** Increased rate of engagement in ACLA's Population Health Management programs among members diagnosed with obesity.
  - **Action Measurement:** The percentage of members with a primary or secondary diagnosis of obesity who are engaged in a population health management program in 2020 compared to the percentage engaged in 2019.

- ***Goal 2: In 2020, ACLA will create a multidisciplinary team to identify gaps in access to care for members diagnosed with obesity who are most likely to experience health disparities. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Develop health-equity programming aimed at member populations with historic disparate health outcomes through the use of targeted, innovative programming with the purpose of reducing and/or eliminating gaps in access to health care.
  - **Action Description:** ACLA will determine effective ways to support equitable access for members diagnosed with obesity, address social determinants of health (SDOH), where possible, and to increase compliance in obesity-related HEDIS measures in African American, Hispanic and American Indian/Alaskan Native member groups.
  - **Expected Outcome:** To identify gaps in access to care for members diagnosed with obesity and to brainstorm new initiatives and programs to reduce and/or eliminate these barriers.
  - **Action Measurement:** Increase obesity-related HEDIS measure compliance in African American, Hispanic and American Indian/Alaskan Native member groups in 2020 compared to 2019.

- ***Goal 3: ACLA will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS measures for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***

- **Action Step:** ACLA will utilize program-evaluation data to implement new pilot programs, continue and/or modify current programs, or to discontinue programs.
- **Action Description:** Evaluated programs and interventions will include ACLA Community Center access, member CARE Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, well visit text messaging campaign, Vheda Health chronic disease monitoring, and Mom's Meals NourishCare.
- **Expected Outcome:** The MCO will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS measures for 2020.
- **Action Measurement:** The percentage of increase in obesity-related HEDIS measure rates in 2020 compared to 2019 and/or the 2019 QC for Medicaid 50th percentile.

Obesity Results 2020

Goal	Benchmark	Results
1	At least the same number of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2020.	In 2020, there was a 9.56% increase in the number of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity compared to those engaged in 2019.
2	An increase in HEDIS rates for WCC HEDIS measure data for 2020 for African American, Hispanic and American Indian/Alaskan Native members with obesity, compared to 2019 rates.	In 2020, there was a 9.88% increase for African Americans compliant with meeting all WCC HEDIS sub-measures (including BMI, Counseling for Nutrition and Physical Activity) compared to those in 2019. Those who identify as Hispanic had a 1.11% increase in compliance for all WCC HEDIS sub-measures compared to those in 2019. ACLA recognizes the need to develop targeted initiatives for its American Indian/Alaskan Native members as no year-to-year increase in compliance was noted.
3	The 2019 Medicaid QC 50th percentile or 2% increase for WCC HEDIS measure in 2020.	ACLA did not reach its goal and recognizes that there continue to be opportunities to educate both members and providers on the importance of healthy behaviors. The plan also realizes that closures, restrictions and the overall alarm of society due to the COVID-19 pandemic had a negative effect on access to wellness care for our members.

Obesity Goals 2021

- ***Goal 1: ACLA will develop and implement program to promote a basic needs and healthy living initiative for members with a diagnosis of obesity and other comorbid conditions. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Target population will consist of ACLA members living in Baton Rouge and surrounding parishes linked to a specific provider group.
    - **Action Description:** This program will aim to improve health outcomes for members, such as reduced blood pressure, BMI and blood glucose levels, along with increased exercise, energy and knowledge of disease self-management.
    - **Expected Outcome:** Engagement of at least 25% of targeted population engaged in pilot program.
    - **Action Measurement:** The percentage of members engaged in the United We Feed pilot program by December 2021.

- ***Goal 2: ACLA will improve the health outcomes of obese members with comorbid conditions who are most likely to experience health disparities in 2021. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming with the purpose of promoting self-management of obesity and other comorbid conditions.
    - **Action Description:** ACLA will determine effective ways to support equitable access for obese members, address social determinants of health (SDOH) where possible, and increase compliance in HEDIS measures associated with obesity.
    - **Expected Outcome:** Lowered BMI percentile for obese population engaged in the Make Every Calorie Count program by December 2021.
    - **Action Measurement:** The percentage of members with a diagnosis of obesity engaged in the Make Every Calorie Count program with a decreased BMI percentile by December 2021.

- ***Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2021 to reduce the impact of obesity by providing obese members with education including self-management, treatment and benefits. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help obese members with comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.
    - **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to obese members, and discussion of programs for members with obesity during bi-monthly Member Advisory Council meetings.
    - **Expected Outcome:** Increased engagement of high-risk obese members in ACLA's Population Health Management programs.

- **Action Measurement:** The percentage of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2021 compared to those engaged in 2020.

Appendix D3
Healthy Blue
2020 Diabetes and Obesity Action Plan

Diabetes Goals 2020

- ***Goal 1: Improve YOY HEDIS rates associated with diabetes by at least 2 percentage points, ultimately reaching QC for Medicaid 50th percentile. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Expand provider education and outreach from previous year.
    - **Action Description:** Host provider education programs on documentation and coding best practices, develop action plans using patient-centered care consultants, and offer educational credits to providers through summits and webinars.
    - **Expected Outcome:** See overall improved outcomes for the members we serve through enhanced provider awareness of quality metrics, documentation and coding requirements.
    - **Action Measurement:** Improved YOY rates by achieving at least a 2 percentage point increase in the following measures:
        - Comprehensive Diabetes Care A1c (estimated average glucose) Testing
        - Comprehensive Diabetes Care Eye Exams
        - Comprehensive Diabetes Care Attention for Medical Nephropathy
        - Comprehensive Diabetes Care Poor Control (>9.0%)
        - Comprehensive Diabetes Care Good Control (<8.0%)
        - Diabetes Short-term Complication
        - Diabetes Monitoring for People with Diabetes and Schizophrenia
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

- ***Goal 2: Improve diabetes preventive care practices YOY among adults with diabetes. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Expand member outreach and engagement from previous year.
    - **Action Description:** Engage and educate members through diabetes classes, outreach calls, text campaigns, collaborate with Pennington Biomedical Research Center, case management, community events and a new incentive platform.
    - **Expected Outcome:** See increased member awareness of the importance of preventive care, the benefits of provider follow-ups, and improved management of diabetes.
    - **Action Measurement:** Review the utilization of diabetes preventive care practices among adults with diabetes who receive the following:
        - Annual dilated eye exam
        - One or more A1cs (current reporting period)
        - An influenza vaccine (current reporting period)
        - A pneumonia vaccine (ever received)
        - Daily self-blood glucose monitoring
        - Diabetes self-management education (ever received)

- ***Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to improve diabetes outcomes for the members served. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Increase provider alternative payment model (APM) agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Expected Outcome:** See improved diabetes- and obesity-related outcomes associated with an increase in APM programs.
    - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate diabetes measures.

Diabetes Results 2020

Goal	Benchmark	Results
1	Diabetes-Related HEDIS® Rates	Comprehensive Diabetes Poor Control - Decreased by 1.70%, MY2019 (54.01%) to MY2020 (52.31%)
2	Diabetes Preventative Care Practices	• Annual dilated eye exam: 13,705 (2019) increased to 14,473 (2020)
		• One or more A1cs: 12,033 (2019) increased to 12,219 (2020)
		• Annual influenza vaccine: 2,556 (2019) increased to 2,704 (2020)
		• Pneumonia vaccine (ever received): 1,993 (2019) increased to 2,212 (2020)
		• Diabetes self-management education (ever received): 103 (2019) increased to 160 (2020)
3	# of Providers in APM Programs	2019 Providers in APMs: 51 2020 Providers in APMs: 56

Diabetes Goals 2021

- ***Goal 1: Improved YOY HEDIS Rates associated with diabetes by at least 2%, ultimately reaching NCQA's 50th percentile. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Expanded provider education and outreach from previous year.
    - **Action Description:** Provider education program on documentation and coding best practices, action plan development by Patient Centered Care Consultants and Provider summits/webinars offering educational credits.
    - **Expected Outcome:** Increased provider awareness of quality metrics, documentation and coding requirements and overall improved outcomes for the members we serve.
    - **Action Measurement:** Improved YOY rates by achieving at least a 2 percentage point increase in the following measures:
        - Comprehensive Diabetes Care HbA1c Testing
        - Comprehensive Diabetes Care Eye Exams

        - Comprehensive Diabetes Care Poor Control (>9.0%)
        - Comprehensive Diabetes Care Good Control (<8.0%)
        - Diabetes Short-term Complication
        - Diabetes Monitoring for People with Diabetes and Schizophrenia
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

- ***Goal 2: Improve diabetes preventive care practices YOY among adults with diabetes. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Expanded member outreach and engagement from previous year.
    - **Action Description:** Engaged and educated members through: Diabetes Classes, Outreach Calls, Text Campaigns, Collaboration with Pennington Research Center, Collaboration with BioTel Remote Patient Monitoring Program, Case Management, New Incentive Platform, Community Events, and A1c Home Test Kits.
    - **Expected Outcome:** Improved diabetes preventative care practices YOY among adults with diabetes including:
        - Annual dilated eye exam
        - One or more A1cs (current reporting period)
        - An influenza vaccine (current reporting period)
        - A pneumonia vaccine (ever received)
        - Daily self-blood glucose monitoring
        - Diabetes self-management education (ever received)
    - **Action Measurement:** Improved diabetes preventative care practices YOY among adults with diabetes including:
        - Annual dilated eye exam
        - One or more A1cs (current reporting period)
        - An influenza vaccine (current reporting period)
        - A pneumonia vaccine (ever received)
        - Daily self-blood glucose monitoring
        - Diabetes self-management education (ever received)

- ***Goal 3: Increased Provider Incentive Programs YOY aligning with Healthy Blue's strategy to improve diabetes outcomes for the members served. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Increase provider alternative payment model (APM) agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Expected Outcome:** Increase in APM programs will result in improved outcomes related to diabetes and obesity.
    - **Action Measurement:** Number of providers enrolled in APM Programs aligned with diabetes measures.

Obesity Goals 2020

- ***Goal 1: Improve YOY HEDIS rates associated with obesity by at least 2 percentage points, ultimately reaching QC for Medicaid 50th percentile for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (Age 3-17) and Adult BMI Screening (ABA) (Age 18-64). Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Provider education and outreach.
    - **Action Description:** Host provider education programs on EPSDT requirements, documentation and coding best practices; develop action plans using patient-centered care consultants; and offer educational credits to providers through summits and webinars.
    - **Expected Outcome:** See overall improved outcomes for the members we serve through enhanced provider awareness of quality metrics, documentation and coding requirements.
    - **Action Measurement:** Review HEDIS WCC and ABA measure rates.

- ***Goal 2: Improved EPSDT screening and participation rates YOY. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Provide member education and outreach, specifically targeting children younger than 21 years of age to promote prevention of obesity.
    - **Action Description:** Engage and educate members through Zumba® fitness classes, outreach calls, text campaigns, member incentives, collaboration with Pennington Biomedical Research Center, case management and community events.
    - **Expected Outcome:** See increased member awareness of the importance of preventive care, the benefits of provider follow-ups, and improved management of obesity.
    - **Action Measurement:** Review EPSDT screening and participation rates.

- ***Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to prevent and manage obesity for the members served. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Increase provider APM agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Expected Outcome:** See improved diabetes- and obesity-related outcomes associated with an increase in APM programs.
    - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate obesity and prevention measures.

Obesity Results 2020

Goal	Benchmark	Results	
1	HEDIS Measures	• WCC: Increased by 9.02%, MY2019 (54.01%) to MY2020 (63.02%)	
		• Physical Activity (Members 3-17 years): Increased by 9.16%, MY2019 (45.74%) to MY2019 (54.90%)	
2	EPSDT Screening and Participation Ratio	EPSDT Rates: Screening Ratio/Participation Ratio	
		• January 30, 2019 o Medicaid 93%/62% o CHIP 90%/62%	January 30, 2020 o Medicaid 91%/62% o CHIP 100%/75%
		• April 30, 2019 o Medicaid 91%/62% o CHIP 100%/75%	April 30, 2020 o Medicaid 91%/62% o CHIP 100%/75%
		• July 30, 2019 o Medicaid 95%/63% o CHIP 100%/74%	July 30, 2020 o Medicaid 91%/62% o CHIP 100%/75%
		• October 30, 2019 o Medicaid 95%/63% o CHIP 100%/74%	October 30, 2020 o Medicaid 91%/62% o CHIP 100%/75%
3	Providers in APM Programs	2019 Providers in APMs: 51 2020 Providers in APMs: 56	

Obesity Goals 2021

- ***Goal 1: Improve YOY HEDIS rates associated with obesity by at least 2 percentage points, ultimately reaching QC for Medicaid 50th percentile for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (Age 3-17) and Adult BMI Screening (ABA) (Age 18-64). Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Provider education and outreach.
    - **Action Description:** Provider education program on EPSDT requirements, documentation and coding, action plan development by Patient Centered Care Consultants and provider summits/webinars offering educational credits.
    - **Expected Outcome:** Increased provider awareness of quality metrics, documentation and coding requirements and overall improved outcomes for the members we serve.
    - **Action Measurement:** Review HEDIS Weight Assess and Counseling for Nutrition and Physical Activity Members 3-17 and Well-Child measure rates.

- ***Goal 2: Improved EPSDT screening and participation rates YOY. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Member education and outreach, specifically targeting children under 21 to promote prevention of obesity

- **Action Description:** Engage and educate members through Zumba fitness classes, outreach calls, text campaigns, member incentives, collaboration with Pennington Biomedical Research Center, case management and community events.
- **Expected Outcome:** Increased member awareness of importance of preventative care, follow-ups with provider and management of obesity.
- **Action Measurement:** Review EPSDT screening and participation rates.

- ***Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to prevent and manage obesity for the members served. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Increase provider APM agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
  - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
  - **Expected Outcome:** See improved diabetes- and obesity-related outcomes associated with an increase in APM programs.
  - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate obesity and prevention measures.

Appendix D4
Louisiana Healthcare Connections
2020 Diabetes and Obesity Action Plan

Diabetes Goals 2020

- ***Goal 1: Maintain an annual enrollment rate above 50% in the diabetes program for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Certified Diabetic Educators will be provided member engagement skills training within the first quarter of employment.
    - **Action Description:** Training will ensure staff knowledge and promote optimal member engagement opportunity through provision of effective program descriptions and awareness of program benefits during member encounters.
    - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
    - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which indicates enrollment into the disease management program.

- ***Goal 2: Maintain the percentage of acute diabetes-related episodes each quarter below the target of 3.10% for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Certified Diabetes Educators will provide a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding diabetes management.
    - **Action Description:** Coaching/evaluation sessions with Certified Diabetes Educators will include identifying barriers to self-management and coordination of services to eliminate those barriers.
    - **Expected Outcome:** The action of providing enhanced coaching techniques and care coordination is expected to prevent gaps in condition-specific awareness which in return will decrease the number of acute episodes for members with diabetes.
    - **Action Measurement:** Successful outcomes of this intervention will be reflected by maintaining or decreasing the quarterly rate of acute diabetes-related episodes.

- ***Goal 3: Maintain percentage of members who have diabetes and complete their annual A1c testing at or above 86.91% for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Monthly automated phone calls and mailed letters will be sent to members who are identified as non-compliant with annual A1c testing.
    - **Action Description:** Member outreach via automated calls and letters will provide reminders and information to promote awareness and support in non-compliant diabetic members. This outreach will encourage annual A1c testing.
    - **Expected Outcome:** This action is expected to increase the number of diabetic members who complete annual A1c testing.

- **Action Measurement:** Successful outcomes of this intervention will be reflected by an increase in the rate of diabetic members who complete annual A1c testing. (Goal: 86.91%).

Diabetes Results 2020

Goal	Benchmark	Results
1	2020 Diabetes Program Enrollment Rate >50%	2020 Diabetes Program enrollment rate met/exceeded goal at 88%
2	Short term diabetes complications admission rate <20.82%	2020 short term diabetes complications admission rate met/exceeded goal at 19.92%
3	HEDIS® CDC Annual A1c Testing >86.91%	2020 Annual A1c testing rate was below goal at 80.54%; this decline from prior year was attributed to the impact of COVID-19 on routine care delivery and access interruptions during the pandemic

Diabetes Goals 2021

- ***Goal 1: LHCC will maintain or exceed an enrollment rate of 75% for the Diabetes Program for 2021. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Certified Diabetic Educators will be provided member engagement skills training within the first quarter of employment.
  - **Action Description:** Training will ensure staff knowledge and promote optimal member engagement opportunity through provision of effective program descriptions and awareness of program benefits during member encounters.
  - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
  - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which indicates enrollment into the disease management program.

- ***Goal 2: LHCC will improve provider engagement in comprehensive diabetes care outcomes through revised provider incentives aligned with LDH HEDIS priority measures, including comprehensive diabetes care HEDIS metrics. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Revise provider performance incentive program to promote provider engagement in improving diabetes outcomes through inclusion of targeted performance thresholds for HEDIS CDC sub-measures.

- **Action Description:** Realign LHCC's provider performance incentive program to include improvement thresholds for HEDIS Comprehensive Diabetes Care sub measures, including provider education and resources to support improved performance and member outcomes.
- **Expected Outcome:** Improvement in diabetic member outcomes as evidenced by improvement in selected HEDIS CDC performance metrics YOY.
- **Action Measurement:** Improvement in HEDIS CDC sub measures CDC-A1c Poor Control and CDC-Eye Exam by at least 2 percentage points over prior year.

- ***Goal 3: LHCC will optimize member risk identification and engagement in diabetes care by increasing the percentage of diabetic members who complete annual A1c testing. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Promote diabetes management and clinical monitoring recommendations via targeted outreach to diabetic members identified as noncompliant with annual A1c testing.
  - **Action Description:** Member engagement in diabetes management will be facilitated through member outreach, promoting access to diabetes education and resources, as well as promotion of available member incentives for completing health and wellness milestones for diabetes care.
  - **Expected Outcome:** These efforts are expected to increase annual A1c testing for diabetic members as evidenced by improved HEDIS CDC A1c testing rates.
  - **Action Measurement:** Improvement in HEDIS CDC annual A1c testing rates by at least 2 percentage points over prior year.

Obesity Goals 2020

- ***Goal 1: Maintain an annual enrollment rate in the weight management program above 40% for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Health coaches will be provided member engagement skills training within the first quarter of employment.
  - **Action Description:** Training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
  - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
  - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which will indicate enrollment into the disease management program.

- ***Goal 2: Increase the percentage of members who report an increase in physical activity from the previous quarter. Start Date: 1/1/2020 End Date: 12/31/2020***

- **Action Step:** Health coaches will provide a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding physical activity and weight management.
- **Action Description:** Sessions with health coaches will include identifying and reviewing best practices to facilitate behavior change regarding physical activity.
- **Expected Outcome:** The action of providing enhanced coaching techniques is expected to guide the members in making SMART goals to increase physical activity and to connect members with exercise physiologists for additional support.
- **Action Measurement:** Successful outcomes of this intervention will be reflected by the percentage of members who report an increase in physical activity for each quarter.

- ***Goal 3: Increase the percentage of members who report an increase in daily servings of fruits and vegetables from the previous quarter. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Health coaches will provide a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding nutrition and weight management.
  - **Action Description:** Coaching/evaluation sessions with health coaches will include identifying and reviewing best practices to facilitate behavior change regarding proper nutrition.
  - **Expected Outcome:** The action of providing enhanced coaching techniques is expected to guide the members in making SMART goals to increase daily servings of fruits and vegetables through awareness and building confidence.
  - **Action Measurement:** Successful outcomes of this intervention will be reflected by the percentage of members who report an increase in daily servings of fruits and vegetables for each quarter.

Obesity Results 2020

Goal	Benchmark	Results
1	2020 Obesity Management Program Enrollment Rate >40%	2020 Obesity Management Program enrollment rate met/exceeded goal at 74%.
2	Activity Metric: % Members reporting increase in physical activity	LHCC's 2020 percentage of members reporting an increase in physical activity improved 5% for adult programs, while a decline of 11.4% was noted in pediatric programs. This decline in pediatric outcomes was attributed to limited pediatric engagement and COVID-19 impacts on care access during the measurement period, as well as program changes impacting consistency in data measurement in 2020.

3	Q1 and Q2 Daily Servings of Fruits and Vegetables Metric	LHCC's 2020 percentage of members reporting an increase in daily servings of fruits and vegetables improved 14.6% for adult programs and 2.5% in pediatric programs.

Obesity Goals 2021

- ***Goal 1: LHCC will maintain an enrollment rate above 50% for Obesity Disease Management Programs for 2021. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Health coaches will be provided member engagement skills training within the first quarter of employment.
    - **Action Description:** Training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
    - **Expected Outcome:** This action is expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
    - **Action Measurement:** Action measurement/outcomes will be monitored via successful initial health assessments which will indicate enrollment into the disease management program.

- ***Goal 2: LHCC will increase member referrals to case management over prior year baseline for those identified as at risk for obesity-related comorbidities. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Improve Case Management identification of members at risk for obesity-related adverse outcomes through health risk assessments (HRA).
    - **Action Description:** Enhanced case management training will ensure staff knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
    - **Expected Outcome:** The expected outcome would be increased HRA completions that would facilitate case management identification and referral for members with identified obesity risks.
    - **Action Measurement:** Increase identification of members with obesity risks through HRA completions.

- ***Goal 3: Improve HEDIS outcomes for pediatric obesity related measures (WCC) by at least 2% over prior year. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Promote obesity management and improved member health behaviors through member and provider outreach, education and access to weight and nutrition management resources.

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

Appendix D5
UnitedHealthcare of Louisiana
2020 Diabetes and Obesity Action Plan

Diabetes Goals 2020

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by 2% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Increase the use of HRAs for new members.
    - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
    - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.
- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **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 3% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results.
    - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health 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 PHCs 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 PHCs educate providers on the importance of A1c testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, PHCs ensure the providers are aware of the vision vendor MARCH® Vision Care.

- **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS Comprehensive Diabetes Care (CDC) rate and to see an upward trend in the monthly rates.
- **Action Measurement:** The indicators used to measure this goal include claims/encounter data and medical/treatment record abstractions.

Diabetes Results 2020

Goal	Benchmark	2019 Results
1	2019 HRAs completed: 8,831	2020 HRAs completed: 18,819
	2019 # Members reached: 28,565	# Members reached: 55,873
2	2019 # Members identified: 10,370	2020 # Members identified: 13,154
	2019 # Members qualified: 7,154	2020 # Members qualified: 10,843
3	HEDIS CDC MY2019: • Eye Exams: 55.47% • A1c Testing: 86.13%	HEDIS CDC MY2020: • Eye Exams: 60.58% • A1c Testing: 82.73%

Diabetes Goals 2021

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2% year over year. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Increase the use of HRAs for new members.
  - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
  - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
  - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: 1/1/2021 End Date: 12/31/2021***

- **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
- **Action Description:** Utilize the Healthy First Steps program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
- **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
- **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- ***Goal 3: Increase engagement with providers by at least 2% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results. Educate members in understanding their A1c and lipid panel and need to complete HbA1c, eye exams and medical attention for nephropathy.
  - **Action Description:** Clinical Consultants engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS measure targets. The HEDIS guidelines and tip sheets are also distributed by Clinical Consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the Clinical Consultants educate providers on the importance of A1c (estimated average glucose) testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, Clinical Consultants ensure the providers are aware of the vision vendor MARCH Vision Care. Qualified providers are incentivized through our CP-PCPi Program for members with good HbA1c control <or = 9. Implemented Diabetic Wellness days pilot as an opportunity for members to receive diabetic education.
  - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS CDC rate and to see an upward trend in the monthly rates.
  - **Action Measurement:** Increase engagement with providers by at least 2 percentage points YOY to ensure familiarity with current clinical practice guidelines and HEDIS measurements.

Obesity Goals 2020

- ***Goal 1: Increase member awareness of healthy lifestyles by 3% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Educate members using weight management education materials.
  - **Action Description:** Newly diagnosed existing members and new members who are diagnosed with obesity receive educational materials and newsletters with weight-

management-specific information, including recommended routine appointment frequency, health logs, monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
    - **Expected Outcome:** The expected outcome is to see an improvement in the number of members who are provided with weight management education materials.
    - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and in reports.

- ***Goal 2: Facilitate healthy lifestyles by increasing the number of members in the Heart Smart Sisters® program reached by 2% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Continue partnership with faith- and community-based organizations to offer Heart Smart Sisters program.
    - **Action Description:** Heart Smart Sisters is a program designed to empower women in ethnic communities to make positive changes to help reduce the risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of a healthy diet and the importance of regular exercise.
    - **Expected Outcome:** The expected outcome is to see an increase in the number of members contacted for the Heart Smart Sisters program.
    - **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and in the UHC database/report.

- ***Goal 3: Increase engagement with providers by 3% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Educate providers by distributing resources including obesity toolkits.
    - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health 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 PHCs to providers at individual offices and at provider expositions around the state. 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 annual WCC rate, and an upward trend in the monthly rates.
    - **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 2020

Goal	Benchmark	Results
1	2019 # of mailings to members: 17,723	2020 # of mailings to members: 12,272
2	2019 # of members reached: 160	2020 # of members reached: 1,226
	2019 # of events: 16	2020 # of events: 33
3	HEDIS MY2019 Adult BMI Assessment (ABA): 91.97%	HEDIS MY2020 Adult BMI Assessment (ABA): Retired measure
	HEDIS MY2019 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total) (WCC): 80.54%	HEDIS MY2020 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total) (WCC): 81.02%

Obesity Goals 2021

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% year over year. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Educate members using weight management education materials.
    - **Action Description:** Members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended dietary intake, monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
    - **Expected Outcome:** The expected outcome is to see an improvement in the number of members who are provided with weight management education materials.
    - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and in reports.

- ***Goal 2: Facilitate healthy lifestyles by increasing the number of members engaged in community-based programs reached by 2% year over year. Start Date: 1/1/2021 End Date: 12/31/2021***
    - **Action Step:** Continue and build partnerships with community based organizations. Continue offering Weight Watchers® program information.
    - **Action Description:** There are a number of community-based organizations that can empower members to make positive changes in their lifestyles. For example, Heart Smart

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

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

- ***Goal 3: Increase engagement with providers by 2% year over year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2021 End Date: 12/31/2021***
  - **Action Step:** Educate providers by distributing resources including obesity toolkits.
  - **Action Description:** Consultants engage in educating providers about HEDIS. Consultants distribute HEDIS guidelines and HEDIS tips sheets to providers. Diabetes and obesity toolkits are also distributed to providers.
  - **Expected Outcome:** The expected outcome is to see an increase in the number of providers educated, an improvement in the final measurement year WCC percentile rate and upward trend in the monthly rate.
  - **Action Measurement:** The indicators used to measure this goal include information in the UHC database, information in claims/encounter data and medical/treatment record abstractions.

Appendix E – Standards of Diabetes Care

American Diabetes Association
Standards of Medical Care in Diabetes - 2018
http://care.diabetesjournals.org/content/diacare/suppl/2017/12/08/41.Supplement_1.DC1/DC_41_S1_Combined.pdf

Consensus Statement by the American Association of Clinical Endocrinologist and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm – 2018
https://www.aace.com/sites/all/files/diabetes-algorithm-executive-summary.pdf

American Association of Clinical Endocrinologists and American College of Endocrinology – Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan – 2015
https://www.aace.com/files/dm-guidelines-ccp.pdf

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