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

Glossary

Current Procedural Terminology (CPT®) – Current version is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The Louisiana Department of Health (LDH) has designated the CPT code set as the national coding standard for physicians and other healthcare professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA).

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

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

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

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

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

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

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's program authorized by Title XXI of the Social Security Act in 1997. Provides healthcare coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% of the Federal Poverty Level (FPL) and a separate state CHIP program for the unborn child option and children with income from 200% up to and including 250% of the FPL.

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

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

Measurement Year (MY) – Concerning healthcare quality measure reporting, measurement year refers to

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

National Committee for Quality Assurance (NCQA) – A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans. HEDIS and the Quality Compass (QC) are registered trademarks of NCQA.

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

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

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

Executive Summary

This report is submitted under Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with and receiving comments from the medical directors of each of its contracted Medicaid partners. Data on prevalence, utilization, and costs of obesity and diabetes are based on 2023 paid healthcare claims submitted by each of the six Medicaid MCOs to Louisiana Medicaid and represent the Louisiana Medicaid managed care population only.

Below are some highlights from this year's report:

- State of Obesity is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to The State of Obesity 2024 report, Louisiana was ranked fourth highest in the nation, down from second in 2023.[1] The following obesity summary was based on 2023 MCO claims data:
    - In 2023, 61,157 Medicaid managed care enrollees under the age of 18 years had an obesity diagnosis. This is 8.30% of the managed care child population. Additionally, 13.20% of adult enrollees 18 years of age or older (136,743) had an obesity diagnosis in 2023. The overall obesity prevalence was 11.16% of the total managed care population of 1,773,080 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 2023 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2023) was 25.67% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2023.

- Louisiana was also ranked third highest in the nation for adult diabetes in 2023, up from seventh in 2022.[2] The following diabetes summary was based on 2023 MCO claims data:
    - In 2023, 8.98% (93,013 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.33% (2,402 enrollees). The managed care population (1,773,080) had a diabetes prevalence of 5.38% (95,415). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish, and age group.
    - While adults with diabetes make up 8.98% of the total managed care population, they accounted for 38.84% of total claim payments for all adults enrolled in managed care dates of service in 2023.
    - Of the 183,150 inpatient discharges in 2023, 3.04% (5,571 discharges) had a primary or secondary diagnosis of diabetes. There were 1,301,824 emergency department visits in 2023 for all Medicaid managed care enrollees and 2.26% (29,365) of those visits had a primary or secondary diagnosis of diabetes.
    - The average cost per enrollee with diabetes in 2023 was $18,839.15 and the average cost per member without diabetes in 2023 was $3,912.95.

[1] *State of Obesity 2024: Better Policies for a Healthier America*. (September 2024). Retrieved October 28, 2024 from https://www.tfah.org/report-details/state-of-obesity-2024/

[2] Ibid.

1 Introduction

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

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

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 six MCOs contracted with Louisiana in 2023 submitted a standardized diabetes and obesity action plan, which provided goals, action steps taken, and results of their efforts to minimize the impact of diabetes and obesity on the Medicaid managed care population. The report cites widely accepted national diabetes- and obesity-related reports published by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS), and the Robert Wood Johnson Foundation.

1.1.2 Improvements

Changes were made in the production of the 2020 Act 210 Diabetes and Obesity Report and were continued for future reports. Modifications made in 2020 streamline data validation and allow prevalence rates to be calculated and reported by Louisiana Medicaid regions, races, and age groups. All diagnosis, procedure, CPT, and HCPCS codes were updated in the 2022 data extraction methodology and continued in 2023 and 2024 to reflect updates in the respective manuals.

1.2 Obesity Overview

1.2.1 National Prevalence

Although national, state, and local governments and many private employers and payers have increased their efforts to address obesity since 1998,[3] the national prevalence of obesity in adults was 41.9% from 2017 to 2020; the national prevalence of obesity in children was 19.7% from 2017 to 2020.[4]

1.2.2 What is Obesity?

Obesity is a complex health issue resulting from a combination of causes and individual factors, such as social determinants of health, behavior, and genetics.[5] For adults, a body mass index (BMI) below 18.5 is considered underweight, between 18.5 and less than 25 is the healthy weight range, 25 to less than 30 is overweight, and 30 or higher is obese.[6] For children and teens ages 2 through 19, obesity is defined as a

[3] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer-and service-specific estimates. Health Aff (Millwood). 2009 Sep-Oct;28(5):w822-31. doi: 10.1377/hlthaff.28.5.w822. Epub 2009 Jul 27. PMID: 19635784. Retrieved October 24, 2024 from https://pubmed.ncbi.nlm.nih.gov/19635784/

[4] *State of Obesity 2024: Better Policies for a Healthier America.* (September 2024). Retrieved October 28, 2024 from https://www.tfah.org/report-details/state-of-obesity-2024/

[5] *Risk Factors for Obesity* (March 18, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/obesity/risk-factors/risk-factors.html

[6] *Adult BMI Categories* (March 19, 2024). Retrieved March 27, 2025 from https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html

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

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

1.3 Diabetes Overview

1.3.1 National Prevalence

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

1.3.2 What is Diabetes?

Diabetes is a disease in which the body either does not make enough insulin or cannot use its insulin as well as it should, causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body, including: the eyes, heart, blood vessels, kidneys, and nerves. This damage makes diabetes the leading cause of adult blindness and end-stage kidney disease. People with diabetes are also at a greater risk for heart disease, stroke, and amputations of the foot and/or leg.[11]

1.3.3 Types of Diabetes

Type 1 diabetes develops when the pancreas produces little to no insulin due to the destruction of the pancreatic cells that make insulin. To survive, people with type 1 diabetes must have insulin delivered by injection or through an insulin pump. This form of diabetes usually occurs in children and young adults, although disease onset can occur at any age. In adults, type 1 diabetes accounts for approximately 5% to 10% of all diagnosed cases of diabetes. There is no known way to prevent type 1 diabetes.[12]

Type 2 diabetes develops with insulin resistance, a condition in which cells (e.g., liver, muscles) do not use insulin properly.[13] The risk factors for developing this type of diabetes include older age, obesity, family history of type 2 diabetes, personal history of gestational diabetes, physical inactivity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, some Asian Americans, and some Pacific Islanders are at a higher risk for the development of type 2 diabetes and its complications. Type 2 diabetes may be preventable through proven lifestyle changes. [14]

Gestational diabetes is a type of diabetes that can develop during pregnancy in people who did not have diabetes before being pregnant.[15] The risk factors for gestational diabetes are similar to those for type 2 diabetes.[16] Gestational diabetes requires treatment. Often, gestational diabetes can be controlled through

[7] *Child and Teen BMI Categories* (June 28, 2024). Retrieved March 27, 2025 from https://www.cdc.gov/bmi/child-teen-calculator/bmi-categories.html
[8] *About Body Mass Index (BMI)* (May 20, 2024). Retrieved March 27, 2025 from https://www.cdc.gov/bmi/about/index.html
[9] *About Obesity* (January 23, 2024). Retrieved March 27, 2025 from https://www.cdc.gov/obesity/php/about/index.html.
[10] *National Diabetes Statistics Report* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/php/data-research/index.html
[11] *Diabetes Basics* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/about/index.html
[12] *Type 1 Diabetes*. (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/about/about-type-1-diabetes.html
[13] *Type 2 Diabetes.* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html
[14] *Diabetes Risk Factors* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/risk-factors/index.html
[15] *Gestational Diabetes* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/about/gestational-diabetes.html
[16] *Diabetes Risk Factors* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/risk-factors/index.html

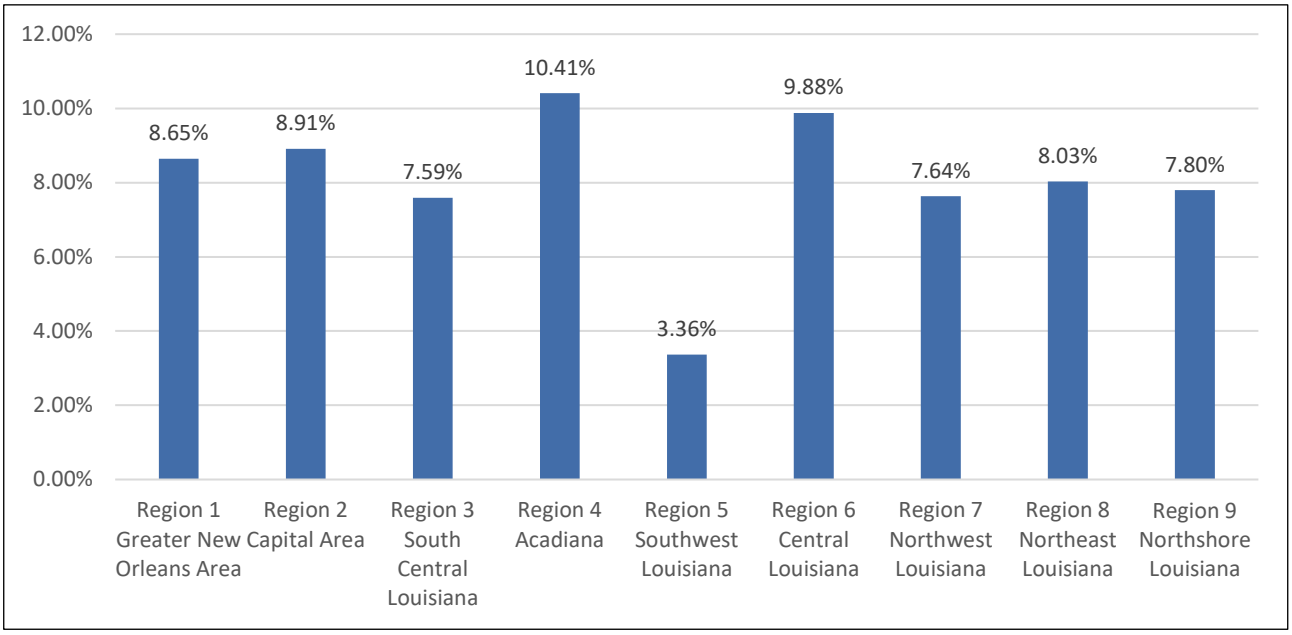
eating healthy foods, regular exercise, and monitoring blood sugar levels. Sometimes, those with gestational diabetes must also take insulin.[17]

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

The State of Obesity report published by the Trust for America's Health and the Robert Wood Johnson Foundation reports that Louisiana's adult obesity rate was 39.9% in 2023, the fourth highest adult obesity rate in the U.S.[18] In comparison, the obesity rate for the Medicaid managed care adult population calculated using claims data was 13.20% for 2023. The discrepancy between rates indicates that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data and yields an artificially low prevalence rate when exclusively using Louisiana Medicaid medical claims data to calculate the rate.

In this report, Medicaid managed care enrollees with obesity were identified by medical claims with dates of service in 2023 that included a primary or secondary diagnosis of obesity. Based on 2023 claims data, the managed care overall obesity prevalence rate was 11.16% of 1,773,080 MCO enrollees. Figure 2.1 shows that Louisiana Medicaid Region 4 had the highest child obesity prevalence rate (10.41%), followed closely by Louisiana Medicaid Region 6 (9.88%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 3 at 15.98%, followed closely by Louisiana Medicaid Region 4 at 14.96% (Figure 2.2). When the data were stratified by age, gender, and race, the highest prevalence rates were found in adult females. The female adult obesity prevalence rate by race was 20.31% African American, 15.41% white, and 12.49% other races (Figure 2.3). The remaining age, gender, and race strata had obesity prevalence rates below 9.98%. For parish-level obesity prevalence rates, please see Appendix B.

Figure 2.1: Louisiana Medicaid Managed Care - Prevalence of Obesity in Children (Age <18) in 2023 by Region



[17] *Gestational Diabetes* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/about/gestational-diabetes.html
[18] *State of Obesity 2024: Better Policies for a Healthier America*. (September 2024). Retrieved October 24, 2024 from https://www.tfah.org/report-details/state-of-obesity-2024/

Figure 2.2: Louisiana Medicaid Managed Care – Prevalence of Obesity in Adults (Age ≥18) in 2023 by Region

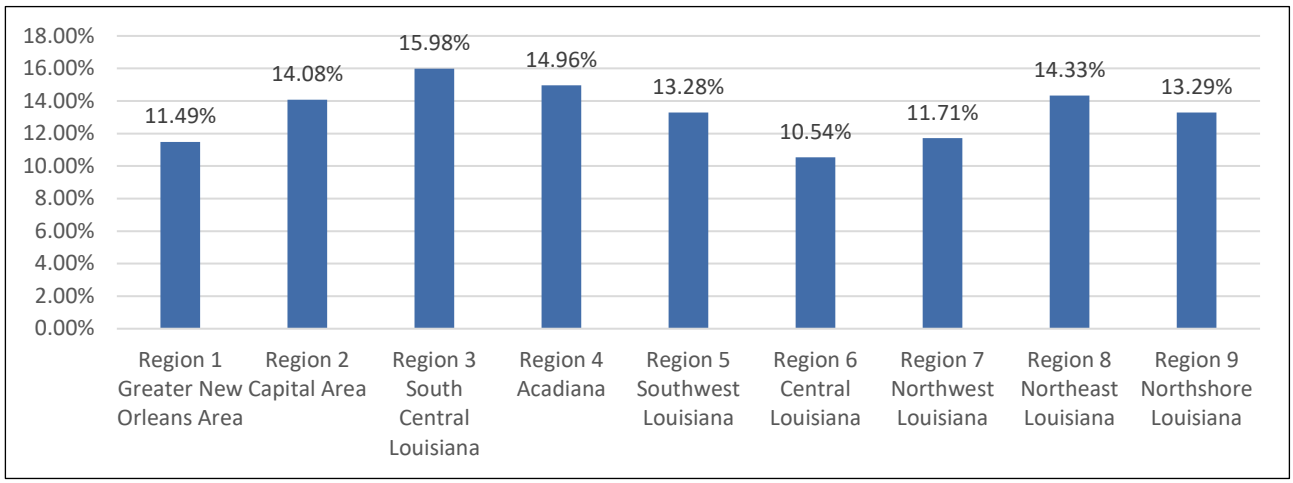
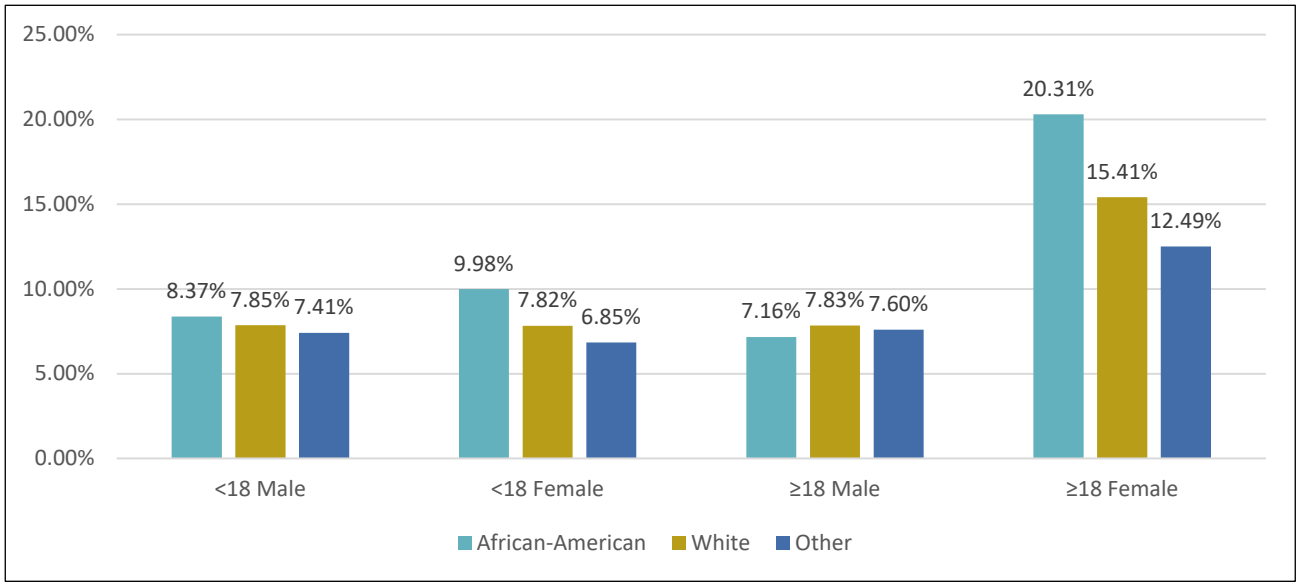


Figure 2.3: Louisiana Medicaid Managed Care – Prevalence of Obesity in 2023 by Age Group, Gender, and Race



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 2023 associated with Medicaid managed care enrollees with and without obesity. All paid claims for enrollees were included and categorized by age and obesity status.

The overall prevalence of obesity in the Medicaid managed care population is 11.16%. Healthcare claim costs for these enrollees totaled $2,122,574,479 in 2023, which accounts for 25.38% of the total MCO claims payments ($8,362,163,186). In other words, of the entire Medicaid managed care population, the 11.16% who have a diagnosis of obesity account for 25.38% of the total healthcare claim costs.

Table 2.1: Total Cost of Obesity in 2023 among Medicaid Managed Care Enrollees by Claim Type, Age Group, and Obesity Category

Claim Type	Total Cost: Children Diagnosed with Obesity*	Total Cost: Children Without an Obesity Diagnosis	Total Cost: Adults Diagnosed with Obesity **	Total Cost: Adults Without an Obesity Diagnosis	Percent of Total Costs Associated with Enrollees Diagnosed with Obesity
Medical	$173,149,284	$1,380,186,250	$1,102,262,890	$2,621,619,010	24.17%
Pharmacy	$57,079,067	$341,860,609	$764,843,296	$1,729,326,912	28.41%
Other* **	$15,398,306	$121,324,252	$9,841,635	$45,271,674	13.16%
Total	$245,626,658	$1,843,371,110	$1,876,947,821	$4,396,217,597	25.38%

*Includes claims, with dates of service in 2023, for any child MCO enrollee diagnosed with obesity in 2023.
**Includes claims, with dates of service in 2023, for any adult MCO enrollee diagnosed with obesity in 2023.
***Includes dental, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and adult daycare.

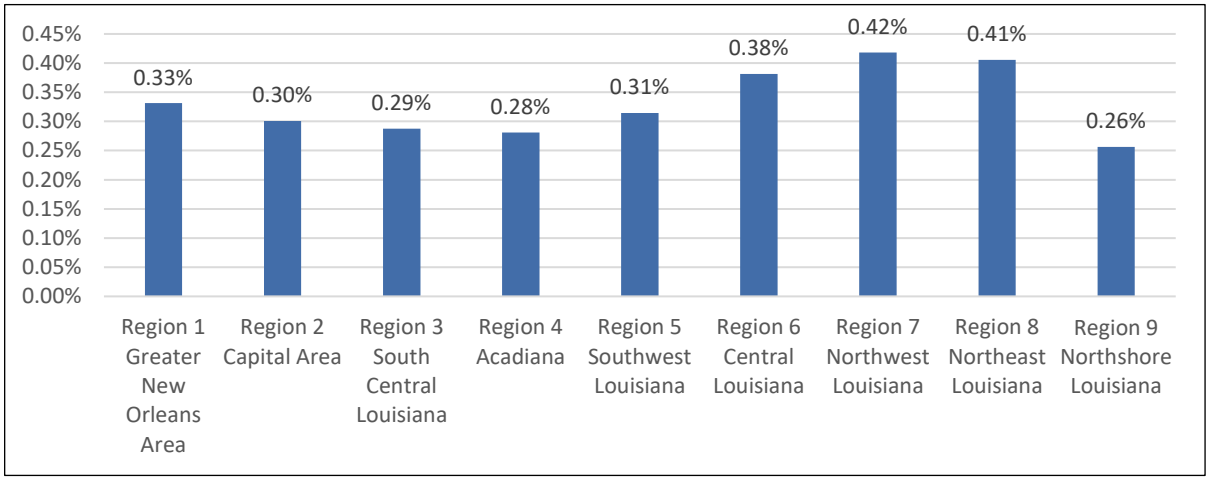
3 The Scope of Diabetes in the Medicaid Managed Care Program

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

The National Diabetes Statistics Report published by the CDC states that the overall adult crude prevalence of diagnosed diabetes in the U.S. was 11.3% for the years 2017 to 2020 and that 3.4% of adults (age ≥ 18 years) who met laboratory criteria for diabetes were unaware, or did not report, that they had diabetes. The report also indicated that the total direct and indirect costs of diagnosed diabetes in the U.S. in 2022 were $413 billion.[19]

For the 2024 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2023 that included a primary or secondary diagnosis of diabetes. Based on 2023 claims data, the adult diabetes prevalence was 8.98% of 1,036,026 unique managed care adults. The child diabetes prevalence was 0.33% of 737,054 enrollees under the age of 18 years. Louisiana Medicaid Regions 7 and 8 had the highest child prevalence rates, 0.42% and 0.41% respectively (Figure 3.1). Louisiana Medicaid Region 3 had the highest adult prevalence rate, 9.99%, although all other regions had prevalence rates of over 8.24% (Figure 3.2).

Figure 3.1: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Children (Age <18) in 2023 by Region



[19] *National Diabetes Statistics Report* (May 15, 2024). Retrieved October 24, 2024 from https://www.cdc.gov/diabetes/php/data-research/index.html

Figure 3.2: Louisiana Medicaid Managed Care – Prevalence of Diabetes in Adults (Age ≥ 18) in 2023 by Region

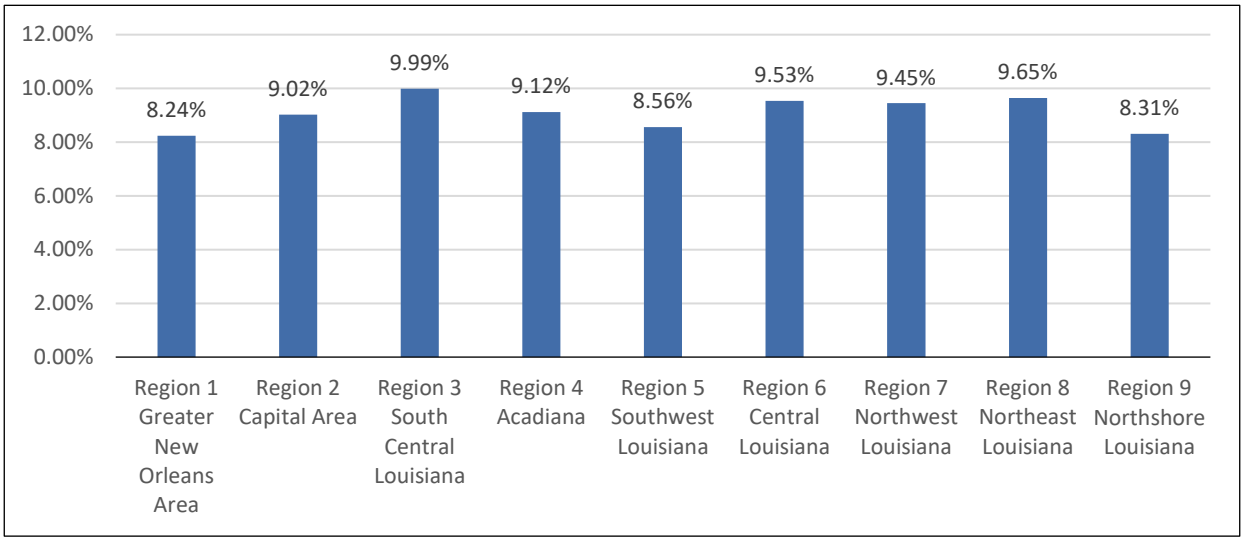


Figure 3.3 shows diabetes prevalence stratified by age group, gender, and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among African American adult females (11.17%) and other race adult females (9.80%). The CDC's National Diabetes Statistics Report states that the prevalence of adult-diagnosed diabetes was highest among non-Hispanic African Americans (12.7%).[20]

Figure 3.3: Louisiana Medicaid Managed Care – Prevalence of Diabetes in 2023 by Age, Gender, and Race

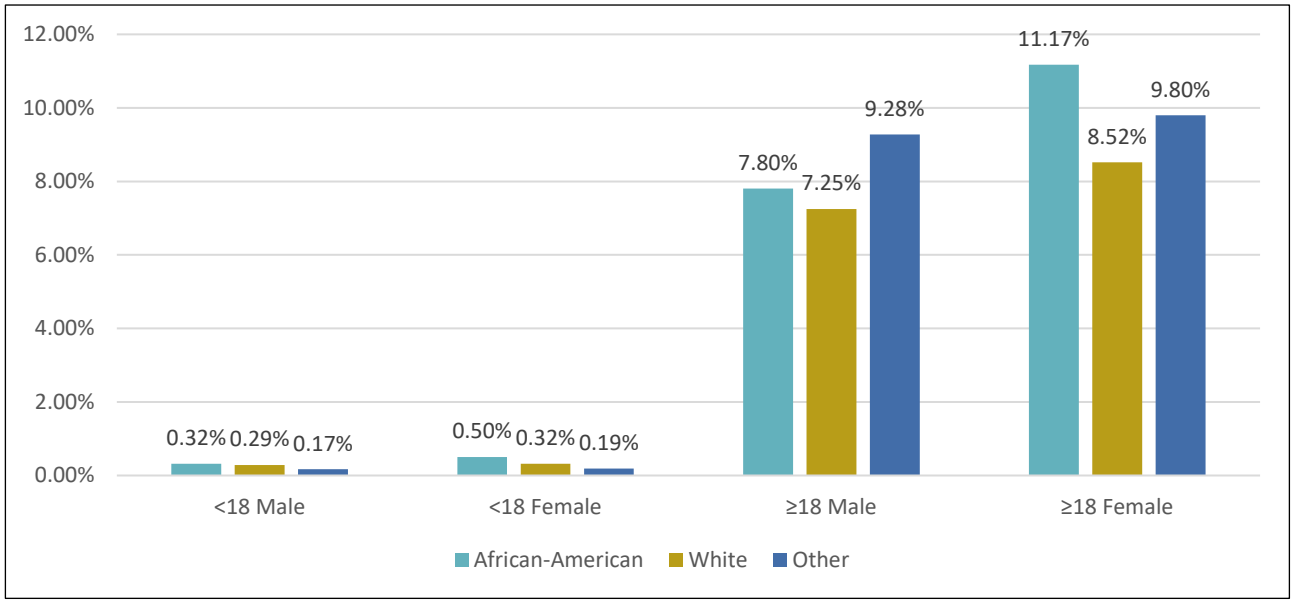
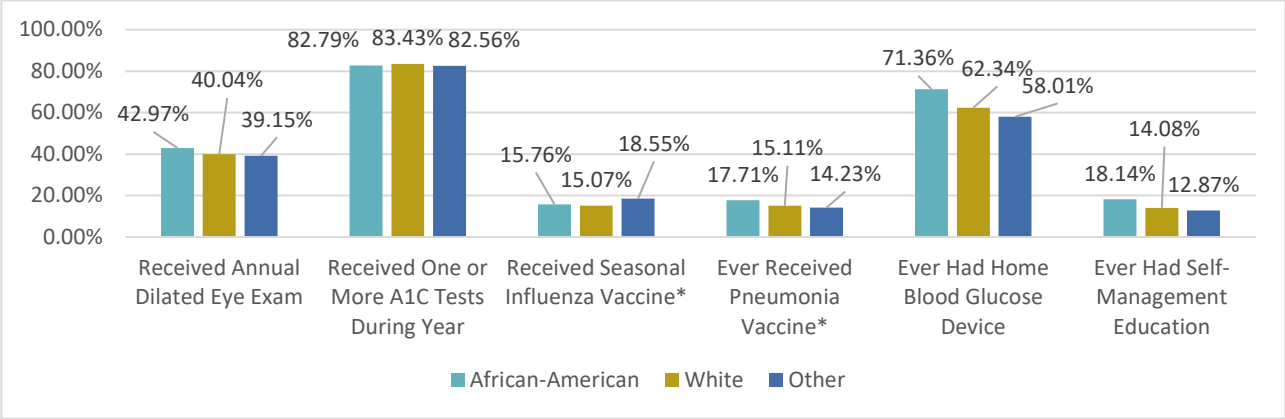


Figure 3.4 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes across races. The distribution of care practices is very similar across races except for home blood glucose devices and self-management education. Higher rates of owning a home glucose monitoring device were found among African Americans (71.36%) when compared to whites (62.34%) and other races (58.01%).

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

Higher rates of receiving self-management education were also higher among African Americans (18.14%) when compared to whites (14.08%) and other races (12.87%).

Figure 3.4: Louisiana Medicaid Managed Care – Diabetic Preventive Care Practices in 2023 among Adults with Diabetes by Race



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

3.1 Diabetes and Pregnancy

Table 3.1.1 shows the cost of Medicaid managed care enrollee pregnancies in 2023 with and without diabetes. The total cost per pregnant enrollees with diabetes was 1.79 times greater than those who did not have a diabetes complication during their pregnancy ($8,388 vs $4,679). Of the MCO enrollees who were pregnant during 2023 (52,581), 10.91% had a diagnosis of diabetes.

Table 3.1.1: Louisiana Medicaid Managed Care – Diabetes* and Pregnancies in 2023

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,739	$48,136,162	$8,388
Pregnancies without diabetes	46,842	$219,195,529	$4,679

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

3.2 The Financial Impact of Diabetes and Its Complications

The estimated total economic cost of diagnosed diabetes in the U.S. for 2022 was $413 billion.[21]

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

Table 3.2.1 lists total costs, by claim type, for healthcare claims with dates of service in 2023 associated with Louisiana Medicaid managed care adult enrollees with and without diabetes. Managed care adult enrollees with diabetes were identified by medical claims with dates of service in 2023 that included a primary or secondary diagnosis of diabetes. All paid claims for enrollees with diabetes were included in the "Total Cost of MCO Adult Enrollees with Diabetes" column. If an enrollee did not meet the criteria to enter the diabetes category, all of their paid claims were included in the "Total Cost of MCO Adult Enrollees without Diabetes" column.

[21] Economic Costs of Diabetes in the U.S. in 2022, American Diabetes Association, Diabetes Care 2024, dci230085; Retrieved March 27, 2025 from https://doi.org/10.2337/dci23-0085

The prevalence of diabetes in the adult Medicaid managed care population is 8.98%. Healthcare claim costs for these enrollees totaled $1,754,743,535 in 2023, which accounts for 27.97% of the total adult MCO claims payments ($6,273,165,418) with dates of service in 2023.

Table 3.2.1: Louisiana Medicaid Managed Care – Cost of Adults with Diabetes in 2023 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	$908,000,017	$2,815,881,885	24.38%
Pharmacy	$840,178,772	$1,653,991,435	33.69%
Other**	$6,564,746	$48,548,562	11.91%
Total	$1,754,743,535	$4,518,421,883	27.97%

*Includes claims, with dates of service in 2023, for any adult MCO enrollee with diabetes in 2023.
**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 2023 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows, by age group and race, the percentage of 2023 Medicaid managed care enrollees with diabetes who also had a diabetic complication.

For enrollees under 18 years of age with diabetes, the most prevalent complication was hyperglycemia (52.37%), followed by ketoacidosis (13.61%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (36.93%) and neurological manifestations (17.13%).

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

In 2023, for the Medicaid managed care population, 26,365 ED visits were diabetes-related. These diabetes-related visits represented 2.26% of ED visits for managed care enrollees during 2023. Of these diabetes-related visits, 17,544 visits (59.74%) were associated with diabetes-related complications.

Table 3.2.2: Louisiana Medicaid Managed Care - Prevalence of Diabetic Complications Among Enrollees with Diabetes in 2023 by Race and Age Group*

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total
Ketoacidosis	13.77%	14.98%	9.25%	13.61%	2.48%	2.24%	1.80%	2.29%
Hyperosmolarity	0.72%	0.94%	0.36%	0.75%	1.33%	1.08%	1.24%	1.22%
Coma	0.87%	1.08%	0.00%	0.83%	0.37%	0.32%	0.33%	0.34%
Renal Manifestations	1.01%	1.48%	0.71%	1.12%	11.19%	9.34%	10.61%	10.45%
Ophthalmic Manifestations	1.74%	1.08%	0.71%	1.42%	10.42%	8.30%	10.95%	9.74%
Neurological Manifestations	0.65%	0.40%	0.71%	0.58%	16.81%	18.28%	15.45%	17.13%
Peripheral Circulatory Disorders	0.29%	0.54%	0.36%	0.37%	5.93%	6.36%	6.13%	6.11%
Arthropathy	0.00%	0.00%	0.00%	0.00%	0.41%	0.58%	0.40%	0.47%
Skin Complications	0.87%	0.81%	0.71%	0.83%	3.49%	4.68%	3.53%	3.92%
Oral Complications	0.07%	0.00%	0.00%	0.04%	0.08%	0.05%	0.04%	0.06%

Hypoglycemia	4.28%	7.56%	9.61%	5.91%	3.12%	3.20%	2.59%	3.07%
Hyperglycemia	51.16%	57.09%	45.91%	52.37%	38.37%	36.16%	33.94%	36.93%
Other Specified Complications	7.32%	5.94%	6.05%	6.74%	13.30%	13.53%	12.46%	13.26%
Unspecified Complications	4.57%	5.13%	1.78%	4.41%	7.26%	6.55%	6.19%	6.85%
Count of Enrollees with Any Diabetes Diagnosis	1,380	741	281	2,402	46,240	33,014	13,759	93,013

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

Table 3.2.3: Louisiana Medicaid Managed Care – Prevalence of ED Visits with a Diagnosis of Diabetes and Prevalence of Diabetic ED Visits with a Diabetic Complication in 2023

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	191,688	733	0.38%	511	69.71%
White, < 18 years	112,961	405	0.36%	317	78.27%
Other, < 18 years	96,283	94	0.10%	71	75.53%
Total, < 18 years	400,932	1,232	0.31%	899	72.97%
African American, ≥ 18 years	480,180	15,955	3.32%	9,558	59.91%
White, ≥ 18 years	328,407	9,113	2.77%	5,284	57.98%
Other, ≥ 18 years	92,305	3,065	3.32%	1,803	58.83%
Total, ≥ 18 years	900,892	28,133	3.12%	16,645	59.17%
Total, All Ages	1,301,824	26,365	2.26%	17,544	59.74%

***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 2023, among managed care enrollees who were diagnosed with one of the reported chronic conditions, hypertension (239,106 enrollees) was the most prevalent, followed by asthma (103,596 enrollees) and diabetes (95,415 enrollees). In 2023, for the reported chronic conditions, the highest total paid by the MCOs was $753,610,962 for hypertension. The total paid for diabetes during 2023 was $384,361,201. In 2023, the highest average cost per enrollee for the reported chronic conditions was for congestive heart failure ($9,114). The average cost paid for diabetes per enrollee was $4,028.

Table 3.2.4: Louisiana Medicaid Managed Care – Prevalence of Selected Chronic Conditions and Cost Comparisons among Diabetes and Selected Chronic Conditions in 2023

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Diabetes	95,415	5.38%	$384,361,201	$4,028
Hypertension	239,106	13.49%	$753,610,962	$3,152

Asthma	103,596	5.84%	$153,360,654	$1,480
Arthritis	62,677	3.53%	$85,353,590	$1,362
Congestive Heart Failure	18,944	1.07%	$172,658,370	$9,114
Chronic Obstructive Pulmonary Disease (COPD)	25,528	1.44%	$119,142,373	$4,667
Coronary Heart Disease	25,218	1.42%	$128,651,956	$5,102

*A unique enrollee may be included in more than one chronic disease count.
**The prevalence denominator is the 2023 total unique enrollee count in MCOs (1,773,080).

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 empowering the community, promoting self-management training, and monitoring health outcomes.

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

5 Conclusion

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

Appendix A – Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

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

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

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	68,608	95,310	9.26%	11.54%
Orleans	54,957	100,872	7.52%	11.44%
Plaquemines	3,060	4,341	8.50%	10.92%
St. Bernard	9,223	12,252	10.80%	11.71%
Total – Region 1	135,848	212,775	8.65%	11.49%
Region 2 Capital Area				
Ascension	16,548	19,874	8.76%	17.45%
East Baton Rouge	67,783	93,017	8.34%	12.77%
East Feliciana	2,535	4,145	12.35%	17.03%
Iberville	5,101	7,223	12.76%	17.08%
Pointe Coupee	3,035	4,344	12.75%	15.31%
West Baton Rouge	4,121	5,261	9.97%	16.71%
West Feliciana	1,301	1,745	6.30%	14.84%
Total – Region 2	100,424	135,609	8.91%	14.08%
Region 3 South Central Louisiana				
Assumption	2,497	4,106	11.57%	20.80%
Lafourche	12,521	17,897	10.45%	16.38%
St. Charles	6,440	8,366	8.48%	13.05%
St. James	2,867	4,459	6.07%	17.20%
St. John the Baptist	7,984	11,090	8.50%	13.40%
St. Mary	9,438	13,258	5.72%	16.74%
Terrebonne	18,422	24,946	5.59%	16.40%
Total – Region 3	60,169	84,122	7.59%	15.98%
Region 4 Acadiana				
Acadia	11,027	15,072	6.15%	13.69%
Evangeline	6,058	8,303	9.41%	14.89%
Iberia	13,379	18,924	15.65%	12.75%
Lafayette	35,603	48,562	10.56%	13.94%
St. Landry	18,081	24,522	7.54%	18.01%
St. Martin	8,429	11,294	14.85%	15.38%
Vermilion	9,507	12,913	9.59%	17.40%
Total – Region 4	102,084	139,590	10.41%	14.96%
Region 5 Southwest Louisiana				
Allen	3,683	4,810	5.57%	12.31%
Beauregard	6,151	7,690	3.02%	12.61%
Calcasieu	33,347	42,869	2.93%	12.93%
Cameron	317	455	5.36%	11.87%
Jefferson Davis	5,164	6,755	4.84%	17.07%
Total – Region 5	48,662	62,579	3.36%	13.28%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Avoyelles	7,324	9,901	8.87%	9.61%
Catahoula	1,642	2,756	7.06%	9.00%
Concordia	3,964	5,672	2.35%	7.63%
Grant	3,252	4,446	10.67%	10.98%
LaSalle	2,260	3,135	5.49%	11.90%
Rapides	22,330	30,129	13.70%	11.22%
Vernon	6,402	8,486	2.42%	10.91%
Winn	2,097	3,042	15.45%	10.65%
Total – Region 6	49,271	67,567	9.88%	10.54%
Region 7 Northwest Louisiana				
Bienville	2,401	3,567	7.21%	10.71%
Bossier	17,734	21,491	7.85%	11.73%
Caddo	41,303	57,833	8.65%	12.25%
Claiborne	2,131	3,028	5.54%	10.57%
DeSoto	4,522	6,067	6.83%	13.02%
Natchitoches	6,145	8,641	5.00%	10.06%
Red River	1,619	2,174	3.34%	7.31%
Sabine	3,704	5,440	3.59%	10.04%
Webster	6,551	9,740	7.86%	11.71%
Total – Region 7	86,110	117,981	7.64%	11.71%
Region 8 Northeast Louisiana				
Caldwell	1,847	2,948	2.71%	12.35%
East Carroll	1,460	2,026	6.78%	16.39%
Franklin	3,970	6,054	3.50%	13.51%
Jackson	1,974	3,051	8.26%	13.96%
Lincoln	6,383	9,332	7.54%	11.67%
Madison	2,375	3,344	5.98%	11.09%
Morehouse	5,012	7,876	9.02%	21.53%
Ouachita	29,111	41,333	9.09%	13.54%
Richland	3,897	5,779	9.98%	15.12%
Tensas	679	1,274	4.12%	12.56%
Union	3,818	5,748	8.67%	14.32%
West Carroll	1,889	3,113	4.76%	19.95%
Total – Region 8	62,415	91,878	8.03%	14.33%
Region 9 Northshore Louisiana				
Livingston	22,414	27,709	7.62%	13.71%
St. Helena	1,336	1,910	11.60%	16.18%
St. Tammany	32,420	45,141	6.74%	10.82%
Tangipahoa	26,816	36,215	8.64%	15.14%
Washington	9,085	12,950	8.93%	15.36%
Total – Region 9	92,071	123,925	7.80%	13.29%

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**
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Jefferson	68,608	95,310	0.27%	8.72%
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Total – Region 1	135,848	212,775	0.33%	8.24%
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Ascension	16,548	19,874	0.31%	8.86%
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West Baton Rouge	4,121	5,261	0.32%	10.95%
West Feliciana	1,301	1,745	0.08%	10.03%
Total – Region 2	100,424	135,609	0.30%	9.02%
Region 3 South Central Louisiana				
Assumption	2,497	4,106	0.40%	13.57%
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Vermilion	9,507	12,913	0.27%	9.63%
Total – Region 4	102,084	139,590	0.28%	9.12%
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Beauregard	6,151	7,690	0.24%	10.39%
Calcasieu	33,347	42,869	0.33%	7.81%
Cameron	317	455	0.00%	9.89%
Jefferson Davis	5,164	6,755	0.23%	9.36%
Total – Region 5	48,662	62,579	0.31%	8.56%

Medicaid Region	Medicaid Managed Care Enrollees		Diabetes Prevalence	
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Concordia	3,964	5,672	0.28%	9.98%
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LaSalle	2,260	3,135	0.53%	13.11%
Rapides	22,330	30,129	0.48%	8.77%
Vernon	6,402	8,486	0.28%	9.16%
Winn	2,097	3,042	0.24%	10.91%
Total – Region 6	49,271	67,567	0.38%	9.53%
Region 7 Northwest Louisiana				
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DeSoto	4,522	6,067	0.40%	9.96%
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Red River	1,619	2,174	0.12%	9.06%
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Jackson	1,974	3,051	0.71%	13.37%
Lincoln	6,383	9,332	0.55%	9.20%
Madison	2,375	3,344	0.42%	9.27%
Morehouse	5,012	7,876	0.50%	9.66%
Ouachita	29,111	41,333	0.35%	8.49%
Richland	3,897	5,779	0.67%	11.25%
Tensas	679	1,274	0.44%	12.56%
Union	3,818	5,748	0.39%	9.93%
West Carroll	1,889	3,113	0.16%	11.76%
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St. Helena	1,336	1,910	0.22%	10.47%
St. Tammany	32,420	45,141	0.23%	6.93%
Tangipahoa	26,816	36,215	0.26%	9.40%
Washington	9,085	12,950	0.31%	10.57%
Total – Region 9	92,071	123,925	0.26%	8.31%

Appendix D – 2023 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 2023 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2023 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2023 Diabetes and Obesity Action Plan
Appendix D4	Humana Healthy Horizons 2023 Diabetes and Obesity Action Plan
Appendix D5	Louisiana Healthcare Connections 2023 Diabetes and Obesity Action Plan
Appendix D6	United Healthcare 2023 Diabetes and Obesity Action Plan

Appendix D1
Aetna Better Health of Louisiana
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

- ***Goal 1: Increase the percentage of members 18 to 75 years of age with diabetes (Type 1 and Type 2) with an HbA1c (estimated average glucose) test by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the mPulse integrated voice response (IVR) programs.
    - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools through the mPulse nanosite. The program is used to motivate and help members better track and manage their conditions, engage in preventive actions, and share valuable information with their care teams.
    - **Expected Outcome:** Increase in HbA1c testing among members aged 18 to 75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 2: Increase the percentage of members 18 to 75 years of age with diabetes (Type 1 and Type 2) with an eye exam by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the mPulse integrated voice response (IVR) programs.
    - **Action Description:** Provide our vendor, HealPros, HEDIS® Gaps in Care reports to identify members with a gap in care for dilated eye exam (CDC). HealPros will schedule appointments and complete eye exams in a convenient location for the member.
    - **Expected Outcome:** Increase in eye exams and HbA1c testing among members aged 18 to 75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS Gaps in Care reports.

- ***Goal 3: Increase access to care for this metric through value-based agreements with providers. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Review provider contracts to align with diabetes goals and support providers through value-based incentives.
    - **Action Description:** Distribute patient-specific data to providers to enhance the necessary care delivered to align with value-based goals.
    - **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.
    - **Action Measurement:** Use value-based contracts.

Diabetes Results 2023

Goal	Benchmark	Results
1	HbA1c (estimated average glucose) test performance measure, 2023 compared to 2022	2022: 56.20% 2023: 59.61% Did meet goal.
2	Eye exams for members with diabetes performance measure, 2023 compared to 2022	2022: 52.31% 2023: 46.96% Did not meet goal.
3	Include HbA1c in value-based contracts	In 2023, 25 value-based contracts included HbA1c.

Diabetes Goals 2024

- ***Goal 1: Increase the percentage of members 18 to 75 years of age with diabetes (Type 1 and Type 2) with an HbA1c (estimated average glucose) test by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Aetna Better Health of Louisiana (ABHLA) will initiate a culturally appropriate nutritional intervention program with the company, GA Foods, through our value-added benefits offered to adult members. Eligible member criteria are adult and noncompliant with Controlling High Blood Pressure (CBP) and Hemoglobin A1c Control for Patients with Diabetes (HBD) HEDIS measures.
    - **Action Description:** ABHLA will offer home-delivered, culturally appropriate, and dietary-specific meals, ensuring accessibility for low-income, rural, and ethnically diverse members. Our strategy in partnering with this organization is to reduce food and nutrition insecurities of members with chronic conditions through targeted efforts. We introduce members to the knowledge and skills needed to make healthy food choices. The GA Foods vendor cooks and delivers nutritious, medically appropriate meals to enrollees (e.g., non-specialty, breakfast, vegetarian, puree, renal, kosher, shelf stable, medically tailored meals). Eligible member criteria are adult and noncompliant with CBP and HBD HEDIS measures. Members can participate in this program every quarter (if they are still not compliant with CBP and HBD). They are provided two meals per day for 14 days, for a total of 28 meals quarterly. When approved for the service, members will be notified through outreach within 24 to 72 hours of receiving authorization. GA Foods provides a welcome call to discuss the program's value and services offered. GA Foods also completes/confirms referrals and the delivery of meals. Members are also notified about each status update: “referral received, member reached, accepted meals and delivery, refused meals, and unable to reach.” Although our goal is to help with providing nutritionally appropriate meals, there are limitations or barriers, such as the inability to reach members to set up their meal service. Inactive or inaccurate phone numbers would

be the top challenge. In this instance, we continue to work with our members, GA Foods, and our provider partner to attain accurate contact information to ensure members are given the opportunity to receive the meals they deserve. Additionally, ABHLA has operationalized efforts with our RN health coach to facilitate outreach to the members who received food boxes from this program and "members who received food and accepted outreach engagement from the RN health coach."

- **Expected Outcome:** Increase compliant adult members 18 to 75 with diabetes (Type 1 and Type 2).
- **Action Measurement:** Enrollee files, or HEDIS data and claims data, are used to identify eligible members. GA Foods Referral received, member reached, accepted meals and delivery, refused meals, and unable to reach.

- ***Goal 2: Increase the percentage of members 18 to 75 years of age with diabetes (Type 1 and Type 2) with an eye exam by at least 2 percentage points year-over-year (YOY) as compared to baseline. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Utilize the Healthcare Effectiveness Data and Information Set (HEDIS®) outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Send screening reminder through vendor mPulse SMS program.
  - **Action Description:** As part of ABHLA's HEDIS Outreach team's ongoing outreach to members, the HEDIS Outreach team contacts members with identified gaps in care to remind the members of screenings due and works with the member to schedule an appointment with their primary care provider. The SMS mPulse campaigns are strategically designed to enhance enrollee awareness of health services and foster improved connections to care and local community resources.
  - **Expected Outcome:** Increase in eye exams among members aged 18 to 75 with a diabetes diagnosis.
  - **Action Measurement:** Use HEDIS Gaps in Care reports.

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

Obesity Goals 2023

- ***Goal 1: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Work with community-based organizations to expand partnerships across the state to address obesity education.
    - **Action Description:** Gather information about what our partners are doing to combat obesity and how we can best support their work.
    - **Expected Outcome:** Expand our partnerships and obesity program support capacity.
    - **Action Measurement:** Track the number of new partnerships and support provided around obesity initiatives.

- ***Goal 2: Hire a health coach and begin active health coaching for adult members with obesity. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Hire a health coach with a focus on diabetes and obesity.
    - **Action Description:** Expanding internal capacity for obesity program function and support.
    - **Expected Outcome:** Enrolling members in health coaching that promotes a healthy lifestyle and addresses obesity.
    - **Action Measurement:** Increase the number of members receiving health coaching.

- ***Goal 3: Host community events across Louisiana and provide education about obesity to attendees. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Partner with community development to provide educational material around obesity, healthy eating, and physical activity at community events.
    - **Action Description:** Track the number of materials distributed at the events.
    - **Expected Outcome:** Increased member knowledge about obesity, healthy eating, and physical activity.
    - **Action Measurement:** Internal reports tracking distributed materials.
    - **Action Description:** Inform departments about VABs available to our members to ensure that our members are aware of those benefits and support VABs.
    - **Expected Outcome:** Increase utilization of VABs and further support of participating organizations/vendors.
    - **Action Measurement:** VAB reports

Obesity Results 2023

Goal	Benchmark	Results
1	Events held by community outreach team	75 vouchers distributed to households with a child aged 3 to 17 who is currently enrolled in ABHLA. The child lives in or has a primary health care provider in the Northshore region(Washington, Tangipahoa, or St. Helena parish) or

		Acadiana region (St. Landry, Acadia or Lafayette parish.)
2	Members receiving health coaching	35 of the members actively enrolled in health coaching by December 2023
3	Uitilization of value-added benefits (VABs)	Pop-up grocery markets provided 1,200 families with free, fresh, and healthy food options that make meals including: ground beef and turkey; shelf stable items such as rice, cereal, and canned goods; eggs, bread, fresh fruits and vegetables, milk and juice.

Obesity Goals 2024

- ***Goal 1: Expand partnerships around Louisiana that will expand the education about healthy eating and physical activity. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Work with partners to increase access to healthy fruits and vegetables and education to address obesity.
    - **Action Description:** Healthy Families Produce Rx (HFPRx) is an innovative food access program, developed in partnership with Aetna Better Health of Louisiana, Share Our Strength's No Kid Hungry campaign, Vouchers for Veggies, and LSU Ag Center, with funding from the USDA's Gus Schumacher Nutrition Incentive Grant Program (GusNIP). The program will provide eligible families with $40 per month to purchase fresh fruits and vegetables at select local farmers markets and grocery retailers. Eligible families receive up to $240 to purchase fruits and vegetables over six months, and eligible members are enrolled in SNAP and WIC. Program Eligibility: Households with a child aged 3 to 17 who is currently enrolled in any Medicaid health plan. The child lives in or has a primary healthcare provider in the Northshore region (Washington, Tangipahoa, or St. Helena parish) or the Acadiana region (St. Landry, Acadia or Lafayette parish). Communication with the enrollees begins as soon as the card/vouchers is mailed. Program partners do an introduction welcome call and then, if the enrollees opt in, do a monthly reminder via SMS or phone call to remind the enrollee to use the benefit. If the enrollees aren't using the benefit, they will receive additional reminders to encourage them, as well as a follow-up call to address any issues. At the end of the six months, program partners do a final outreach.
    - **Expected Outcome:** Increase access to healthy fruits and vegetables, as well as education in Regions 4 and 9. Improve dietary health and food security for families in rural Louisiana who are disproportionately impacted by poor nutrition and related health outcomes.
    - **Action Measurement:** Vouchers received.

- ***Goal 2: Promote physical activity in the school system in support of Louisiana State Act 84 resolution. Start Date: 1/1/2024 End Date: 12/31/2024***

- **Action Step:** Support playground equipment sponsorship through collaboration with a school board.
- **Action Description:** ABHLA to approve $5,000 sponsorship to fund playground equipment for the Evangeline Parish School Board.
- **Expected Outcome:** Promote childhood physical activity in support of healthy lifestyle and weight management.
- **Action Measurement:** Evangeline Parish School reported outcomes.

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

Appendix D2
AmeriHealth Caritas Louisiana (ACLA)
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

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

- ***Goal 2: ACLA will increase member compliance for members with diabetes linked to quality-educated provider groups, including value-based care (VBC) groups who selected Hemoglobin A1c Control for Patients with Diabetes (HBD) as a measurable outcome, by December 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Continue the process of educating provider groups to continually improve member compliance rates for the HBD measure via multidisciplinary provider education, quarterly trainings, and ad hoc provider trainings.
    - **Action Description:** ACLA will identify and target providers with paneled members with diabetes to assist in improving their member compliance rates through diabetes compliance education, application access, real-time member data, and care gap resolution.
    - **Expected Outcome:** Increased member compliance, as evidenced by improved rates for HBD measures for quality-educated and VBC groups who selected HBD as a measurable outcome.
    - **Action Measurement:** The percentage of improvement shown for HBD measures for both quality-educated and VBC provider groups who selected HBD as a measurable outcome in 2023 compared to 2022.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2022 Medicaid QC 50th percentile or 2% decrease goal for HBD Poor Control, with a special focus on our members with diabetes who are most likely to experience health disparities by December 2023. Start Date: 1/1/2023 End Date: 12/31/2023***

- **Action Step:** ACLA will utilize program evaluation data to implement new pilot programs, continue and/or modify current programs, or discontinue programs.
- **Action Description:** Evaluated programs/interventions will include: ACLA Community Center access and Mobile Wellness units, with multi-departmental initiatives; Community Center Exercise Programs and cooking classes; Diabetic Retinopathy (DR) eye examinations at Wellness Center, with an educational component; HELS "We're Here for You" proactive member education campaign aimed at newly diagnosed African American and Spanish-speaking enrollees in rural areas; Make Every Calorie Count program (MECC); gym membership; fitness kit, for those whoqualify; Member Care Card Benefits; updated web content; member portal access; 24/7 Nurse Helpline; transportation program; automated reminder calls (call blasts); emergency room follow-up visits; educational mailings; member newsletter; social media posts and invitations; RROT working with high PICS population in Transition to Care; member mobile apps; diabetic text messaging campaign; voicemail messaging; Vheda Health for chronic disease monitoring; Heart Healthy program; Care Meals; ACLA Nutrition Pilot; PHM outreach to HbA1c >8%; faith-based organization presentations, Member Advisory Council; member surveys.
- **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2022 Medicaid QC 50th percentile or 2% decrease goal for HBD poor control measure for 2023.
- **Action Measurement:** The percentage decrease in HBD poor control measure rates in 2023 compared to 2022 and/or the 2022 Medicaid QC 50th percentile.

Diabetes Results 2023

Goal	Benchmark	Results
1	An increase in the percentage of diabetic member results received for 2023, compared to results received in 2022.	In 2022, there were 41874 CPT CAT II Codes billed. In 2023, there were 59756 CPT CAT II Codes billed, reflecting a 42.704% increase.
2	Improved rates for Glycemic Status Assessment for Patients with Diabetes (GSD) measures for providers participating in VBC who selected GSD measure(s) or quality-educated provider groups in 2023 compared to compliance in 2022.	Ten (10) value-based care (VBC) providers were identified by tax ID number (TIN) who chose HBD Control (HbA1c <8%) or HBD poor control (HbA1c >9%) as a measurable outcome. Eighty (80) quality-educated provider groups selected HBD poor control as a measureable outcome. HBD poor control (HbA1c >9%) rate in 2022 was 67.20%. HBD poor control (HbA1c >9%) rate in 2023 was 62.62%, showing improvement. (A lower rate is better for this measure.)

3	The 2022 Medicaid QC 50th percentile or 2% decrease for HBD measure HBA1c >9.0% in 2023.	ACLA achieved HEDIS Quality Compass 2022 Medicaid 75th percentile, 33.45% with a final rate of 33.09% in 2023. The plan's 2023 goal of a 2% annual decrease, 37.66%, was met. The 2023 LDH Goal QC 2022 Medicaid 50th percentile, 39.9%, was met.

Diabetes Goals 2024

- ***Goal 1: ACLA will increase provider use of CPT CAT II codes for member diabetic test results by December 2024, to identify necessary clinical data for closing gaps in care for members with diabetes to ensure members receive the best health care achievable. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** ACLA will analyze claims data to identify provider groups who have diabetic members attributed to their practice and will benefit from billing CPT CAT II codes.
    - **Action Description:** ACLA will outreach to engage providers in usage of CPT CAT II codes by sharing benefits of usage through multidisciplinary provider education, projects involving specialized file sharing with identified provider groups, comprehensive CPT CAT II Provider flyer for distribution (web posting), and quarterly provider alerts on incentives.
    - **Expected Outcome:** Increased number of diabetic results received for members linked to providers who submit CPT CAT II codes for member diabetic test results.
    - **Action Measurement:** The percentage of diabetic member results received for 2024, compared to results received in 2023.

- ***Goal 2: ACLA will increase member compliance for diabetic members linked to quality-educated provider groups, including VBC groups who selected GSD as a measurable outcome, by December 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Continue process for educating provider groups to continually improve member compliance rates for the GSD measure via multidisciplinary provider education, quarterly trainings, and ad hoc provider trainings.
    - **Action Description:** ACLA will identify and target providers with paneled diabetic members to assist in improving their member compliance rates through diabetes compliance education, application access, real-time member data, and care gap resolution.
    - **Expected Outcome:** Increased member compliance, as evidenced by improved rates for GSD measures for quality-educated and VBC groups who selected GSD as a measurable outcome.

- **Action Measurement:** The percentage of improvement shown for GSD measures for both quality-educated and VBC provider groups who selected GSD as a measurable outcome in 2024 compared to 2023.

- ***Goal 3: ACLA will meet and/or exceed the LDH goal of the 2023 Medicaid QC 50th percentile or 2% decrease goal for GSD >9.0% for 2024, with a special focus on our diabetic members who are most likely to experience health disparities by December 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** ACLA will utilize program evaluation data to implement new pilot programs, continue and/or modify current programs or discontinue programs.
  - **Action Description:** Evaluated programs/interventions will include: ACLA Community Center access and Mobile Wellness units (with multidepartmental initatives; Community Center Exercise Programs and cooking classes; DR eye examinations at Wellness Center, with an educational component; Wellness Center events in English and Spanish; members offered a translator for provider visits; MECC; gym membership; fitness kit, for those who qualify; Member Care Card Benefits; updated web content; member portal access; 24/7 Nurse Helpline; transportation program; automated reminder calls (call blasts); emergency room follow-up visits; educational mailings; member newsletter; social media posts and invitations; RROT working with high PICS population in Transition to Care; member mobile apps; diabetic text messaging campaign; voice messaging campaign; remote monitoring program for chronic disease monitoring; Heart Healthy program; Care Meals; PHM outreach to HbA1c >8; Faith-Based Organization presentations; Make Every Calorie Count program; Member Advisory Council; Member Surveys.
  - **Expected Outcome:** ACLA will meet and/or exceed the LDH goal of the 2023 Medicaid QC 50th percentile or 2% decrease goal for the measure GSD >9.0% for 2024.
  - **Action Measurement:** The percentage decrease in measure GSD >9.0% rates in 2024 compared to 2023 and/or the 2023 Medicaid QC 50th percentile.

Obesity Goals 2023

- ***Goal 1: ACLA will develop and implement programs to promote basic needs and healthy living initiatives for members with a diagnosis of obesity and other comorbid conditions. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** The target population will consist of ACLA members living in East Baton Rouge parish and surrounding parishes linked to specific provider groups.
  - **Action Description:** This program will aim to improve health outcomes for members, such as reduced blood pressure, BMI, and blood glucose levels, along with increased exercise, energy, and knowledge of disease self-management.
  - **Expected Outcome:** Engagement of at least 10% of the targeted population in the pilot program.
  - **Action Measurement:** The percentage of members engaged in the ACLA Nutrition pilot program by December 2023.

- ***Goal 2: ACLA will improve the health outcomes of members with obesity with comorbid conditions who are most likely to experience health disparities in 2023. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Focus on member populations with historic disparate health outcomes through the use of tailored programming to promote self-management of obesity and other comorbid conditions through early intervention.
    - **Action Description:** ACLA will determine effective ways to support equitable access for African American members with obesity, address social determinants of health (SDOH) where possible, and increase compliance with Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with obesity.
    - **Expected Outcome:** Increased engagement of African American members with obesity in ACLA's Make Every Calorie Count (MECC) program by December 2023.
    - **Action Measurement:** The percentage of African American members with a diagnosis of obesity engaged in the Make Every Calorie Count program by December 2023 compared to that of members engaged in 2022.

- ***Goal 3: ACLA will increase member engagement in its Population Health Management programs by December 2023 to reduce the impact of obesity by providing members who are obese with education including self-management, treatment, and benefits. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** ACLA will increase member awareness of Population Health Management programs designed to help members with obesity with comorbid conditions adopt a healthy lifestyle to achieve improved health outcomes.
    - **Action Description:** Several avenues will be utilized to increase member engagement, including provider education on ACLA's Population Health Management program referral process, enhanced member communication tailored specifically to members with obesity, and discussion of programs for members with obesity during Member Advisory Council and Provider Advisory Council meetings.
    - **Expected Outcome:** Increased engagement of members who are at high risk for obesity in ACLA's Population Health Management programs.
    - **Action Measurement:** The percentage of members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2023 compared to those engaged in 2022.

Obesity Results 2023

Goal	Benchmark	Results
1	At least 10% of targeted population engaged in ACLA Nutrition pilot program by December 2023.	ACLA fell short of the 10% engagement. We had 6% of the targeted population engaged and receiving deliveries in 2023 (8 of 141 targeted members).
2	An increase of at least 2% of African American members with obesity engaged in the	ACLA exceeded its goal with a 7% increase ofAfrican American obese members engaged in the Make Every Calorie Count program by December

	Make Every Calorie Count program by December 2023 compared to the number of members engaged by December 2023.	2023, with 229 members enrolled in 2023 compared to 214 members enrolled in 2022.
3	At least the same number of high-risk members engaged in a Population Health Management program with a primary or secondary diagnosis of obesity in 2023.	Members with diabetes and obesity engaged in case management in MY2022: Diabetes - 1,513; Obesity- 1452. Total eligible - 5,857; 50.6% engagement rate in 2022. Members with diabetes and obesity engaged in case management in MY2023: Diabetes- 1,077; Obesity- 1210; Total eligible- 4,698; 48.7% engagement rate in 2023. 2022 was 1.9 percentage points higher than 2023.

Obesity Goals 2024

- ***Goal 1: ACLA will develop and implement programs to promote basic needs and healthy living initiatives for members with a diagnosis of obesity and other comorbid conditions. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Target population will consist of ACLA members living in Orleans and Jefferson parishes linked to specific provider groups.
    - **Action Description:** This program will aim to improve health outcomes for members, such as reduced blood pressure, BMI, and blood glucose levels, along with increased exercise, energy, and knowledge of disease self-management.
    - **Expected Outcome:** Engagement of at least 10% of the targeted population in the pilot program.
    - **Action Measurement:** The percentage of members engaged in the ACLA Nutrition pilot program by December 2024.

- ***Goal 2: ACLA will improve the health outcomes of members with obesity with comorbid conditions who are most likely to experience health disparities in 2024. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Target member populations with historic disparate health outcomes through the use of tailored programming, with the purpose of promoting self-management of obesity and other comorbid conditions through early intervention.
    - **Action Description:** ACLA will determine effective ways to support equitable access for African American obese members assisted with identification by HELS/collaborative intervention to outreach, address social determinants of health (SDOH) where possible,

and increase compliance in Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with obesity.

- **Expected Outcome:** Increased engagement of obese African American members in ACLA's Make Every Calorie Count (MECC) program by December 2024.
- **Action Measurement:** The percentage of members with a diagnosis of obesity engaged in the Make Every Calorie Count program by December 2024 compared to that of members engaged by December 2023.

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

Appendix D3
Healthy Blue
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

- ***Goal 1: Improve year-over-year (YOY) HEDIS rates associated with diabetes by at least 2% and/or 50th percentile based on NCQA benchmark. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Expand provider outreach and education from the prior year.
    - **Action Description:** Increase collaboration between health plan and providers on programs and educational offerings available to improve documentation and coding, as well as gap in care reports, and practice consultants to improve overall HEDIS and Medicaid Quality Rating System rates.
    - **Expected Outcome:** Increased provider awareness of quality goals and metrics, coding and documentation requirements, and overall improved outcomes for Healthy Blue members.
    - **Action Measurement:** Improved year-over-year rates by 2% and/or 50th percentile for the following HEDIS measures: Hemoglobin A1c Control for Patients with Diabetes, Good Control <8% (HBD); Hemoglobin A1c Control for Patients with Diabetes, Poor Control >9% (HBD); Blood Pressure Control for Patients with Diabetes (BPD); Eye Exam for Patients with Diabetes (EED); Kidney Health Evaluation for Patients with Diabetes (KED); Statin Therapy for Patients with Diabetes, received therapy (SPD); Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD); Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).

- ***Goal 2: Improve Diabetes Preventative Care Practices with a focus on decreasing racial disparities. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Decrease Black/white disparity rate in diabetes control.
    - **Action Description:** Reach out to members and their attributed providers with uncontrolled diabetes using geographic and racial information;identify and increase engagement with providers who have a high number of Black patients with HbA1c >9%; monitor diabetes drug adherence, and target outreach to members with poor adherence.
    - **Expected Outcome:** Increased provid.er awareness of disparities and strategies to improve quality metrics and overall outcomes for the members we serve with an increased awareness of health equity.
    - **Action Measurement:** Increased percentage of Black members with HbA1c >9% engaged in case management programs and increased percentage of drug-adherent members

- ***Goal 3: Increase provider enrollment within value-based programs to improve diabetes outcomes for members served. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Increase provider engagement in value-based programs that align with diabetes outcomes.

- **Action Description:** Expand value-based offerings for providers that align with health plan strategy to improve outcomes overall.
- **Expected Outcome:** Increased provider enrollment will result in an increased number of members receiving diabetic care and improved outcomes related to diabetes.
- **Action Measurement:** Total number of providers enrolled in value-based programs aligned with diabetes measures.

Diabetes Results 2023

Goal	Benchmark	Results
1	HEDIS rates for HBD, BPD, EED, KED, SPD, SSD, and SMD	Hemoglobin A1c Control for Patients With Diabetes Good Control <8% (HBD) = 80.00% American Indian and Alaska Native, 53.70% Asian, 52.66% Black, 54.84% white Hemoglobin A1c Control for Patients With Diabetes Poor Control >9% (HBD) = 20.00% American Indian and Alaska Native, 35.19% Asian, 37.77% Black, 37.42% white Health plan educated providers regarding the importance of diabetes management and the measures specific to diabetes. Some of the below measures were also included in VBP programs to ensure emphasis was placed on showing quality improvement. MY23 HBD(<8%) had an 8% improvement with a final rate of 62.29%; MY23 HBD (>9%) had a 6.8% decrease (inverse measure which shows improvement) with a final rate of 30.66% BPD has an opportunity to work closely with providers and members to improve; MY23 BPD had 1% decrease with final rate of 63.50% EED - MY23 showed slight improvement with an increase of .24% with final rate of 55.47% KED - MY23 showed improvement of 1.43% with a final rate of 28.62% SPD - MY23 SPD-Received Statin Therapy decreased by 1% with final rate of 64.53%; Statin Adherence 80% decrease of 7.7% with a final rate of 50.45%; created a pathway to address this through Rx programs to help close this gap SSD - MY23 improvement of 2.23% with a final rate of 84.08% SMD - MY23 improvement of 5.25% with a final rate of 72.14%
2	Case management	The health plan had an increase of 24% Black members enrolled into Case Management related to HbA1c >9%.
3	Number of providers added to VBP	A total of 12 new VBP providers were added to focus on measures specific to diabetes for a total of 101 providers.

	and total VBP providers	

Diabetes Goals 2024

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

- ***Goal 2: Improve Diabetes Preventive Care Practices. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase the amount of members enrolled in case management with A1c > 9%
    - **Action Description:** Reach out to members and their attributed providers with uncontrolled diabetes using gap-in-care reports; identify and increase engagment with providers who have a high number of patients with A1c > 9%, monitor diabetes drug adherence; and target outreach to members with poor adherence.
    - **Expected Outcome:** Increase member and provider awareness of strategies to improve diabetes control and overall outcomes.
    - **Action Measurement:** Increase the percentage of members with an A1c > 9% engaged in case management programs.

- ***Goal 3: Increase the number of providers within VBP programs aligned to diabetes management. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Increase provider engagement in value-based programs that align with diabetes outcomes.
    - **Action Description:** Expand value-based offerings for providers that align with health plan strategy to improve outcomes overall.

- **Expected Outcome:** Increased provider enrollment will result in an increased number of members receiving diabetic care and improved outcomes related to diabetes.
- **Action Measurement:** Increase the total number of providers enrolled in value-based programs aligned with diabetes measures by adding an additional 15 providers.

Obesity Goals 2023

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

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

- ***Goal 3: Increase provider enrollment within value-based programs to prevent and manage obesity for Healthy Blue members. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Increase provider engagement in value-based programs that align with obesity and overall health plan strategy.
  - **Action Description:** Expand value-based offerings for providers that align with health plan strategy to improve outcomes overall.
  - **Expected Outcome:** Increased provider enrollment will result in improved outcomes related to obesity and physical health.
  - **Action Measurement:** Total number of providers enrolled in value-based programs that incorporate obesity and prevention measures.

Obesity Results 2023

Goal	Benchmark	Results
1	HEDIS rates for WCC	Ensured providers received the necessary materials regarding HEDIS documentation and coding for the WCC measure. Additional opportunity to provide education regarding BMI. BMI - MY23 .24% decrease with final rate of 76.89%. Emphasis is being put on closing the gap for this measure through provider education; Counseling for Nutrition -MY23 improvement of 1.7% with final rate of 64.23%; Counseling for physical activity - MY23 3.65% improvement with a final rate of 59.61%.
2	W30 and WCV rates	Campaigns were conducted for members to encourage the completion of well-child visits, as well as back-to-school events that encouraged the need to complete necessary screenings. W30: First 15 months - MY23 improvement of 4.24% with a final rate of 62.83%; W30: First 30 Months - MY23 improvement of 7.56% with a final rate of 70.09% WCV: MY23 improvement of 2.61% with a final rate of 48.13%
3	VBP providers added to program with focus on obesity	A total of 12 new VBP providers were added to focus on measures specific to obesity, for a total of 101 providers

Obesity Goals 2024

- ***Goal 1: Improve year-over-year HEDIS rates associated with obesity by 2% or greater and/or reach the 66.67th percentile NCQA benchmark for Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Expand provider outreach and education from the prior year.
    - **Action Description:** Increase collaboration between health plan and providers, as well as communities and schools, to provide programs and education on the need for physical activity and the appopriate documentation to improve obesity rates and HEDIS rates.
    - **Expected Outcome:** Increase provider awareness and education of quality metrics, appropriate documentation, and coding requirements, and provide member education on how to improve physical activity through strategic partnerships within the community.
    - **Action Measurement:** Review and monitor HEDIS rates for Weight Assessment and Counseling for Nutrition and Physical Activity for children/adolescents (WCC).

- ***Goal 2: Increase engagement in EPSDT screening and participation. Start Date: 1/1/2024 End Date: 12/31/2024***

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

- ***Goal 3: Increase provider enrollment within value-based programs to prevent and manage obesity for Healthy Blue members. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Increase provider engagement in value-based programs that align with obesity and overall health plan strategy.
  - **Action Description:** Expand value-based offerings for providers that align with health plan strategy to improve outcomes.
    - **Expected Outcome:** Increased provider enrollment will result in improved outcomes related to obesity and physical health. **Action Measurement:** Increase total number of providers enrolled in value-based programs that incorporate obesity and prevention measures with an additional 15 providers.

Appendix D4
Humana Healthy Horizons in Louisiana
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

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

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

- ***Goal 3: Increase utilization of Go365 incentives and value-added benefits (VAB) offered for diabetes care and management, for those members with diabetes, by 2% compared to baseline data (CY 2023). Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Educate and promote awareness for members with diabetes on the resources (i.e., Go365 incentives and value-added benefits) offered to assist with their care and management of diabetes.

- **Action Description:** Go365 member incentives for diabetes include $25 in rewards for completing a retinal eye exam and $50 in rewards for completing an annual diabetic screening. The VAB includes up to $25 per calendar month for over-the-counter (OTC) diabetes medications and supplies. Members are provided education on the Go365 incentives and value-added benefits with their new member welcome packets and new member welcome calls. Members are encouraged to download the Go365 app and the MyHumana app. Humana is also planning a text campaign to send to members educating them about the Go365 incentives and how to earn and redeem their rewards.
- **Expected Outcome:** Increase utilization by 2% of any of the Go365 incentives and/or VAB offered for members with diabetes.
- **Action Measurement:** Review and analyze the member usage reports for the Go 365 incentives and VAB and the Sharepoint site for the Go365 incentives.

Diabetes Results 2023

Goal	Benchmark	Results
1	The Medicaid HEDIS BI Suite, Gap in Care (GIC) Reports in Compass platform, and Provider Performance Rollup Reports	The baseline data includes January to June 2023 compared to January to June 2024. The GIC reports in Compass only show individual provider groups performance; therefore, we used the Medicaid HEDIS BI Suite, which displays the collective Louisiana Medicaid provider performance. For baseline data, the GSD poor control measure performance rate was 49.38% and the comparison timeframe measure performance rate was 49.97%. This shows a steady rate and does not indicate improvement towards our goal of ultimately achieving the NCQA 50th percentile. The plan did experience a change in the member mix from the implementation year (2023), as compared to Plan Year Two (2024). The initial membership allocated to the plan was intentionally less acute, as per LDH allocation strategy, to avoid disrupting care for members who were considered to have special healthcare needs. In Plan Year Two, the plan has seen a difference in membership related to open enrollment and the

		disenrollment of members, eligible through the Federal COVID-19 Public Health Emergency (COVID-19 PHE), related to the end of the COVID-19 PHE resulting in membership acuity increasing. This shift in membership may be impacting the data noted above. Since 2023 was our baseline measurement year, the 50th percentile target goal for MY2024 for GSD Poor Control is 37.96%, and as of August 2024 our performance rate is 44.23%. We will continue to identify and implement action steps to work towards achieving the NCQA 50th percentile target.
2	Guiding Care report for members engaged in CM and Ochsner RPM Pilot Program Enrollment Dashboard	Guiding Care reports for baseline data, January to June 2023, indicate that 11.35% of members in CM have a diagnosis of diabetes, and of those, 9.74% are actively engaged in a CM program related to treatment of their diabetes. For the baseline period, Humana was establishing community partnerships to increase digital engagement and differentiate ourselves in the community, by offering eligible members participation in the Ochsner RPM program. The program launched in March 2024. As Humana and Ochsner were in development establishing and testing connectivity in Program Year One, there is no enrollment data for 2023. For the comparison timeframe, January to June 2024, data indicate that 12.35% of members in CM have a diagnosis of diabetes, and of those, 8.68% are actively engaged in a CM program related to treatment of their diabetes. As of June 2024, 88 members are enrolled in the Ochsner RPM program, and 112 members enrolled as of September 2024. This data reflects an increase in either active CM and/or the

		Ochsner RPM program engagement, which shows improvement. Will continue to focus on increasing active CM member engagement and enrollment in the Ochsner RPM program.
3	Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits	For the baseline period of January to June 2023, data indicate: Go365 incentives utilization for members with diabetes - 11 distinct members complete diabetes health/A1c screening, and 4,143 distinct members had a diabetes CDC/retinal eye exam. 2,790 members downloaded the Go365 app. For the value-added benefits, 53 total pharmacy prescriptions were filled for diabetes medications and supplies. For the comparison timeframe January to June 2024, data indicate: Go365 incentives utilization for members with diabetes - 6,174 distinct members complete diabetes health/A1c screening, and 5,300 distinct members had a diabetes CDC/retinal eye exam. 4,420 members downloaded the Go365 app. For the value-added benefits, 143 total pharmacy prescriptions were filled for diabetes medications and supplies. This data reflects an improvement and increase of greater than 2% utilization of any of the Go365 healthy incentives and/or value-added benefits for members with diabetes.

Diabetes Goals 2024

- ***Goal 1: Improve the HEDIS GSD HbA1c Poor Control (> 9.0%) measure performance rate by July 2025 to ultimately achieve the NCQA 50th percentile, compared to baseline data July 2024, for members 18 to 75 years of age with diabetes. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Review the Gap in Care (GIC) report for the GSD Poor Control measure performance rate in Compass with individual provider groups during our recurring meetings. Share best practices for closing care gaps, resources; identify any barriers providers are having, and assist them with closing care gaps. Request a feature in

Compass for a dashboard to show month-over-month measure peformance rates to track and trend results to share with the providers. Upload monthly Provider Performance Rollup report in Availity for providers to access, and the quality team liasions will review the report results during our recurring provider group meetings. Monitor GSD Poor Control measure performance rate trends in the Medicaid HEDIS BI suite. Send a Go365 Diabetic Member Preventive Care Marketing Campaign to members via multiple modalities that includes information about screenings for A1c, diabetic eye exam, blood pressure, and kidney health. Planning and initial development is underway to include care gap alerts in Guiding Care for diabetic members to engage them in CM.

- **Action Description:** The Gap in Care report will help the providers identify those members with diabetes whose HbA1c is >9.0%, so they may conduct member outreach to schedule an appointment for their diabetes monitoring and routine testing.
- **Expected Outcome:** Improve the HEDIS GSD HbA1c Poor Control (> 9.0%) measure performance rate (a lower rate indicates better performance for HbA1c Poor Control).
- **Action Measurement:** Review and track provider performance rates in Compass. Analyze GSD Poor Control measure performance rate in the Medicaid HEDIS BI suite. Evaluate member response results from the Go365 Diabetic Preventive Care Marketing Campaign. Monitor the status of implementing care gap alerts in Guiding Care, and if successfully implemented, request a report to determine if those members engaged in a CM program related to treatment of their diabetes.

- ***Goal 2: Increase the number of members with diabetes enrolled in disease management and/or care management programs, by 2% compared to baseline data (CY 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Increase outreach efforts to members with diabetes to enroll in the Ochsner Digital Medicine Remote Patient Monitoring (RPM) Pilot Project and/or Humana care management (CM) program.
  - **Action Description:** The Ochsner RPM program will enroll up to 1,000 members with Type 2 diabetes, and they will receive a glucometer, diabetic testing supplies, and personalized care plans from licensed clinicians, as well aslifestyle support from professional health coaches from their Smartphones. Case managers will continue outreach to members with Type 2 diabetes to enroll in CM program.
  - **Expected Outcome:** Increase members with diabetes enrollment, by 2%, in either the Ochsner RPM program and/or active CM.
  - **Action Measurement:** Reports from the Ochsner RPM program to track member enrollment and reports from Guiding Care to track members with diabetes who are actively engaged in CM.

- ***Goal 3: Increase member utilization of Go365 incentives and value-added benefits (VAB) offered for diabetes care and management, for those members with diabetes, by 2% compared to baseline data (CY 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate and promote awareness for diabetic members on the resources (i.e., Go365 incentives and value-added benefits) offered to assist with their care and management of diabetes.

- **Action Description:** Go365 member incentives for diabetes include a $20 in rewards for completing an annual diabetic screening and $25 in rewards for completing a retinal eye exam. The VAB include up to $25 per calendar month for OTC diabetes medications and supplies. Members are provided education on the Go365 incentives and value-added benefits with their new member welcome packets and new member welcome call. Members are encouraged to download the Go365 app and the MyHumana app. Humana is also planning a text campaign to send to members educating them about the Go365 incentives andhow to earn and redeem their rewards.
- **Expected Outcome:** Increase utilization by 2% of any of the Go365 incentives and/or VAB offered for members with diabetes.
- **Action Measurement:** Review and analyze the Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits.

Obesity Goals 2023

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

- ***Goal 2: Improve HEDIS measure (WCC) performance rate to ultimately achieve the NCQA 50th percentile, compared to baseline data (CY 2023), for members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN during the MY, and who had evidence of BMI percentile documentation and counseling for both nutrition and physical activity. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Provide a Gap in Care report to providers for their members diagnosed with obesity during the calendar year who do not have evidence of BMI percentile documentation and counseling for both nutrition and physical activity (WCC).

- **Action Description:** The Gap in Care report will help the providers identify those members with obesity and no evidence of their weight assessment and counseling, so they may conduct member outreach to schedule an appointment for their BMI monitoring and provide counseling for nutrition and physical activity.
- **Expected Outcome:** Improve HEDIS measure (WCC) performance rate for Weight Assessment (BMI) and Counseling for Nutrition and Physical Activity for Children/Adolescents.
- **Action Measurement:** Gap in Care reports accessed by providers via the Compass platform. When we meet with providers, will gauge their knowledge and verify their use of Compass to access their Gap in Care reports.

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

Obesity Results 2023

Goal	Benchmark	Results
1	Quickbase report for Community Event tracking and the Humana website KidsHealth content education links.	27 events held in Regions 1, 2, 3, 4, 7, and 9, with a focus on nutrition education and physical activity through community partnerships with the Boys and Girls Club, American Heart Association, Pennington Biomedical, LSUAg, SUAg, Love Our Schools, Office of Minority Health, Well Ahead

		Louisiana, YMCA, BREC, NORD, and CHNOLA. Nineteen events held in Regions 1, 2, 3, 4, 5, 7, and 9 with a focus on obesity/diabetes through community partnerships with the American Diabetes Association, Pennington Biomedical, Ochsner and FMOL. Seven events held in Regions 1, 2, 3, 7, and 9, with a focus on food insecurity through community partnerships with the Three O'Clock Project, Second Harvest Food Bank, and Food Bank of Greater Baton Rouge. These events also included SBHCs offering physicals with BMI screening; healthy cooking demonstrations; health education on a wide variety of topics related to diabetes and/or obesity and geared towards expectant and new parents during pregnancy and the postpartum period; farmers' markets with fresh produce and health screenings; pop-up grocery markets; basketball camp; and offering healthy meals and snacks to summer camps. There are several new community-based projects in the proposal development phase. The Humana Website Kids Health Education utilization data: Access by group - 52.3% by parents, 34.21% by teens, 12.73% by kids. 11,189 – page sessions (directed outside of Humana website), 14,176 – page views (directed via Humana website). The top article: Learning about calories – for kids. The number of community events that were held, and various topics related to obesity and diabetes, show ongoing community engagement support as HHH continues to offer community grants and expand partnerships around Louisiana to host regular health and resources events to

		help bring access, provide nutrition education, and help promote physical activity and improved overall health. The KidsHealth educational content is consistently reviewed to ensure relevant articles and videos are offered and the utilization data shows an increase in access among parents, children, and adolescents.
2	The Medicaid HEDIS BI Suite, and Gap in Care (GIC) reports in Compass platform.	The baseline timeframe was January to July 2023 compared to January to July 2024. The GIC reports in Compass only show individual provider groups performance; therefore, we used the Medicaid HEDIS BI Suite, which displays the collective Louisiana Medicaid provider performance. As of baseline July 2023, the WCC BMI percentile measure performance rate was 31.51%, the WCC Counseling for Nutrition was 15.70%, and the WCC Counseling for Physical Activity was 14.36%. For comparison July 2024, the WCC BMI percentile measure performance rate was 34.30%, the WCC Counseling for Nutrition was 20.35% and the WCC Counseling for Physical Activity was 18.43%. This shows an improvement in overall measure performance from baseline data to the comparison timeframe, although still short of achieving the benchmark NCQA 50th percentile.
3	Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits.	For the baseline period of January to June 2023 data indicate: Go365 incentives/rewards member utilization- 12,659 distinct members completed an adolescent annual wellness visit, 7683 distinct members completed a annual well baby visit, and 2,475 distinct members completed an annual early child wellness visit, all of which include a BMI assessment. For the value-added

		benefits, 26 members participated in the Weight Management Program and received the initial reward. 411 members had a one-year gym membership at a participating YMCA. 2,790 downloaded the Go365 app. For the comparison timeframe January to June 2024 data indicate: Go365 incentives/rewards member utilization- 21,087 distinct members completed an annual wellness visit, 9,708 distinct members completed a annual well baby visit, and 2,685 distinct members completed an annual early child wellness visit. For the value-added benefits, 79 members participated in the Weight Management Program and received the initial reward, and nine members completed the Weight Management Program and received the final reward. 507 members had a one-year gym membership at a participating YMCA. 4,420 members downloaded the Go365 App. This data reflects an improvement and increase of greater than 2% utilization of any of the Go365 healthy incentives and/or value-added benefits for members with a diagnosis of obesity or members to prevent obesity.

Obesity Goals 2024

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

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

- **Action Description:** The Gap in Care report will help the providers identify those members who are noncompliant with the measure, so they may conduct member outreach to schedule an appointment for their BMI monitoring and provide counseling for nutrition and physical activity.
- **Expected Outcome:** Improve the HEDIS WCC measure performance rate to ultimately achieve the NCQA 50th percentile.
- **Action Measurement:** Review and track provider performance rates in Compass. Analyze WCC measure performance rate in the HEDIS BI suite.

- ***Goal 2: Continue to offer community grants, community engagement, and expanded partnerships around Louisiana that will provide nutrition education, help promote physical activity, and improve overall health to prevent and combat obesity. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Continue to work with community outreach to identify where they are hosting events and ensure that there is education about obesity, healthy eating, and physical activity available at those events.
  - **Action Description:** In support of the Louisiana Healthy Child Task Force, Humana has partnered with various organizations across Louisiana including: the Boys and Girls Club of Metro Louisiana; American Heart Association; Healthy BR; Healthy Start; Eat, Move, Grow; Three O'Clock Project; and Tensas Healthy Communities Coalition to provide nutrition education; access to healthy, nutritious food, and physical activity to adolescents and children. There are also KidsHealth education links available on the HHH website that offer educational videos and articles. In addition, the community engagement team hosts regular health and resources events to help bring access, promote healthy habits, and identify resources in local communities.
  - **Expected Outcome:** Members will increase their knowledge about obesity, healthy eating, and physical activity, and increase awareness of value-added benefits and community partnerships that provide resource and safe physical activity to participants.
  - **Action Measurement:** Use Quickbase internal reports to track the number of community events hosted.

- ***Goal 3: Increase utilization of Go365 incentives and value-added benefits (VABs), offered for members with a diagnosis of obesity, by 2% compared to baseline data (CY 2024). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate and promote awareness for members with obesity on the resources (i.e., Go365 incentives and value-added benefits) offered to assist with their care and management of obesity.
  - **Action Description:** Go365 member incentives for obesity include up to $50 in rewards for participating in the Weight Management Program, and $25 in rewards for completing

one annual wellness child visit that includes a BMI assessment. The VAB includes a free one-year gym membership at a participating YMCA and adolescent members are eligible for one annual sports physical that includes an assessment of height and weight. Members are provided education on the Go365 incentives and value-added benefits with their new member welcome packets and new member welcome call. Members are encouraged to download the Go365 App and the MyHumana App. Humana is also planning a text campaign to send to members educating them about the Go365 incentives and how to earn and redeem their rewards.

- **Expected Outcome:** Increase utilization by 2% of any of the Go365 incentives and/or VAB offered for members with obesity.
- **Action Measurement:** Review and analyze the Power BI Dashboard and member utilization reports for the Go365 incentives and value-added benefits.

Appendix D5

Louisiana Healthcare Connections
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

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

- ***Goal 2: Optimize member risk identification in targeted areas for referral and linkage to clinical partner organizations for diabetes preventive care and engagement. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Identify members through health risk assessments and claims analysis who may benefit from referral to local community and clinical partner programs in targeted areas supporting diabetes preventive care and self-management resources.
    - **Action Description:** Member referral to Pennington Biomedical Research Center's education and wraparound supports to improve member awareness of disease process, impact of food intake and physical activity, and lifestyle modification.
    - **Expected Outcome:** Increase member referrals to Pennington's diabetes treatment program, which helps people to lose weight and develop long-term lifestyle changes through in-person sessions, meal replacement/calorie control, and medication management when clinically indicated.
    - **Action Measurement:** Outcomes will be reflected by increased member referrals to Pennington's diabetes program from the prior year.

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

Diabetes Results 2023

Goal	Benchmark	Results
1	2% improvement over prior year performance for Diabetes Care HEDIS measures	LHCC demonstrated improvements in 2023 Diabetes Care HEDIS measures, exceeding established goals for the following: Hemoglobin A1c Control for Patients With Diabetes: - HbA1C Control < 8.0% : 61.56%, >2% improvement over prior year rate 44.77% (+16.79) and exceeding national 50th percentile rate of 52.31% - HbA1C Poor Control* > 9.0%: 31.63%, >2% improvement over prior year rate of 45.99% (-14.36) and exceeding national 50th percentile rate of 37.96% *lower is better - BP control (<140/90 mm Hg): 63.02%, >2% improvement over prior year rate of 50.61% (+12.41)
2	Increase in member referrals to Pennington's Diabetes program	LHCC achieved goal of increasing referrals to Pennington's Diabetes Program Management Program. In 2023, 44 members with diabetes risk identified on Health Risk Assessments (HRAs) were successfully enrolled out of 160 referrals received. (For 2022- 101 referred and 26 enrolled)

3	2% improvement over prior year performance for EED HEDIS measures	LHCC demonstrated improvement in 2023 Eye Exam for Patients With Diabetes: EED: 59.37%, >2% improvement over prior year rate of 53.04% (+6.33) and exceeding the national 50th percentile rate of 52.31%

Diabetes Goals 2024

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

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

- ***Goal 3: Increase member engagement in recommended diabetes screenings and self-care activities, as demonstrated by an improvement in related diabetes HEDIS measures. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Promote member and provider engagement in diabetes management through outreach, education, and incentives for completing recommended diabetes screenings/testing.
    - **Action Description:** Provide member and provider outreach using a variety of approaches (mailers, direct calls, community screening events, in-person visits, webinars, incentives, etc.) to encourage participation in diabetes screenings and testing to improve outcomes and prevent diabetes complications.
    - **Expected Outcome:** Improvement in clinical measure of diabetes control as evidenced by improvement in selected HEDIS performance measures associated with diabetes.
    - **Action Measurement:** Improvement in the following HEDIS diabetes measures by 2% over prior year:
        - Hemoglobin A1c Control for Patients With Diabetes:
        - HbA1C Control < 8.0%
        - HbA1C Poor Control > 9.0%
        - Eye Exam for Patients With Diabetes
        - BP control (<140/90 mm Hg)

Obesity Goals 2023

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

- ***Goal 2: Improve HEDIS outcomes for pediatric obesity-related measures (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents), BMI percentile, Counseling for Nutrition, and Counseling for Physical Activity by at least 2% over the prior year. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Increase provider engagement and awareness of obesity-related programs, resources, and HEDIS improvement opportunities.
    - **Action Description:** Offer and promote EPSDT support and resources to providers for increased focus on pediatric obesity intervention, improved capture of clinical documentation to support clinical efforts, highlighting HEDIS/WCC practices, and communicating care gap opportunities for a collaborative approach to improving member outcomes.
    - **Expected Outcome:** Improvement in member obesity-related outcomes, as evidenced by improvement in selected HEDIS CDC performance metrics year-over-year.
    - **Action Measurement:** LHCC will improve HEDIS outcomes for pediatric obesity-related measures (WCC) by 2% over the prior year or meeting/exceeding the national 50th percentile in the following measures: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI percentile, Counseling for Nutrition, Counseling for Physical Activity.

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

Obesity Results 2023

Goal	Benchmark	Results
1	Annual Enrollments in Weight (lifestyle) Management Programs > 80%	LHCC achieved goal of increasing referrals to the Weight (lifestyle) Management Program. In 2023, 384 members with obesity were successfully enrolled, representing a 9.4 % increase over prior year. (351 enrollments in 2022)
2	NCQA Quality Compass 50th percentile or 2% improvement over prior year performance for WCC measure	LHCC demonstrated improvements in 2023 for Pediatric Obesity-related measures (WCC), exceeding established goals for the following: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: - BMI percentile: 81.5%, >2% improvement over prior year rate of 60.58% (+20.92) and exceeding the national 50th percentile rate of 79.56% - Counseling for Nutrition: 70.56%, > 2% improvement over prior year rate of 57.18% (+13.38) and meeting the national 50th percentile rate of 70.56% - Counseling for Physical Activity: 59.12%, >2% improvement over prior year rate of 51.58% (+7.54)
3	Member and Community Engagement/Participation at LHCC sponsored events/programs, SNAP Benefit Investments, and Community Coalition Events	Nutrition Education -LHCC continued its partnership with LSU Ag Center SNAP-Ed and EFNEP program to produce quick and easy dollar-store recipes to help Medicaid families make healthier food choices. In 2023, focused on diabetic-friendly and heart-healthy meals, producing 10 additional videos (in total, 28 over the five-year partnership) that received over 23,854 YouTube views cumulatively. Pennington Diabetes Clinic research -14,841 mail and email outreaches to members living in or near Baton Rouge

		who were likely to meet criteria for participation in the clinic program. Social media related to diabetes/obesity -In 2023, our diabetes and obesity social media messaging reached a total of 15,065 individuals, with a significant highlight being our targeted campaign in March for National Nutrition Month, which alone engaged 7,023 people. This campaign focused on reversing prediabetes through healthy eating and exercise, while also promoting the importance of diabetic screenings. SNAP Match -As SNAP match programs transitioned to a new statewide Greaux the Good SNAP program in 2023, LHCC invested over $92,000 in nutrition, diabetes, and obesity-related community events and services, including farmers' markets, food banks, community organizations, and schools. Community Events related to diabetes or obesity -17 events -2,740 participants

Obesity Goals 2024

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

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

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

Appendix D6
UnitedHealthcare of Louisiana
2023 Diabetes and Obesity Action Plan

Diabetes Goals 2023

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2 percentage points year-over-year (YOY). Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Increase the use of HRAs for new members.
    - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
    - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by at least 2 percentage points YOY. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
    - **Action Description:** Utilize the Healthy First Steps program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
    - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- ***Goal 3: Increase engagement with providers by at least 3 percentage points year-over-year, to ensure familiarity with current clinical practice guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) measurements. Start Date: 1/1/2023 End Date: 12/31/2023***
    - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results. Educate members in understanding their HbA1c and the need to complete HbA1c and eye exams.
    - **Action Description:** Clinical consultants engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan shares information about evidence-based guidelines tailored to the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, Population Health Consultants (PHCs), along with members of the leadership team, in some cases, distribute provider scorecards that indicate whether the

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

- **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS (HBD) Hemoglobin A1c control for patients with diabetes and EED eye exam for patients with diabetes rate and to see an upward trend in the monthly rates.
- **Action Measurement:** Increase engagement with providers by at least 2 percentage points year-over-year to ensure familiarity with current clinical practice guidelines and HEDIS measurements.

Diabetes Results 2023

Goals	Benchmark	2019 Results
1	Completed HRAs	2022 HRA's completed: 15,780 members reached. 2023 HRA's completed: 6,075. The decrease in HRA's completed was attributed to the member redistribution and redetermination that occurred during this calendar year, which correlates with the decrease in overall membership.
2	Case management referral of identified and qualified pregnant members	2022- 16,107 members were identified and of those 14,124 qualified. 2023- 17,943 members were identified and 15,676 qualified.
3	EED and HBD rates	2022 - EED eye exams 55.72% HBD (Comprehensive Diabetes Care HbA1c<8%) 57.91% 2023 - EED 54.74% HBD (Comprehenisve Diabetes Care HbA1c<8) 70.07%

Diabetes Goals 2024

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by at least 2 percentage points year-over-year (YOY). Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Increase the number of members partcipating in and completing their HRAs.
  - **Action Description:** Deploying Health Assessment and Reearch Communities (HARC) and case management to conduct HRA's for new members within 90 days of enrolling and for

those beyond 90 days who need to close their assessment gaps focusing on diabetes. Additionally, UHC increased the Health Needs Assessments (HNA) rewards to incentivize partcipation.

- **Expected Outcome:** The expected outcome should show an increase in the number of members completing their HRAs.
- **Action Measurement:** The indicators used to measure this goal include telephonic outreach, increased incentives, targeted engagement, and comprehensive communication.

- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by at least 2 percentage points year-over-year. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
  - **Action Description:** Utilize the Healthy First Steps® program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
  - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
  - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- ***Goal 3: Increase engagement with providers by at least 3 percentage points year over year, to ensure familiarity with current clinical practice guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) measurements. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate providers on current HEDIS standards, and use outcomes to focus on the initiatives and results. Educate members in understanding their HbA1c and need to complete HbA1c and eye exams.
  - **Action Description:** Clinical consultants engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team, in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS measure targets. The HEDIS guidelines and tip sheets are also distributed by clinical consultants to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the clinical consultants educate providers on the importance of A1c (estimated average glucose) testing, retinal eye exams, and blood pressure control. In the case of retinal exams, clinical consultants ensure the providers are aware of the vision vendor MARCH® Vision Care. Qualified Providers are incentivized through our CP-PCPi Program for members with good HbA1c control < or = 9.

- **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS (HBD) HbA1C control for patients with diabetes and (EED) eye exam for patients with diabetes rate and to see an upward trend in the monthly rates.
- **Action Measurement:** Increase engagement with providers by at least 2 percentage points year-over-year, to ensure familiarity with current clinical practice guidelines and HEDIS measurements.

Obesity Goals 2023

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% year-over-year. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Educate members using weight management education materials.
  - **Action Description:** Members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended dietary intake, monitoring, and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
  - **Expected Outcome:** The expected outcome is to see an improvement in the number of members sent weight management education materials.
  - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and reports.

- ***Goal 2: Facilitate healthy lifestyles early in life by targeting children and adolescents on the importance of appropriate EPSDT screenings with a 2% increase year over year. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Send monthly preventive letters to all eligible and new members to educate and convey the importance of receiving/scheduling appropriate screenings/well visits. Continue Weight Watchers vouchers.
  - **Action Description:** Our EPSDT coordinator continues to work with providers on current EPDST recommendations using toolkits. Live agents make outbound calls to members and assist them with appointment scheduling through a three-way call with clinic scheduling staff. Weight Watchers is available to all enrollees as a value-added benefit.
  - **Expected Outcome:** The expected outcome is an improvement in the number of members contacted to educate on healthy nutrition and lifestyle.
  - **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and the UHC database/report.

- ***Goal 3: Increase engagement with providers by 2% year-over-year to ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2023 End Date: 12/31/2023***
  - **Action Step:** Educate providers by distributing resources including obesity toolkits.

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

Obesity Results 2023

Goal	Benchmark	Results
1	Mailings/emails sent to members	2022 # of mailings/ emails sent to members - 25,647 2023 # of mailings/emails sent to members - 28,668
2	Distributed Weight Watchers vouchers	2022: Weight Watchers vouchers were distributed and continued to be offered 2023: 20 Weight Watchers vouchers were distributed and UHC participated in approximately 87 events attracting an estimated 21,844 attendees. These events focused on obesity, nutrition, and chronic disease prevention.
3	WCC rate	2022 WCC BMI percentile 83.21% 2023 WCC BMI percentile 83.21%

Obesity Goals 2024

- ***Goal 1: Increase member awareness of healthy lifestyles by 2% year-over-year. Start Date: 1/1/2024 End Date: 12/31/2024***
  - **Action Step:** Educate members using weight management education materials.
  - **Action Description:** Members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended dietary intake, monitoring, and self-care. Materials are designed to

empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
    - **Expected Outcome:** The expected outcome is an improvement in the number of members sent weight management education materials.
    - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and reports.

- ***Goal 2: Facilitate healthy lifestyles early in life by targeting children and adolescents on the importance of appropriate EPSDT screenings with a 2% increase year-over-year. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Send monthly preventive letters to all eligible and new members to educate and convey the importance of receiving/scheduling appropriate screenings/well visits. Continue Weight Watchers vouchers.
    - **Action Description:** Our EPSDT coordinator continues to work with providers on current EPDST recommendations using toolkits. Live agents make outbound calls to members and assist them with appointment scheduling through a three-way call with clinic scheduling staff. Weight Watchers is available to all enrollees as a value-added benefit.
    - **Expected Outcome:** The expected outcome is an improvement in the number of members contacted to educate on healthy nutrition and lifestyle.
    - **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and the UHC database/report.

- ***Goal 3: Increase engagement with providers by 2% year-over-yearto ensure familiarity with current clinical practice guidelines and HEDIS measurement. Start Date: 1/1/2024 End Date: 12/31/2024***
    - **Action Step:** Educate providers by distributing resources, including obesity toolkits.
    - **Action Description:** Consultants engage in educating providers about HEDIS. Consultants distribute HEDIS guidelines, and HEDIS tips sheets to providers. Diabetes and obesity toolkits are also distributed to providers.
    - **Expected Outcome:** The expected outcomes are an increase in the number of providers educated, an improvement in the final measurement year WCC percentile rate, and an upward trend in the monthly rate.

Action Measurement: The indicators used to measure this goal include information in the UHC database, information in claims/encounter data, and medical/treatment record abstractio

Appendix E – Standards of Diabetes Care

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

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

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

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