Diabetes and Obesity Report for the Medicaid Managed Care Program

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

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

This report is submitted pursuant to Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2019 paid healthcare claims submitted by each of the five Medicaid managed care organizations (MCOs) to Louisiana Medicaid, and represent the Louisiana Medicaid managed care population only.

Below are some highlights from this year's report:

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity* 2020 report, Louisiana was ranked ninth highest in the nation with an adult obesity rate of 35.9%.[1] The following obesity summary was based on 2019 MCO claims data:
    - In 2019, 54,741 Medicaid managed care enrollees under the age of 18 years had an obesity diagnosis. This is 7.07% of the managed care child population. Additionally, 12.20% of adult enrollees 18 years of age or older (99,654 enrollees) had an obesity diagnosis in 2019. The overall obesity prevalence was 10.09% of the total managed care population of 1,529,768 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 2019 for Medicaid managed care enrollees diagnosed with obesity (at any time in 2019) was 21.14% of the total paid for medical and pharmacy services delivered to the Medicaid managed care population in 2019.

- Louisiana was also ranked ninth highest in the nation for adult diabetes in 2019 with a rate of 12.6%.[2] The following diabetes summary was based on 2019 MCO claims data:
    - In 2019, 9.09% (74,440 enrollees) of the adult Medicaid managed care population had a diabetes diagnosis. The prevalence of diabetes in children in the managed care population was 0.27% (1,952 enrollees). The total managed care population (1,529,768 enrollees) had a diabetes prevalence of 4.99% (76,392). See Appendix C for a breakdown of diabetes prevalence by Louisiana Medicaid region, parish and age group.
    - Adult Medicaid managed care enrollees with diabetes during 2019 were associated with 25.42% of the adult total managed care paid claims with dates of service in 2019.
    - Of the 179,299 inpatient discharges in 2019, 2.89% (5,173 discharges) had a primary diagnosis of diabetes. There were 1,392,435 emergency department visits in 2019 and 2.60% (36,204) had a primary diagnosis of diabetes.
    - The average cost per enrollee with diabetes in 2019 was $3,918.90.

[1] *The State of Obesity: Better Policies for a Healthier America 2020.* (September 2020). Retrieved December 16, 2020 from https://www.tfah.org/wp-content/uploads/2020/09/TFAHObesityReport_20.pdf
[2] Ibid.

1 Introduction

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

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

1.1 Report Methodology

1.1.1 Data Sources

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

1.1.2 Improvements

Changes were made in the production of the 2021 Act 210 *Diabetes and Obesity Report*. To improve efficiency and consistency, the data are now extracted from the Louisiana Medicaid Administrative Reporting Subsystem (MARS) rather than aggregating summarized data received separately from each of the five MCOs. This modification streamlines data validation and allows prevalence rates to be calculated and reported by Louisiana Medicaid regions, races and age groups. Finally, to improve consistency of the Diabetes and Obesity Action Plans submitted by the five MCOs, a standardized reporting template was developed and utilized.

1.2 Obesity Overview

1.2.1 National Prevalence

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

1.2.2 What is Obesity?

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

[3] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer-and service-specific estimates. Health Aff (Millwood). 2009 Sep-Oct;28(5):w822-31. doi: 10.1377/hlthaff.28.5.w822. Epub 2009 Jul 27. PMID: 19635784. Retrieved December 17, 2020 from https://pubmed.ncbi.nlm.nih.gov/19635784/

[4] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018. NCHS data brief, no 360 Hyattsville, MD: National Center for Health Statistics. 2020. Retrieved December 16, 2020 from https://www.cdc.gov/nchs/data/databriefs/db360-h.pdf

[5] *Adult Obesity Causes and Consequences* (September 2020). Retrieved December 16, 2020 from https://www.cdc.gov/obesity/adult/causes.html

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

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

1.3 Diabetes Overview

1.3.1 National Prevalence

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

1.3.2 What is Diabetes?

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

1.3.3 Types of Diabetes

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

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

Gestational diabetes is a type of diabetes that is first seen in pregnant women who did not have diabetes before being pregnant.[14] The risk factors for gestational diabetes are similar to those for Type 2 diabetes.[15] Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger

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

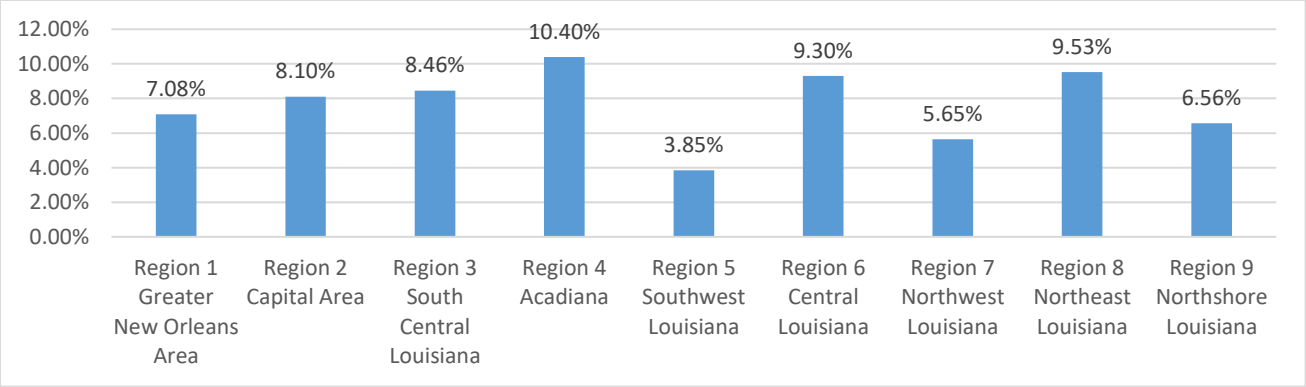
babies requiring cesarean sections, preeclampsia, and increased risk of Type 2 diabetes for both the mother and the child later in life. Often, gestational diabetes can be controlled through eating healthy foods and regular exercise. Sometimes a woman with gestational diabetes must also take insulin.[16]

2 The Scope of Obesity in the Medicaid Managed Care Program

The *State of Obesity* published by the Trust for America's Health and the Robert Wood Johnson Foundation reports that Louisiana's adult obesity rate was 35.9% in 2019, which is the ninth highest adult obesity rate in the United States.[17] Given our reported obesity rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data and yields an artificially low prevalence rate when exclusively using Louisiana Medicaid medical claims data to calculate the rate.

In this report, Medicaid managed care enrollees with obesity were identified by medical claims with dates of service in 2019 that included a primary or secondary diagnosis of obesity. Based on 2019 claims data, the managed care overall obesity prevalence rate was 10.09% of 1,529,768 MCO enrollees. Figure 2.1 shows that Louisiana Medicaid Region 4 had the highest child obesity prevalence rate (10.40%), followed closely by Louisiana Medicaid Region 8 (9.53%). The adult obesity prevalence rate was the highest for Louisiana Medicaid Region 4 at 15.80% and was again followed closely by Louisiana Medicaid Region 8 at 14.90% (Figure 2.2). When the data were stratified by age, gender and race, the highest prevalence rates were found in adult females. The female adult obesity prevalence rate by race was 17.40% African-American, 16.03% Other race, and 11.65% White (Figure 2.3). The remaining age, gender and race strata had obesity prevalence rates below 9.10%. For parish level obesity prevalence rates please see Appendix B.

Figure 2.1: Medicaid Managed Care Child Obesity Prevalence in 2019 by Medicaid Regions Age < 18 Years



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

[17] *The State of Obesity in Louisiana*. (September 2019). Retrieved December 7, 2020 from https://www.tfah.org/wp-content/uploads/2020/09/TFAHObesityReport_20.pdf

Figure 2.2: Medicaid Managed Care Adult Obesity Prevalence in 2019 by Medicaid Regions Age ≥ 18 Years

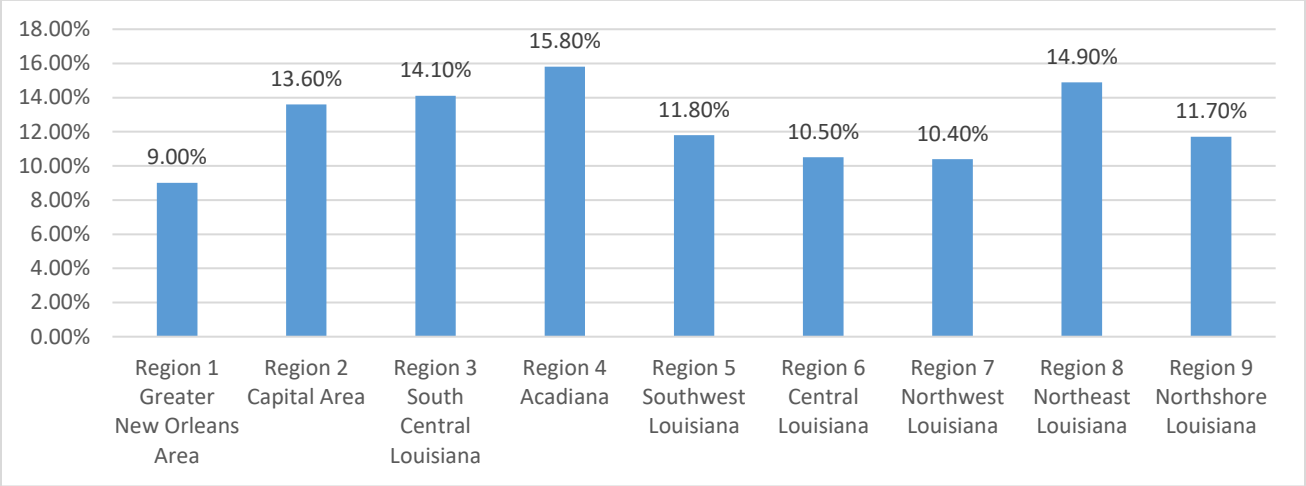
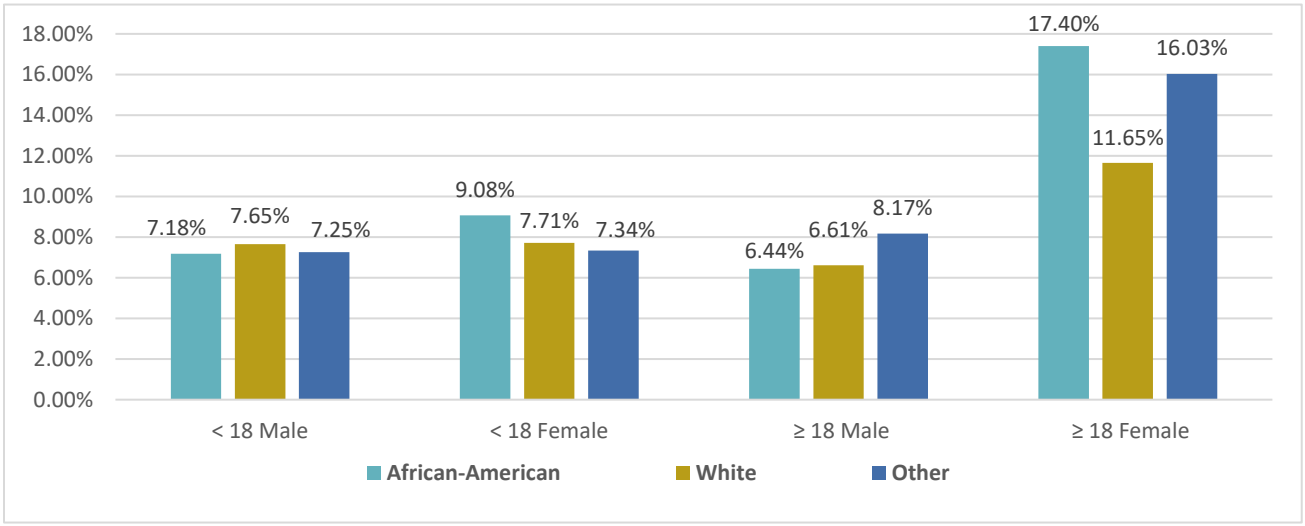


Figure 2.3: Medicaid Managed Care Obesity Prevalence in 2019 by Age Group, Gender and Race



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 2019 associated with Medicaid managed care enrollees with and without obesity. All paid claims for enrollees were included and categorized by age and obesity status.

The overall prevalence of obesity in the Medicaid managed care population is 10.09%. Healthcare claim costs for these enrollees totaled $1,220,940,040 in 2019, which accounts for 21.14% of the total MCO claims payments ($5,775,532,166). In other words, of the entire Medicaid managed care population, the 10.09% who have a diagnosis of obesity account for 21.14% of the total healthcare claim costs.

Table 2.1: Total Cost of Obesity in 2019 Among Medicaid Managed Care Enrollees by Claim Type, Age Group and Obesity Category

Claim Type	Total Cost: Children Diagnosed with Obesity*	Total Cost: Non-Obese Children	Total Cost: Adults Diagnosed with Obesity **	Total Cost: Non-Obese Adults	Percent of Total Costs Associated with Enrollees Diagnosed with Obesity
Medical	$125,106,260	$1,166,639,004	$739,347,321	$2,125,405,578	20.80%
Pharmacy	$31,709,783	$228,094,813	$309,123,396	$911,010,866	23.03%
Other***	$11,858,194	$102,153,728	$3,795,086	$21,288,137	11.25%
Total	$168,674,237	$1,496,887,545	$1,052,265,803	$3,057,704,581	21.14%

*Includes claims, with dates of service in 2019, for any child MCO enrollee diagnosed with obesity in 2019.
**Includes claims, with dates of service in 2019, for any adult MCO enrollee diagnosed with obesity in 2019.
***Includes dental, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and adult daycare.

3 The Scope of Diabetes in the Medicaid Managed Care Program

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

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

For the 2021 Act 210 Diabetes and Obesity Report, managed care enrollees with diabetes were identified by medical claims with dates of service in 2019 that included a primary or secondary diagnosis of diabetes. Based on 2019 claims data, the adult diabetes prevalence was 9.09% of 819,440 unique managed care adults. The child diabetes prevalence was 0.27% of 710,724 enrollees under the age of 18 years. Louisiana Medicaid Regions 7 and 8 had the highest child prevalence rates, 0.38% and 0.36% respectively (Figure 3.1). The same regions led in adult diabetes prevalence (Figure 3.2) with Region 7 at 10.6% and Region 8 at 9.72%.

[18] *National Diabetes Statistics Report, 2020* (2020). Retrieved December 16, 2020 from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Figure 3.1: Medicaid Managed Care Child Diabetes Prevalence in 2019 by Medicaid Regions Age < 18 Years

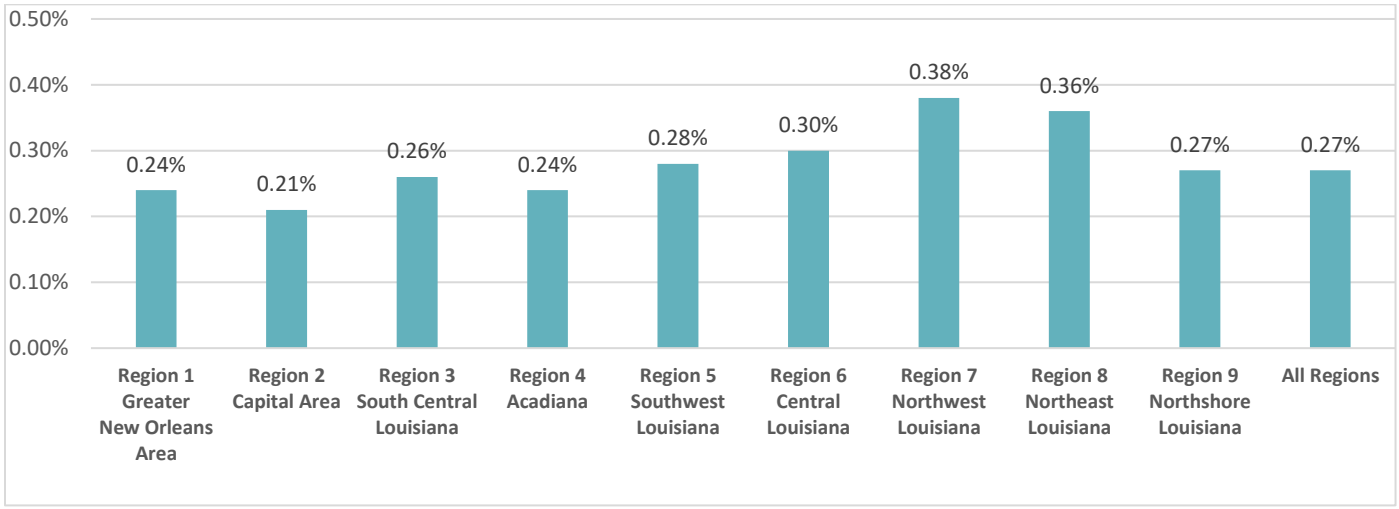


Figure 3.2: Medicaid Managed Care Adult Diabetes Prevalence in 2019 by Medicaid Regions Age ≥ 18 Years

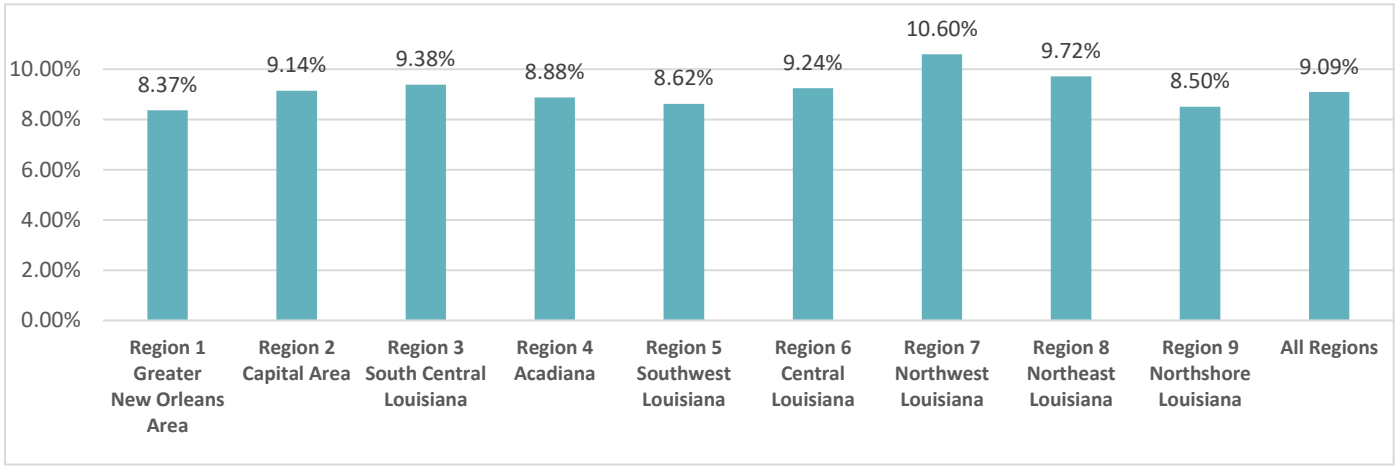


Figure 3.3 shows diabetes prevalence stratified by age group, gender and race among all Medicaid managed care enrollees. Adult diabetes prevalence is highest among Other race adult females (11.65%) and Other race adult males (10.74%). These increased prevalence rates are in agreement with trends reported in the CDC *National Diabetes Statistics Report 2020*. The CDC reports that the prevalence of adult-diagnosed diabetes was highest among American Indians/Alaska Natives (14.7%) and people of Hispanic origin (12.5%).[19]

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

Figure 3.3: Medicaid Managed Care Diabetes Prevalence in 2019 by Age, Gender and Race

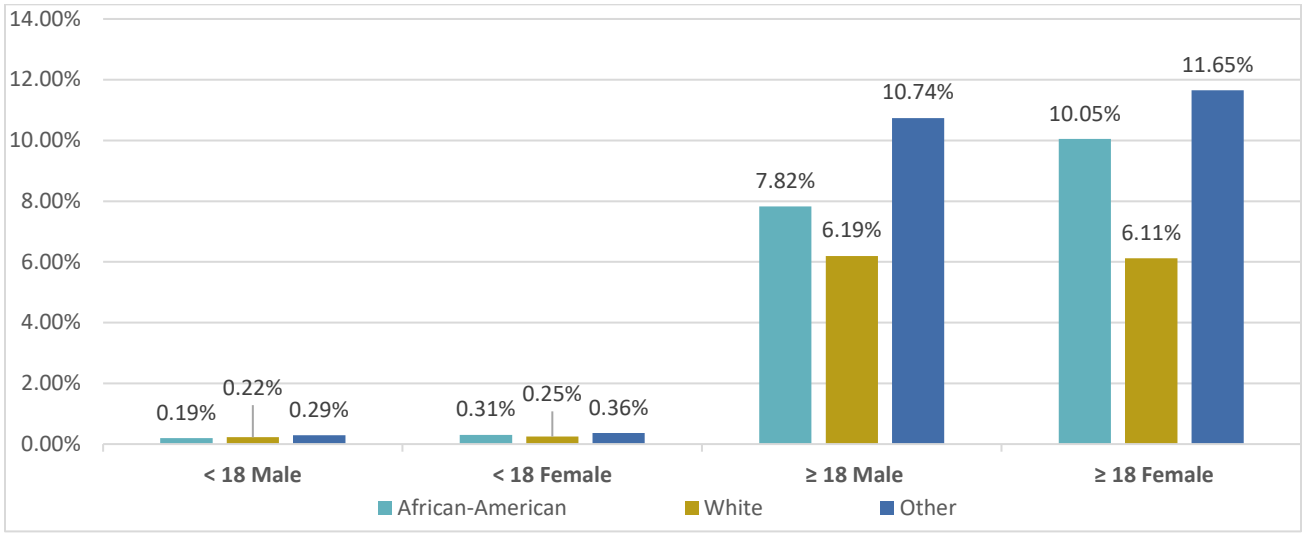


Table 3.1 compares the utilization of selected preventive practices in Medicaid managed care enrollees with diabetes to state and national utilization rates for the same practices. Louisiana's BRFSS percentages were slightly less than the 2016 national numbers for most of the listed preventive care practices. The managed care dilated eye exam rate was considerably lower than the 2016 national median (40.99% versus 62.2%). For enrollees with diabetes in Medicaid managed care, A1C testing was slightly higher than the U.S. median (78.22% versus 69.7%). However, the rate of ever having received self-management education was notably lower in the Medicaid managed care population when compared to the 2016 national median. The distribution of care practices across race in the managed care population is displayed in Figure 3.4. The distribution of care practices is very similar across race with the exception of home blood glucose devices. Higher rates of owning a home glucose monitoring device were found among the African-American (67.1%) and Other (63.0%) race categories when compared to the White (51.3%) race category.

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

Preventive Care Practice	Medicaid Managed Care (2019 Data)	BRFSS Louisiana (2016 Data) †	BRFSS United States (2016 Data)†
Received annual dilated eye exam	40.99%	55.8%	62.2%
Received one or more A1C tests during year	78.22%	56.0%††	69.7%††
Received seasonal influenza vaccine	25.10%*	(Not reported)	(Not reported)
Ever received pneumonia vaccine	15.35%*	(Not reported)	(Not reported)
Ever had home blood glucose device	62.21%	49.6%**	60.9%**
Ever had self-management education	0.35%	47.2%	55.3%

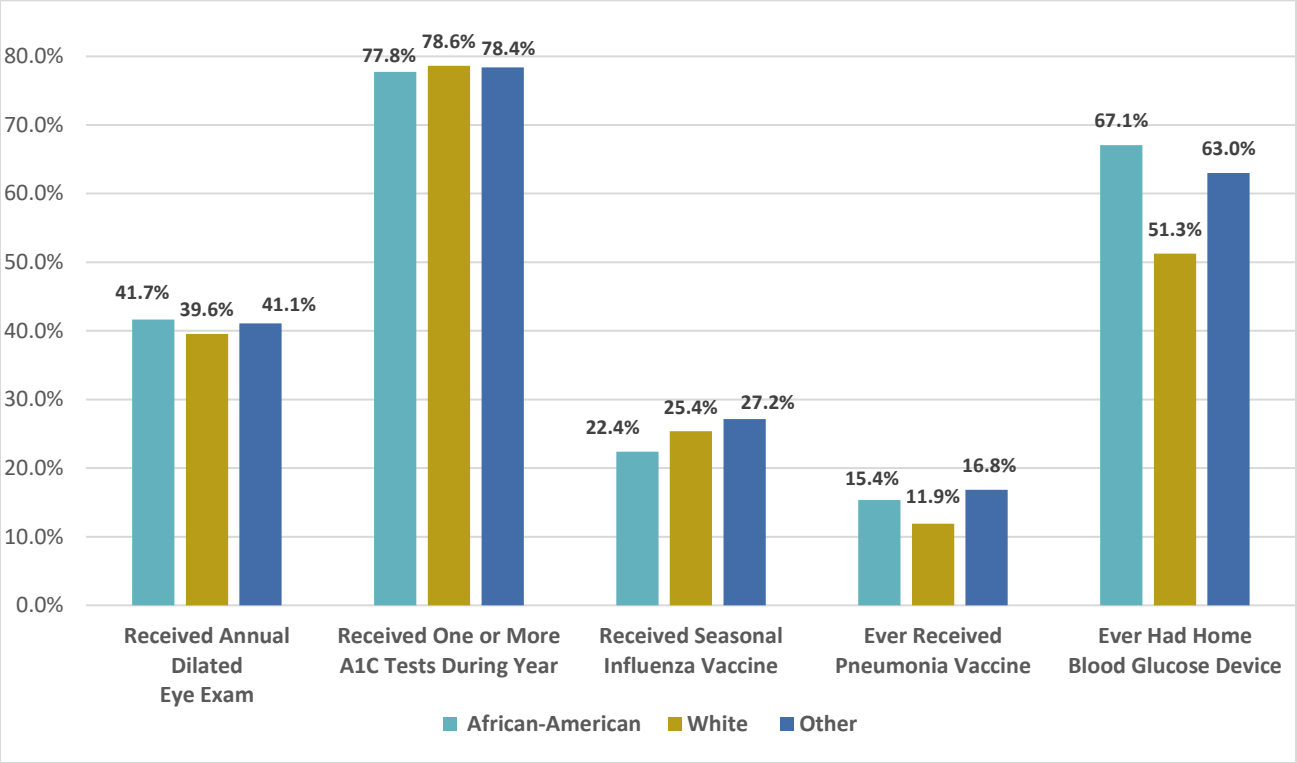
†2016 is the most recent year reported in the CDC *Diabetes Report Card 2019*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020 Available at: www.cdc.gov/diabetes/pdfs/library/Diabetes-Report-Card-2019-508.pdf.

†† Rate reported by BRFSS in the CDC *Diabetes Report Card 2019* reflects two or more A1C tests in the last year.

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

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

Figure 3.4: Medicaid Managed Care Diabetic Preventive Care Practices in 2019 Among Adults with Diabetes by Race



3.1 Diabetes and Pregnancy

Table 3.1.1 shows the cost of Medicaid managed care enrollee pregnancies in 2019 with and without diabetes. The total cost per pregnant enrollees with diabetes was 1.75 times greater than those who did not have a diabetes complication during their pregnancy ($7,889 vs $4,515). Of the MCO enrollees who were pregnant during 2019 (53,977), 9.58% had a diagnosis of diabetes.

Table 3.1.1: Medicaid Managed Care Diabetes* and Pregnancies in 2019

Pregnancy Categories	Unique Count of Enrollees with Pregnancy	Total Cost of Pregnancies	Total Cost of Pregnancies per Enrollee
Pregnancies with diabetes	5,171	$40,793,894	$7,888.98
Pregnancies without diabetes	48,806	$220,352,085	$4,514.86

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

3.2 The Financial Impact of Diabetes and Its Complications

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

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

3.2.1 Costs Due to Diabetes in Adult Medicaid Managed Care

Table 3.2.1 lists total costs, by claim type, for healthcare claims with dates of service in 2019 associated with managed care adult enrollees with and without diabetes. Managed care adult enrollees with diabetes were identified by medical claims with dates of service in 2019 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 Adult MCO Enrollees without Diabetes" column.

The prevalence of diabetes in the adult Medicaid managed care population is 9.09%. Healthcare claim costs for these enrollees totaled $1,044,951,896 in 2019 which accounts for 25.42% of the total adult MCO claims payments ($4,109,970,384) with dates of service in 2019.

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

Claim Type	Total Cost of MCO Adult Enrollees with Diabetes*	Total Cost of MCO Adult Enrollees without Diabetes	Percent Costs for Enrollees with Diabetes
Medical	$683,654,540	$2,181,098,360	23.86%
Pharmacy	$358,549,720	$861,584,542	29.39%
Other**	$2,747,637	$22,335,586	10.95%
Total	$1,044,951,896	$3,065,018,488	25.42%

*Includes claims, with dates of service in 2019, for any adult MCO enrollee with diabetes in 2019.
**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 2019 that included a diagnosis code for a diabetic complication. Table 3.2.2 shows, by age group and race, the percentage of 2019 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 (53.5%), followed by ketoacidosis (14.9%). The most prevalent diabetic complications in enrollees 18 years of age and older were hyperglycemia (36.8%) and neurological manifestations (19.9%).

3.2.3 Emergency Department (ED) Visits Due to Diabetes

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

In 2019, for the Medicaid managed care population, 36,204 ED visits were diabetes-related. These diabetes-related visits represented 2.60% of ED visits for managed care enrollees during 2019. Of these diabetes-related visits, 19,147 visits (52.89%) were associated with diabetes-related complications.

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

Diabetic Complication	Age < 18 Years				Age ≥ 18 Years			
	African-American	White	Other	Total	African-American	White	Other	Total
Ketoacidosis	14.8%	10.5%	17.3%	14.9%	2.1%	2.4%	2.7%	2.4%
Hyperosmolarity	1.8%	0.0%	0.5%	0.8%	1.2%	0.8%	1.4%	1.2%
Coma	1.4%	0.4%	1.4%	1.2%	0.5%	0.3%	0.6%	0.5%
Renal Manifestations	1.8%	1.7%	3.1%	2.4%	10.1%	6.6%	11.9%	10.2%
Ophthalmic Manifestations	2.1%	2.2%	2.2%	2.2%	10.6%	7.9%	10.9%	10.2%
Neurological Manifestations	1.1%	1.7%	0.7%	1.1%	17.8%	16.8%	22.9%	19.9%
Peripheral Circulatory Disorders	0.3%	0.0%	0.5%	0.3%	4.7%	3.9%	6.4%	5.3%
Arthropathy	0.2%	0.0%	0.0%	0.1%	0.5%	0.6%	0.6%	0.6%
Skin Complications	1.1%	1.5%	1.0%	1.2%	2.8%	3.3%	4.7%	3.7%
Oral Complications	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%
Hypoglycemia	7.6%	9.2%	9.6%	8.9%	2.8%	2.3%	3.4%	3.0%
Hyperglycemia	53.7%	46.8%	57.0%	53.5%	36.7%	33.5%	38.4%	36.8%
Other Specified Complications	7.3%	5.9%	8.3%	7.4%	6.8%	6.7%	8.1%	7.4%
Unspecified Complications	8.6%	7.2%	11.1%	9.4%	11.5%	8.6%	12.1%	11.2%
Count of Enrollees With Any Diabetes Diagnosis	628	459	865	1,952	26,866	14,399	33,175	74,440

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

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

Race Age, Group	All ED Visits	Primary or Secondary Diabetes Diagnosis ED Visits*	Percent of ED Visits with Primary or Secondary Diabetes Diagnosis*	Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**	Percent of Primary or Secondary Diabetes Diagnosis ED Visits with Diabetic Complication**
African-American, < 18 years	154,112	421	0.27%	296	70.31%
White, < 18 years	96,769	284	0.29%	202	71.13%
Other, < 18 years	194,859	686	0.35%	510	74.34%
Total, < 18 years	445,740	1,391	0.31%	1,008	72.47%
African-American, ≥ 18 years	354,488	12,791	3.61%	6,282	49.11%
White, ≥ 18 years	211,547	5,122	2.42%	2,516	49.12%
Other, ≥ 18 years	380,660	16,900	4.44%	9,341	55.27%
Total, ≥ 18 years	946,695	34,813	3.68%	18,139	52.10%
Total, All Ages	1,392,435	36,204	2.60%	19,147	52.89%

***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 2019, among managed care enrollees who were diagnosed with one of the reported chronic conditions, hypertension

(205,799 enrollees) was the most prevalent, followed by asthma (108,427 enrollees) and diabetes (76,392 enrollees). In 2019, for the reported chronic conditions, the highest total paid by the MCOs was $602,192,074.95 for hypertension. The total paid for diabetes during 2019 was $299,372,351.89. In 2019, for the reported chronic conditions, the highest average cost per enrollee was for congestive heart failure ($8,306.65). The average cost per enrollee with diabetes was $3,918.90.

Table 3.2.4: Medicaid Managed Care 2019 Prevalence of Selected Chronic Conditions and Cost Comparisons Among Diabetes and Selected Chronic Conditions

Chronic Disease	Chronic Disease MCO Enrollees*	Prevalence**	Total Cost of Chronic Disease	Average Cost Per MCO Enrollee with Chronic Disease
Hypertension	205,799	13.45%	$602,192,074.95	$2,926.12
Asthma	108,427	7.09%	$121,411,513.88	$1,119.75
Diabetes	76,392	4.99%	$299,372,351.89	$3,918.90
Arthritis	54,810	3.58%	$62,088,959.37	$1,132.80
COPD	28,871	1.89%	$114,881,371.97	$3,979.13
Coronary Heart Disease	23,815	1.56%	$117,578,099.77	$4,937.14
Congestive Heart Failure	16,895	1.10%	$140,340,793.94	$8,306.65

*A unique enrollee may be included in more than one chronic disease count.
**The prevalence denominator is the 2019, total unique enrollee count, in MCOs (1,529,768).

4 LDH and MCO Recommendations

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

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

5 Conclusion

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

Appendix A – Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

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

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

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Region 1 Greater New Orleans Area				
Jefferson	67,639	77,170	8.41%	9.20%
Orleans	58,048	85,628	5.19%	8.62%
Plaquemines	3,006	3,402	9.68%	9.64%
St Bernard	8,954	9,594	8.39%	10.50%
Total – Region 1	137,647	175,794	7.08%	9.00%
Region 2 Capital Area				
Ascension	14,086	13,642	7.98%	15.60%
East Baton Rouge	64,481	70,180	7.79%	12.10%
East Feliciana	2,548	3,467	16.80%	23.40%
Iberville	5,297	5,971	8.16%	16.90%
Pointe Coupee	3,080	3,542	9.19%	13.20%
West Baton Rouge	3,617	3,900	6.72%	19.60%
West Feliciana	1,275	1,404	8.24%	16.60%
Total – Region 2	94,384	102,106	8.10%	13.60%
Region 3 South Central Louisiana				
Assumption	2,647	3,342	10.20%	18.30%
Lafourche	12,074	14,459	12.10%	15.90%
St Charles	6,420	6,642	11.20%	10.60%
St James	2,933	3,470	12.30%	14.40%
St John The Baptist	7,834	8,674	8.63%	11.80%
St Mary	9,361	11,327	5.93%	14.40%
Terrebonne	18,397	20,861	5.49%	14.10%
Total – Region 3	59,666	68,775	8.46%	14.10%
Region 4 Acadiana				
Acadia	10,618	11,888	8.40%	15.40%
Evangeline	5,901	6,909	8.34%	13.20%
Iberia	13,205	15,030	16.10%	12.10%
Lafayette	31,825	35,358	10.60%	16.00%
St Landry	17,706	19,452	6.08%	19.00%
St Martin	7,821	8,671	15.70%	18.90%
Vermilion	8,727	10,161	9.34%	13.80%
Total – Region 4	95,803	107,469	10.40%	15.80%
Region 5 Southwest Louisiana				
Allen	3,628	3,753	4.80%	10.70%
Beauregard	5,625	6,028	4.04%	8.66%
Calcasieu	32,481	33,914	3.00%	12.50%
Cameron	340	464	6.47%	9.48%
Jefferson Davis	4,896	5,379	8.46%	12.00%
Total – Region 5	46,970	49,538	3.85%	11.80%
Region 6 Central Louisiana				

Medicaid Region	Medicaid Managed Care Enrollees		Obesity Prevalence	
Parish	**<18 Years**	**≥ 18 Years**	**<18 Years**	**≥ 18 Years**
Avoyelles	7,236	8,319	11.30%	12.70%
Catahoula	1,661	2,286	9.33%	8.88%
Concordia	3,964	4,598	2.02%	8.03%
Grant	3,159	3,620	12.30%	9.94%
La Salle	1,980	2,401	4.60%	13.30%
Rapides	22,142	24,277	11.20%	10.80%
Vernon	5,927	6,501	1.77%	7.14%
Winn	2,123	2,583	17.10%	12.60%
Total – Region 6	48,192	54,585	9.30%	10.50%
Region 7 Northwest Louisiana				
Bienville	2,378	3,009	5.89%	8.91%
Bossier	16,033	15,758	6.53%	10.20%
Caddo	41,399	46,523	5.59%	11.20%
Claiborne	2,158	2,602	4.08%	9.45%
De Soto	4,103	4,889	7.31%	12.00%
Natchitoches	6,308	7,113	4.34%	8.83%
Red River	1,612	1,789	1.74%	5.98%
Sabine	3,515	4,264	8.31%	9.50%
Webster	6,455	8,072	4.00%	9.28%
Total – Region 7	83,961	94,019	5.65%	10.40%
Region 8 Northeast Louisiana				
Caldwell	1,766	2,358	3.57%	10.80%
East Carroll	1,609	1,833	15.50%	14.50%
Franklin	4,070	4,960	4.25%	10.40%
Jackson	1,979	2,464	9.15%	18.50%
Lincoln	5,964	7,427	6.52%	11.80%
Madison	2,621	2,964	5.61%	11.30%
Morehouse	5,234	6,855	14.30%	16.30%
Ouachita	28,221	33,121	10.00%	16.70%
Richland	3,725	4,754	13.80%	14.10%
Tensas	786	1,141	13.40%	11.10%
Union	3,834	4,451	8.58%	14.20%
West Carroll	1,881	2,544	8.13%	15.20%
Total – Region 8	61,690	74,872	9.53%	14.90%
Region 9 Northshore Louisiana				
Livingston	18,558	19,709	7.40%	13.90%
St Helena	1,311	1,579	8.54%	12.50%
St Tammany	28,946	32,239	5.87%	9.22%
Tangipahoa	24,984	27,794	6.34%	12.30%
Washington	8,612	10,565	7.37%	13.40%
Total – Region 9	82,411	91,886	6.56%	11.70%

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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Plaquemines	3,006	3,402	0.17%	9.41%
St Bernard	8,954	9,594	0.26%	8.16%
Total – Region 1	137,647	175,794	0.24%	8.37%
Region 2 Capital Area				
Ascension	14,086	13,642	0.13%	8.84%
East Baton Rouge	64,481	70,180	0.22%	8.68%
East Feliciana	2,548	3,467	0.20%	10.80%
Iberville	5,297	5,971	0.28%	11.40%
Pointe Coupee	3,080	3,542	0.13%	11.00%
West Baton Rouge	3,617	3,900	0.14%	11.30%
West Feliciana	1,275	1,404	0.16%	11.30%
Total – Region 2	94,384	102,106	0.21%	9.14%
Region 3 South Central Louisiana				
Assumption	2,647	3,342	0.19%	12.50%
Lafourche	12,074	14,459	0.30%	9.51%
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Total – Region 3	59,666	68,775	0.26%	9.38%
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St Martin	7,821	8,671	0.26%	9.42%
Vermilion	8,727	10,161	0.28%	9.01%
Total – Region 4	95,803	107,469	0.24%	8.88%
Region 5 Southwest Louisiana				
Allen	3,628	3,753	0.22%	9.27%
Beauregard	5,625	6,028	0.23%	9.26%
Calcasieu	32,481	33,914	0.31%	8.32%
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De Soto	4,103	4,889	0.24%	10.60%
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Jackson	1,979	2,464	1.41%	16.90%
Lincoln	5,964	7,427	0.64%	8.72%
Madison	2,621	2,964	0.27%	9.14%
Morehouse	5,234	6,855	0.44%	10.10%
Ouachita	28,221	33,121	0.26%	8.72%
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Tensas	786	1,141	0.00%	12.00%
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St Helena	1,311	1,579	0.31%	10.60%
St Tammany	28,946	32,239	0.29%	7.03%
Tangipahoa	24,984	27,794	0.25%	9.71%
Washington	8,612	10,565	0.22%	11.40%
Total – Region 9	82,411	91,886	0.27%	8.50%

Appendix D – 2019 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 2019 Diabetes and Obesity Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana 2019 Diabetes and Obesity Action Plan
Appendix D3	Healthy Blue 2019 Diabetes and Obesity Action Plan
Appendix D4	Louisiana Healthcare Connections 2018 Diabetes and Obesity Action Plan
Appendix D5	United Healthcare 2018 Diabetes and Obesity Action Plan

Appendix D1
Aetna Better Health of Louisiana
2019 Diabetes and Obesity Action Plan

Diabetes Goals 2019

- ***Goal 1: Improve member health outcomes by ensuring needed services, screenings, and tests are completed each year. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Use Welltok® text messaging to communicate needed services and reminders to members.
    - **Action Description:** Outreach directly to members or legal guardians and physicians about any gaps in care. Monthly lists are generated for outreach to members who have not received needed services, tests, and screenings.
    - **Expected Outcome:** See improvement in members' quality of health and awareness of diabetes-related complications.
    - **Action Measurement:** Use Healthcare Effectiveness Data and Information Set (HEDIS®) rates.

- ***Goal 2: Provide enhanced care management and needed resources for members with diabetes. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Outreach directly to members to engage in enhanced diabetes care management.
    - **Action Description:** Identify members with diabetes or obesity for care management by predictive modeling, claims analyses, health risk questionnaires, care management assessments, concurrent review/prior authorization referrals, as well as member and provider referrals. Interventions include:
        - telephonic and printed education on self-monitoring;
        - member support through a secure member portal with website log-in link to evidence-based health appraisal and self-management tools and digital coaching programs;
        - a health information line where nurses are available 24-hours a day, seven days a week, to assist members with wellness and prevention information;
        - care management activation strategies that emphasize prevention of exacerbations and complications by using evidence-based clinical guidelines and member engagement;
        - care management assistance providing techniques to help members better adhere to medication regimens, clinical monitoring, and treatment plans, and collaborating with providers and caregivers (with member consent).
    - **Expected Outcome:** See increased diabetes care management engagement among members with diabetes.
    - **Action Measurement:** Use the care management 2018 and 2019 reports for Outreach and Enrollment.

- ***Goal 3: Increase provider and member awareness of care needs by promoting earlier adoption of preventive behaviors through newsletter distribution, disease-specific mailers, outreach calls and text messages to members and providers to encourage completion of services. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Host provider diabetes-related webinars and workshops, use Eliza® interactive voice response (IVR) calls and Welltok® text messaging to reach members, and provide incentive to members via gift cards.
    - **Action Description:** Send diabetes and obesity newsletters to members twice a year. Send member-specific mailers three times per year listing specific services and/or tests that need to be completed. These mailers include: Control Your Diabetes Letter, Diabetes Follow-Up Letter for Care, and Diabetes Retinopathy Letter.
    - **Expected Outcome:** Increase diabetes-related knowledge among members and providers, increase diabetes screenings and enhance diabetes management by providers, and change member behavior.
    - **Action Measurement:** Report the number of webinars and education offerings to providers, number of monthly mailers, and number of Value-Add Benefits gift cards issued.

Diabetes Results 2019

Goal	Benchmark	Results
1	2018 HEDIS® A1C (estimated average glucose) testing: 87.83% (administrative rate)	2019 HEDIS® A1C testing: 87.83% (administrative rate) *(2018 rate reported due to COVID-19)*
	2018 Welltok®: 1,282 member messaging sent	2019 Welltok®: 172,663 member messaging sent *(count includes duplicates)*
2	2018 Unique members needing outreach: 2,872	2019 Unique members needing outreach: 2,018
	2018 Total diabetes/obesity care management enrollment: 329	2019 Total diabetes/obesity care management enrollment: 268
3	2018 Value-Add Benefits cards issued related to the Comprehensive Diabetes Care (CDC) HEDIS® measure: • A1C: 61 • Retinal screening: 11	2019 Value-Add Benefits cards issued related to the Comprehensive Diabetes Care (CDC) HEDIS® measure: • A1C: 298 • Retinal screening: 64
	2018 Welltok®: 1,282 member messaging sent	2019 Welltok®: 172,663 member messaging sent *(count includes duplicates)*
	IVR: 972 (2018)	IVR: (Not Reported for 2019)

Diabetes Goals 2020

- ***Goal 1: Increase the percentage of members 18-75 years of age with diabetes (type 1 and type 2) with an A1C test, eye exam, and medical attention for nephropathy by 2% year-over-year (YOY) as compared to baseline. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Utilize the HEDIS® outreach team to contact members via telephone when screenings have not been performed. The call is to remind the member to schedule these screenings. Screening reminders are also included in the Care4Life® and IVR programs.
    - **Action Description:** Provide users with a broad range of personalized educational content and evidence-based tools in the Care4Life® program. The program is used to motivate and help members better track and manage their condition, engage in preventive actions, and share valuable information with their care teams. Additionally, the IVR call campaign, completed quarterly, focuses on the importance of receiving evidence-based health services aimed at reducing mortality and morbidity associated with diabetes.
    - **Expected Outcome:** Increase in A1C testing, retinal screenings, and medical attention to nephropathy among members age 18-75 with a diabetes diagnosis.
    - **Action Measurement:** Use HEDIS® Gaps in Care reports.

- ***Goal 2: Increase the number of members 18-75 years of age with diabetes (type 1 and type 2) with A1C control (<8%) and with BP control (<140/90 mm Hg) by 2% YOY as compared to baseline. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Contact identified members to enroll in a remote patient monitoring program, and provide each enrolled member with a Bluetooth®-enabled tablet.
    - **Action Description:** Prompt each member to test blood sugar and/or blood pressure daily. If a measurement is outside of an established threshold, the member is contacted to retake and resubmit the measurement. If the second (or third) reading is still outside the established threshold, the member's primary care physician (PCP) is contacted by a clinician health coach to obtain further direction. The PCP direction may include re-monitoring, scheduling a PCP office visit, sending the member to emergency department (ED) or urgent care, ordering a medication change, or suggesting other appropriate actions. If the PCP is unavailable, the clinician health coach may advise the member to access the ED or urgent care as warranted. Also, the Bluetooth®-enabled tablet will provide member education and quizzes to increase knowledge of diabetes.
    - **Expected Outcome:** Show improved control of diabetes and blood pressure among members with diabetes.
    - **Action Measurement:** Use Remote Patient Monitoring report.

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

- **Expected Outcome:** Increase partnership with providers to promote timely and regular screenings and tests for members.
- **Action Measurement:** Use value-based reports.

Obesity Goals 2019

- ***Goal 1: Provide care management and needed resources for members diagnosed with obesity. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Outreach members to engage in enhanced obesity care management.
  - **Action Description:** Members with diabetes or obesity are identified for care management by predictive modeling, claims analyses, health risk questionnaires, care management assessments, concurrent review/prior authorization referrals, as well as member and provider referrals. Interventions include:
    - telephonic and printed education on self-monitoring;
    - member support through a secure member portal with website log-in link to evidence-based health appraisal and self-management tools and digital coaching programs;
    - a health information line where nurses are available 24-hours a day, seven days a week to assist members with wellness and prevention information;
    - care management activation strategies that emphasize prevention of exacerbations and complications by using evidence-based clinical guidelines and member engagement;
    - care management assistance providing techniques to help members better adhere to medication regimens, clinical monitoring, and treatment plans, and collaborating with providers and caregivers (with member's consent).
  - **Expected Outcome:** See increased obesity care management engagement among members diagnosed with obesity.
  - **Action Measurement:** Use the care management 2018 and 2019 reports for outreach and enrollment.

- ***Goal 2: Increase member engagement in lowering Body Mass Index (BMI) and obesity risk through incentives. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Use the annual wellness exam claims data to identify members who are eligible for value-add benefits.
  - **Action Description:** Members who complete wellness appointments that address both obesity and BMI are given gift cards and, if age appropriate, are offered to be enrolled in a weight management program for children and adolescents 5 through 20 years of age.
  - **Expected Outcome:** See increased member participation and see a reduction in child and adolescent BMI.
  - **Action Measurement:** Report the number of gift cards sent to members for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) incentive.

- ***Goal 3: Create community events that promote and support healthy lifestyle choices. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Host community outreach events that occur throughout the calendar year.
    - **Action Description:** Aetna Better Health of Louisiana actively participates in the Healthy Schools Training Krewe which collaborates with Well-Ahead School Health on providing "Smarter Lunchroom" workshops. The mission of these workshops, focusing on lunchroom strategies to improve healthy food choices, is to enhance the knowledge and skills of those working directly with students.
    - **Expected Outcome:** Provide education and promote understanding of healthy lifestyles.
    - **Action Measurement:** Report the number of workshops provided to schools.

Obesity Results 2019

Goal	Benchmark	Results
1	Unique members identified for obesity-related outreach: 356	Unique members identified for obesity-related outreach: 1,665
	Enrollment in care management: 93	Enrollment in care management: 110
2	2018 Value-Add Benefits gift cards issued for WCC: 24	2019 Value-Add Benefits gift cards issued for WCC: 324
3	2018 events scheduled to promote healthy lifestyle choices: 3	2019 events scheduled to promote healthy lifestyle choices: 24
	2018 healthcare equity events: 5	2019 healthcare equity events: 4

Obesity Goals 2020

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

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

- ***Goal 3: [Not Submitted]. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Send text messages to members through the Text4Health and Text4Kids Welltok® campaigns.
    - **Action Description:** Through the Welltok® Text4Health and Text4Kids campaigns, Aetna Better Health sends members text messages that provide encouragement to make smart food choices and gives members an opportunity to participate in exercise challenges.
    - **Expected Outcome:** See an increase in member participation in exercise challenges and improvements in member healthy lifestyle choices.
    - **Action Measurement:** Use Welltok® reports.

Appendix D2
AmeriHealth Caritas Louisiana (ACLA)
2019 Diabetes and Obesity Action Plan

Diabetes Goals 2019

- ***Goal 1: ACLA will increase member engagement in its Population Health Management programs by December 2019 to reduce the impact of diabetes by providing diabetic members with education including self-management, treatment, and benefits. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Implement new processes for identifying diabetic members who would benefit from engagement in population health management.
    - **Action Description:** Several mechanisms will be used to identify members for participation in ACLA's Population Health Management programs for diabetes including: health risk assessments (HRAs), claims analyses, provider referrals, member calls/contacts, and state referrals.
    - **Expected Outcome:** Increased diabetic member engagement in ACLA's Population Health Management programs.
    - **Action Measurement:** The percentage of members with a primary or secondary diagnosis of diabetes who are engaged in a population health management program in 2019 compared to the percentage engaged in 2018.

- ***Goal 2: ACLA will increase the focus on Healthcare Effectiveness Data and Information Set (HEDIS®) Comprehensive Diabetes Care (CDC) sub-measures as a measurable outcome in providers participating in value-based contracting (VBC) by December 2019 to improve diabetic health, reduce unnecessary costs, and to promote accountable care. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Implement a new process for helping provider groups create and support infrastructure for measurement of success and continuous improvement in HEDIS® CDC sub-measures.
    - **Action Description:** ACLA will identify and share best practices, work with provider groups to develop goals and a strategic improvement plan, assist in utilizing and interpreting analytic tools. ACLA will also assist with monitoring and tracking improvement activities.
    - **Expected Outcome:** Increased number of HEDIS® CDC sub-measures used as a measurable outcome for providers participating in VBC.
    - **Action Measurement:** The percentage of available HEDIS® CDC sub-measures used as a measurable outcome by providers participating in VBC in 2019 compared to the percentage of available HEDIS® CDC sub-measures used as a measurable outcome by those providers participating in VBC in 2018.

- ***Goal 3: ACLA will meet or exceed the Louisiana Department of Health (LDH) goal of the 2018 Quality Compass (QC) for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two HEDIS® CDC sub-measures for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Continue programs and interventions from the previous year as well as implement new programs and interventions to address diabetic member barriers.
    - **Action Description:** Implemented programs and interventions include: ACLA Community Center access, member CARE Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, diabetic text messaging campaign, Vheda Health chronic disease monitoring, and Mom's Meals NourishCare®.
    - **Expected Outcome:** ACLA expects to meet or exceed the LDH goal of the 2018 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two HEDIS® CDC sub-measures for 2019.
    - **Action Measurement:** The percentage of increase in HEDIS® CDC sub-measure rates in 2019 compared to 2018 and/or the 2018 QC for Medicaid 50th percentile.

Diabetes Results 2019

Goal	Benchmark	Results
1	At least the same number of members with a primary or secondary diagnosis of diabetes who were engaged in a population health management program in 2018.	In 2019, there was a 3.92% increase in the number of members with a primary or secondary diagnosis of diabetes who were engaged in a population health management program compared to the number engaged in 2018.
2	At least the same number of HEDIS® CDC sub-measures used as a measurable outcome in 2018 for providers participating in VBC.	In 2019, ACLA met its goal with a 22.22% increase in the number of HEDIS® CDC sub-measures used as a measurable outcome for providers participating in VBC compared to those participating in 2018.
3	The 2018 QC for Medicaid 50th percentile or at least a 2 percentage point increase for at least two HEDIS® CDC sub-measures in 2019.	In 2019, HEDIS® CDC Eye Exam met the 2018 QC for Medicaid 50th percentile goal. ACLA did not reach its goal for at least two HEDIS® CDC sub-measures and recognizes that there continues to be opportunities to educate both members and providers on the importance of recommended diabetic tests and screenings.

Diabetes Goals 2020

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

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

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

- **Expected Outcome:** ACLA will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two HEDIS® CDC sub-measures for 2020.
- **Action Measurement:** The percentage of increase in HEDIS® CDC sub-measure rates in 2020 compared to 2019 and/or the 2019 QC for Medicaid 50th percentile.

Obesity Goals 2019

- ***Goal 1: ACLA will increase member engagement in its Population Health Management programs by December 2019 to reduce the impact of obesity by providing education (including self-management, treatment, and benefits) to members diagnosed with obesity. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Implement new processes for identifying members diagnosed with obesity who would benefit from engagement in population health management.
  - **Action Description:** Several mechanisms will be used to identify members for participation in ACLA's obesity-related Population Health Management programs including: health risk assessments (HRAs), claims analyses, provider referrals, member calls/contacts, and state referrals.
  - **Expected Outcome:** Increased engagement in ACLA's Population Health Management programs for members diagnosed with obesity.
  - **Action Measurement:** The percentage of members with a primary or secondary diagnosis of obesity who are engaged in a population health management program in 2019 compared to the percentage engaged in 2018.

- ***Goal 2: ACLA will increase community accessibility to ACLA's weight loss programs by December 2019 to improve the health of members diagnosed with obesity and to provide them with necessary resources and education. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Implement at least one new weight loss program in a member-dense area to promote improved quality of life among the community and active participation with community members and stakeholders.
  - **Action Description:** ACLA will utilize the ACLA Community Wellness Centers to host weight loss support group meetings, provide community with healthy dieting and eating tips from local nutritionists, and track weight loss. In addition, other programs that support members through their weight loss journey such as *Diabetes Destination* and *Make Every Calorie Count* will continue.
  - **Expected Outcome:** Increased community accessibility to ACLA's weight loss program and increased member engagement.
  - **Action Measurement:** Successful implementation and offering of the weight loss support group meetings at one or more ACLA Community Wellness Centers.

- ***Goal 3: ACLA will meet or exceed the LDH goal of the 2018 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS® measures for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Continue programs and interventions from the previous year as well as implement new programs and interventions to address obese member barriers.
    - **Action Description:** Implemented programs and interventions include: ACLA Community Center access, member CARE Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member mobile apps, well visit text messaging campaign, Vheda Health chronic disease monitoring, and Mom's Meals NourishCare®.
    - **Expected Outcome:** The MCO will meet or exceed the LDH goal of the 2018 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS® measures for 2019.
    - **Action Measurement:** The percentage of increase in obesity-related HEDIS® measure rates in 2019 compared to 2018 and/or the 2018 QC for Medicaid 50th percentile.

Obesity Results 2019

Goal	Benchmark	Results
1	At least the same number of members with a primary or secondary diagnosis of obesity who are engaged in a population health management program in 2018.	In 2019, there was a 3.87% increase in the number of members with a primary or secondary diagnosis of obesity who are engaged in a population health management program as compared to the number engaged in 2018.
2	Weight loss support group meeting is offered to the community in at least one ACLA Community Wellness Center.	In 2019, the MCO met its goal. There were 15 weight loss support group meetings held at the New Orleans Community Wellness Center.
3	The 2018 QC for Medicaid 50th percentile or at least a 2 percentage point increase for at least two obesity-related HEDIS® measures in 2019.	In 2019, the MCO met its goal of the 2018 QC for Medicaid 50th percentile or at least a 2 percentage point increase for at least two obesity-related HEDIS® measures. For the HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure, BMI assessment increased by at least 2%, from 75.18% to 77.64% and met the QC 50th percentile goal of 75.55% for BMI assessment. For HEDIS® WCC, the rate of physical activity counseling increased by at least 2%, from 55.96% to 63.14% and also met the QC 50th percentile goal of 56.45% for physical activity.

Obesity Goals 2020

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

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

- ***Goal 3: ACLA will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS® measures for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** ACLA will utilize program-evaluation data to implement new pilot programs, continue and/or modify current programs, or to discontinue programs.
    - **Action Description:** Evaluated programs and interventions will include: ACLA Community Center access, member CARE Card benefits, updated web content, member portal access, 24/7 nurse helpline, automated reminder calls, emergency room follow-up visits, educational mailings, member newsletter, social media posts and invitations, member

mobile apps, well visit text messaging campaign, Vheda Health chronic disease monitoring, and Mom's Meals NourishCare®.

- **Expected Outcome:** The MCO will meet or exceed the LDH goal of the 2019 QC for Medicaid 50th percentile or achieve at least a 2 percentage point increase for at least two obesity-related HEDIS® measures for 2020.
- **Action Measurement:** The percentage of increase in obesity-related HEDIS® measure rates in 2020 compared to 2019 and/or the 2019 QC for Medicaid 50th percentile.

Appendix D3
Healthy Blue
2019 Diabetes and Obesity Action Plan

Diabetes Goals 2019

- ***Goal 1: Improved year-over-year (YOY) Healthcare Effectiveness Data and Information Set (HEDIS®) rates associated with diabetes by achieving at least a 2 percentage point increase, ultimately reaching 2018 Quality Compass (QC) for Medicaid 50th percentile. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Conduct provider education and outreach.
    - **Action Description:** Host provider education programs on documentation and coding best practices, develop action plans using patient-centered care consultants, and offer educational credits to providers through summits and webinars.
    - **Expected Outcome:** See overall improved outcomes for the members we serve through enhanced provider awareness of quality metrics, documentation, and coding requirements.
    - **Action Measurement:** Improved YOY rates by achieving at least a 2 percentage point increase in the following measures:
        - Comprehensive Diabetes Care A1C (estimated average glucose) Testing
        - Comprehensive Diabetes Care Eye Exams
        - Comprehensive Diabetes Care Attention for Medical Nephropathy
        - Comprehensive Diabetes Care Poor Control (>9.0%)
        - Comprehensive Diabetes Care Good Control (<8.0%)
        - Diabetes Short-term Complication
        - Diabetes Monitoring for People with Diabetes and Schizophrenia
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

- ***Goal 2: Improve diabetes preventive care practices YOY among adults with diabetes. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Conduct member education and outreach.
    - **Action Description:** Engage and educate members through: diabetes classes, outreach calls, text campaigns, case management, incentives and community events.
    - **Expected Outcome:** See increased member awareness of the importance of preventive care, the benefits of provider follow-ups, and improved management of diabetes.
    - **Action Measurement:** Review the number of members who are diagnosed with diabetes who are utilizing diabetes preventive care practices.

- ***Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to improve diabetes outcomes for the members served. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Increase provider alternative payment model (APM) agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Expected Outcome:** See improved diabetes- and obesity-related outcomes associated with an increase in APM programs.
    - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate diabetes measures.

Diabetes Results 2019

Goal	Benchmark	Results
1	Diabetes-Related HEDIS® Rates	**Comprehensive Diabetes Care**
		• A1C Testing Increased by 2.19 percentage points (pp), MY2018 (83.45%) to MY2019 (85.64%)
		• Eye Exams Decreased by 0.97pp, MY2018 (59.12%) to MY2019 (58.15%)
		• Attention for Medical Nephropathy Decreased by 2.43pp, MY2018 (92.21%) to MY2019 (89.78%)
		• Poor Control (A1C >9.0%) Increased by 1.94pp, MY2018 (52.07%) to MY2019 (54.01%)
		• Good Control (A1C <8.0%) Increased by 0.5pp, MY2018 (38.93%) to MY2019 (39.42%)
		Other Diabetes-Related Measures
		• Diabetes Short-term complication by Age Group (18-64) Decreased by 0.92pp, MY2018 (17.60%) to MY2019 (16.68%) (65+) Increased by 22.38pp, MY2018 (0%) to MY2019 (22.38%)
		• Diabetes monitoring for people with Diabetes and Schizophrenia Increased by 0.5pp, MY2018 (66.93%) to MY2019 (67.43%)
		• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications Increased by 2.14pp, MY2018 (82.61%) to MY2019 (84.75%)
2	Members Receiving Diabetes Preventive Care Practices	• Annual dilated eye exam: 11,948 (2018) increased to 13,705 (2019)
		• One or more A1Cs: 10,360 (2018) increased to 12,033 (2019)
		• Annual influenza vaccine: 2,066 (2018) increased to 2,556 (2019)
		• Pneumonia vaccine (ever received): 1,717 (2018) increased to 1,993 (2019)
		• Report daily self-blood glucose monitoring: 4,628 (2018) increased to 5,564 (2019)
		• Diabetes self-management education (ever received): 46 (2018) increased to 103 (2019)
3	Providers in APM Programs	• Providers in APMs: 30 (2018)
		• Providers in APMs: 51 (2019)

Diabetes Goals 2020

- ***Goal 1: Improve YOY HEDIS® rates associated with diabetes by at least 2 percentage points, ultimately reaching QC for Medicaid 50th percentile. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Expand provider education and outreach from previous year.
    - **Action Description:** Host provider education programs on documentation and coding best practices, develop action plans using patient-centered care consultants, and offer educational credits to providers through summits and webinars.
    - **Expected Outcome:** See overall improved outcomes for the members we serve through enhanced provider awareness of quality metrics, documentation, and coding requirements.
    - **Action Measurement:** Improved YOY rates by achieving at least a 2 percentage point increase in the following measures:
        - Comprehensive Diabetes Care A1C (estimated average glucose) Testing
        - Comprehensive Diabetes Care Eye Exams
        - Comprehensive Diabetes Care Attention for Medical Nephropathy
        - Comprehensive Diabetes Care Poor Control (>9.0%)
        - Comprehensive Diabetes Care Good Control (<8.0%)
        - Diabetes Short-term Complication
        - Diabetes Monitoring for People with Diabetes and Schizophrenia
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

- ***Goal 2: Improve diabetes preventive care practices YOY among adults with diabetes. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Expand member outreach and engagement from previous year.
    - **Action Description:** Engage and educate members through diabetes classes, outreach calls, text campaigns, collaborate with Pennington Biomedical Research Center, case management, community events, and a new incentive platform.
    - **Expected Outcome:** See increased member awareness of the importance of preventive care, the benefits of provider follow-ups, and improved management of diabetes.
    - **Action Measurement:** Review the utilization of diabetes preventive care practices among adults with diabetes who receive the following:
        - Annual dilated eye exam
        - One or more A1Cs (current reporting period)
        - An influenza vaccine (current reporting period)
        - A pneumonia vaccine (ever received)
        - Daily self-blood glucose monitoring
        - Diabetes self-management education (ever received)

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

Obesity Goals 2019

- ***Goal 1: Improve YOY HEDIS® rates associated with obesity by at least 2 percentage points, ultimately reaching QC for Medicaid 50th Percentile for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (Age 3-17), Adult Body Mass Index (BMI) Screening (ABA) (Age 18-64) and Well-Child Visits. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Conduct provider education and outreach.
    - **Action Description:** Host provider education programs on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, documentation and coding best practices, develop action plans using patient-centered care consultants and offer educational credits to providers through summits and webinars.
    - **Expected Outcome:** See overall improved outcomes for the members we serve through enhanced provider awareness of quality metrics, documentation, and coding requirements.
    - **Action Measurement:** Review HEDIS® WCC, ABA and Well-Child Visit measure rates.

- ***Goal 2: Improve EPSDT screening and participation rates YOY. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Provide member education and outreach, specifically targeting children younger than 21 years of age to promote prevention of obesity.
    - **Action Description:** Engage and educate members through Zumba® fitness classes, outreach calls, text campaigns, member incentives, case management and community events.
    - **Expected Outcome:** See increased member awareness of the importance of preventive care, the benefits of provider follow-ups, and improved management of obesity.
    - **Action Measurement:** Review EPSDT screening and participation rates.

- ***Goal 3: Increase provider incentive programs YOY to align with Healthy Blue's strategy to prevent and manage obesity for the members served. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Increase provider APM agreements YOY that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Action Description:** Develop and implement annual APM programs for providers that align with Healthy Blue's Diabetes and Obesity Strategy.
    - **Expected Outcome:** See improved diabetes- and obesity-related outcomes associated with an increase in APM programs.
    - **Action Measurement:** Review the number of providers enrolled in APM programs that incorporate obesity and prevention measures.

Obesity Results 2019

Goal	Benchmark	Results
1	HEDIS® Measures	• WCC: Increased by 0.97 percentage points (pp), MY2018 (53.04%) to MY2019 (54.01%)
		• Physical Activity (Members 3-17 years): Increased by 1.21pp, MY2018 (44.53%) to MY2019 (45.74%)
		• ABA (Members 18-64 years): Increased by 2.43pp, MY2018 (81.75%) to MY2019 (84.18%)
		• Well-Child: Increased by 7.54pp, MY2018 (58.15%) to MY2019 (65.69%)
2	EPSDT Screening and Participation Ratio	**EPSDT 2018 Screening Rates to 2019 Screening Rates**
		• Medicaid: Q1 2018 88% improved to Q1 2019 90% Q2 2018 85% improved to Q2 2019 91% Q3 2018 85% improved to Q3 2019 95% Q4 2018 91% improved to Q4 2019 95%
		• Children's Health Insurance Program (CHIP): Q1 2018 100% decreased to Q1 2019 90% Q2 2018 78% improved to Q2 2019 100% Q3 2018 85% improved to Q3 2019 100% Q4 2018 100% remained steady to Q4 2019 100%
3	Providers in APM Programs	• Providers in APMs: 30 (2018)
		• Providers in APMs: 51 (2019)

Obesity Goals 2020

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

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

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

Appendix D4
Louisiana Healthcare Connections
2019 Diabetes and Obesity Action Plan

Diabetes Goals 2019

- ***Goal 1: Maintain an annual enrollment rate above 50% in the diabetes program for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Certified Diabetes Educators were provided member engagement skills training within the first quarter of employment.
    - **Action Description:** Training ensured staff had the knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
    - **Expected Outcome:** This action was expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
    - **Action Measurement:** Action measurement/outcomes was/were monitored via successful initial health assessments which indicated enrollment into the disease management program and resulted in an 85% engagement rate for 2019.

- ***Goal 2: Maintain the percentage of acute diabetes-related episodes each quarter below the target of 3.10% for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Certified Diabetes Educators provided a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding diabetes management.
    - **Action Description:** Coaching/evaluation sessions with Certified Diabetes Educators included identification of barriers to self-management and coordination of services to eliminate those barriers.
    - **Expected Outcome:** The action of providing enhanced coaching techniques and care coordination was expected to prevent gaps in condition-specific awareness which resulted in a decrease in the number of acute episodes for members with diabetes.
    - **Action Measurement:** Successful outcomes of this intervention were reflected by the rate of acute diabetes-related episodes. Each of the quarters was below the benchmark. The rates for 2019 were as follows: Quarter 1: 1.5%, Quarter 2: 0.5%, Quarter 3: 1.2%, Quarter 4: 1.0%.

- ***Goal 3: Maintain the percentage of members with diabetes who complete annual A1C (estimated average glucose) testing at or above 86.91% for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Monthly telephonic outreach was provided to members who were identified as non-compliant with annual A1C testing.

- **Action Description:** Member outreach via automated calls and contact by internal staff provided reminders and information for non-compliant diabetic members. This outreach promoted awareness and encouraged members to complete annual A1C testing.
- **Expected Outcome:** This action was expected to increase number of diabetic members who were compliant with annual A1C testing.
- **Action Measurement:** The outcome was determined by the percentage of diabetic members who completed annual A1C testing (85.40% rate for 2019).

Diabetes Results 2019

Goal	Benchmark	Results
1	Maintain a diabetes program enrollment rate of ≥ 50%	In 2019, the diabetes program enrollment rate was 85%
2	Maintain acute diabetes-related episodes rate of ≤ 3.10%	In 2019, members within the diabetes program with acute episodes remained below 3.10% each quarter. Quarter 1: 1.5%, Quarter 2: 0.5%, Quarter 3: 1.2%, Quarter 4: 1.0%
3	Maintain annual A1C testing compliance rate of ≥ 86.91%	In 2019, there was a total percentage of 85.40% of members who have diabetes and had completed their annual A1C testing

Diabetes Goals 2020

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

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

- ***Goal 3: Maintain percentage of members who have diabetes and complete their annual A1C testing at or above 86.91% for 2020. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Monthly automated phone calls and mailed letters will be sent to members who are identified as non-compliant with annual A1C testing.
    - **Action Description:** Member outreach via automated calls and letters will provide reminders and information to promote awareness and support in non-compliant diabetic members. This outreach will encourage annual A1C testing.
    - **Expected Outcome:** This action is expected to increase the number of diabetic members who complete annual A1C testing.
    - **Action Measurement:** Successful outcomes of this intervention will be reflected by an increase in the rate of diabetic members who complete annual A1C testing. (Goal: 86.91%).

Obesity Goals 2019

- ***Goal 1: Maintain an annual enrollment rate in the weight management program above 40% for 2019. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Health coaches were provided member engagement skills training within the first quarter of employment.
    - **Action Description:** Training ensured staff had the knowledge to promote optimal member engagement opportunities through the provision of effective program descriptions and awareness of program benefits during member encounters.
    - **Expected Outcome:** This action was expected to improve member engagement and decrease the rate of members declining disease management through enhanced engagement techniques.
    - **Action Measurement:** Action measurement/outcomes was/were monitored via successful initial health assessments which indicated enrollment into the disease management program and resulted in a 91% engagement rate for 2019.

- ***Goal 2: Increase the percentage of members who report an increase in physical activity from the previous quarter. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Health coaches provided a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding physical activity and weight management.
    - **Action Description:** Coaching/evaluation sessions with health coaches included identifying and reviewing best practices to facilitate behavior change regarding physical activity.
    - **Expected Outcome:** The action of providing enhanced coaching techniques was expected to guide members in making Specific, Measurable, Achievable, Realistic, and Time-based (SMART) goals to increase physical activity and to connect members with exercise physiologists for additional support.
    - **Action Measurement:** Successful outcomes of this intervention were reflected by the rate of increase in member-reported physical activity in each quarter. Results for 2019 were as follows: Quarter 1: 0%, Quarter 2: 38.5%, Quarter 3: 14.3%, Quarter 4: 27.8%.

- ***Goal 3: Increase the percentage of members who report an increase in the number of daily servings of fruits and vegetables when compared with the previous quarter. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Health coaches provided a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding nutrition and weight management.
    - **Action Description:** Sessions with health coaches included identifying and reviewing best practices to facilitate behavior change regarding proper nutrition.
    - **Expected Outcome:** The action of providing enhanced coaching techniques was expected to guide the members in making SMART goals to increase daily servings of fruits and vegetables through awareness and building confidence.
    - **Action Measurement:** Outcomes of this intervention were reflected by the rate of members reporting an increase in daily servings of fruits and vegetables in each quarter. Results for 2019 were as follows: Quarter 1: 0%, Quarter 2: 34.8%, Quarter 3: 30.0%, Quarter 4: 22.2%.

Obesity Results 2019

Goal	Benchmark	Results
1	Maintain a weight management program enrollment rate of ≥ 40%	In 2019, the weight management program enrollment rate was 91%
2	Baseline Year	The quarterly percentage of members who reported an increase in physical activity - Quarter 1: 0, Quarter 2: 38.5%, Quarter 3: 14.3%, Quarter 4: 27.8%
3	Baseline Year	The quarterly percentage of members who reported an increase in daily servings of fruits and vegetables - Quarter 1: 0, Quarter 2: 34.8%, Quarter 3: 30.0%, Quarter 4: 22.2%

Obesity Goals 2020

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

- ***Goal 2: Increase the percentage of members who report an increase in physical activity from the previous quarter. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Health coaches will provide a minimum of three quarterly clinical coaching/evaluation sessions to enrolled members to provide education and resources regarding physical activity and weight management.
    - **Action Description:** Sessions with health coaches will include identifying and reviewing best practices to facilitate behavior change regarding physical activity.
    - **Expected Outcome:** The action of providing enhanced coaching techniques is expected to guide the members in making SMART goals to increase physical activity and to connect members with exercise physiologists for additional support.

- **Action Measurement:** Successful outcomes of this intervention will be reflected by the percentage of members who report an increase in physical activity for each quarter.

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

Appendix D5
UnitedHealthcare of Louisiana
2019 Diabetes and Obesity Action Plan

Diabetes Goals 2019

- ***Goal 1: Facilitate self-management for members with a diagnosis of diabetes by increasing health risk assessments (HRA) by 2% year-over-year (YOY). Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Increase the use of HRAs for new members.
    - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
    - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
    - **Action Description:** Utilize the Healthy First Steps® program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
    - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- ***Goal 3: Increase engagement with providers by 3% YOY to ensure familiarity with current clinical practice guidelines and HEDIS® measurements. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Educate providers on current HEDIS® standards, and use outcomes to focus on the initiatives and results.
    - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health consultants engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS® rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that

indicate whether the providers have met HEDIS® measure targets. The HEDIS® guidelines and tip sheets are also distributed by PHCs to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the PHCs educate providers on the importance of A1C testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, PHCs ensure the providers are aware of the vision vendor MARCH® Vision Care.

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

Diabetes Results 2019

Goal	Benchmark	2019 Results
1	HRA's completed: 5,000	HRA's completed: 8,831
	Members reached: 15,000	Members reached: 28,565
2	Members referred to case management in Measurement Year 2018	Members identified: 10,370 Members qualified: 7,154 Members reached: 3,166 Members referred to case management: 1,742
3	Measurement Year 2018 Rates based on HEDIS® specifications	HEDIS® CDC • Eye Exams: 55.47% • A1C Testing: 86.13% • Medical Attention for Nephropathy: 91.97% • Blood Pressure Control (<140/90): 57.18% • A1C Control (<8.0%): 50.36% • Poor A1C Control (>9.0%): 38.69%

Diabetes Goals 2020

- ***Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes by increasing Health Risk Assessments (HRA) by 2% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Increase the use of HRAs for new members.
  - **Action Description:** Conduct a telephonic HRA that includes monitoring for diabetes risk. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).
  - **Expected Outcome:** The expected outcome should show an increase in the number of members reached.
  - **Action Measurement:** The indicators used to measure this goal include telephone service data and call center data.

- ***Goal 2: Minimize poor birth outcomes due to complications of diabetes by increasing the case management referral of identified and qualified members by 2% YOY. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Educate and refer pregnant women with diabetes to maternal case management.
    - **Action Description:** Utilize the Healthy First Steps® program as a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions, like diabetes, that may complicate pregnancy.
    - **Expected Outcome:** The expected outcome should show an increase in the number of pregnant women with diabetes who are enrolled in case management.
    - **Action Measurement:** The indicators used to measure this goal include telephone service data and the case management database.

- ***Goal 3: Increase engagement with providers by 3% year over year to ensure familiarity with current clinical practice guidelines and HEDIS® measurement. Start Date: 1/1/2020 End Date: 12/31/2020***
    - **Action Step:** Educate providers on current HEDIS® standards, and use outcomes to focus on the initiatives and results.
    - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health consultants engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS® rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS® measure targets. The HEDIS® guidelines and tip sheets are also distributed by PHCs to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers. To help combat diabetes, the PHCs educate providers on the importance of A1C testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, PHCs ensure the providers are aware of the vision vendor MARCH® Vision Care.
    - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS® Comprehensive Diabetes Care (CDC) rate and to see an upward trend in the monthly rates.
    - **Action Measurement:** The indicators used to measure this goal include claims/encounter data and medical/treatment record abstractions.

Obesity Goals 2019

- ***Goal 1: Increase member awareness of healthy lifestyles by 3% year over year. Start Date: 1/1/2019 End Date: 12/31/2019***
    - **Action Step:** Educate members using weight management education materials.

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

- ***Goal 2: Facilitate healthy lifestyles by increasing the number of members in the Heart Smart Sisters® program by 2% YOY. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Continue partnership with faith- and community-based organizations to offer Heart Smart Sisters® program.
  - **Action Description:** Heart Smart Sisters® is a program designed to empower women in ethnic communities to make positive changes to help reduce the risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet, and the importance of regular exercise.
  - **Expected Outcome:** The expected outcome is to see an increase in the number of members contacted for the Heart Smart Sisters® program.
  - **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and in the UHC database/report.

- ***Goal 3: Increase engagement with providers by 3% YOY to ensure familiarity with current clinical practice guidelines and HEDIS® measurements. Start Date: 1/1/2019 End Date: 12/31/2019***
  - **Action Step:** Educate providers by distributing resources including obesity toolkits.
  - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health consultants engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS® rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS® measure targets. The HEDIS® guidelines and tip sheets are also distributed by PHCs to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers.
  - **Expected Outcome:** The expected outcome is to see an improvement in the annual HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) body mass index (BMI) and Adult BMI Screening (ABA) rates and to see an upward trend in the monthly rates.

- **Action Measurement:** The indicators used to measure this goal include information included in claims/encounter data and in medical/treatment record abstractions.

Obesity Results 2019

Goal	Benchmark	Results
1	Mailings to members: 3000	Mailings to members: 17,723
2	Members reached: 100 Events: 10	Members reached: 160 Events: 16
3	Measurement Year 2018 Rates based on HEDIS® technical specifications	ABA: 91.97% WCC: 80.54%

Obesity Goals 2020

- ***Goal 1: Increase member awareness of healthy lifestyles by 3% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Educate members using weight management education materials.
  - **Action Description:** Newly diagnosed existing members and new members who are diagnosed with obesity receive educational materials and newsletters with weight-management-specific information, including recommended routine appointment frequency, health logs, monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to manage their weight.
  - **Expected Outcome:** The expected outcome is to see an improvement in the number of members who are provided with weight management education materials.
  - **Action Measurement:** The indicators used to measure this goal include information contained in claims data, in the UHC database, and in reports.

- ***Goal 2: Facilitate healthy lifestyles by increasing the number of members in the Heart Smart Sisters® program reached by 2% year over year. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Continue partnership with faith- and community-based organizations to offer Heart Smart Sisters® program.
  - **Action Description:** Heart Smart Sisters® is a program designed to empower women in ethnic communities to make positive changes to help reduce the risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet, and the importance of regular exercise.

- **Expected Outcome:** The expected outcome is to see an increase in the number of members contacted for the Heart Smart Sisters® program.
- **Action Measurement:** The indicators used to measure this goal include information included in telephone data, event logs, and in the UHC database/report.

- ***Goal 3: Increase engagement with providers by 3% year over year to ensure familiarity with current clinical practice guidelines and HEDIS® measurement. Start Date: 1/1/2020 End Date: 12/31/2020***
  - **Action Step:** Educate providers by distributing resources including obesity toolkits.
  - **Action Description:** The Population Health Consultant (PHC) Program includes five nurses for Louisiana. Population health consultants engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS® rates, the plan shares information about evidence-based guidelines tailored for the providers' needs based on the providers' requests for condensed information. For those providers who choose to participate in the value-based care initiative, PHCs, along with members of the leadership team in some cases, distribute provider scorecards that indicate whether the providers have met HEDIS® measure targets. The HEDIS® guidelines and tip sheets are also distributed by PHCs to providers at individual offices and at provider expositions around the state. Diabetes and obesity toolkits are also distributed to providers.
  - **Expected Outcome:** The expected outcome is to see an increase in the number of providers educated, an improvement in the annual WCC rate, and an upward trend in the monthly rates.
  - **Action Measurement:** The indicators used to measure this goal include information in the UHC database, information in claims/encounter data and medical/treatment record abstractions.

Appendix E – Standards of Diabetes Care

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

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

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

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