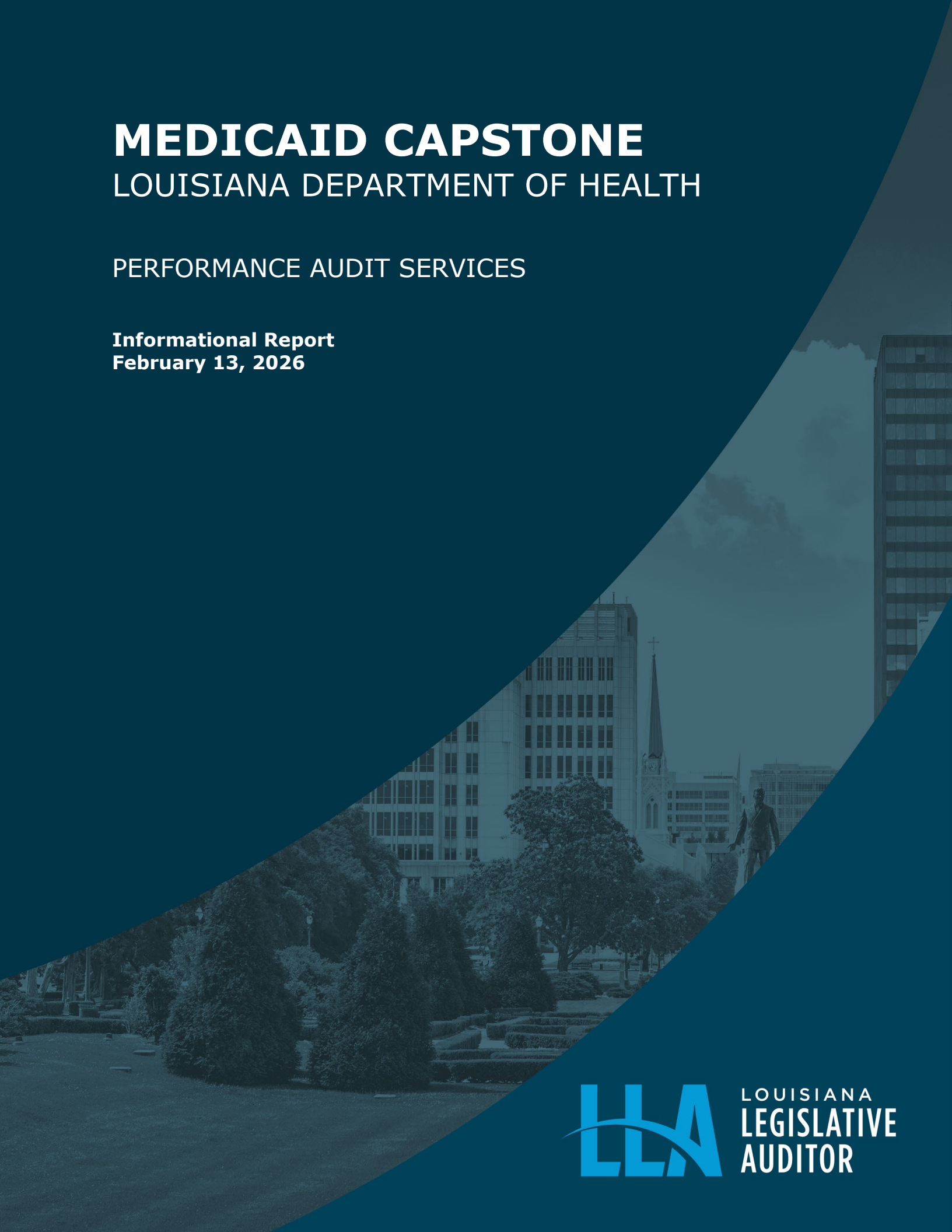
MEDICAID CAPSTONE
LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES

Informational Report
February 13, 2026



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LOUISIANA LEGISLATIVE AUDITOR

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February 13, 2026

The Honorable J. Cameron Henry, Jr.,
President of the Senate
The Honorable Phillip R. Devillier,
Speaker of the House of Representatives

Dear Senator Henry and Representative Devillier:

This capstone report provides information on changes to health care access, outcomes, and fiscal efficiency in Louisiana since the onset of Medicaid Expansion in July 2016. In addition, we evaluated the progress made by the Louisiana Department of Health (LDH) to improve its processes for administering the Medicaid program in Louisiana. This report is intended to provide timely information based on a legislative request. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to LDH for its assistance during this review.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/ch

CAPSTONE

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Medicaid Capstone
Louisiana Department of Health

February 2026

Audit Control # 40250024

Introduction

This capstone report provides information on changes to health care access, outcomes, and fiscal efficiency in Louisiana since the onset of Medicaid Expansion in July 2016. In addition, we evaluated the progress made by the Louisiana Department of Health (LDH) to improve its processes for administering the Medicaid program in Louisiana. During calendar years 2017 through 2025, the Louisiana Legislative Auditor (LLA) issued 57 reports containing at least 143 recommendations to LDH related to its oversight of Medicaid, including ways to improve processes and prevent improper payments (see Appendix B for a list of all reports).[1] We identified approximately $456.3 million in potential improper payments through claims and encounters[2] in past reports focused on the integrity of the Medicaid program. This report includes a summary of prior LLA Medicaid-related reports, the status of LDH's implementation of select recommendations contained in those reports, and an update of select analyses. We compiled this report based on a legislative request to analyze health care access, outcomes, and the fiscal impact of Medicaid Expansion.

Louisiana adopted Medicaid Expansion in January 2016, which made Louisiana residents at or below 138% of the federal poverty level eligible for Medicaid. Expansion enrollment began in June 2016, and coverage began in July 2016. In 2025, a family of four with a yearly income at or below $44,367 was eligible to receive health insurance through Medicaid Expansion.

Managed Care. LDH transitioned from a fee-for-service program to a managed care model in February 2012, seeking to improve access to care, quality of care, health outcomes, and care coordination; and to increase emphasis on disease prevention and early diagnosis and management of chronic conditions. Through its managed care model, LDH pays contracted private insurance companies, or Managed Care Entities (MCEs), a monthly fee/premium, referred to as a per-member-per-month (PMPM) payment. The MCEs manage the care of Medicaid beneficiaries enrolled in their plans, including those enrolled through Medicaid Expansion, by providing case management and care coordination and

[1] Due to time constraints, this report did not evaluate LDH's progress on all 143 recommendations. Instead, we followed up on select recommendations with the potential for the greatest impact to the Medicaid program or those not already followed up on through yearly audits, such as the LLA's Financial Audit Services Management Letters.

[2] Claims are submitted by the provider to the MCE to receive payment for services rendered, and encounters are copies of these claims sent by the MCOs to LDH.

paying providers for services delivered to beneficiaries. As of January 2026, LDH contracts with nine MCEs. This includes six Managed Care Organizations (MCOs)[3] for physical and behavioral health services, two dental benefit program managers (DBPM) for dental services, and one coordinated system of care (CSoC) provider for children with significant behavioral challenges.[4] LDH maintains responsibility for Medicaid functions such as monitoring the MCEs, determining Medicaid beneficiary eligibility, enrolling applicants into Medicaid programs, and ensuring beneficiaries receive quality health care.

Medicaid Eligibility and Expansion. Louisiana residents may qualify for Medicaid coverage by meeting income and/or disability eligibility criteria. Prior to Medicaid Expansion, Medicaid coverage was limited to low-income people who were 65 years or older, disabled, parents of dependent children, qualified pregnant women, or children. On January 12, 2016, then-Governor John Bel Edwards signed an executive order to expand Medicaid access to adults who are at or below 138% of the federal poverty level.[5] According to the executive order, the objective of Medicaid Expansion was to provide access to quality health care and result in significantly better health outcomes for people whose incomes made it exceedingly difficult to afford health care coverage. LDH began enrolling people in Medicaid Expansion in June 2016, with coverage beginning in July 2016. By the end of fiscal year 2017, LDH had enrolled or transferred more than 433,000 beneficiaries to Medicaid Expansion coverage, resulting in a 21.7% decrease in uninsured rates in Louisiana. Medicaid enrollment peaked in May 2023 at 2,055,782 due to the COVID-19 Public Health Emergency (COVID-19 PHE) and decreased 26.5% from that peak to 1,511,488 as of December 2025.

Further, Medicaid Expansion was expected to save the state money by having the federal government cover a larger percentage of health care costs for beneficiaries. Prior to Medicaid Expansion, the traditional split between federal and state funding for Medicaid was approximately 62.2% federal and 37.8% state. For those people qualifying under Medicaid Expansion, the split was initially 100.0% federal and 0.0% state. In 2020, the split changed to 90.0% federal and 10.0% state, as designed by federal law.

Medicaid Services and Providers. Medicaid beneficiaries have access to physical health, behavioral health, dental, and other service providers through their MCEs. The MCEs contract with providers throughout the state to provide access to these services. Contracts between LDH and the MCEs require the MCEs to meet certain network adequacy standards to ensure there are enough providers located throughout the state to serve Medicaid beneficiaries. Exhibit 1 provides examples of the types of Medicaid services provided in Louisiana.

[3] An MCO is a private insurance company that manages the care of beneficiaries enrolled in its plan.
[4] Aetna, AmeriHealth Caritas Louisiana, Healthy Blue Louisiana, Humana, Louisiana Healthcare Connections, and United Healthcare are the physical and behavioral health MCOs; DentaQuest and Managed Care of North America are the DBPMs; and Magellan is the CSoC.
[5] Executive Order No. JBE 16-01

Exhibit 1 Categories of Medicaid Services	
Service Type	**Examples of Services**
Physical Health	Doctor and hospital visits, laboratory and x-ray tests, prescription drugs
Behavioral Health	Substance use treatment, mental health counseling, crisis intervention
Dental	Teeth cleanings, exams, fillings, x-rays
Other	Transportation to and from services
Source: Prepared by legislative auditor's staff using information from LDH.	

Program Integrity. Federal regulations[6] require states to have a surveillance and utilization review system to identify suspicious provider billing patterns. LDH's Program Integrity section fulfills this role and is tasked with preventing, detecting, and addressing improper payments that result from fraud, waste, or abuse.

The objective of this review was:

To provide information on changes to health care access, outcomes, and fiscal efficiency since the onset of Medicaid Expansion and determine LDH's progress in addressing issues identified in previous LLA reports.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains our scope and methodology. Appendix B lists past LLA Medicaid-related reports issued during January 2017 through December 2025. Appendix C summarizes Medicaid enrollment, by month, from July 2015 through December 2025, and Appendix D includes a list of data sources used to verify Medicaid eligibility.

Informational reports are intended to provide more timely information than standards-based performance audits. While these informational reports do not follow *Government Auditing Standards*, we conduct quality assurance activities to ensure the information presented is accurate. We provided a draft to LDH and incorporated its feedback throughout this informational report.

[6] 42 Code of Federal Regulations (CFR) Part 456

Objective: To provide information on changes to health care access, outcomes, and fiscal efficiency since the onset of Medicaid Expansion and determine LDH's progress in addressing issues identified in previous LLA reports.

Overall, we found that Medicaid Expansion resulted in improved healthcare access and fiscal efficiency of state general funds. In addition, LDH has improved its oversight of Medicaid providers and beneficiaries, as well as the integrity of its Medicaid eligibility determination process. However, we found that LDH still needs to improve the accuracy and adequacy of MCO provider networks, health outcomes for Medicaid beneficiaries, and its oversight of the Medicaid program by using its own data, beneficiary complaints, and provisions in its MCO contracts, such as fines. Specifically, we found the following:

- **Medicaid enrollment increased starting in June 2016 due to Medicaid Expansion, resulting in people obtaining health care coverage who previously did not qualify and more comprehensive coverage for some beneficiaries already enrolled. Medicaid enrollment peaked in 2023 due to the COVID-19 Public Health Emergency (COVID-19 PHE).** More than 433,000 people gained Medicaid coverage under Medicaid Expansion in the first year. However, more than half of these Medicaid beneficiaries were already enrolled in a Medicaid program offering limited coverage and received more comprehensive coverage through expansion. After the first year of Medicaid Expansion, Medicaid enrollment remained relatively steady except for changes to LDH's eligibility verification processes and the COVID-19 PHE and subsequent "unwind."

- **Overall Medicaid expenditures have increased since fiscal year 2016 because of rising enrollment and health care costs, but the majority of these increased expenditures have been paid through federal funds. State general funding for the Medicaid program decreased during fiscal years 2016 through 2024.** Expanding Medicaid allowed Louisiana to draw down additional federal funding, increase revenues through an MCO premium tax, and decrease expenditures for uninsured individuals. During fiscal years 2016 through 2024, federal funding for LDH's Medicaid program increased 146.1%, while state funding increased 52.2%. The increase in state funding was due to other means of state financing, as state general funding decreased 1.1% during this time. The amount of state funding spent per beneficiary increased by 14.8% during fiscal years 2016 through 2024. The majority (97.3%) of Medicaid funds spent

during this period were for health care payments to providers or MCEs, with the remaining funds (2.7%) going toward administrative costs.

- **LDH's Program Integrity (PI) section is responsible for identifying improper payments and potential fraud in the Medicaid program. We previously recommended ways to strengthen oversight of the Medicaid program, and LDH has implemented these and other measures.** PI and its contractors investigated 14,482 improper payment allegations during July 2015 through November 2025, resulting in $40.5 million in recoveries. The most commonly identified improper payments involved Home and Community Based Services (HCBS), resulting in $17.0 million (42.0%) of total recoveries during this period. During October 2017 through March 2023, we issued seven reports related to behavioral health services because of the increase of these services and the percentage of fraud notices and referrals from the MCOs for behavioral health providers. We followed up on five recommendations made in these reports, and LDH implemented or partially implemented four (80.0%) as of November 2025. LDH created a task force in April 2025 to address fraud, waste, and abuse in the Medicaid program, and Act 427 of the 2025 Regular Legislative Session will allow for more transparency related to LDH's identification of Medicaid fraud.

- **LDH analyzes the eligibility of Medicaid applicants and beneficiaries through various data matches and information submitted by applicants. LDH has improved its use of data as recommended in prior LLA reports, resulting in strengthened eligibility verification processes. Recent changes in state and federal law will require LDH to further enhance how it analyzes Medicaid eligibility.** During May 2018 through August 2025, we issued nine reports specifically focused on strengthening LDH's processes related to Medicaid eligibility. We followed up on nine recommendations made in these reports and found LDH implemented all nine (100.0%) as of November 2025. Act 427 of the 2025 Regular Legislative Session codified many eligibility checks LDH performs to ensure they are conducted in the future. Further, House Resolution 1 of the 119th Congress made changes to Medicaid eligibility requirements and monitoring.

- **Despite increases in insurance coverage rates, Louisiana's overall health outcomes have not improved over the last decade. While both LLA and LDH have identified issues with the accuracy and adequacy of MCE provider networks and recommended ways to address them, these issues persist.** We analyzed LDH Medicaid complaint data and found the majority of Medicaid beneficiaries' complaints were related to a lack of transportation to access care or the inability to find a provider. We analyzed network adequacy reports as of December 2024 and found

10,081 (31.1%) of the 32,402 unique Medicaid providers had no claims for services provided during the six-month period of July 2024 through December 2024. However, as of December 5, 2025, LDH only levied two monetary penalties for network inadequacy since July 2019. LDH suspended its provider directory audits and initiative to clean up provider networks during calendar year 2024 due to staffing shortages. LDH resumed the provider directory audits in March 2025.

- **While LDH has implemented various programs and initiatives to increase quality of care for Medicaid beneficiaries, Louisiana continues to rank low in health outcomes when compared to other states. LDH is making changes to some of these programs and initiatives to improve quality as a result of issues identified in past LLA reports.** LDH has historically withheld 1.0% of PMPMs to incentivize MCOs to increase quality of care, but LDH's design of the program allowed for instances in which withholds were paid to MCOs without demonstrating improved outcomes. LDH recently amended MCO contracts to increase emphasis on improved outcomes. Similarly, LDH's design and lack of oversight of the Managed Care Incentive Program (MCIP) historically led to the majority of MCIP program funds being paid for activities that did not have a direct, measurable impact for how they improve access to health care, improve quality of care, or enhance the health of Medicaid beneficiaries. LDH made changes to the program effective January 2026 to address these issues. LDH receives complaints from beneficiaries in various ways. According to LDH, it plans to implement LLA's previous recommendation to compile these complaints into one database to identify trends and analyze its Medicaid program by March 31, 2026. We previously found a small percentage of Medicaid beneficiaries in certain high-risk populations receive case management services. LDH recently changed case management requirements.

This information is discussed in more detail in the following sections.

Medicaid enrollment increased starting in June 2016 due to Medicaid Expansion, resulting in people obtaining health care coverage who previously did not qualify and more comprehensive coverage for some beneficiaries already enrolled. Medicaid enrollment peaked in 2023 due to the COVID-19 PHE.

Louisiana residents may qualify for Medicaid coverage by meeting specific eligibility criteria, including income, household composition, and disability status. Prior to Medicaid Expansion, Medicaid coverage was limited to people who were 65 years or older, disabled, parents of dependent children, qualified pregnant women, or children. As a result of the expansion, adults earning at or below 138.0% of the federal poverty level (FPL) became eligible.[7]

> "Most of the people affected by Medicaid Expansion are gainfully employed, yet have incomes where it is exceedingly difficult to afford health care coverage."
>
> Executive Order No. JBE 16-01

More than 433,000 people gained Medicaid coverage under Medicaid Expansion in the first year. However, more than half of these Medicaid beneficiaries were already enrolled in a Medicaid program offering limited coverage and received more comprehensive coverage through expansion. According to LDH's Medicaid enrollment data, as of May 2016, there were 1,394,133 Medicaid beneficiaries in Louisiana. In June 2016, Medicaid Expansion allowed LDH to enroll new Medicaid beneficiaries and transitioned 225,382 Medicaid beneficiaries from partial to full coverage plans. The expansion provided beneficiaries with access to services for which they previously did not have access, including preventative screenings such as mammograms and colorectal screenings. By June 2017, there were 1,581,306 Medicaid beneficiaries, which represented a 13.4% increase from May 2016.

After the first year of Medicaid Expansion, Medicaid enrollment remained relatively steady, except for changes to LDH's eligibility verification processes and the COVID-19 PHE and subsequent "unwind." The number of Medicaid beneficiaries increased 1.4%, from 1,583,198 in July 2017 to 1,604,957 in February 2020. One enrollment fluctuation in April 2019 resulted from our recommendation for LDH to use Louisiana Workforce Commission (LWC) wage data on a quarterly basis rather than only using it annually to verify income eligibility. This contributed to LDH removing 105,379 beneficiaries who no longer met income eligibility requirements from Medicaid between March 2019 and June 2019.[8]

[7] The FPL for an individual eligible for Medicaid Expansion in 2016 was $16,394 and $33,534 for a family of four. The FPL for an individual eligible for Medicaid Expansion in 2025 was $21,597 and $44,367 for a family of four.

[8] Eligibility criteria, the eligibility determination process, and Medicaid Expansion will be discussed in detail later in this report.

As people lost their jobs permanently or temporarily because of the COVID-19 PHE, the number of Medicaid beneficiaries in Louisiana increased by 28.1%, from 1,604,957 in February 2020 to a peak of 2,055,782 in May 2023. During the PHE, the Families First Coronavirus Response Act (FFCRA) authorized an increase[9] in the federal share of the cost of Medicaid services in each state. To qualify for this increase, states could not use their normal process to determine Medicaid eligibility and instead could only terminate a beneficiary's coverage for three reasons *(see text box at right).* LDH could not begin removing ineligible beneficiaries from Medicaid through annual eligibility reviews until the end of the COVID-19 PHE, known as the "unwind" period.[10] As of December 2025, there were 1,511,488 Medicaid beneficiaries, which is the fewest number of beneficiaries since October 2016. Exhibit 2 shows the change in beneficiary enrollment in Medicaid and Medicaid expansion during May 2016 through December 2025. Appendix C shows Medicaid enrollment by month during July 2015 through December 2025.

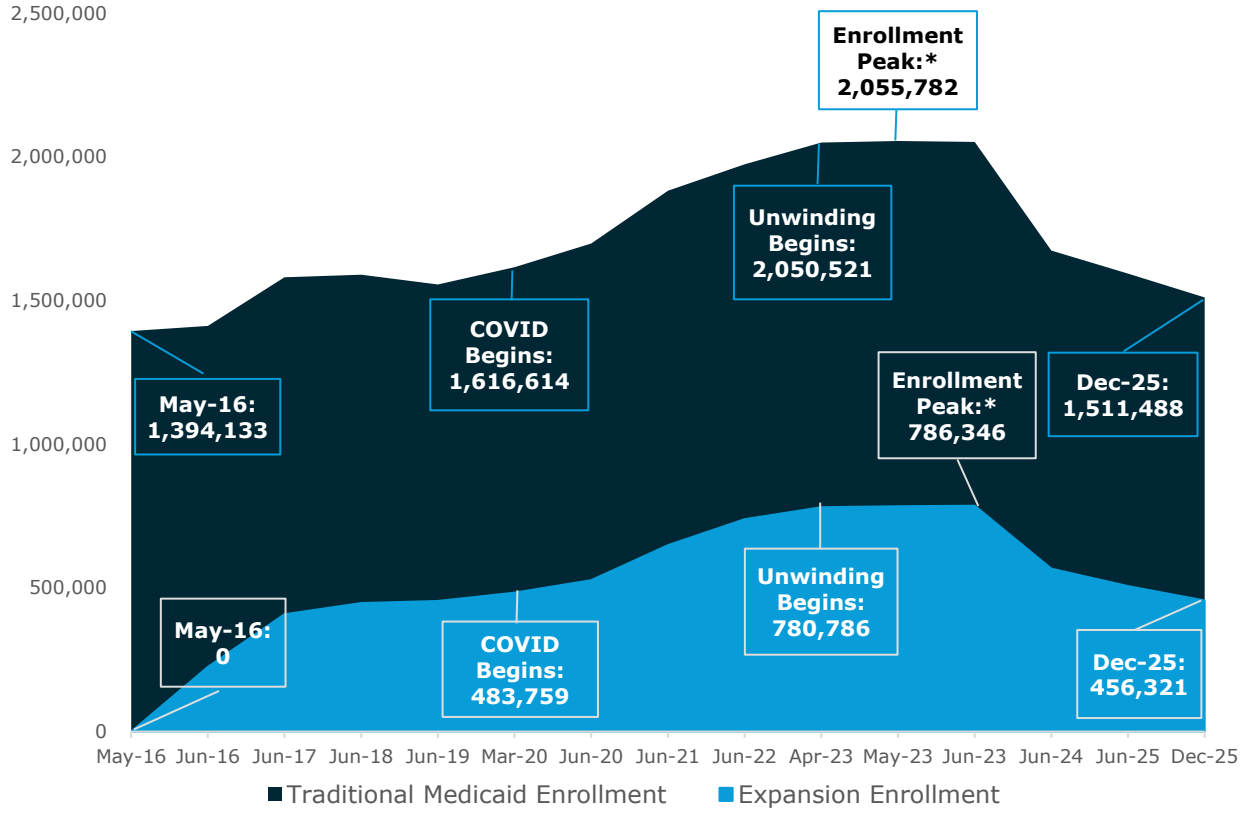
During the COVID-19 PHE, the three reasons LDH could close Medicaid cases were if a beneficiary:

1. Moved out of state,
2. Died, or
3. Requested closure.

[9] The FFCRA authorized an increase of 6.2 percentage points to the states' Federal Medical Assistance Percentage (FMAP), which was estimated to increase federal funding for Medicaid in Louisiana by approximately $570 million.

[10] The PHE ended on March 31, 2023, allowing states to resume normal operations, including restarting full Medicaid and Children's Health Insurance Program (CHIP) eligibility renewals and terminations of coverage for individuals who were no longer eligible. Beginning April 1, 2023, states were able to terminate Medicaid enrollment for individuals no longer eligible. States had up to 12 months to return to normal eligibility and enrollment operations.

Exhibit 2
Change in Beneficiary Enrollment in Medicaid and Medicaid Expansion
May 2016 through December 2025



* The peak in enrollment occurred after unwinding because LDH did not make beneficiary eligibility determinations until at least 45 days after notifying the beneficiary.
Source: Prepared by legislative auditor's staff using information from LDH.

Overall Medicaid expenditures have increased since fiscal year 2016 because of rising enrollment and health care costs, but the majority of these increased expenditures have been paid through federal funds. State general funding for the Medicaid program decreased during fiscal years 2016 through 2024.

States design their Medicaid programs to provide coverage and benefits for certain groups of

"By failing to expand Medicaid under the previous administration, Louisiana lost the opportunity to receive over $3 [billion] in federal health care funds; with Medicaid Expansion, Louisiana could realize additional State General Fund savings of nearly $100 [million] through FY2020."

Executive Order No. JBE 16-01

individuals, as specified under federal law,[11] in order to receive federal funding for health care and administrative costs. As previously mentioned, Medicaid Expansion saved the state money since the federal government funded a larger percentage of health care costs.

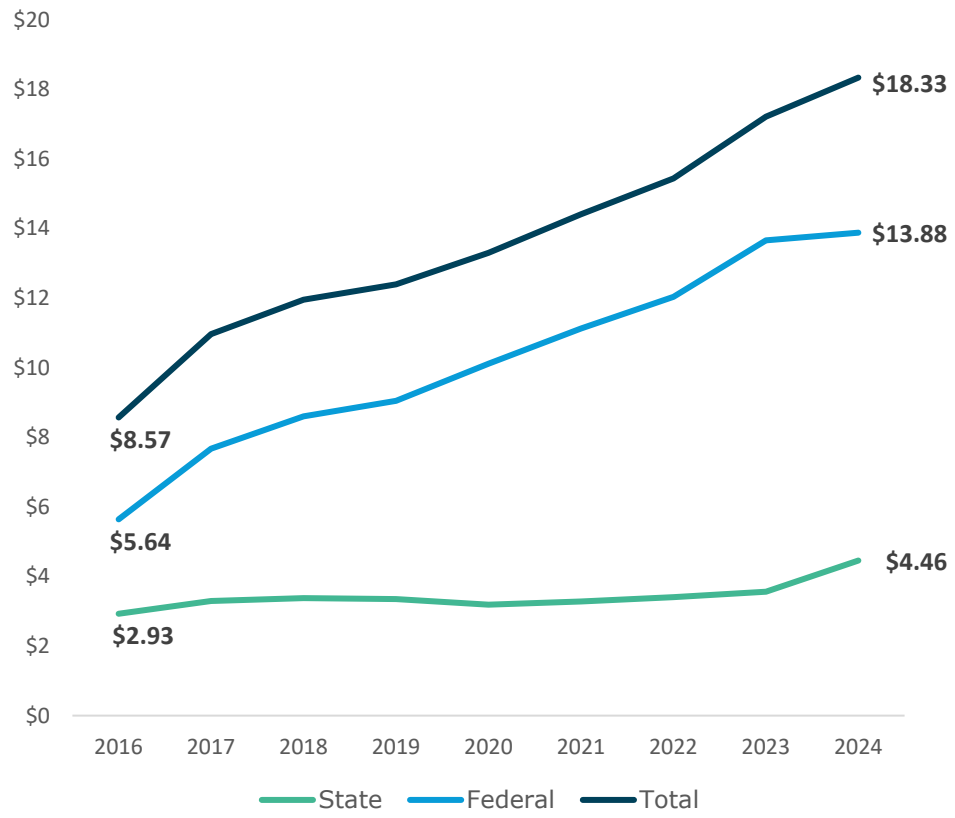
Expanding Medicaid allowed Louisiana to draw down additional federal funding, increase revenues through an MCO premium tax, and decrease expenditures for uninsured individuals. Louisiana was experiencing a $2.0 billion budget deficit when Medicaid was expanded in fiscal year 2016. According to LDH, Medicaid Expansion saved the state $199 million by fiscal year 2017 and was projected to save the state increasing amounts in subsequent years by drawing down additional federal funds with a higher federal match rate and decreasing hospital payments for uninsured individuals. Unlike traditional Medicaid, where Louisiana paid approximately 37.8% of the cost to cover a beneficiary, required state matching funds are a significantly lower percentage for Medicaid Expansion coverage. Initially, federal funds paid 100.0% of the cost of Medicaid Expansion coverage, with that amount decreasing to 90.0% in 2020.[12] According to LDH, additional ways savings in state general funds were achieved were through the following:[13]

- Increasing revenue from a premium tax on MCOs.
- Decreasing disproportionate share payments,[14] which are payments LDH makes to qualifying hospitals that serve a large number of Medicaid and uninsured individuals for uncompensated costs, as the uninsured population decreased.
- Decreasing the state share of hospital supplemental payments as a result of increased federal funding under Expansion.
- Increasing inpatient hospital savings by providing Medicaid coverage for newly released state prisoners under Expansion.

During fiscal years 2016 through 2024, federal funding for LDH's Medicaid program increased 146.1%, from $5.64 billion in fiscal year 2016 to $13.88 billion in fiscal year 2024. While state funding increased 52.2%, from $2.93 billion to $4.46 billion over this period, the amount of state funding spent per beneficiary increased by 14.8%. Total enrollment in Medicaid increased by 455,089 (32.7%) during these years, but state funds spent per beneficiary increased by 14.8%. Although federal funding spent per beneficiary increased by 85.5%, this is at least partially explained by the increased number of Medicaid Expansion beneficiaries added to the Medicaid program and the higher federal match rate during the COVID-19 PHE, as previously discussed. Exhibit 3 shows the change in state, federal, and total funding during fiscal years 2016 through 2024.

[11] Title 42 CFR
[12] Specifically, the federal government paid 100.0% of the funding for new enrollees through 2016, 95.0% in 2017, 94.0% in 2018, 93.0% in 2019, and 90.0% thereafter.
[13] https://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2017.pdf
[14] These payments are also known as Uncompensated Care Costs payments.

Exhibit 3
Change in State, Federal, and Total Funding Since Expansion (in billions)
Fiscal Years 2016 through 2024

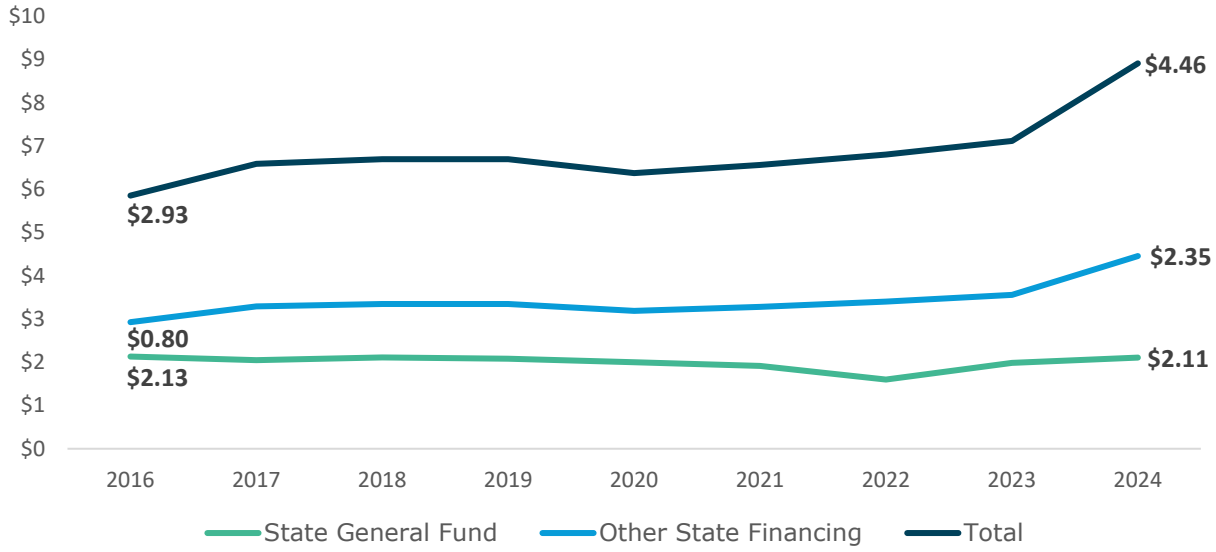


Source: Prepared by legislative auditor's staff using data from LDH's Medicaid Annual Reports.

Although total state funding for Medicaid increased during fiscal years 2016 through 2024, state general funding decreased 1.1% during this period. State funding for the Medicaid program is comprised of state general funds and other state financing. According to LDH, examples of other state financing include funding streams such as the premium taxes discussed previously and from entities to pay the state's share of programs, such as the Managed Care Incentive Payment (MCIP) program.[15] During fiscal years 2016 through 2024, the use of the state general fund decreased 1.1% from $2.13 billion to $2.11 billion. The use of other state financing increased 195.5% from $795.3 million to $2.35 billion, causing the overall increase in state funding since fiscal year 2016, as shown in Exhibit 4.

[15] The MCIP program will be discussed in detail later in this report.

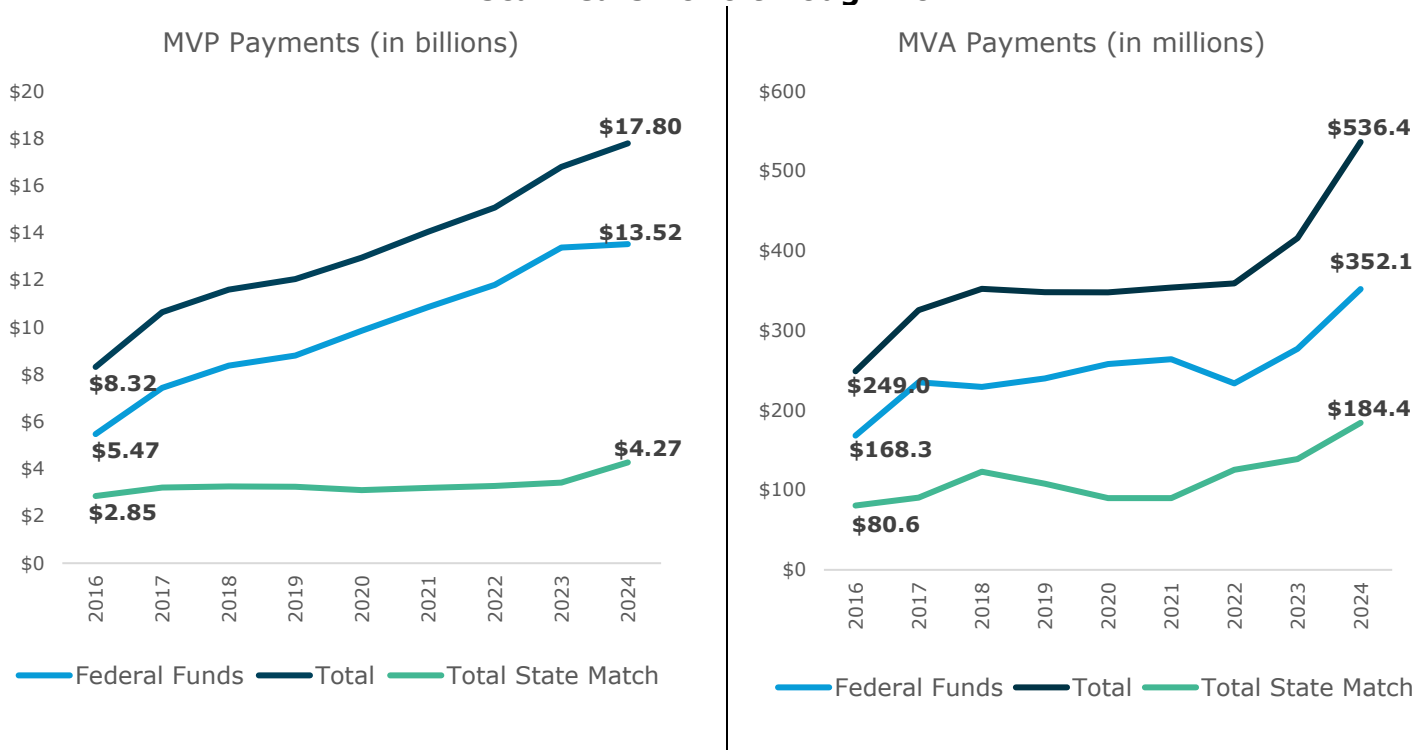
Exhibit 4
Change in State Funding for Medicaid (in billions)
Fiscal Years 2016 through 2024



Source: Prepared by legislative auditor's staff using data from LDH's Medicaid Annual Reports.

During fiscal years 2016 through 2024, 97.3% ($119.26 billion) of Medicaid funds were spent on health care payments to providers or MCEs. The remaining 2.7% ($3.29 billion) in Medicaid expenditures were for administrative costs. LDH's Medical Vendor Payment (MVP) Program is the financial entity from which all health care providers serving Medicaid enrollees and the uninsured and the managed care plans are paid. LDH's Medical Vendor Administration (MVA) is responsible for the development, implementation, and enforcement of the administrative and programmatic policies of the Medicaid program with respect to eligibility. Federal funding pays for the majority of MVP and MVA expenditures and accounts for most of the increase in the cost of the Medicaid program. Exhibit 5 shows the changes in state, federal, and total funding for MVP and MVA payments during fiscal years 2016 through 2024.

Exhibit 5
Change in State, Federal, and Total Funding for MVP and MVA Payments Since Expansion
Fiscal Years 2016 through 2024



Source: Prepared by legislative auditor's staff using data from LDH's Medicaid Annual Reports.

LDH's Program Integrity (PI) section is responsible for identifying improper payments and potential fraud in the Medicaid program. We previously recommended ways to strengthen oversight of the Medicaid program, and LDH has implemented these and other measures.

PI is responsible for assuring the programmatic and fiscal reliability of Louisiana Medicaid. Federal regulations and state law[16] require PI to oversee fraud and abuse detection, investigations, enforcement, and sanctioning. PI works with fraud units from the MCEs and the Louisiana Attorney General's Medicaid Fraud Control Unit (MFCU). These entities identify potential improper payments through Medicaid claims and encounter data mining and analysis, as well as investigating complaints. PI receives complaints from providers, private citizens, other agencies or offices within LDH through the fraud and abuse hotline,[17] LDH's website, and

[16] 42 CFR Part 455 and Louisiana Revised Statute (La. R.S.) 46:437.1 through 46:440.3
[17] The state has a toll-free hotline for reporting possible fraud and abuse in the Medicaid program. Providers are encouraged to provide the hotline number to individuals who want to report possible cases of fraud or abuse.

written reports. The MCEs are also required to submit reports of fraud and abuse notices and referrals to LDH. Previous LLA reports included recommendations related to preventing and detecting improper provider payments.

PI and its contractors investigated 14,482 improper payment allegations during July 2015 through November 2025, resulting in $40.5 million in recoveries. The most commonly identified improper payments involved Home and Community Based Services (HCBS), resulting in $17.0 million (42.0%) of total recoveries during this period. HCBS provides services to various populations, such as the elderly and individuals with disabilities, to enable them to remain in their homes and communities. These types of services are particularly vulnerable to abuse by providers because they are generally provided in the homes of beneficiaries who often have cognitive impairments, such as Alzheimer's disease. Using PI data, we found at least 5,015 (34.6%) allegations investigated by PI and its contractors during July 2015 through November 2025 were for improper HCBS provider payments, resulting in $17.0 million (42.0%) in recoveries during this period. According to LDH, HCBS providers are the largest category of allegations because it is easier for providers to file fraudulent claims when unsupervised in a home-based setting.

In July 2017, we found issues with LDH's oversight of HCBS and made recommendations for strengthening LDH's provider application, screening, and billing processes. LDH implemented our recommendation to ensure prospective HCBS direct service workers are not listed on the registry for abuse, neglect, or misappropriation of property and are properly conducting and billing visits. Further, LDH implemented our recommendation to establish an electronic visit verification (EVV) system to ensure providers are submitting claims for accurate times and locations.

During October 2017 through March 2023, we issued seven reports related to behavioral health services because of the increase of these services and the percentage of fraud notices and referrals from MCOs for behavioral health providers. We followed up on five recommendations made in these reports, and LDH implemented or partially implemented four (80.0%) as of November 2025. We analyzed fraud and abuse notices and referrals submitted monthly by the MCOs to LDH and found that 2,304 (46.2%) of 4,991 were for behavioral health providers during January 2015 through July 2025. In our analysis of improper provider payment allegations investigated by PI and its contractors, we found at least 1,697 (11.7%) of 14,482 allegations during July 2015 through November 2025 were behavioral health related, resulting in $2.8 million (7.0%) of $40.5 million in total recoveries during this period.

LLA reports related to LDH's behavioral health program issued between October 2017 and March 2023 found LDH should strengthen its oversight of two common types of services, Psychosocial Rehabilitation (PSR) and Community Psychiatric Support and Treatment (CPST), because of findings of noncompliance with state laws and Medicaid requirements. It is critical that LDH monitor these providers and establish controls to prevent or identify potentially improper

payments because LDH and other stakeholders, such as the MFCU within the Louisiana Attorney General's Office, have identified PSR and CPST services as an area of potential high risk and noncompliance. A March 2023 LLA report found payments for PSR and CPST encounters totaled $824.3 million during October 2017 through June 2022.[18]

Beginning in calendar year 2019, LDH met with stakeholders to identify ways to bring more integrity to PSR and CPST services. As a result, Act 503 was passed during the 2022 Regular Session[19] to establish new PSR and CPST definitions and provider qualification and licensure requirements, effective January 1, 2023. LDH has issued guidance and clarification on the provision of PSR and CPST services, such as requirements for assessments, locations in which providers may offer services, and monitoring and documenting beneficiary progress. Exhibit 6 details select issues we identified related to behavioral health providers and recommendations made in previous reports and the status of LDH's implementation of these recommendations as of November 2025.

Exhibit 6
Issues Related to Improper Behavioral Health Provider Claims for Reports Issued During October 2017 through March 2023

Summary of Identified Issue	Recommendation for LDH	Status of Implementation as of November 2025
114,963 (40.2%) of the 286,307 CPST and PSR encounters provided from January 1, 2019, to March 31, 2019, did not include the National Provider Identification (NPI) number of the individual providing the service as required in state law.	Implement an edit check to require CPST and PSR service providers to provide NPIs on encounters and collect recoupments of improper payments.	**Implemented.** LDH created an edit check to deny CPST and PSR encounters with dates of service starting January 1, 2019, when they do not have individual NPIs.
825 providers improperly billed at least $582,53713 for the services provided in excess of 12 hours per day between August 2, 2019, through September 7, 2022, which appears to violate state law.	Implement an edit check to identify providers billing for more than 12 hours in a day to identify any instances of improper billing and identify potentially risky providers.	**Partially implemented.** According to LDH, it did not implement an edit because of complexities in coding the edit and because exceptions are allowed to the 12-hour law if care over 12 hours is determined medically necessary. However, LDH stated that it has implemented a quarterly report to identify providers who billed more than 12 hours of these services on the same calendar day.

[18] This total also includes Crisis Intervention (CI) encounters for services, such as preliminary assessments and linkages to community services, provided to people experiencing a psychiatric crisis. However, CI encounters are substantially less common than PSR and CPST encounters.
[19] https://legis.la.gov/legis/ViewDocument.aspx?d=1289616

Exhibit 6
Issues Related to Improper Behavioral Health Provider Claims for Reports Issued During October 2017 through March 2023

Summary of Identified Issue	Recommendation for LDH	Status of Implementation as of November 2025
$223,372 was paid for 2,367 encounters billed from September 9, 2020, through September 22, 2022, where a recipient received PSR, CPST, or CI services while in an inpatient setting, which is prohibited by the Provider Manual.	Enforce the inpatient services requirement in the Provider Manual.	**Not implemented.** LDH does not perform analyses to identify instances where these services are provided in an inpatient setting. However, as of January 2026, LDH stated that it is working to perform these analyses.
There were $1,998,778 in payments for 29,406 encounters billed from March 31, 2020, through September 22, 2022, where Specialized Behavioral Health (SBH) providers did not properly code SBH services delivered via telehealth.	Enforce telehealth service and coding requirements and develop guidance regarding the environment from which telehealth services should be provided.	**Implemented.** LDH created additional guidance regarding coding requirements and which services are allowed to be delivered via telehealth when clinically appropriate, which generally include those conducted by licensed mental health practitioners whose professional boards have established standards of care for telehealth services.
Approximately $47.5 million in Behavioral Health encounters and claims for services between December 2015 through June 2019 were paid by LDH, the MCOs, and Magellan even though the encounters and claims did not comply with LDH's fee schedule.	Establish edit checks to ensure that behavioral health encounters are accepted only when they comply with the fee schedule.	**Partially implemented.** According to LDH, while it has not implemented edit checks to identify these billings, it instead performs post-payment reviews of a small sample of encounters and claims to identify whether they were billed in accordance with the fee schedule. Recent analyses show that the amount of billing identified as potentially improper increased in fiscal year 2025 when compared to fiscal year 2024.

Source: Prepared by legislative auditor's staff using information from prior LLA reports and information from LDH.

To further increase its oversight of behavioral health providers, LDH stated PI is conducting a provider compliance review of all behavioral health providers. As part of this review, PI is analyzing the credentials and licenses of providers, whether they have required policies and procedures, and ensuring employees working for providers have not had past issues with improper activities, among other items. Because some behavioral health services are provided in the home and community like HCBS services discussed previously, PI staff stated EVV could potentially be applied to behavioral health providers to monitor service provision and ensure claims are submitted for the proper location and time.

In April 2025, LDH created the Fraud, Waste, and Abuse Task Force (FWA Task Force) to address the state's most pressing health care challenges, including those related to PI. Requirements in Act 427 of the 2025 Regular Legislative Session[20] will allow for more transparency related to LDH's identification of Medicaid fraud. As part of the FWA Task Force, LDH is

[20] La. R.S. 46:440.21

partnering with the University of Louisiana at Lafayette to identify and address waste, abuse, and fraudulent practices within Louisiana Medicaid using artificial intelligence and data analytics. LDH is also enhancing collaboration with the Attorney General's MFCU to increase LDH's ability to detect, investigate, and prosecute fraudulent activity and maximize recoveries for the Medicaid program. To increase transparency related to Medicaid fraud, Act 427 requires LDH to report quarterly on its website the number of Medicaid cases investigated for program violations or fraud and the total number and type of cases referred to the Attorney General's office for prosecution beginning June 20, 2025.

LDH analyzes the eligibility of Medicaid applicants and beneficiaries through various data matches and information submitted by applicants. LDH has improved its use of data as recommended in prior LLA reports, resulting in strengthened eligibility verification processes. Recent changes in state and federal law will require LDH to further enhance how it analyzes Medicaid eligibility.

LDH's Bureau of Health Services Financing's (BHSF) Medicaid Eligibility Section is responsible for determining whether applicants qualify for Medicaid. Applicants must submit a Medicaid application by mail, online, in person, or through a responsible authorized representative at any Medicaid office. Individuals determined to be eligible for Medicaid are classified into eligibility categories or groups based on specified criteria. LDH is required to make eligibility determinations and inform the applicant within 90 days for applications requesting coverage based on disability and within 45 days for all other applications. Medicaid eligibility is determined based on the information contained in the application and additional sources of verification detailed in the following sections.

LDH is required by federal law[21] to request information to verify income, residency, citizenship, immigration status, and other financial and non-financial eligibility requirements. LDH uses electronic sources from other state agencies and federal programs to verify this information. Appendix D contains a list of data sources used by LDH to verify Medicaid eligibility.

During May 2018 through August 2025, we issued nine reports specifically focused on strengthening LDH's processes related to Medicaid eligibility. We followed up on nine recommendations made in these reports and found LDH implemented all nine (100.0%) as of November 2025. Because the Medicaid program is a large portion of Louisiana's state budget, we have routinely evaluated LDH's processes to determine the eligibility of Medicaid

[21] 42 CFR 435.945-435.956

beneficiaries and applicants to strengthen the integrity of the Medicaid program. Specifically, we have analyzed eligibility processes related to income, incarceration and deceased status, and residency. These evaluations generally found that LDH was meeting requirements in these areas but could enhance its processes to improve eligibility determinations.

In our November 2018 report, we found LDH was conducting matches with LWC wage data on an annual basis to determine whether applicants meet Medicaid income requirements. Businesses submit employee wage data to LWC on a quarterly basis, which LDH can use to identify beneficiaries who may no longer meet Medicaid income eligibility requirements. When we asked LDH why it did not check wages quarterly, LDH stated it would be too expensive to do so. We performed this analysis in our November 2018 report and identified 19,789 potentially ineligible individuals who no longer met Medicaid income eligibility requirements. As a result, LDH began conducting these matches on a quarterly basis and reported savings of $14.7 million for the month of January 2019.[22] Exhibit 7 details select issues we identified, recommendations made related to Medicaid eligibility in previous reports, and the status of LDH's implementation of these recommendations and projected costs savings, where applicable, as of November 2025.

Exhibit 7
Select LLA Medicaid Eligibility Recommendations and LDH Action for Reports Issued During May 2018 through August 2025

Summary of Identified Issue	Recommendation for LDH	Status of Implementation and Cost Savings as of November 2025*
LDH's reasonable compatibility standard of 25% was higher than any other state.	Consider adopting a reasonable compatibility standard that is in line with other states.	**Implemented.** LDH lowered its reasonable compatibility standard to 10% in June 2018 and further reduced it to 4% in September 2025. The change from 10% to 4% was projected to save approximately $26.0 million annually.
The formula LDH used to calculate reasonable compatibility was incorrect.	Consider using a different formula to calculate reasonable compatibility.	**Implemented.** LDH changed its formula to correctly calculate reasonable compatibility.
Unlike 30 other states, LDH was not using federal or state income tax data to assist in eligibility determinations.	Consider obtaining federal income tax data to assist in making eligibility determinations.	**Implemented.** LDH began using tax data as part of its eligibility determinations.
LDH paid for Medicaid coverage for beneficiaries who were incarcerated.	Work with the Louisiana Department of Corrections to improve its process to identify incarcerated Medicaid beneficiaries.	**Implemented.** LDH began another initiative to further identify potentially incarcerated members. This new initiative is expected to save approximately $10.8 million in fiscal year 2026.

[22] According to our May 2019 follow-up report.

Exhibit 7
Select LLA Medicaid Eligibility Recommendations and LDH Action for Reports Issued During May 2018 through August 2025

Summary of Identified Issue	Recommendation for LDH	Status of Implementation and Cost Savings as of November 2025*
LDH paid for Medicaid coverage for beneficiaries who were deceased.	Determine whether to utilize additional third-party data sources as part of its eligibility determination process.	**Implemented.** LDH began obtaining access to various third-party data sources to identify deceased Medicaid beneficiaries. This change allowed LDH to recover $6.2 million paid on behalf of deceased Medicaid beneficiaries and is expected to save approximately $9.6 million in fiscal year 2026.
LDH paid for Medicaid coverage for beneficiaries who appeared to live out of state.	Obtain and incorporate Office of Motor Vehicle (OMV) data to identify Medicaid beneficiaries who potentially live out of state.	**Implemented.** LDH obtained OMV data and implemented it as part of its eligibility determination process. This is a third initiative of the FWA Task Force described previously. Through October 2025, LDH had saved approximately $91.9 million by removing beneficiaries who were identified as living out of state through this analysis.
LDH paid for Medicaid coverage for beneficiaries who only received services out of state.	Incorporate analyses of the Centers for Medicare and Medicaid Services' NPI database and its claims and encounter data to identify Medicaid beneficiaries who potentially live out of state.	**Implemented.** LDH began conducting these analyses and analyzing them through their Program Integrity section.
LDH paid for Medicaid coverage for beneficiaries whose wages were higher than allowed to qualify for Medicaid.	Conduct more frequent wage data matches to identify Medicaid beneficiaries with incomes that exceed amounts allowable to be eligible for Medicaid.	**Implemented.** LDH began conducting quarterly wage checks in February 2019 and reported an estimated $385 million in annual cost avoidance identified during its first three quarterly checks.
LDH paid for Medicaid coverage for beneficiaries who did not qualify based on unreported income of a family member who was a Medicaid provider.	Compare Medicaid applicants and beneficiaries to LDH's Medicaid providers database to identify those who may not be eligible for Medicaid benefits.	**Implemented.** LDH ran this analysis twice, resulting in 17 terminations. According to LDH, it is including this type of analysis in a new analytics and case tracking system it is currently procuring.

* Cost savings are included in this column if available.
Source: Prepared by legislative auditor's staff using prior LLA reports and information from LDH.

Act 427 of the 2025 Regular Legislative Session codified many eligibility checks LDH performs to ensure they are conducted in the future. Further, House Resolution 1 (H.R. 1) of the 119th Congress made changes to Medicaid eligibility requirements and monitoring. Act 427 of the 2025 Regular Legislative Session requires LDH to enter into data matching agreements to verify beneficiary eligibility by cross-checking certain information with specified data sources on a regular basis. While LDH was already conducting some of these matches, Act 427 made these matches statutorily required effective June 20, 2025. Exhibit 8 details the specified eligibility data verification requirements.

Exhibit 8
Act 427 Medicaid Eligibility Verification Requirements
Effective June 20, 2025

Verified Beneficiary Eligibility Information	Data Source	Frequency
Residency Status	Department of Public Safety and Office of Motor Vehicles	Quarterly
	Louisiana Department of Revenue tax records	Semi-annually
Income and Employment Status	LWC Wage data	Quarterly
	Louisiana Department of Revenue tax records	Semi-annually
Deceased Status	State Registrar Vital Records	Monthly
Incarceration Status	Department of Corrections (CAJUN Interface); local prisons, clerks, and mental health authorities; court documents; legal representatives; and discharge arrangements	At least annually
Disability Status	Social Security Administration	Monthly

Source: Prepared by legislative auditor's staff based on Act 427 requirements.

On July 4, 2025, H.R. 1[24] was signed into federal law and will involve numerous technical changes to Medicaid eligibility, enrollment, and renewal policies *(see text box at right)*. According to LDH, the agency will incur additional system development and labor costs to implement these new eligibility processes. H.R. 1 allocates $300 million across all 50 states to implement select Medicaid provisions. In addition, H.R. 1 includes provisions requiring states to reduce duplicate enrollment of beneficiaries enrolled in Medicaid in two states and review of the Master Death File quarterly to identify and unenroll deceased enrollees. The timeline for implementing these changes varies by provision. For example, work requirements begin December 31, 2026, although exemptions are available through December 31, 2028.

Major eligibility changes contained in H.R. 1:

1. An 80 hour per-month work or community engagement requirement to qualify for Medicaid with exceptions for certain groups.[23]
2. Requires Medicaid eligibility re-determinations every six months rather than annually.
3. Restricts Medicaid coverage for people who are not a U.S. resident, citizen, or lawful permanent resident with certain exceptions. Refugees, asylees, and parolees will no longer be eligible for Medicaid.
4. Reduces Medicaid and CHIP retroactive eligibility from 3 months to 1 month for Medicaid Expansion beneficiaries and from 3 months to 2 months for all other Medicaid beneficiaries.

Despite increases in insurance coverage rates, Louisiana's overall health outcomes have not improved over the last decade. While both LLA and LDH have identified issues with the accuracy and adequacy of MCE provider networks and recommended ways to address them, these issues persist.

According to the 2025 America's Health Rankings (AHR), Louisiana has been named the least healthy state overall for the fourth consecutive year.[25] Louisiana has remained in the bottom three spots nationwide for overall health of the state since 1990. AHR determines overall state rankings by performance on measures across five categories of health – Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. While Louisiana's clinical care

The objective of Medicaid Expansion was to "provide our working poor residents with access to quality health insurance"

2017 Medicaid Expansion Annual Report

[23] Exempts pregnant women, parents, caretakers of children, children under the age of 14, American Indians, and veterans with disabilities.
[24] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[25] See AHR's 2025 overall state summary rankings, and the measures used to determine rankings here https://www.americashealthrankings.org/explore/measures/reports/annual. This health ranking serves as an indicator of the health of the state as a whole, not specifically of LDH's Medicaid program, and includes factors such as physical environment, social, and economic factors not within the control of LDH.

ranking has improved by four points since 2022, the state's ranking in the other four categories has remained consistently low over the last four years. See Exhibit 9 for a breakdown of Louisiana's national health rankings by category during 2022 through 2025.

Exhibit 9
Louisiana's National Health Ranking by Category
2022 through 2025

AHR Ranking Categories	2022	2023	2024	2025
Social and Economic Factors	50	50	50	50
Physical Environment	48	47	47	48
Clinical Care	42	38	34	38
Behaviors	50	49	49	50
Health Outcomes	50	48	50	50
Overall Ranking	**50**	**50**	**50**	**50**

Source: Prepared by legislative auditor's staff using AHR data.

LDH has attempted to address poor health outcomes by improving Medicaid access and quality through its contracts with the MCEs and a variety of other initiatives. According to the U.S. Department of Health and Human Services, lack of access to quality care contributes to poor health outcomes. As stated by LDH leadership at a March 2024 Health and Welfare Committee meeting, "there is a very clear distinction between [Medicaid] coverage and access…having coverage does not mean that [beneficiaries] have access to services." MCEs are required by their contracts to maintain an adequate network of providers and an accurate directory of available providers to meet the needs of Medicaid beneficiaries.[26] LDH can hold MCEs accountable for meeting these requirements by conducting oversight activities and issuing penalties for non-compliance.

Having accurate provider directories with adequate provider networks is important because they inform beneficiaries of available health care providers in their area. Inaccurate provider data can create a barrier to care that prohibits beneficiaries from improving their health and makes it difficult for LDH to determine whether network adequacy requirements are being met. In a May 2024 report, we found that 11,084 (66.9%) of 16,557 complaints made by Medicaid beneficiaries during January 2019 through December 2022 were related to a lack of quality care or a lack of access to care. LDH's contracts with MCEs include the following processes to hold MCEs accountable for meeting network adequacy standards and maintaining accurate provider directories:

1. *Network adequacy reporting and review.* LDH requires MCOs to submit semi-annual reports to document the adequacy of their provider networks. LDH reviews these reports for issues such as providers being listed multiple times on the report.

[26] Provider directories are lists of in network providers for health plans and include information such as the provider's phone number, physical address, and whether the provider is accepting new patients.

2. *Provider directory audits.* LDH performs quarterly audits of provider directories by conducting secret shopper calls to verify the accuracy of provider information, such as addresses, telephone numbers, provider specialty, and whether the provider is currently accepting new patients.

3. *Monetary penalties.* According to LDH contracts with MCEs, LDH may levy penalties on MCEs for failure to meet network adequacy, provider access, and provider directory contract requirements. LDH did not assess any penalties between March 2024 and December 2025 because it suspended provider directory audits.

We analyzed LDH Medicaid complaint data and found the majority of Medicaid beneficiaries' complaints were related to a lack of transportation, issues with access to care, or issues with quality of care. In a May 2024 audit, we compiled all beneficiary complaints received by LDH and MCOs during January 2018 through December 2022 to analyze trends. We found that 11,084 (66.9%) of 16,557 unique beneficiary complaints during this time were related to the issues described above, as summarized in Exhibit 10.

Exhibit 10
Beneficiary Complaints Related to Transportation, Access to Care, and Quality of Care
January 2018 through December 2022

Type of Complaint	Number of Complaints	Percent of Complaints
Transportation	7,493	45.3%
Access to care	2,849	17.2%
Quality of care	742	4.5%
Total	**11,084**	**66.9%**

Source: Prepared by legislative auditor's staff using information from past LLA reports.

We also previously found examples of access and transportation-related complaints when looking at specific beneficiary groups, such as pregnant Medicaid beneficiaries in our March 2025 report. For example, one beneficiary who was 30-weeks pregnant filed a complaint in November 2019 claiming she missed several prenatal care appointments because scheduled transportation did not pick her up timely or at all. Her obstetrician notified her they would stop seeing her due to the missed appointments. The beneficiary spoke to a supervisor at her non-emergency medical transportation (NEMT) provider to stress the importance of receiving transport to her next appointment, yet transportation failed to show up. We recommended in a November 2020 report that LDH should update the Medical Transportation Provider Manual or the MCE Manual to include all current Medicaid guidelines for the NEMT program, among other recommendations. As of April 2024, LDH had implemented all five (100%) select recommendations we followed up on as part of this project.

Previous LLA reports have identified issues with the accuracy and adequacy of MCE provider networks. We analyzed network adequacy reports as of December 2024 and found 10,081 (31.1%) of the 32,402

unique Medicaid providers had no claims for services provided during the six-month period of July 2024 through December 2024. Contracts between LDH and the MCEs specify requirements the MCEs must meet regarding provider network adequacy and access.[27] In some instances, it is difficult for the MCEs to meet these requirements, as 73.0% of Louisiana residents live in a primary care health professional shortage area, according to LDH.

LLA analyzed network adequacy reports submitted by MCOs to LDH in previous reports and found the following:

- 10,790 (33.2%) of the 32,512 unique Medicaid providers had no claims for services provided during the six-month period during July 2022 through December 2022.
- Neither of the two dental plans met all requirements for network adequacy, and three parishes (Assumption, Cameron, and Jackson) had no dental providers at all as of June 2023.
- 24 (37.5%) of 64 parishes had no OBGYNs who provided services as of December 2023.*
- 1,539 (44.8%) of 3,438 providers listed as Licensed Mental Health Professionals did not meet licensure requirements during October 2016 through December 2016.

* Twenty-two (91.7%) of 24 parishes with no providers are rural parishes according to LDH.
Source: Prepared by legislative auditor's staff using information from past LLA reports.

We analyzed Medicaid provider data as of December 2024 to determine if the MCOs were still listing providers on the provider network adequacy reports who do not actually provide any services.[28] We found 10,081 (31.1%) of the 32,402 unique Medicaid providers had no claims for services provided during the six-month period during July 2024 through December 2024. Although the accuracy of provider network adequacy reports has slightly improved from 33.2% since our December 2022 analysis, MCOs continue to include a high percentage of providers who do not actually provide services to Medicaid beneficiaries in their directories. We recommended LDH use Medicaid data to identify providers that are not providing services, similar to the analysis detailed above, in October 2017 and again in May 2024. According to LDH, it plans to begin using Medicaid encounter data to assess network adequacy by March 31, 2026.

As of December 5, 2025, LDH only levied two monetary penalties on MCEs for network inadequacy since July 2019. The only instance we identified where LDH levied a penalty for network inadequacy on an MCO during July 2019 through November 2025 was a $225,000 penalty levied against UHC in July 2021 for failure to maintain an adequate network of pediatric surgeons. Although LDH has penalized MCOs for failure to maintain an accurate provider directory

[27] To be considered an active provider prior to January 1, 2026, a provider was required to file at least 25 claims for services within the previous six months. However, LDH amended this standard to one claim for services within the previous six months effective January 1, 2026, to help strengthen network adequacy in rural areas of the state.
[28] We only included the MCOs in this analysis because they were the only MCEs included in our original December 2022 analysis.

(discussed in the following section), LDH has not issued a monetary penalty for network inadequacy to an MCO in more than four years. A $40,000 network inadequacy penalty was issued against the DBPM DentaQuest in August 2023. This penalty was based on a complaint from providers about a shortage of oral surgeons and lack of primary dental providers available to service intermediate care facilities for individuals with intellectual disabilities.

According to LDH, it suspended its initiative to improve the accuracy of provider networks, monitor provider directories, and penalize MCOs[29] for inaccurate provider directories during calendar year 2024[30] because of staffing shortages. LDH resumed performing provider directory audits beginning in March 2025. In October 2017, we found LDH had not conducted secret shopper calls on all behavioral health provider types during October 2016 through February 2017, as required by its policy. LDH did conduct the calls for psychiatrists and found 940 (61.5%) of 1,529 psychiatrists called either did not accept Medicaid or did not provide services at the location listed by the MCO. Of the 589 psychiatrists who indicated they were accepting Medicaid beneficiaries, 119 (20.2%) stated they did not accept new Medicaid beneficiaries, meaning the beneficiaries' access is more limited.

We also found in our May 2024 audit that LDH required the MCOs to maintain a provider directory accuracy rate of at least 90.0% during February 2018 through March 2019 to avoid being penalized by LDH. However, the MCOs never achieved this accuracy rate, so LDH lowered the minimum required accuracy rate starting in April 2019. The minimum accuracy rate was changed to 75.0%, or 50.0% if the MCO had a 2.0% increase in accuracy from the previous quarter's audit. According to LDH, the rate was lowered to "…grant leniency to the MCOs while promoting gradual improvement…"; however, gradual improvement did not occur despite LDH not assessing any penalties.

LDH's provider directory audits have routinely found that MCO provider directories are inaccurate. The median accuracy rate across 70 provider directory audits during May 2018 through February 2023 was 49.4%, which is below the required 75.0%. LDH penalized the MCOs $2,771,000 for not meeting the required accuracy rate during May 2018 through February 2022. In March 2024, after meeting with LLA to discuss provider directory accuracy issues, LDH began a six-month initiative to require MCOs to perform activities to ensure the accuracy of their provider directories. However, according to LDH, this initiative was discontinued due to staffing shortages. Also, despite LLA and LDH repeatedly finding issues with network adequacy and the accuracy of provider directories, LDH did not levy any penalties for inaccurate provider networks during March 2024 through December 2025, primarily because the department suspended provider directory audits and its initiative to clean up provider networks due to staffing shortages. LDH resumed performing provider directory audits in March 2025.

[29] We only included the MCOs in this analysis because they were the only MCEs included in our original May 2024 analysis.

[30] Although LDH issued a penalty for inaccurate provider directories in February 2024, this was from its audit of provider networks using data from December 2023.

While LDH has implemented various programs and initiatives to increase quality of care for Medicaid beneficiaries, Louisiana continues to rank low in health outcomes when compared to other states. LDH is making changes to some of these programs and initiatives to improve quality as a result of issues identified in past LLA reports.

In Louisiana, the uninsured rate for adults decreased from 22.7% in 2015 prior to Medicaid expansion to 7.9% in 2023.[31] However, as previously cited, Louisiana's health ranking has remained between 48th and 50th in the decade since expansion. LDH monitors and incentivizes improvements in overall Medicaid health care quality in the following ways:[32]

"Expansion of Medicaid will… result in significantly better health outcomes for the working poor."

Executive Order No. JBE 16-01

1. Analyzing outcomes on performance measures and withholding a percentage of capitation (PMPM) rates from MCOs to incentivize improved outcomes;
2. Tracking beneficiary complaints;
3. Participation in incentive programs; and
4. Other departmental quality improvement initiatives.

According to LDH staff, its "largest lever" for holding MCOs accountable in Louisiana's Medicaid program is its quality withhold incentive program.

LDH has historically withheld 1.0% of PMPMs to incentivize MCOs to increase quality of care, but LDH's design of the program allowed for instances in which withholds were paid to MCOs without demonstrating improved outcomes. LDH recently amended MCO contracts to increase emphasis on improved outcomes. LDH primarily evaluates MCO quality of care through patient outcome performance measures annually reported to LDH by MCOs. Many of these performance measures[33] are required by the Center for Medicare and Medicaid Services (CMS) and determined by LDH's Medicaid Managed Care Quality Strategy prior to the start of a calendar year. Performance measure outcomes are reported on LDH's website.[34] Beginning February 2018, LDH

[31] Based on latest available Louisiana Health Insurance Survey; https://ldh.la.gov/assets/medicaid/LHIS/2023/LHIS-survey-2023.pdf

[32] Offices within LDH may spearhead population-specific quality improvement initiatives. For example, we previously reported improvements in maternal health outcomes associated with LDH's Bureau of Family Health's Safe Birth Initiative.

[33] These measures include the Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics, CMS Adult and Children Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and state-specified quality measures.

[34] https://qualitydashboard.ldh.la.gov/

began incentivizing health outcomes for certain performance measures by withholding and then paying MCOs a percentage of total capitation rates for achieving certain rates.

In our May 2024 audit, we found that LDH's design of the quality withhold program allowed MCOs to receive quality withhold funds without improving performance, despite the purpose of the program being to incentivize improvement. Overall, we found only 45.7% of the quality withhold amount was paid back to MCOs for improving performance measures during calendar years 2018 through 2022. We recommended LDH consider the design of its withhold program, including potentially increasing the PMPM withhold rate. LDH updated its contracts, effective January 1, 2026, to increase the quality withhold percentage from 1.0% to 3.0% of all PMPMs to further incentivize quality improvement on performance measures.

LDH paid MCOs the following amounts without showing performance measure improvement during 2018 through 2022:

- $32.2 million (11.4%) of $283.6 million withheld for incentivized measures where the MCOs met LDH's target but the MCO's performance decreased from the prior year.
- $50.9 million (18.0%) of $283.6 million withheld for just reporting the results of certain incentivized measures, rather than requiring the actual improvement of performance.

Source: Prepared by legislative auditor's staff using information from past LLA reports.

LDH's design and lack of oversight of the Managed Care Incentive Program (MCIP) historically led to the majority of MCIP program funds being paid for activities that did not have a direct, measurable impact for how they improve access to health care, improve quality of care, or enhance the health of Medicaid beneficiaries. LDH made changes to the program effective January 2026 to address these issues. MCIP is an incentive program that began in February 2018 and is designed to provide payments up to 5.0% of Medicaid capitation payments to LDH, MCOs,[35] quality networks,[36] and participating hospitals for quality improvement initiatives. In our February 2025 report, we found issues with the program that limited its impact. For example, the MCIP program allowed two separate Quality Networks to have different incentive projects and goals, resulting in each of the networks striving for different outcomes. Also, the MCIP program prioritized funding for non-milestone activities. In total, we found LDH paid $437.2 million (18.3%) of the $2.39 billion total MCIP payments for reporting results timely, submitting annual reports, and holding annual meetings. Further, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones. LDH did not monitor how

[35] All six MCOs are contractually required to participate in MCIP, according to LDH's contracts with MCOs.

[36] MCOs subcontracted with two separate hospital networks, the Louisiana Quality Network and the Quality and Outcome Improvement Network (collectively referred to as the "Quality Networks"), to operate the MCIP program on their behalf.

$1.08 billion (45.3%) of the $2.39 billion MCIP program funds were used by the MCOs or the Quality Networks.

LDH implemented changes to the MCIP program to focus payments on actual outcomes. According to LDH's MCIP Protocol document, effective January 1, 2026, MCOs and Quality Networks are no longer receiving incentive payments for submitting annual reports, holding annual meetings, or reporting results timely. Instead, incentive payments are solely based on achievement of respective milestones. According to LDH, incentives are now the same across the two Quality Networks, ensuring the state is collectively working to address the same issues and all participating providers across the state.

LDH receives complaints from beneficiaries in various ways, but it does not compile these complaints to identify trends and analyze its Medicaid program, especially as they relate to quality of services. LDH receives beneficiary complaints from MCOs in required monthly reports directly from beneficiaries through a customer service center, and from providers, legislators, and other parties. We found in our May 2024 report that, while LDH receives and manages beneficiary complaints in various ways, it does not document the complaints in a consolidated database, which would allow LDH to monitor and analyze beneficiary complaints for trends. For example, some beneficiary complaints are maintained in Excel files, some in text-form case notes for beneficiaries, and others in separate databases. We recommended LDH combine these complaints into one database, such as Excel. LDH disagreed with our three recommendations about capturing complaints in a consistent and unified way to be able to analyze them across the entire Medicaid program due to concerns about the cost of implementing this recommendation. We explained in subsequent conversations that creating a consolidated spreadsheet in Excel would not require additional funding. According to LDH, it plans to establish processes to consolidate Medicaid complaints into one database by March 31, 2026.

We previously found a small percentage of Medicaid beneficiaries in certain high-risk populations receive case management services. LDH changed case management requirements of the MCOs effective January 2026 after receiving feedback from MCOs. Some changes may streamline case management processes, while others may decrease outreach, participation, and accountability for providing case management services to specific high-risk groups. Case management services help to ensure beneficiaries receive appropriate and coordinated care by assisting beneficiaries with accessing medical, social, educational, and other support services. In previous reports, we analyzed case management outreach and participation to beneficiaries who may benefit the most from these services, such as beneficiaries with a behavioral health diagnosis and pregnant and postpartum women and found a small percentage of these populations were receiving case management services. For example, in February 2018, we found only 1,895 (7.4%) of 25,726 beneficiaries who received case management in December 2016 had a behavioral health diagnosis. Similarly, in March 2025, we found only 1,706 (5.2%) of 32,836 Medicaid beneficiaries who gave birth in calendar year 2023 received case

management services. Our previous reports made six recommendations for LDH to require monitoring and outreach to these specific populations.

As a result of our recommendations and feedback from MCOs, LDH modified its contract extension to allow case managers to conduct virtual outreach (via phone, email, or text) and streamline required assessments to boost case management participation, effective January 1, 2026. LDH also broadened the definition of beneficiaries required to receive case management outreach based on this feedback. Previous MCO contracts included specific enrollees required to receive case management, such as women with high-risk pregnancies or members of the Department of Justice Agreement Target Population. According to LDH, this change was made to allow more flexibility with case management to increase member participation. However, this change also eliminates outreach requirements to these specific high-risk populations, which could decrease participation from these groups. With this change to MCO contracts, LDH will no longer be required via contracts to monitor case management outreach to these high-risk populations and levy penalties for failure to provide case management services.

APPENDIX A: SCOPE AND METHODOLOGY

This report provides information on changes to health care access, outcomes, and fiscal efficiency in Louisiana since the onset of Medicaid Expansion in January 2016. In addition, we evaluated the progress made by the Louisiana Department of Health (LDH) to improve its processes for administering the Medicaid program in Louisiana. We conducted this informational report under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This report covered the period of January 2016 through December 2025. Our objective was:

To provide information on changes to health care access, outcomes, and fiscal efficiency since the onset of Medicaid Expansion and determine LDH's progress in addressing issues identified in previous LLA reports.

Informational reports are intended to provide more timely information than standards-based performance audits. While these informational reports do not follow Government Auditing Standards, we conduct quality assurance activities to ensure the information presented is accurate. To answer our objective, we performed the following steps:

- Reviewed the Louisiana Legislative Auditor (LLA) website for LLA reports related to LDH's Medicaid program issued since January 2017. Reviewed these 57 reports and selected certain recommendations and issues to analyze as part of this report.

- Met with LDH staff regarding past reports, current issues in the Medicaid program, activities currently being undertaken by LDH to strengthen its Medicaid program, and potential future changes to the Medicaid program.

- Sent select recommendations made in previous reports to LDH for its input on how, and if, they have implemented the recommendations. Met with LDH staff to further discuss these actions and their activities.

- Researched federal and state laws, rules, regulations, policies, and procedures related to the Medicaid program.

- Researched LDH's website for information related to enrollment trends, expenditure trends for both payments to providers and administrative costs, past Medicaid annual reports, and reports specifically focused on the impacts of Medicaid Expansion.

- Researched the impact of Medicaid Expansion on Louisiana's budget in the year following Medicaid Expansion.

- Researched the impacts of the COVID-19 Public Health Emergency on the Medicaid program, including the increase in Medicaid beneficiaries and expenditures and eventual "unwind."

- Obtained the executive order authorizing the expansion of Medicaid in Louisiana and other related documents detailing the purpose of Medicaid Expansion, how it was supposed to improve health care in Louisiana, and any other benefits it would bring.

- Reviewed LDH's policies and procedures related to Medicaid eligibility, including efforts to use databases to assist in eligibility determinations. Analyzed changes in the use and frequency of these checks over the years.

- Researched changes to Medicaid program eligibility, specifically those changes related to Act 427 of the 2025 Regular Legislative Session and House Resolution 1 of the 119th Congress.

- Analyzed contracts between LDH and the Managed Care Organizations (MCOs) related to the accuracy and adequacy of the MCO's provider networks, as well as LDH's options to hold the MCOs accountable to these requirements. Assessed past LLA reports and LDH analyses related to these issues and updated select analyses.

- Analyzed issues related to beneficiary complaints reported in past LLA reports and obtained information related to LDH's efforts to address these issues.

- Analyzed issues related to case management reported in past LLA reports and obtained information related to LDH's efforts to address these issues.

- Analyzed issues related to health outcomes for Medicaid beneficiaries and the various programs LDH administers to improve these outcomes reported in past LLA reports, and obtained information related to LDH's efforts to address these issues.

- Sent a draft of the report to LDH, met with LDH staff regarding the report, and incorporated feedback throughout.

APPENDIX B: LLA MEDICAID REPORTS ISSUED BETWEEN JANUARY 2017 AND OCTOBER 2025

Calendar Year	Issued Date	Report Title
2025	10/13/2025	Progress Report: Medicaid Beneficiaries With No Services
2025	8/6/2025	Progress Report: Deceased Medicaid Beneficiaries
2025	5/28/2025	Progress Report: Medicaid Residency
2025	4/9/2025	Louisiana Department of Health
2025	3/12/2025	Maternal Health Outcomes
2025	3/5/2025	Managed Care Incentive Payment Program
2024	7/31/2024	Medicaid Dental Benefit Program Manager - DentaQuest
2024	5/23/2024	Oversight of Medicaid Quality Care
2024	3/13/2024	Louisiana Department of Health
2023	10/4/2023	Medicaid Dental Benefit Program Managers
2023	8/16/2023	Medicaid Residency
2023	4/12/2023	Louisiana Department of Health
2023	3/15/2023	Progress Report: Medicaid Behavioral Health Services
2022	6/22/2022	Louisiana Department of Health
2022	4/12/2022	Hospital and Physician Payments and Related Funding
2021	4/16/2021	Louisiana Department of Health
2021	3/10/2021	Oversight of Behavioral Health Provider Requirements
2021	3/10/2021	Medicaid Recipient Report No. 12
2021	1/20/2021	Behavioral Health Provider - Destined for a Change, Inc.
2020	12/10/2020	Medicaid Recipient Report No. 11
2020	11/12/2020	Progress Report: Non-Emergency Medical Transportation
2020	10/14/2020	Medicaid Recipient Report No. 10
2020	9/30/2020	Medicaid Recipient Report No. 9
2020	9/30/2020	Medicaid Recipient Report No. 8
2020	9/23/2020	Medicaid Recipient Report No. 7
2020	9/16/2020	Medicaid Recipient Report No. 6
2020	9/9/2020	Medicaid Recipient Report No. 5
2020	9/3/2020	Medicaid Recipient Report No. 4
2020	8/5/2020	Individual Behavioral Health Providers Billing More than 12 Hours of Services in a Day
2020	6/17/2020	Medicaid Recipient Report No. 3
2020	6/17/2020	Behavioral Health Provider - New Horizon Counseling Agency, LLC
2020	2/26/2020	Louisiana Department of Health
2020	1/22/2020	Medicaid Recipient Report No. 2
2019	9/11/2019	Medicaid Eligibility Determinations: Status on the Use of Federal Tax Information
2019	9/4/2019	Improper Billing of Services Within the Medicaid Behavioral Health Program
2019	5/15/2019	Identification of Behavioral Health Service Providers
2019	5/1/2019	Update on Wage Verification Process of the Medicaid Expansion Population
2019	4/17/2019	Medicaid Behavioral Health Provider - Walk with me Community Improvement Center
2019	4/17/2019	Medicaid Recipient Report No. 1
2018	12/12/2018	Medicaid Eligibility: Modified Adjusted Gross Income Determination Process

Calendar Year	Issued Date	Report Title
2018	12/5/2018	Oversight of Surveillance and Utilization Review Subsystem (SURS) - Medicaid Program Integrity Activities
2018	11/8/2018	Medicaid Eligibility: Wage Verification Process of the Expansion Population
2018	10/31/2018	Identification of Incarcerated Medicaid Recipients
2018	7/25/2018	Medical Assistance Programs Fraud Detection Fund
2018	6/20/2018	Reliability of Medicaid Provider Data
2018	5/2/2018	Strengthening of the Medicaid Eligibility Determination Process
2018	3/14/2018	Louisiana Department of Health
2018	2/14/2018	Access to Comprehensive and Appropriate Specialized Behavioral Health Services in Louisiana
2017	11/29/2017	Improper Payments for Deceased Medicaid Recipients
2017	11/15/2017	Accuracy of Medicaid Rates for Nursing Facilities
2017	10/18/2017	Network Adequacy of Specialized Behavioral Health Providers
2017	10/4/2017	Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)
2017	9/6/2017	Improper Payments in the Medicaid Laboratory Program
2017	7/12/2017	Progress Report: Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services Programs
2017	3/29/2017	Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers
2017	3/22/2017	Program Rule Violations in the Medicaid Dental Program
2017	1/25/2017	Louisiana Department of Health

Source: Prepared by legislative auditor's staff using information from LLA's website.

APPENDIX C: MEDICAID ENROLLMENT FROM JULY 2015 THROUGH DECEMBER 2025

Year/Month	Enrollment	Monthly Change	Monthly % Change
July 2015	1,376,869		
August 2015	1,386,152	9,283	0.67%
September 2015	1,392,583	6,431	0.46%
October 2015	1,396,773	4,190	0.30%
November 2015	1,392,235	-4,538	-0.32%
December 2015	1,391,538	-697	-0.05%
January 2016	1,393,111	1,573	0.11%
February 2016	1,399,169	6,058	0.43%
March 2016	1,396,151	-3,018	-0.22%
April 2016	1,392,636	-3,515	-0.25%
May 2016	1,394,133	1,497	0.11%
June 2016	1,412,011	17,878	1.28%
July 2016	1,448,703	36,692	2.60%
August 2016	1,483,997	35,294	2.44%
September 2016	1,489,750	5,753	0.39%
October 2016	1,510,314	20,564	1.38%
November 2016	1,528,923	18,609	1.23%
December 2016	1,544,748	15,825	1.04%
January 2017	1,562,504	17,756	1.15%
February 2017	1,573,521	11,017	0.71%
March 2017	1,577,645	4,124	0.26%
April 2017	1,580,101	2,456	0.16%
May 2017	1,582,411	2,310	0.15%
June 2017	1,581,306	-1,105	-0.07%
July 2017	1,583,198	1,892	0.12%
August 2017	1,578,858	-4,340	-0.27%
September 2017	1,580,179	1,321	0.08%
October 2017	1,581,148	969	0.06%
November 2017	1,584,231	3,083	0.19%
December 2017	1,591,323	7,092	0.45%
January 2018	1,595,161	3,838	0.24%
February 2018	1,599,265	4,104	0.26%
March 2018	1,598,376	-889	-0.06%
April 2018	1,597,412	-964	-0.06%
May 2018	1,593,369	-4,043	-0.25%
June 2018	1,590,511	-2,858	-0.18%
July 2018	1,590,126	-385	-0.02%
August 2018	1,597,083	6,957	0.44%
September 2018	1,600,602	3,519	0.22%
October 2018	1,606,353	5,751	0.36%
November 2018	1,637,830	31,477	1.96%
December 2018	1,649,518	11,688	0.71%
January 2019	1,663,503	13,985	0.85%
February 2019	1,663,069	-434	-0.03%
March 2019	1,661,963	-1,106	-0.07%
April 2019	1,598,236	-63,727	-3.83%
May 2019	1,587,355	-10,881	-0.68%

Year/Month	Enrollment	Monthly Change	Monthly % Change
June 2019	1,556,584	-30,771	-1.94%
July 2019	1,562,379	5,795	0.37%
August 2019	1,588,048	25,669	1.64%
September 2019	1,601,785	13,737	0.87%
October 2019	1,609,342	7,557	0.47%
November 2019	1,588,884	-20,458	-1.27%
December 2019	1,581,925	-6,959	-0.44%
January 2020	1,606,372	24,447	1.55%
February 2020	1,604,957	-1,415	-0.09%
March 2020	1,616,614	11,657	0.73%
April 2020	1,650,271	33,657	2.08%
May 2020	1,674,652	24,381	1.48%
June 2020	1,698,699	24,047	1.44%
July 2020	1,721,489	22,790	1.34%
August 2020	1,742,690	21,201	1.23%
September 2020	1,762,454	19,764	1.13%
October 2020	1,778,703	16,249	0.92%
November 2020	1,797,193	18,490	1.04%
December 2020	1,817,530	20,337	1.13%
January 2021	1,830,586	13,056	0.72%
February 2021	1,841,513	10,927	0.60%
March 2021	1,854,714	13,201	0.72%
April 2021	1,864,487	9,773	0.53%
May 2021	1,873,294	8,807	0.47%
June 2021	1,882,486	9,192	0.49%
July 2021	1,893,310	10,824	0.57%
August 2021	1,904,776	11,466	0.61%
September 2021	1,910,956	6,180	0.32%
October 2021	1,919,714	8,758	0.46%
November 2021	1,927,833	8,119	0.42%
December 2021	1,937,265	9,432	0.49%
January 2022	1,946,322	9,057	0.47%
February 2022	1,951,143	4,821	0.25%
March 2022	1,958,037	6,894	0.35%
April 2022	1,965,265	7,228	0.37%
May 2022	1,968,349	3,084	0.16%
June 2022	1,974,812	6,463	0.33%
July 2022	1,982,593	7,781	0.39%
August 2022	1,991,308	8,715	0.44%
September 2022	1,998,519	7,211	0.36%
October 2022	2,005,242	6,723	0.34%
November 2022	2,014,452	9,210	0.46%
December 2022	2,023,866	9,414	0.47%
January 2023	2,032,783	8,917	0.44%
February 2023	2,038,391	5,608	0.28%
March 2023	2,045,359	6,968	0.34%
April 2023	2,050,521	5,162	0.25%
May 2023	2,055,782	5,261	0.26%
June 2023	2,052,605	-3,177	-0.15%
July 2023	2,017,579	-35,026	-1.71%
August 2023	1,986,923	-30,656	-1.52%
September 2023	1,949,368	-37,555	-1.89%
October 2023	1,917,197	-32,171	-1.65%
November 2023	1,889,806	-27,391	-1.43%

Year/Month	Enrollment	Monthly Change	Monthly % Change
December 2023	1,864,036	-25,770	-1.36%
January 2024	1,834,234	-29,802	-1.60%
February 2024	1,807,547	-26,687	-1.45%
March 2024	1,781,169	-26,378	-1.46%
April 2024	1,749,847	-31,322	-1.76%
May 2024	1,712,169	-37,678	-2.15%
June 2024	1,674,556	-37,613	-2.20%
July 2024	1,648,253	-26,303	-1.57%
August 2024	1,651,609	3,356	0.20%
September 2024	1,649,422	-2,187	-0.13%
October 2024	1,636,813	-12,609	-0.76%
November 2024	1,632,586	-4,227	-0.26%
December 2024	1,648,889	16,303	1.00%
January 2025	1,637,855	-11,034	-0.67%
February 2025	1,640,774	2,919	0.18%
March 2025	1,634,380	-6,394	-0.39%
April 2025	1,622,060	-12,320	-0.75%
May 2025	1,610,066	-11,994	-0.74%
June 2025	1,594,002	-16,064	-1.00%
July 2025	1,576,099	-17,903	-1.12%
August 2025	1,566,618	-9,481	-0.60%
September 2025	1,562,177	-4,441	-0.28%
October 2025	1,541,055	-21,122	-1.35%
November 2025	1,522,285	-18,770	-1.22%
December 2025	1,511,488	-10,797	-0.71%

Source: Prepared by legislative auditor's staff using information from LDH's website.

APPENDIX D: LDH DATA SOURCES USED TO VERIFY MEDICAID ELIGIBILITY

Data Source Post-Enrollment for Verification	Current Verification Sources	Planned
Age (Date of birth)	• Social Security Administration (SSA)	
Caretaker Relative	• Supplemental Nutrition Assistance Program (SNAP)	
Citizenship	• SSA • Systematic Alien Verification for Entitlement (SAVE)	
Death	• Louisiana Vital Records Registry • SSA	
Earned Income	• Internal Revenue Service Federal Data Services Hub • TALX (Equifax Workforce Solutions) Work Number Data • Louisiana Workforce Commission • SNAP • Temporary Assistance for Needy Families	
Household Composition	• SNAP	• Household real-time eligibility is planned for Quarter 4 2025 via Equifax
Immigration Status	• Department of Homeland Security - SAVE and Verify Lawful Presence Hub	
Medicare	• SSA	
Residency	• SNAP • Enrollment broker, Managed Care Organizations, Equifax, United States Postal Service	
Resources	• Accuity (Contractor): Used to identify liquid financial assets (e.g., money market accounts, checking accounts, etc.) • Lexus Nexus: Used to identify physical assets (e.g., property, aircraft, boats, etc.)	• Vehicle checks are planned from Quarter 4 of 2024 through Quarter 3 of 2025, and Property checks are planned for Quarter 3 and Quarter 4 of 2026 via TransUnion • Property and Vehicle real-time eligibility are planned initiatives for Quarter 1 of 2027 via TransUnion
Social Security Number	• SSA • Federal Data Services Hub	

Data Source Post-Enrollment for Verification	Current Verification Sources	Planned
Third Party Liability	• Health Management Systems (Contractor)/Electronic Fee Program	
Unearned Income (SSA, SSI, Title II)	• SSA • State Online Query Internet - Title II - daily	

Source: Prepared by legislative auditor's staff using information from LDH.