

PROGRESS REPORT: MEDICAID BENEFICIARIES WITH NO SERVICES

LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES
DATA ANALYTICS UNIT

October 13, 2025

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October 13, 2025

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 report provides the results of our progress report of the Louisiana Department of Health (LDH). The purpose of this review was to analyze the progress made by LDH to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible.

Overall, we found that LDH has not started analyzing its Medicaid data to identify Medicaid beneficiaries who receive no services. As a result, LDH is not using Medicaid data to determine whether beneficiaries no longer need Medicaid services or to monitor the Managed Care Organizations' (MCOs) management of Medicaid beneficiary care.

We found that LDH paid the MCOs \$1.23 billion to manage the care of 50,299 beneficiaries who appear to have been continuously enrolled in Medicaid for 36 to 84 months between January 2018 and December 2024 but received no services. For some beneficiaries identified in our analysis, it is unlikely that they did not need any services for the period we analyzed due to their Medicaid coverage type. Further, the beneficiary may not have had access to providers or may have had other private insurance.

The report contains our conclusions and recommendations. 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

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MEDICAIDNOSERVICES



Louisiana Legislative Auditor

Michael J. “Mike” Waguespack, CPA



Progress Report: Medicaid Beneficiaries with No Services Louisiana Department of Health

October 2025

Audit Control # 40240031

Introduction

We evaluated the progress made by the Louisiana Department of Health (LDH) to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible and whether their care is being properly managed by the Managed Care Organizations (MCOs).¹ We conducted this progress report to follow-up on a May 2024 LLA report in which we evaluated LDH’s oversight of MCOs to ensure Medicaid beneficiaries are receiving quality care and necessary services.² In our May 2024 report, we identified Medicaid beneficiaries who were continuously enrolled in Medicaid between 13 and 60 months and received no services. This included beneficiaries who were disabled, aged, and blind and may be at higher health risk if they do not receive needed services. We also conducted this review, in part, to further the goals of the Governor’s Fiscal Responsibility Program, known as LA DOGE.³

Medicaid and Managed Care in Louisiana. LDH administers the Medicaid program to provide health and medical services for uninsured and medically-indigent citizens. In February 2012, LDH transitioned from a fee-for-service program, where LDH directly paid for services rendered by providers, to managed care. Under managed care, LDH pays MCOs a monthly fee/premium, referred to as a per-member per-month (PMPM) payment, to manage the health needs of the Medicaid population. MCOs then pay providers for services delivered to beneficiaries. However, LDH maintains responsibility for monitoring the MCOs to ensure beneficiaries receive quality healthcare and determining Medicaid beneficiary eligibility, including enrolling applicants in and removing ineligible beneficiaries from Louisiana’s Medicaid program.

¹ LDH pays a per-member per-month (PMPM) premium to six private insurance companies to serve as MCOs to manage the care of Medicaid beneficiaries enrolled in their plans. The six MCOs include Aetna Better Health Louisiana, AmeriHealth Caritas of Louisiana, Healthy Blue, Humana Healthy Horizons in Louisiana, Louisiana Healthcare Connections, and United Healthcare Community Plan.

² [Oversight of Medicaid Quality Care](#)

³ The Fiscal Responsibility Program, also known as LA DOGE, was created through an executive order ([Executive Order Number JML 24-176](#)) by Governor Jeff Landry on December 12, 2024, to monitor state spending and ensure Louisiana government operates in the most efficient and effective manner.

During fiscal years 2012 through 2023, while changing the Medicaid delivery system to better coordinate care and deliver better outcomes, Louisiana's Medicaid enrollment and funding both increased, with the average annual cost per beneficiary increasing by 59.4%, from \$4,356 to \$6,944. However, according to America's Health Rankings,⁴ Louisiana's health ranking decreased from 49th to 50th in the nation during the same time. 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. Appendix C details by year the number of beneficiaries in relation to the state's population and information about the cost of Medicaid during fiscal years 2012 through 2023.

Managed Care Goal of Improving Outcomes. In transitioning to a managed care model, LDH sought to improve access to care, quality of care and health outcomes, and care coordination. LDH also placed an increased emphasis on disease prevention, as well as early diagnosis and management of chronic conditions. However, Louisiana has been named by America's Health Rankings as one of the three least healthy states each year since 2011 despite its move to a managed care model in 2012 and the expansion of Medicaid coverage in 2016.

Although the MCOs are responsible for managing the care of individual Medicaid beneficiaries, LDH is responsible for the oversight of Louisiana's Medicaid program and the MCOs to ensure the quality of services and to improve health outcomes. Federal regulations⁵ require LDH to implement a written quality strategy for assessing and improving the quality of healthcare and services provided by the MCOs for Medicaid beneficiaries, which LDH does through its Medicaid Managed Care Quality Strategy (Quality Strategy).

LDH's Quality Strategy is guided by a Triple Aim that partners with beneficiaries, providers, and MCOs to achieve (1) Better Care, (2) Healthier People, Healthier Communities, and (3) Smarter Spending.

The objective of this review was:

To analyze progress made by LDH to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains LDH's response, and Appendix B contains our scope and methodology. Appendix C details by year the number of beneficiaries in relation to the state's population and information about the cost of Medicaid during fiscal years 2012 through 2023. Appendix D shows beneficiaries enrolled in Medicaid between 36 and 84 months but received no services by age range, coverage type, MCO, and parish.

⁴ <https://www.americashealthrankings.org/>

⁵ 42 Code of Federal Regulations 438.340

Objective: To analyze progress made by LDH to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible.

Overall, we found that LDH has not started analyzing its Medicaid data to identify Medicaid beneficiaries who receive no services. As a result, LDH is not using Medicaid data to determine whether beneficiaries no longer need Medicaid services or to monitor the MCO's management of Medicaid beneficiary care. Specifically, we found that:

- **LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services. We found that LDH paid the MCOs \$1.23 billion to manage the care of 50,299 beneficiaries who appear to have been continuously enrolled in Medicaid for 36 to 84 months between January 2018 and December 2024 but received no services.** For some beneficiaries identified in our analysis, it is unlikely that they did not need any services for the period we analyzed due to their Medicaid coverage type. Further, the beneficiary may not have had access to providers or may have had other private insurance.

Our findings and recommendations are discussed in more detail in the following section.

LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services. We found that LDH paid the MCOs \$1.23 billion to manage the care of 50,299 beneficiaries who appear to have been continuously enrolled in Medicaid for 36 to 84 months between January 2018 and December 2024 but received no services.

LDH's MCO contracts require the MCOs to monitor and manage the care received by beneficiaries enrolled in Louisiana's Medicaid program, while LDH is responsible for monitoring the MCOs for contract compliance. However, LDH does not analyze its comprehensive Medicaid data, which includes all services provided to Medicaid beneficiaries under each MCO and could assist the department in determining whether LDH's Triple Aim is being met. Analyzing this data could allow LDH to identify any beneficiaries who have not received services for extended

periods of time or specific populations of beneficiaries who should be receiving services, such as those who are disabled, aged, or blind.

We analyzed Medicaid data and identified 50,299 beneficiaries who appear to have been continuously enrolled in Medicaid for 36 to 84 months between January 2018 and December 2024 but received no services.⁶ LDH paid the MCOs \$1,233,547,133 to manage these beneficiaries' care during this period.^{7,8} Some of these Medicaid beneficiaries may not seek or need Medicaid services because they are healthy. For example, the age range with the largest number of beneficiaries and the most PMPMs identified in our analysis were those beneficiaries aged 26 through 35, accounting for 11,140 beneficiaries (22.1%) and \$344.0 million (27.9%) in PMPMs. However, it becomes less likely that beneficiaries do not need Medicaid services as more time passes. Exhibit 1 shows the length of time and cost of PMPMs associated with beneficiaries who received no services while enrolled in Medicaid, while Appendix D.1 shows the age range of beneficiaries identified through this analysis.

Exhibit 1		
Number of Months Beneficiaries Received No Medicaid Services		
January 2018 through December 2024		
Range of Months	Number of Beneficiaries	PMPMs Paid
36 to 47 months	29,120	\$595,710,402
48 to 59 months	13,322	318,500,264
60 to 71 months	1,130	36,023,438
72 to 83 months	3,332	135,533,108
84 months*	3,395	147,779,921
Total	50,299	\$1,233,547,133
* Beneficiaries in this group represent those who were enrolled and received no services during the entire scope of our analysis.		
Source: Prepared by legislative auditor's staff using Medicaid data.		

It is unlikely that certain groups of beneficiaries identified did not need any services for the period analyzed. However, we identified some factors that may contribute to beneficiaries not receiving services. There were 6,338 disabled, aged, or blind beneficiaries (12.6%) with \$245.5 million (19.9%) in PMPMs paid on their behalf who received no services while enrolled in Medicaid during our audit scope. Appendix D.2 shows the various coverage types for beneficiaries identified through this analysis. In addition, 11,127 (22.1%) of the beneficiaries we identified reside in a rural parish and may have difficulty obtaining services. Appendix D.3 shows the beneficiaries' parish and whether the parish is urban, rural, or out-of-state. Also, 9,927 (19.7%) beneficiaries had third-party

⁶ Of these, 23,123 (46.0%) beneficiaries were still enrolled during the month of June 2025.

⁷ For the purposes of our analysis, we only included those beneficiaries who were continuously enrolled for at least a 36-month period and received no services. There were additional Medicaid beneficiaries continuously enrolled for fewer than 36 months and received no services.

⁸ Of these, 3,300 (6.6%) beneficiaries were identified as possibly living out-of-state in the May 2025 LLA report [Progress Report: Medicaid Residency](#) and 161 (0.3%) were identified as deceased in the August 2025 LLA report [Progress Report: Deceased Medicaid Beneficiaries](#).

private or Medicare insurance in all months identified through our analysis, potentially indicating they do not need Medicaid coverage.⁹ Lastly, 4,526 (9.0%) of the beneficiaries we identified were on Medicaid because the Social Security Administration deemed them eligible for Supplemental Security Income. When this occurs, LDH certifies the beneficiary for Medicaid coverage at both application and renewal without asking for additional information to determine eligibility.

LDH does not conduct routine analyses of Medicaid data to identify Medicaid beneficiaries who have not received any Medicaid services for extended periods of time. As of March 2025, or 10 months after we initially recommended that LDH use Medicaid data for this purpose, LDH stated that it had not yet implemented the recommendation because it was still working on developing a process to conduct this analysis twice a year. In addition, LDH stated that it is the MCOs' responsibility to manage the care of beneficiaries and to identify those beneficiaries who have not received any services.

According to MCOs we previously interviewed, they analyze claims data to identify beneficiaries who have not received services for certain periods of time and then conduct various outreach activities.¹⁰ However, the MCOs stated that they do not share the results of these analyses with LDH and consider this an "eligibility issue" that is LDH's responsibility. Prior to receiving our results from this analysis, LDH stated that it had not requested these results from the MCOs. LDH could better accomplish its Triple Aim by identifying beneficiaries who have been enrolled in Medicaid for extended periods of time without receiving services and determine the reason why they have not received any services. LDH could then either remove beneficiaries from Medicaid if coverage is no longer needed or report this information to the MCOs to ensure they perform case management activities as required by their contracts. Appendix D.4 shows the number of beneficiaries and amount of PMPMs identified through this analysis by MCO.

LDH's Triple Aim includes:

The aim "Better Care" is focused on making health care more person-centered, coordinated, and accessible so it occurs at the "right care, right time, right place."

The aim "Healthier People, Healthier Communities" is focused on improving the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

The aim "Smarter Spending" is focused on demonstrating good stewardship of public resources by ensuring high-value, efficient care.

Recommendation 1: LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to re-determine whether they are still eligible for or need Medicaid coverage.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will complete a regular analysis of members with no services for 30 or more months. LDH also said it is completing enhancements to the Medicaid Eligibility System so that members

⁹ A total of 19,396 (38.6%) beneficiaries identified in this analysis had third-party private or Medicare insurance for at least one month during the months we identified them receiving no services.

¹⁰ Outreach activities cited included phone calls, text messages, emails, and physical mailings.

with no services for 30 or more months will be required to complete a standard renewal. LDH anticipates these system changes will be complete by December 2025. See Appendix A for LDH's full response.

Recommendation 2: LDH should ensure the MCOs are managing the care of beneficiaries enrolled in their plan by conducting analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time and requiring MCOs to provide outreach information they conducted for those beneficiaries to ensure they conduct appropriate outreach activities to manage the beneficiaries' care.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will complete this analysis. LDH stated that it will hold the MCOs accountable for outreach to members with no services for 30 or more months biannually and that the MCOs are in the process of conducting this outreach. See Appendix A for LDH's full response.

APPENDIX A: MANAGEMENT’S RESPONSE



State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

October 13, 2025

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Progress Report: Medicaid Beneficiaries with No Services

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated September 22, 2025 titled Progress Report: Medicaid Beneficiaries with No Services. LDH appreciates the opportunity to provide this response to your office's conclusions and recommendations.

Conclusion 1: LDH does not use Medicaid data as a part of its Quality Strategy to identify beneficiaries who have not received any services. We found that LDH paid the MCOs \$1.23 billion to manage the care of 50,299 beneficiaries who appear to have been continuously enrolled in Medicaid for 36 to 84 months between January 2018 and December 2024 but received no services.

Recommendation 1: *LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to re-determine whether they are still eligible for or need Medicaid coverage.*

LDH Response: LDH concurs with the recommendation.

LDH has reviewed all of the individuals identified as having no services. Of the 50,299 individuals identified, coverage for 27,176 has closed, or ended prior to June 2025.

LDH will ensure that the Managed Care Plans complete a regular analysis of members with no services for 30 or more months. LDH will ensure that our data review team completes this same analysis and holds the MCOs accountable for outreach to members with no services for 30 or more months.

LDH is completing enhancements to the Medicaid Eligibility System so that members with no services for 30 or more months will be required to complete a standard renewal. A standard renewal means that the member will have to complete a renewal packet and return it to Medicaid so their eligibility can be redetermined. Renewals are completed annually based on when their Medicaid enrollment began. We anticipate these system changes will be complete by December 2025.

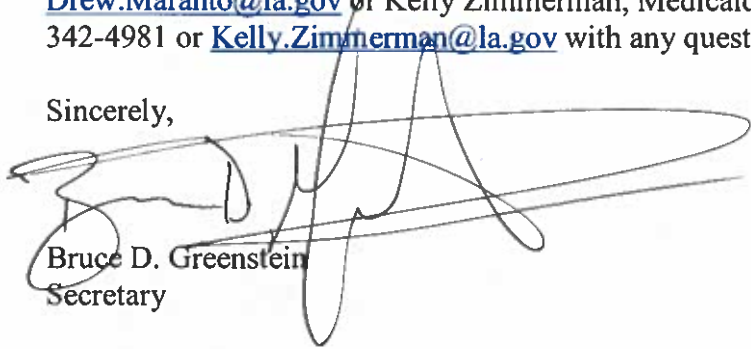
Recommendation 2: *LDH should ensure the MCOs are managing the care of beneficiaries enrolled in their plan by conducting analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time and requiring MCOs to provide outreach information they conducted for those beneficiaries to ensure they conduct appropriate outreach activities to manage the beneficiaries' care.*

LDH Response: LDH concurs with the recommendation.

The MCOs are in the process of conducting outreach to members with no services. In addition to the Managed Care Plans completing a regular analysis of members with no services, and ongoing outreach, LDH will ensure that our data review team completes this same analysis and holds the MCOs accountable for outreach to members with no services for 30 months or more biannually.

You may contact Drew Maranto, Undersecretary at (225) 342-6726 or via e-mail at Drew.Maranto@la.gov or Kelly Zimmerman, Medicaid Special Projects Officer at (225) 342-4981 or Kelly.Zimmerman@la.gov with any questions about this matter.

Sincerely,



Bruce D. Greenstein
Secretary

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our data analytics unit progress report of the Louisiana Department of Health (LDH). The purpose of this review was to analyze the progress made by LDH to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible. We conducted this progress report under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This review covered the period of January 1, 2018, through December 31, 2024. In some instances, our analyses included information before and after this scope. Our objective was:

To analyze progress made by LDH to improve its processes to identify Medicaid beneficiaries who do not utilize Medicaid services and determine whether they are still eligible.

To conduct this review, we performed the following steps:

- Researched relevant federal and state laws, rules, and regulations.
- Researched relevant LDH policies, procedures, informational bulletins, Quality Strategy documents, and Managed Care Organization (MCO) contracts.
- Researched relevant Centers for Medicaid and Medicare Services and Centers for Disease Control and Prevention policies, procedures, data, and other documentation.
- Met with LDH staff to gain an understanding of the processes it uses to monitor MCOs and ensure quality services are provided to Medicaid beneficiaries.
- Met with MCO staff as part of the previous evaluation to gain an understanding of the processes they use to ensure beneficiaries have access to and receive quality Medicaid services, as well as the outreach they conduct when beneficiaries are not receiving services.
- Obtained Medicaid data from LDH, including claims and encounters and beneficiary eligibility information.
- Used SQL, ACL, and Excel to analyze Medicaid data to identify beneficiaries who received no services for certain periods of time.
- Provided our results to LDH to review and incorporated edits throughout the report.

APPENDIX C: FISCAL YEAR ENROLLMENT, MEDICAID MEDICAL VENDOR EXPENDITURES, AND LOUISIANA'S AMERICA'S HEALTH RANKING FISCAL YEARS 2012 THROUGH 2023

Fiscal Year	Medicaid Program Enrollment (in Millions)	State Population Estimate (in Millions)	Estimated Population on Medicaid	Medicaid Payments (in Millions)	Average Annual Cost per Beneficiary	America's Health Ranking*
2012	1.36	4.57	29.7%	\$5,924.35	\$4,356	49
2013	1.41	4.60	30.7%	6,176.84	\$4,367	48
2014	1.42	4.62	30.6%	6,226.25	\$4,393	48
2015	1.49	4.64	31.9%	6,764.26	\$4,555	50
2016	1.60	4.67	34.3%	7,172.86	\$4,475	49
2017	1.79	4.68	38.3%	9,810.24	\$5,478	49
2018	1.86	4.68	39.6%	10,687.99	\$5,757	50
2019	1.85	4.65	39.8%	11,416.85	\$6,159	49
2020**	1.88	4.64	40.5%	12,046.13	\$6,397	50
2021	1.95	4.64	42.0%	13,305.93	\$6,812	50
2022	2.06	4.62	44.5%	14,512.79	\$7,052	50
2023***	2.14	4.59	46.5%	14,832.09	\$6,944	50
Total				\$118,876.58		

* 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.

** The COVID-19 Public Health Emergency (PHE) was declared in March 2020 and led to an increase in the number of beneficiaries enrolled in Medicaid because federal regulations only allowed LDH to terminate a beneficiary's Medicaid coverage if they moved out-of-state, died, or requested closure.

*** According to LDH's monthly Enrollment Analysis report, Medicaid program enrollment was 1,594,002 in June 2025. The large decrease is due to the Medicaid unwind that began on April 1, 2023, and allowed states to resume Medicaid eligibility determinations and to terminate the coverage for beneficiaries who were no longer eligible for Medicaid following the end of the PHE.

Source: Prepared by legislative auditor's staff using information and Medicaid data from LDH, state population data from the United States Census Bureau, and health rankings from United Health Foundation's Health Rankings.

APPENDIX D: BENEFICIARIES WITH NO SERVICES BY AGE RANGE, COVERAGE TYPE, MCO, AND PARISH

Exhibit D.1 shows the results of our no services analysis by age range.

Exhibit D.1 No Services by Beneficiary Age Range January 2018 through December 2024		
Age Range	Unique Beneficiaries	PMPMs Paid
0-17	10,833	\$119,426,354
18-20	2,986	38,146,610
21-25	7,012	179,279,652
26-35	11,140	344,045,149
36-45	7,897	240,599,476
46-55	4,594	143,754,885
56-65	3,686	130,979,802
Over 65	2,151	37,315,205
Total	50,299	\$1,233,547,133
Source: Prepared by legislative auditor's staff using Medicaid data from LDH.		

Exhibit D.2 shows the results of our no services analysis by coverage type, which denotes the primary reason the Medicaid beneficiary was eligible for Medicaid coverage.

Exhibit D.2 No Services by Coverage Type January 2018 through December 2024		
Coverage Type	Unique Beneficiaries	PMPMs Paid
Aged	2,204	\$40,680,736
Blind	56	3,116,316
Disabled	4,078	201,708,367
Families and Children	12,620	128,225,607
Low-Income Families with Children (LIFC) Group	1,667	38,068,322
Other	345	9,184,541
Medicaid Expansion Adult Group	29,329	812,563,244
Total	50,299	\$1,233,547,133
Source: Prepared by legislative auditor's staff using Medicaid data from LDH.		

Exhibit D.3 shows the results of our no services analysis by parish of residence, as well as whether that parish is considered a rural or urban parish. This represents the most recent parish in which the Medicaid beneficiary lived. For example, if a beneficiary previously lived in Ascension Parish but currently lives in Caddo Parish, the beneficiary and all associated PMPMs are included in the Caddo Parish row.

Exhibit D.3 No Services by Parish January 2018 through December 2024			
Parish	Rural or Urban	Unique Beneficiaries	PMPMs Paid
ACADIA	Urban	539	\$11,561,904
ALLEN	Rural	214	4,804,704
ASCENSION	Urban	747	17,167,333
ASSUMPTION	Rural	144	3,904,888
AVOYELLES	Rural	308	8,241,026
BEAUREGARD	Rural	444	10,731,195
BIENVILLE	Rural	160	4,024,690
BOSSIER	Urban	1,278	29,548,708
CADDO	Urban	3,578	84,716,325
CALCASIEU	Urban	2,364	54,438,115
CALDWELL	Rural	92	2,375,350
CAMERON	Rural	27	571,119
CATAHOULA	Rural	94	2,294,699
CLAIBORNE	Rural	136	3,147,388
CONCORDIA	Rural	259	7,201,948
DESOTO	Rural	255	6,184,552
EAST BATON ROUGE	Urban	4,222	106,418,047
EAST CARROLL	Rural	145	3,469,309
EAST FELICIANA	Rural	176	4,090,087
EVANGELINE	Rural	281	7,433,443
FRANKLIN	Rural	213	5,615,179
GRANT	Rural	172	4,045,105
IBERIA	Rural	763	18,054,969
IBERVILLE	Rural	221	5,855,484
JACKSON	Rural	144	3,281,747
JEFFERSON	Urban	4,796	116,031,254
JEFFERSON DAVIS	Rural	243	6,020,702
LAFAYETTE	Urban	2,013	47,852,000
LAFOURCHE	Urban	712	19,362,586
LASALLE	Rural	106	2,433,446
LINCOLN	Rural	563	14,757,678
LIVINGSTON	Urban	1,152	28,277,652
MADISON	Rural	230	5,387,613
MOREHOUSE	Rural	441	11,119,134
NATCHITOCHE	Rural	406	9,105,766
ORLEANS	Urban	6,250	163,077,777
OUACHITA	Urban	2,296	54,371,484
OUT-OF-STATE	Out-of-State	539	12,572,083
PLAQUEMINES	Urban	209	5,047,538
POINTE COUPEE	Rural	143	3,809,262
RAPIDES	Urban	1,486	36,622,320
RED RIVER	Rural	79	1,927,248
RICHLAND	Rural	209	5,132,691
SABINE	Rural	180	4,885,834
ST. BERNARD	Urban	536	13,043,230
ST. CHARLES	Urban	398	9,364,000
ST. HELENA	Rural	64	1,543,717
ST. JAMES	Urban	139	3,572,075
ST. JOHN THE BAPTIST	Urban	467	11,236,831

Parish	Rural or Urban	Unique Beneficiaries	PMPMs Paid
ST. LANDRY	Urban	1,034	\$23,532,230
ST. MARTIN	Urban	438	10,346,178
ST. MARY	Rural	567	14,124,691
ST. TAMMANY	Urban	2,203	54,815,975
TANGIPAHOA	Rural	1,418	36,422,799
TENSAS	Rural	76	1,741,540
TERREBONNE	Urban	1,172	29,590,211
UNION	Rural	228	5,129,224
VERMILION	Rural	493	10,957,867
VERNON	Rural	553	12,951,943
WASHINGTON	Rural	554	14,752,521
WEBSTER	Urban	433	11,177,173
WEST BATON ROUGE	Urban	171	4,633,699
WEST CARROLL	Rural	120	2,639,708
WEST FELICIANA	Rural	66	1,679,307
WINN	Rural	140	3,320,832
Total		50,299	\$1,233,547,133
Source: Prepared by legislative auditor's staff using Medicaid data from LDH.			

Exhibit D.4 shows the results of our no services analysis by MCO. This represents the most recent MCO for which the Medicaid beneficiary had coverage. For example, if a beneficiary was previously enrolled with Aetna but is currently enrolled with Healthy Blue, the beneficiary and all associated PMPMs are included in the Healthy Blue row.

Exhibit D.4 No Services by MCO January 2018 through December 2024		
MCO	Unique Beneficiaries	PMPMs Paid
Aetna Better Health Louisiana	9,780	\$147,196,898
AmeriHealth Caritas of Louisiana	11,677	175,770,084
Healthy Blue	18,317	286,295,532
Humana Healthy Horizons in Louisiana	6,995	46,681,245
Louisiana Healthcare Connections	18,549	278,335,722
United Healthcare Community Plan	20,192	299,267,652
Unique Total	50,299*	\$1,233,547,133
* There were 35,211 beneficiaries enrolled with multiple MCOs during the period covered by our audit who received no services. This represents the total number of unique beneficiaries identified by our analysis. Source: Prepared by legislative auditor's staff using Medicaid data from LDH.		