

MEDICAID SERVICES FOR FOSTER CHILDREN

DEPARTMENT OF CHILDREN AND FAMILY
SERVICES

PERFORMANCE AUDIT SERVICES

Informational Report
Issued April 8, 2026

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April 8, 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 informational report provides information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services. This report is intended to provide timely information related to an area of interest to the legislature or 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 DCFS for its assistance during this review.

Respectfully submitted,



Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/aa

MEDICAIDFOSTERCHILDREN



Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA



Medicaid Services for Foster Children Department of Children and Family Services

April 2026

Audit Control # 40250029

Introduction

This report provides information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services. DCFS has the overall responsibility for the physical, medical, dental, and emotional care of children in foster care and is ultimately responsible for making provisions for preventive and medical care and/or treatment for any condition that is dangerous to the child’s physical or mental health. We compiled this information in response to DCFS’s concern that eligible medical services provided to foster children were not always billed through Medicaid, resulting in increased state general fund expenditures.

Foster Care and Medicaid Overview. Children in foster care are eligible for Medicaid, which provides health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. The Louisiana Department of Health (LDH) administers the Medicaid program in Louisiana. As of February 2012, Medicaid operates under a managed care model, meaning LDH pays Managed Care Entities (MCEs)¹ a monthly fee/premium, referred to as a per-member per-month (PMPM) payment, to manage the health needs of the Medicaid population enrolled in the MCEs. MCEs then pay providers for services delivered to beneficiaries.

The goal of **Medicaid managed care** is to improve access to services and reduce costs by eliminating inappropriate and unnecessary services through improved coordination of care.

Medicaid Costs for Foster Children. During fiscal years 2023 through 2025, at least 9,619 foster children were enrolled in Medicaid at some point during that time. LDH paid MCEs \$78.9 million in PMPM payments for foster children during those three years,² and MCEs paid \$182.3 million in Medicaid encounters³ to providers for services provided to foster children during

¹ As of January 2026, LDH contracts with nine MCEs, including six Managed Care Organizations (MCOs) for physical and behavioral health services know as Healthy Louisiana, two dental benefit program managers for dental services, and one coordinated system of care (CSoC) provider for children with significant behavioral challenges. 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. Aetna Better Health Louisiana and Healthy Blue are DCFS’s preferred MCOs for foster children. Magellan is the CSoC administrator.

² State Medicaid costs are split between federal and state funds.

³ 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.

this time. When an MCE does not pay for a Medicaid-eligible service, usually because the MCE deemed the service not medically necessary, DCFS pays for the services with federal or state general funds.

Foster Children and Behavioral Health. Research shows that foster children have a high rate of behavioral health needs.⁴ As foster children often have significant health, behavioral, social and other needs, the average Medicaid spending is much higher than that of most other children enrolled in Medicaid.⁵ Some foster children are enrolled in the Medicaid Coordinated System of Care (CSoC) due to significant behavioral challenges,⁶ which is administered through Magellan.

To conduct this review, we analyzed Medicaid claims data and DCFS child welfare payments to determine the costs paid for behavioral health services provided to foster children, primarily for inpatient psychiatric hospitalization, psychiatric residential treatment facilities, and/or therapeutic group home services. We focused on these behavioral health services because of the high cost and utilization for foster children. We also reviewed examples of payments for foster children who received these services, and we reviewed DCFS's processes for approving payments for Medicaid-eligible services.

The objective of this review was:

To provide information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains DCFS's response, and Appendix B contains our scope and methodology.

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 DCFS and incorporated its feedback throughout this informational report.

⁴ [National Academy for State Health Policy, *How State Medicaid Programs Serve Children and Youth in Foster Care*.](#)

⁵ [Medicaid and CHIP Payment and Access Commission, *The Intersection of Medicaid and Child Welfare*.](#)

⁶ CSoC is a system to ensure there is a coordinated network of services and supports for children and youth with behavioral health challenges. CSoC brings together the Department of Health (Office of Behavioral Health and Medicaid); the Department of Children & Family Services; the Department of Education; the Office of Juvenile Justice; the Governor's Office; and family, youth and advocate representatives to establish a service delivery system that is better integrated, has enhanced service offerings and achieves improved outcomes.

Objective: To provide information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services.

Overall, we found the following:

- **During fiscal years 2023 through 2025, MCEs and DCFS paid at least \$92.7 million for residential behavioral health services for 1,004 foster children.** Of this, MCEs paid \$68.3 million (73.7%), and DCFS paid \$24.4 million (26.3%).
- **The payment process for Medicaid services for foster children can be complex and confusing, and DCFS's payment approval process for Medicaid-eligible services is not always clear.** As a result, it is unclear whether some of the \$24.4 million DCFS paid for residential behavioral health services should have been paid through the Medicaid program.
- **High costs of inpatient psychiatric hospitalization for foster children are due, in part, to children remaining in inpatient care longer than medically necessary because of delays in subsequent treatment availability or placement options.** For example, a Medicaid step-down placement not being available and DCFS not yet having secured an appropriate placement for the child are reasons why foster children may remain in inpatient psychiatric hospitalization after medical necessity.

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

During fiscal years 2023 through 2025, MCEs and DCFS paid at least \$92.7 million for residential behavioral health services for 1,004 foster children. Of this, MCEs paid \$68.3 million (73.7%), and DCFS paid \$24.4 million (26.3%).

Foster children receive a variety of behavioral health services in various settings. For example, services may be provided in a doctor's office or in the home, and intensive services may be provided in a 24-hour residential placement. The top three behavioral health services, in terms of cost, provided to foster children during

fiscal years 2023 through 2025 were for three types of residential placements, all being Medicaid-eligible services, as shown in Exhibit 1.

Exhibit 1 Residential Behavioral Health Services for Foster Children Paid by MCEs and DCFS Fiscal Years 2023 through 2025				
Type of Service	Description	MCE Payments	DCFS Payments	Total
Inpatient Psychiatric Hospitalization	Inpatient hospitalization, under the supervision of a psychiatrist, providing psychiatric services, social work services, psychiatric nursing, and therapeutic activities. Inpatient hospitalization should only be utilized when community resources are inadequate to meet treatment needs, treatment of the psychiatric condition requires inpatient services, and the services are expected to improve the patient’s condition within a reasonable period of time.	\$24,709,056	\$18,912,395	\$43,621,451
Psychiatric Residential Treatment Facilities	Non-hospital residential facility offering intensive inpatient services to individuals under the age of 21 who have various behavioral health issues. These facilities are required to ensure all medical, psychological, social, behavioral, and developmental aspects of the individual’s situation are assessed and treated.	38,730,800	1,848,967	40,579,767
Therapeutic Group Homes	Facility that provides community-based residential services in a home-like setting of no more than 10 beds under the supervision and oversight of a psychiatrist or psychologist. Therapeutic group homes provide a structured living environment 24 hours per day, seven days per week.	4,810,873	3,639,591*	8,450,464
Total		\$68,250,729	\$24,400,953	\$92,651,682
*DCFS pays for the room and board component of therapeutic group homes, while MCEs pay for the medical services.				
Source: Prepared by legislative auditor’s staff using Medicaid data and DCFS data.				

During fiscal years 2023 through 2025, MCEs paid \$68.3 million (73.7%) of \$92.7 million for residential behavioral health services for foster children. As the three residential behavioral health programs listed above are Medicaid-eligible services, MCEs pay for these services when medically necessary. Behavioral health services, including the residential treatment, make up a significant portion of Medicaid encounters for foster children. Overall, during fiscal years 2023 through 2025, MCEs paid \$182.3 million in Medicaid encounters for foster children, including \$81.7 million (44.8%) for behavioral health services. Of these behavioral health services, \$68.3 million (83.6%) was for inpatient psychiatric hospitalization, psychiatric residential treatment facilities, and therapeutic group homes, with 948 foster children receiving these services. Exhibit

2 shows the total Medicaid encounters for and the number of foster children served by these services for fiscal years 2023 through 2025.

Exhibit 2 Medicaid Encounters for Foster Children in Behavioral Health Residential Services Fiscal Years 2023 through 2025					
FY	Category	Inpatient Psychiatric Hospitalization	Psychiatric Residential Treatment Facilities	Therapeutic Group Homes	Total
2023	Encounter	\$6,665,095	\$8,515,026	\$1,370,217	\$16,550,338
	Number Served	357	114	82	
2024	Encounter	8,691,263	13,155,396	1,685,217	23,531,876
	Number Served	402	150	105	
2025	Encounter	9,352,698	17,060,378	1,755,439	28,168,515
	Number Served	406	185	87	
Total	Encounter	\$24,709,056	\$38,730,800	\$4,810,873	\$68,250,729
	Unique Number Served	873	302	200	948*

*Total unique count of foster children served.

Source: Prepared by legislative auditor’s staff using Medicaid data.

During fiscal years 2023 through 2025, \$24.4 million (26.3%) of \$92.7 million for residential behavioral health services for foster children was paid by DCFS. When an MCE does not pay for a service, usually because the MCE deemed the service not medically necessary,⁷ DCFS may pay for the service. Out of the \$24.4 million DCFS spent on residential behavioral health services, \$11.1 million (45.5%) used Social Services Block Grant funds,⁸ \$9.7 million (39.7%) used state general fund dollars, and \$3.6 million (14.8%) used Titles IV-B and IV-E funds.⁹ In addition, DCFS pays for room and board for therapeutic group homes, while Medicaid pays for the medical services. Exhibit 3 shows the total DCFS payments for and the number of foster children served by these services during fiscal years 2023 through 2025.

⁷ When an MCE declines to authorize or reimburse a service based on its medical necessity criteria, this determination does not necessarily mean the treatment is not clinically indicated; rather, it may mean the service did not meet the payer’s specific coverage standards at that time.

⁸ The Social Services Block Grant program is a flexible funding source administered by the U.S. Administration for Children and Families that allows states and territories to tailor social service programming to their population’s needs.

⁹ Title IV-B provides flexible federal funding for states and tribes to prevent children from entering foster care, support caregivers and strengthen family connections and Title IV-E provides funds for states and tribes to provide foster care, transitional independent living programs for children, guardianship assistance, and adoption assistance for children with special needs. Both are administered by the U.S. Administration for Children and Families.

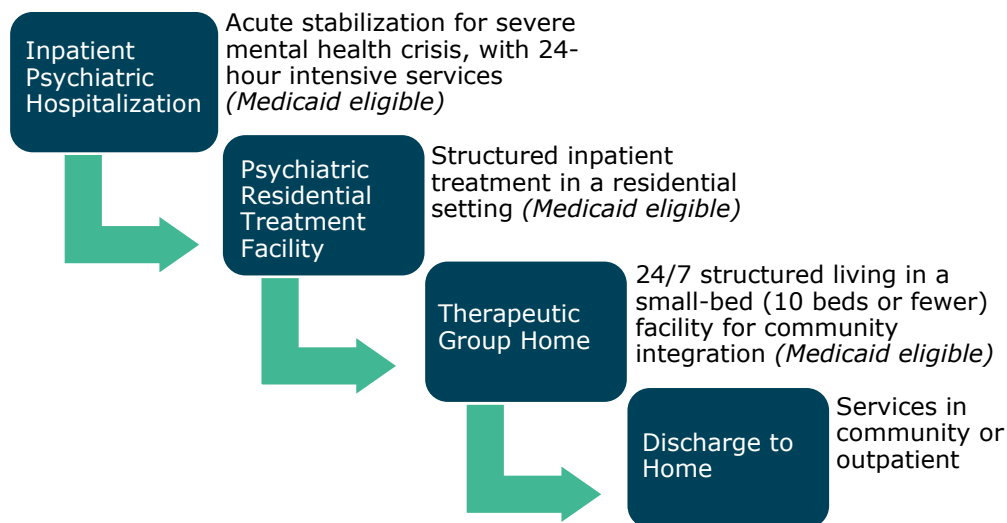
Exhibit 3 DCFS Payments for Foster Children in Behavioral Health Residential Services Fiscal Years 2023 through 2025					
FY	Category	Inpatient Psychiatric Hospitalization	Psychiatric Residential Treatment Facilities	Therapeutic Group Homes*	Total
2023	Invoices	\$6,482,506	\$357,831	\$923,393	\$7,763,730
	Number Served	209	12	93	
2024	Invoices	7,823,138	1,089,751	1,411,378	10,324,267
	Number Served	222	25	122	
2025	Invoices	4,606,751	401,384	1,304,820	6,312,955
	Number Served	144	11	96	
Total	Invoices	\$18,912,395	\$1,848,966	\$3,639,591	\$24,400,952
	Unique Number Served	453	42	217	557**

*DCFS pays for the room and board component of therapeutic group homes, while Medicaid pays for the medical services.
 **Total unique count of foster children served.
Source: Prepared by legislative auditor’s staff using child welfare payment data from DCFS.

The payment process for Medicaid services for foster children can be complex and confusing, and DCFS’s payment approval process for Medicaid-eligible services is not always clear. As a result, it is unclear whether some of the \$24.4 million DCFS paid for residential behavioral health services should have been paid through the Medicaid program.

MCEs pay for medical and behavioral health services that are deemed medically necessary. If a foster child continues to receive a Medicaid-eligible service beyond medical necessity, DCFS will pay for those services in some instances. However, sometimes there is confusion or a lack of communication between DCFS, MCEs, and providers about which party is responsible for payment and/or securing subsequent placement, especially when a foster child is discharged from inpatient psychiatric hospitalization. For example, once medical professionals determine inpatient psychiatric care is no longer necessary, a foster child may be discharged “to home,” meaning medication, community resources, and/or outpatient care are sufficient to meet the child’s needs. Sometimes, “step-down” care is necessary, meaning inpatient hospitalization is not necessary, but a structured, less restrictive setting would meet the child’s needs. Two such step-down services that may follow inpatient psychiatric hospitalization are psychiatric residential treatment facilities or therapeutic group homes. Exhibit 4 outlines the levels of service and step-downs for behavioral health inpatient and residential services.

Exhibit 4 Behavioral Health Residential Step-Downs*



*Foster children may not require all the above services and may not receive them in this order.

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

The payment process for Medicaid services for foster children can be complex and confusing. Both DCFS and MCEs have some responsibility for the placement of foster children discharging from inpatient psychiatric hospitalization depending on the discharge recommendation. While state law¹⁰ mandates DCFS to provide for the daily needs of foster children, including medical services, MCEs also have responsibility for ensuring foster children receive appropriate Medicaid services when transitioning from one Medicaid service to another. For example, LDH's contracts with Managed Care Organizations (MCOs) include:¹¹

- **Network adequacy.** MCOs must meet access and timeliness standards. For example, psychiatric residential treatment facility placement should take no more than 20 calendar days after a healthcare provider makes the placement recommendation. In addition, MCOs must demonstrate that 100% of applicable plan members have access to a service provider within a given distance. The network adequacy standard for psychiatric residential treatment facilities is 200 miles.
- **Transitional case management.** MCOs must support transitions for enrollees between institutional and community care settings, including to/from inpatient hospitals, psychiatric residential treatment facilities, and therapeutic group homes.

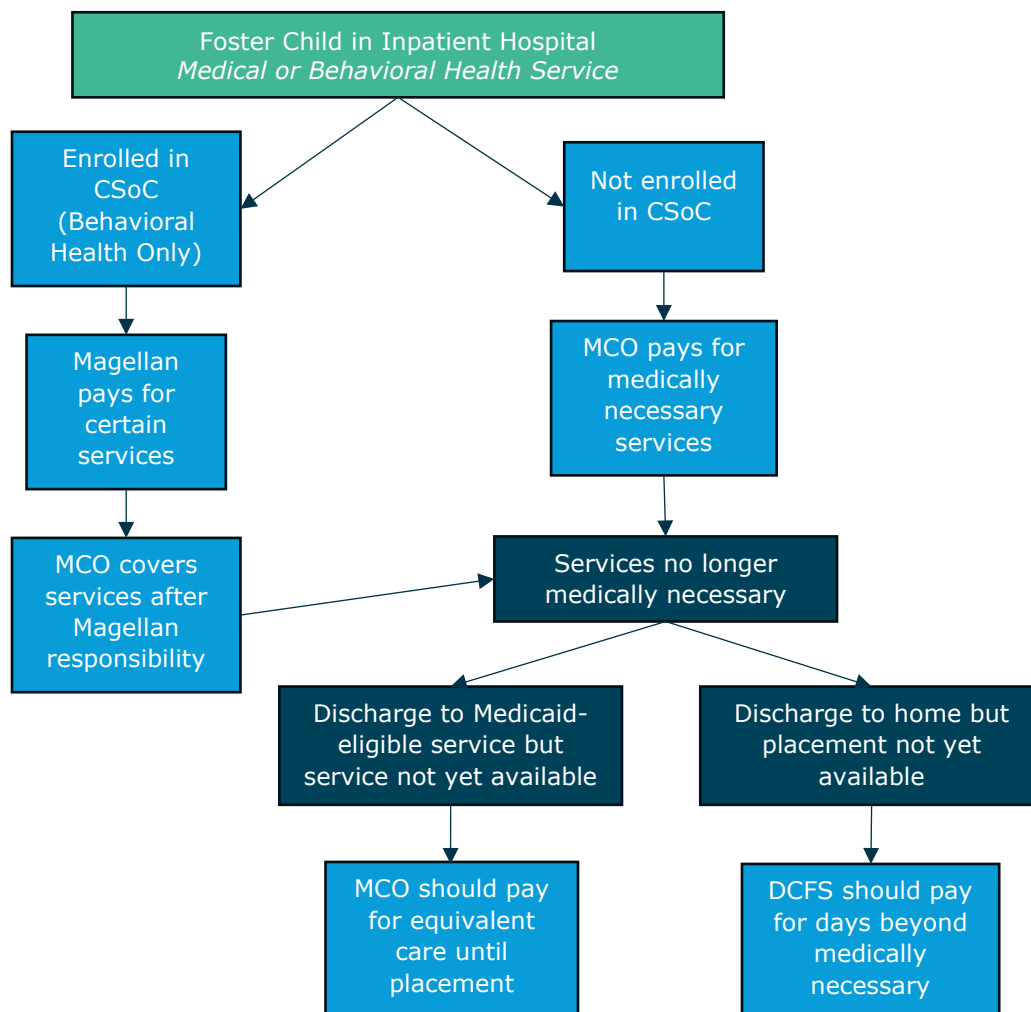
Responsibility for payment for inpatient psychiatric hospitalization depends on whether the services are medically necessary and the discharge

¹⁰ LA R.S. 36:477

¹¹ Other MCEs, including Magellan and dental plans, may have different contract requirements.

recommendation. If inpatient psychiatric hospitalization is no longer medically necessary but placement in a psychiatric residential treatment facility is, the MCE would be responsible for the cost of hospitalization until the child is placed in a psychiatric residential treatment facility. However, if the discharge recommendation is to home, then DCFS is responsible for paying for hospitalization after it is no longer medically necessary until DCFS secures placement. Exhibit 5 shows the responsible payors for Medicaid-eligible inpatient hospital service.

**Exhibit 5
Responsible Payor for Medicaid-Eligible Inpatient Hospital Service**



Source: Prepared by legislative auditor’s staff using information from DCFS and LDH contracts with MCEs.

Providers bill MCEs for Medicaid-eligible services, and if the MCE denies the claim,¹² then providers have the option to appeal the denial. According to DCFS, when providers receive a denial, they may automatically bill DCFS rather than appeal the denial. DCFS stated that billing for Medicaid services for foster children

¹² MCEs may deny claims for a variety of reasons, such as technical errors in the claim, the service is not medically necessary, or the service is not in line with what was pre-authorized.

enrolled in CSoC is especially confusing because there are several entities involved in these cases, including providers, MCEs, and DCFS. In addition, providers and MCOs have expressed uncertainty regarding CSoC, including (1) which entity is financially responsible once inpatient medical necessity ends, (2) whether invoices should be submitted to Magellan or the primary MCO, and (3) how to bill inpatient days incurred while awaiting placement.

DCFS's payment approval process for medical and behavioral health services is not always clear. A clear approval process is important because determining which party is responsible for paying for the service is complex and depends on several factors, which heightens the risk that DCFS will incorrectly approve payments that the Medicaid program could have paid for. DCFS policy does not clearly outline the payment approval steps for paying for Medicaid-eligible services. For example, DCFS policy requires a Medicaid denial letter to approve payment for a Medicaid-eligible service. However, policy does not require staff to obtain and review discharge recommendations, provider appeals, or other relevant documents prior to approving payment. As a result, DCFS may be paying for services that could have been paid for by an MCE. DCFS could not always provide documentation to LLA about denials, discharge recommendations, or other information about a foster child's case.

As DCFS staff may not always be familiar with the complexities of Medicaid, standardized and clear guidance would help ensure only appropriate payments are approved. For example, DCFS makes references to Medicaid services throughout its policies; however, not all relevant information is found in one section. The processing payment section of DCFS's policy for psychiatric hospitalization of foster children only states the data entry codes for use for non-DCFS payable Medicaid psychiatric hospitalization and those for when DCFS pays. The policy does not include guidance on when DCFS should pay for Medicaid-eligible services, what steps to take to ensure payment is appropriate, and what documentation to review and maintain. Another policy states that to approve evaluation and therapy behavioral health service payments, the caseworker should obtain a denial letter, but it does not list other behavioral health services such as inpatient psychiatric hospitalization or psychiatric residential treatment, nor does it refer to other relevant policies.

According to DCFS, it is developing updated forms and guidance for providers on the process for billing for Medicaid-eligible services. Such guidance includes clarifying the steps providers should take before DCFS accepts responsibility for payment, including the provider appealing denials, how to notify DCFS of discharge, and that when the treating physician deems services no longer medically necessary, DCFS will pay standard Medicaid rates. DCFS should also update policy and procedures to reflect the steps that DCFS must take prior to paying invoices for Medicaid-eligible services to ensure the provider took all necessary steps prior to invoicing DCFS.

Recommendation 1: DCFS should develop standardized, clear policy and guidance for DCFS staff outlining the steps and documents needed to approve payment for services that may be Medicaid eligible.

Summary of Management’s Response: DCFS agreed with this recommendation and stated that it has implemented updated, standardized policies effective February 4, 2026, to clarify steps and documentation required before approving payment for services that may be Medicaid eligible. DCFS has also streamlined internal review processes and provided staff education to ensure consistent statewide implementation and strengthened fiscal oversight. Comprehensive training for staff is ongoing to ensure all members of the DCFS team understand and consistently apply the updated policies and procedures. See Appendix A for DCFS’s full response.

Recommendation 2: DCFS should continue to clarify for providers when to bill Medicaid, when to appeal Medicaid denials, and when to bill DCFS for behavioral health services.

Summary of Management’s Response: DCFS agreed with this recommendation and stated that it has taken steps to further clarify expectations for providers regarding when to bill Medicaid, when to pursue appeals of Medicaid denials, and when it is appropriate to submit claims to DCFS for health services. Effective February 4, 2026, DCFS updated CW Form 490 - Letter of Expectations Between DCFS and Hospital to explicitly address both inpatient medical and behavioral health hospitalizations and to reinforce Medicaid as the primary payer, including required authorization and appeal processes prior to billing DCFS. See Appendix A for DCFS’s full response.

High costs of inpatient psychiatric hospitalization for foster children are due, in part, to children remaining in inpatient care longer than medically necessary because of delays in subsequent treatment availability or placement options.

Securing step-down placements for foster children discharging from psychiatric inpatient hospitalization can be challenging because providers may not always accept a treatment referral for a variety of reasons, such as if a bed is not available or the child has needs that exceed providers’ capacity. Psychiatric residential treatment facilities are privately-owned and managed and make their own decision about whether they will admit a youth. According to a 2023 LDH report, while data did not clearly support the need for a significant increase in the overall number of psychiatric residential treatment facility beds in the state, it did see the need to expand current psychiatric residential treatment facility capacity to provide specialty care that can serve youth with co-occurring mental health needs and developmental disability concerns.¹³ In addition, Louisiana faces a shortage of foster homes, which can make it challenging for DCFS to secure placements for

¹³ [LDH, “Study on the Availability of Psychiatric Treatment Facilities: House Resolution No. 262 of Regular Legislative Session 2023,” October 2023](#)

foster children. According to DCFS, as of February 2026 there were 4,396 children in foster care for which DCFS has certified 2,129 foster homes, which have a total availability of 3,542 beds combined.

High costs of inpatient psychiatric hospitalization for foster children are due, in part, to children remaining in inpatient care longer than medically necessary due to delays in subsequent treatment/placements.

Reasons for foster children remaining in inpatient psychiatric hospitalization after medical necessity often include the following reasons:

- **A Medicaid step-down placement was not yet available.** According to DCFS, as of November 2025, there were at least 14 foster children in an inpatient psychiatric hospital waiting for a step-down placement. These youth had been in the hospital for an average of 60 days, with 157 days as the highest number of days. Of the 14 foster children, eight (57.1%) had caseworker notes that the step-down facility¹⁴ would not accept the child because the child's needs were too high, and three (21.4%) were accepted to an in-state facility but there were no beds available.

When a placement cannot be found in state, foster children may be placed in an out-of-state facility, such as a psychiatric residential treatment facility. According to DCFS, as of November 2025, at least 20 foster children were in out-of-state psychiatric residential treatment facilities. On average, foster children were in an inpatient psychiatric hospital for 85 days before being placed in an out-of-state psychiatric residential treatment facility. MCOs generally pay for out-of-state placements as long as the services are deemed medically necessary.

- **The appropriate level of care was not yet available in the community.** When a foster child is discharged from inpatient psychiatric hospitalization to a home, sometimes it is difficult for DCFS to find placement for the child. For example, according to DCFS, during calendar years 2023 through 2025, there were at least 16 children¹⁵ in an inpatient psychiatric hospital that discharged to a foster home, relative, or therapeutic foster home. On average, these children had five days of hospitalization deemed medically necessary and 22 days of hospitalization deemed not medically necessary, with 96 days as the highest number not medically necessary.

We found instances where MCEs paid for the first few days of inpatient psychiatric hospitalization, and then DCFS paid for several weeks or months before the foster child was discharged to another setting. These examples included foster children discharging to a step-down Medicaid service, such as a psychiatric residential treatment facility, and the responsibility for payment and discharge placement may have been the MCE's. We also found foster children discharging to home, which would be DCFS's responsibility for payment and placement. In

¹⁴ Psychiatric residential treatment facility or therapeutic group home.

¹⁵ These 16 youth were enrolled in CSoC.

addition, we found that DCFS and MCEs sometimes paid for the same days of service, as shown in red in the exhibit below. Exhibit 6 shows examples of children in inpatient psychiatric hospitals, for how many days, and the total cost by payor.

Exhibit 6 Examples of Inpatient Psychiatric Hospitalization Paid by MCEs and DCFS Fiscal Years 2023 through 2025					
Example	Begin Service Date	End Service Date	Payor	Amount Paid	Number of Days
Example #1	2/11/2023	2/15/2023	Medicaid	\$3,688	5
	2/16/2023	6/28/2023	DCFS	\$98,105	133
Example #2	4/27/2024	4/29/2024	Medicaid	\$2,213	3
	4/30/2024	7/10/2024	DCFS	\$53,109	72
Example #3	6/2/2024	6/8/2024	Medicaid	\$5,163	7
	6/9/2024	9/15/2024	DCFS	\$72,288	98
Example #4	2/11/2024	2/17/2024	Medicaid	\$5,163	7
	2/18/2024	4/30/2024	DCFS	\$53,847	73
	5/1/2024	5/19/2024	DCFS	\$14,015	19
	5/1/2024	5/20/2024	Medicaid	\$14,015	20

Source: Prepared by legislative auditor’s staff using Medicaid data and DCFS data.

Other states have also found instances where foster children remained in inpatient psychiatric hospitals past medical necessity.¹⁶ Maryland found that children remained in inpatient psychiatric hospitals after their discharge date for a variety of reasons, including gaps in community-based and residential services causing delays in transitioning youth to placement and youth with complex behavioral needs. Maryland is working to expand provider capacity, strengthen local provider networks, expand access to evidence-based practices aimed at reducing hospital admissions, and modernize rate payment structure.¹⁷ In response to foster children remaining in inpatient psychiatric hospitals past medical necessity, Illinois has taken several steps to reduce the length of hospitalizations by working with providers to develop additional therapeutic placements and specialized foster care resources.¹⁸

Recommendation 3: DCFS should work with LDH and the MCEs to reduce the time foster children remain in inpatient psychiatric hospitals past medical necessity.

Summary of Management’s Response: DCFS agreed with this recommendation and stated that it has formally committed to the Home for Every Child Initiative. On February 24, 2026, Governor Jeff Landry signed a proclamation affirming Louisiana's commitment to ensuring children are served in the least restrictive, most appropriate settings and that hospital stays are not prolonged due to system barriers. In addition, DCFS has closely partnered with the Louisiana Department of Health to explore all possible

¹⁶ Connecticut, Illinois, Maryland, Missouri, Rhode Island, Texas

¹⁷ [Maryland Department of Human Services, “Report on Hospital Stays, Average Length of Stay, and Placements after Discharge,” February 2025](#)

¹⁸ [Illinois “Annual Youth in Care Waiting for Placement Report,” December 2024](#)

step-down levels of care when a treatment recommendation is made, including residential, community-based, and family-like settings. See Appendix A for DCFS's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

Jeff Landry
GOVERNOR



Rebecca Harris
SECRETARY

State of Louisiana

Department of Children and Family Services

April 2, 2026

Michael J. "Mike" Waguespack, CPA
Legislative Auditor
1600 North Third Street
Baton Rouge, LA 70804

Re: Child Welfare Medicaid Services for Foster Children # 40250029

Dear Mr. Waguespack:

The Louisiana Department of Children and Family Services (DCFS) has received the Informational Report titled "Medicaid Services for Foster Children" issued by Performance Audit Services. DCFS appreciates the thorough review and remains committed to continuously evaluating and strengthening agency processes to improve outcomes for children in foster care and ensure responsible stewardship of public funds.

While the audit reflects performance from State Fiscal Year (SFY) 2023 through early SFY 2025, the Department has already initiated and implemented several policies, procedural, and oversight enhancements designed to improve coordination, documentation, and fiscal controls within the Child Welfare Division. These actions directly address areas identified in the report and position DCFS to provide stronger oversight of Medicaid-related services for foster children moving forward.

Below is a response to each recommendation and the plans to address each area.

Recommendation 1: DCFS should develop standardized, clear policy and guidance for DCFS staff outlining the steps and documents needed to approve payment for services that may be Medicaid eligible.

DCFS has implemented updated, standardized policies effective February 4, 2026, to clarify the steps and documentation required before approving payment for services that may be Medicaid eligible. Revisions to the CW Form 490 Instructions reinforce Medicaid as the primary payer, require exhaustion of managed care authorization and appeals, and specify mandatory denial documentation and payment calculations at the Medicaid rate. DCFS has also streamlined internal review processes and provided staff education to ensure consistent statewide implementation and strengthened fiscal oversight. Comprehensive training for staff is ongoing to ensure all members of the DCFS team understand and consistently apply the updated policies and procedures.

Recommendation 2: DCFS should continue to clarify for providers when to bill Medicaid, when to appeal Medicaid denials, and when to bill DCFS for behavioral health services.

DCFS has taken steps to further clarify expectations for providers regarding when to bill Medicaid, when to pursue appeals of Medicaid denials, and when it is appropriate to submit claims to DCFS for health services. Effective February 4, 2026, DCFS updated CW Form 490 – Letter of Expectations Between DCFS and Hospital to explicitly address both inpatient medical and behavioral health hospitalizations and to reinforce Medicaid as the primary payer, including required authorization and appeal processes prior to billing DCFS.

In addition, DCFS implemented a new CW Form 491 – Discharge Recommendation to standardize communication from providers regarding treatment progress, level of care recommendations, and discharge planning. This form supports clearer coordination between providers and DCFS and ensures alignment with medical necessity and discharges planning requirements. DCFS will continue ongoing training and education with providers statewide to promote consistent understanding of billing expectations and to strengthen compliance with established payment procedures.

Recommendation 3: DCFS should work with LDH and the MCEs to reduce the time foster children remain in inpatient psychiatric hospitals past medical necessity.

DCFS has formally committed to the Home for Every Child Initiative, and on February 24, 2026, Governor Jeff Landry signed a proclamation affirming Louisiana’s commitment to ensuring children are served in the least restrictive, most appropriate settings and that hospital stays are not prolonged due to system barriers.

DCFS has closely partnered with the Louisiana Department of Health (LDH) to explore all possible step-down levels of care when a treatment recommendation is made, including residential, community-based, and family-like settings. We conduct weekly joint rounds with the Medicaid Managed Care Entities (MCEs) to review complex cases, address barriers to placement, and expedite transitions. In addition, DCFS implemented internal weekly discharge planning rounds beginning in November 2025 for medical admissions and December 2025 for behavioral health admissions to proactively monitor length of stay, coordinate services, and ensure timely movement to appropriate levels of care. These structured processes strengthen cross-agency collaboration and promote safety, clinically appropriate, and timely discharge for children in state custody.

Please advise if additional clarification or information is needed.

Sincerely,



Rebecca Harris
Secretary

cc: Connie Guillory, Assistant Secretary of Child Welfare
Christopher Bahm, Undersecretary
Haley Williams, Deputy Secretary
Sarah Tirrell, General Counsel

APPENDIX B: SCOPE AND METHODOLOGY

This report provides information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services. Our analysis covered fiscal years 2023 through 2025. Our objective for this review was:

To provide information about payments made by the Medicaid program and the Department of Children and Family Services (DCFS) for foster children receiving behavioral health services.

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 incorporated DCFS's feedback throughout this report.

To answer our objective, we performed the following:

- Obtained and reviewed DCFS policies regarding child welfare payments for Medicaid-eligible services.
- Met with DCFS staff to understand the payment processes for Medicaid-eligible services.
- Obtained a SQL backup of the Tracking, Information, and Payment System (TIPS) data system in order to analyze payments for Medicaid-eligible services and placement authorizations.
- Obtained and analyzed Medicaid claims and encounter data to identify Medicaid encounters made on behalf of foster children.
- Obtained and reviewed supporting documentation from DCFS for eight examples of foster children who had both Medicaid and DCFS payments in our data analysis for inpatient psychiatric hospitalization or other services.
- Obtained and reviewed examples provided by DCFS illustrating challenges with payments and placements for foster children receiving Medicaid-eligible services such as inpatient psychiatric hospitalization and psychiatric residential treatment facilities.
- Obtained and reviewed Managed Care Organizations' contracts with LDH.
- Met with LDH to understand Managed Care Entities' responsibilities regarding Medicaid services for foster children.

- Researched other states' placement of foster children in inpatient psychiatric hospitals.
- Discussed and provided our results to DCFS management and incorporated edits throughout.