STATUTORY GROUPS

Foster Care Reimbursement Rate Committee

Felicia Nelsen, Co-Chair

The Foster Care Reimbursement Rate Committee (FCRRC) was codified at Neb. Rev. Stat. §43-4217 to make recommendations on foster care reimbursement rates, statewide standardized level of care assessment, and adoption assistance payments. The Committee is required to submit reports to the Health and Human Services Committee of the Legislature once every four years.

The FCRRC will be submitting the legislatively required report in 2024 to include suggested rates for agencies and foster parents, as well as recommendations for Therapeutic Family Care implementation. The FCRRC and Children's Commission recognize that the cost of caring for a child has increased significantly since the last legislative report due to inflation. The FCRRC commends DHHS in keeping youth in their homes with supports and because of this, youth entering foster care tend to have more significant needs that require more training, support and resources for foster parents and their supporting agencies. Although specific rate recommendations will be provided in the 2024 report, the FCRRC would support any increases to foster care reimbursement and agency support rates to continue supporting youth involved in foster care.

Therapeutic Family Care Workgroup

Trisha Behrens & Doug Kreifels, Co-chairs

The TFC Workgroup was established by the FCRRC to define program elements and create a rate structure for the service, and is composed of foster parents, service providers, Juvenile Probation, and DHHS staff. In 2019, the workgroup created recommendations and a service definition for DHHS to utilize when establishing the treatment family care service. TFC is set to be an available service as of October 1, 2023, pending CMS approval of Nebraska's plan. The workgroup focused on comparing what DHHS is planning to implement to the Commission's recommendations from 2019.

There were two notable differences between the recommendations and the current plan:

1. The 2019 recommendations stated that youth should be eligible to age 20 and younger who have a history of trauma in addition to complex mental health or substance use disorders that are causing functional impairment, available to youth in various family settings (biological, adoptive, and kinship), and should include probation youth. The current implementation plan is to use the Child and Adolescent Functional Assessment Scale (CAFAS) tool to determine eligibility, however, this tool will only be utilized for DHHS state wards placed in foster care. DHHS will implement a clinical care coordination team to support the program and establish eligibility by administering the CAFAS to youth. Current implementation eliminates any youth who are not current wards of the state, resulting in counterproductive efforts to provide supports to keep youth with their families and in their communities.
2. Initial recommendations noted that an Initial Diagnostic Interview (IDI) be completed prior to the beginning of treatment and will identify the level of care needed. The current implementation plan identifies that a child must have an active diagnosis which requires a previous assessment be complete. If an IDI is already completed, the workgroup recommends that it be used to determine eligibility for this service and follow current Medicaid requirements for ongoing assessment. By doing so, resources could be reserved for youth without current assessments and the time until a youth is determined eligible could be reduced.

The TFC workgroup intends to monitor implementation as well as serve as a resource to DHHS while the TFC service continues to be refined to meet CMS approval and the needs of Nebraskan families. Future work includes defining what success is for this new service and creating solutions to best meet this success. The most impactful finding of this workgroup is that there are youth that will not qualify for this service and will continue to struggle to get their needs met and find permanency or will be unnecessarily placed in a higher level of care not within their community. The workgroup also identifies there are current efforts through LB1173 and plans to enhance this service after approval from CMS. The legislative report for 2024 will account for these actions and adjust recommendations as needed.

Recommendations:

1. DHHS revise their implementation strategy to include youth that are not under the Division of Child and Family Services including youth not involved in any state system but eligible for Medicaid to allow them to access services within their own communities and to prevent a higher level of care.

2. Multiple assessments typically occur with youth who meet the criteria to need this service. DHHS should consider utilizing already completed assessments when determining eligibility to be a more inclusive service.