



The following description has been adapted for this AYPF Meeting by highlighting in yellow some of the key provisions of the Family First Prevention Services Act. It should be noted, however, that many of the limitations placed on residential care are likely to have the biggest effect on youth in foster care.

--Finally it should be noted, this is the original description of the Act, HHS is now starting to provide some further refinements in some of the language and parameters of the new law. See ACYF-CB-PI-18-07

FAMILY FIRST PREVENTION SERVICES ACT

PREVENTION ACTIVITIES UNDER TITLE IV--FOSTER CARE PREVENTION SERVICES AND PROGRAMS.

General Description. Starting October 1, 2019 (federal fiscal year 2020) states will have the option to draw down entitlement funding for qualified services and/or programs for children (and/or their families) considered to be candidates for foster care or who are pregnant or parenting foster youth.

Starting on October 1, 2018, HHS will publish a list and the requirements to be included on the list of the qualifying services or programs for a child described as a “candidate for foster care.” These qualifying services or programs may be provided to parents or kin caregivers when the need of the child, a parent, or a caregiver for the services or programs are directly related to the safety, permanence, or wellbeing of the child or to preventing the child from entering foster care.

The services include mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on the date described in this act with respect to the child. Other services beyond these two categories include in-home parent skill-based programs for not more than a 12-month period that begins according to the approved state plan and when the child has been designated as a candidate for foster care.

A child. A qualifying or covered child includes a child who is a candidate for foster care who can remain safely at home or in a kinship placement if services or programs specified in the state plan and in the child’s plan (or a child in foster care who is a pregnant or is a parenting foster youth).

A child must be identified in a prevention plan as being at imminent risk of entering foster care (without regard to whether the child would be eligible for federal Title IV-E foster care maintenance payments or adoption assistance or kinship guardianship assistance payments. The term includes a child whose

adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

As a condition of services, the state must have a written prevention plan for the child that identifies the foster care prevention strategy for the child to remain at home or live temporarily with a kin caregiver until reunification can be safely achieved or live permanently with a kin caregiver. In addition, the child's plan must list the services or programs provided to or on behalf of the child and must comply with requirements HHS has established.

In the case of a pregnant/parenting foster youth described, the plan must be included in the child's case plan, list the services/programs provided to the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent. It must also include the foster care prevention strategy for any child born to the youth.

Services. Any services or programs covered by the prevention plan only if included in advance in the child's prevention plan. Services or programs qualify for coverage if provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

In addition, all covered programs/services must meet a standard of being a promising, supported or well-supported. As part of this all programs must meet the following requirements:

- The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.
- There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.
- Outcome measures are reliable and valid and are administered consistently and accurately across all those receiving the practice.
- There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

More specifically a 'promising practice' is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; and utilized some form of control (such as an untreated group, a placebo group, or a wait list study).

A supported practice is a supported practice if it is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study. The study must be rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; was a rigorous random controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and was carried out in a usual care or practice setting; and the study has shown a sustained effect for at least 6 months beyond the end of the treatment.

A program is considered a 'well-supported practice' if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results of at least 2 studies. The studies must be rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed. Were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); were carried out in a usual care or practice setting; and at least one of the studies established that the practice has a sustained effect for at least 1 year beyond the end of treatment.

Beginning on *October 1, 2018*, HHS must issue guidance to states regarding the practices criteria required for services or programs to satisfy the requirements. The guidance must include a pre-approved list of services and programs that satisfy the requirements. HHS shall issue updates to the guidance required as often as HHS determines necessary.

Measuring the results will be based on the state collecting and reporting to HHS information for each child covered: the specific services or programs provided and the total expenditures for each of the services or programs; the duration of the services or programs provided; the child's placement status at the beginning, and at the end, of the 1-year period, respectively, and whether the child entered foster care within 2 years after being determined a candidate for foster care. That is if a child left services after 12 months, whether s/he entered foster care with the next 12 months.

A state plan will be required for the state to draw-down federal funding. The state must, as part of the state plan, meet these requirements:

How providing services and programs specified is expected to improve specific outcomes for children and families; how the state will monitor and oversee the safety of children who receive services/programs including through periodic risk assessments while services and programs are provided; and for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the services or programs provided.

With respect to the services/programs covered information on the specific promising, supported, or well-supported practices the state plans to use including a description of:

The services or programs and whether the practices used are promising, supported, or well-supported; how the state plans to implement the services/programs, including how implementation will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; how the state selected the services/programs; the target population; and how each service/program will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by HHS.

The plan must also include a description of the consultation that the state child welfare agency engaged in with other state agencies responsible for health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described and their parents or kin caregivers.

The state plan must include a description of how the state will assess children and their parents or kin caregivers to determine eligibility for services or programs specified; a description of how the services or programs are provided for and will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under Child Welfare Services (Title IV-B, part 1) and Promoting Safe and Stable Families programs (Title IV-B, part2).

The plan must include descriptions of steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services. This part of the plan must ensure that staff is qualified to provide services/programs consistent with the promising, supported, or well-supported practice requirements. And that the workforce has skills in developing appropriate prevention plans and conducting the risk assessments.

The state must outline how it will provide training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services. The state must also provide a description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen and must give an assurance that the state will report to HHS information and data as may be required.

The plan must include a well-designed and rigorous evaluation strategy for that practice, but HHS may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if HHS deems the evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements.

To measure the results of the prevention services, beginning with fiscal year 2021 (October 1, 2020), and annually thereafter, HHS will establish the following measures based on information and data reported by states that elect to provide services and programs:

The percentage of candidates for foster care who do not enter foster care, including those placed with a kin caregiver outside of foster care, during the 12-month period in which the services/programs are provided and through the end of the succeeding 12-month period; The total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skill-based programs for each child covered; HHS will establish and annually update the prevention services measures based on the median state values of the information reported and consider state differences in the price levels using the most recent regional price parities based on the Bureau of Economic Analysis of the Department of Commerce or such other data that is appropriate.

Every year HHS will publish the prevention services measures of each state.

Maintaining state level of spending. If a state elects to provide services/programs state foster care prevention spending for the fiscal year shall not be less than the amount of spending fiscal year 2014 (or for small states with a population of children under 200,000--at the option of a state fiscal year 2015 or fiscal year 2016 (whichever that state elects)).

HHS will count in this prevention of foster care spending: Temporary Assistance for Needy Families (TANF) including state spending; Title IV-B (Child Welfare Services and Promoting Safe and Stable Families); Social Services Block Grant (SSBG) and state expenditures for foster care prevention services and activities under any state program that is not described above *other than* any state expenditures for foster care prevention services and activities under this new program (including under a waiver of the program).

The term 'state expenditures' means all State or local funds that are expended by the state or a local agency including state or local funds that are matched or reimbursed by the Federal Government and state or local funds that are not matched or reimbursed by the Federal Government.

As part of this determination HHS will require each state that elects to provide services and programs to report the expenditures specified in the maintenance of effort (MOE) section for fiscal year 2014 and for fiscal years after as necessary to determine whether the state is complying with the MOE. HHS will specify the specific services and activities under each program referred to in MOE section

State Administrative spending for this shall be reimbursed at 50 percent without regard to current AFDC eligibility requirements for foster care. (State spending on administration of prevention-related services will be 50 percent for all populations regardless of Title IV-E AFDC eligibility. For non-services administrative costs, it will continue to be based on AFDC –eligibility link).

Continuing eligibility for Title IV-E foster care. A child considered a candidate for foster care receiving services/programs for more than 6 months while in the home of a kin caregiver, and who would satisfy

the AFDC eligibility requirement (link to AFDC eligibility) under foster care, can still meet the eligibility standard despite being out of the “home of removal” for more than the current 6 months normally required.

Starting time and funding level. Beginning on October 1 2019 (FY 2020), and before October 1, 2026 (FY 2026), an amount equal to 50 percent (50 percent match) of the total amount spent on these services programs in accordance with promising, supported, or well-supported practices that meet the criteria specified under this program will be eligible for federal funding.

On October 1, 2026 (FY 2027), states will be reimbursed at an amount equal to the Federal Medical Assistance Percentage (FMAP-Medicaid matching rate) in the case of a state other than the District of Columbia, or 70 percent, in the case of the District of Columbia.

With respect to the payments to tribes made under a cooperative agreement or contract entered into by the state and an Indian tribe, tribal organization, or tribal consortium an amount equal to the Federal Medical Assistance Percentage (FMAP-Medicaid matching rate) that would apply under the tribal FMAP if the Indian tribe, tribal organization, or tribal consortium made the payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the state

Limitations on funding. Starting on October 1, 2019 (FY 2020), not less than 50 percent of the total amount spent by a state for a fiscal year shall be for services/programs that are provided in accordance with *well-supported practices*; plus, a fifty percent reimbursement for administrative costs.

HHS technical assistance by HHS and information. HHS will provide to states and Indian tribes, tribal organizations, and tribal consortia, technical assistance on the provision of services and programs covered and shall disseminate best practices in the provision of the services and programs, including how to plan and implement a well-designed and rigorous evaluation of a promising, supported, or well-supported practice.

HHS shall, directly or through grants, contracts, or interagency agreements, evaluate research on the practices and programs that meet the requirements and include culturally specific, or location- or population-based adaptations of the practices, identify and establish a public clearing house of the practices that satisfy each category described by such clauses. The clearinghouse must include information on the specific outcomes associated with each practice, including whether the practice has been shown to prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children

HHS directly or through grants, contracts, or interagency agreements, may collect data and conduct evaluations for purposes of assessing the extent to which the services and programs reduce the likelihood of foster care placement; increases use of kinship care arrangements; or improves child well-being. HHS will also submit to the Senate Finance Committee and the House Ways and Means periodic

reports based on the provision of services and programs described in this program. HHS shall make the reports to Congress publicly available.

HHS has \$1,000,000 for fiscal year 2018 and each fiscal year after to carry out this section on data and evaluation.

For a tribe, organization, or consortium that elects to provide services/programs to children and their parents or kin caregivers under the plan, HHS shall specify the requirements applicable to the provision of the services and programs. The requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to states and shall permit the provision of the services/programs in the form of services/programs that are adapted to the culture and context of the tribal communities.

HHS shall establish specific performance measures for each tribe, organization, or consortium that provides services/programs. The performance measures shall, to the greatest extent practicable, be consistent with the prevention services measures required for states and shall allow for consideration of factors unique to tribes, organizations, or consortia.

LIMITATION ON FEDERAL FINANCIAL PARTICIPATION (TITLE IV-E Foster Care) FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES

IN GENERAL Beginning with the third week for which foster care maintenance payments are made under Title IV-E foster care, a child placed in a child-care institution, no federal payment shall be made unless the child is placed in a child-care institution that meets the requirements and standards consistent with section and in the case of a child placed in a qualified residential treatment program (QRTP) as defined. **OF NOTE, MANY OF THE NEW RESTRICTIONS REGARDING INSTITUTIONAL CARE "GROUP HOMES" LIKELY IMPACT YOUTH IN FOSTER CARE)**

The settings defined here include a *qualified residential treatment* program (QRTP), A setting specializing in providing prenatal, post-partum, or parenting supports for youth, in the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently and a setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims in accordance with the definitions and requirements of the 2014 Preventing Sex Trafficking and Strengthening Families Act.

Assessments of children and youth. In the case of a child who is placed in a qualified residential treatment program (QRTP), if the assessment is not completed within 30 days after the placement, Federal payment shall not be made to the state for foster care maintenance payments.

If the assessment determines the placement of a child in a QRTP is not appropriate, a court disapproves such a placement under section or a child who has been in an approved placement in a QRTP is going to return home or be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home, federal payments shall be made to the state for amounts expended for foster care maintenance payments while the child remains in the QRTP only during the period necessary for the child to transition home or to such a placement.

In no event will a state receive federal payments for foster care maintenance payments on behalf of a child who remains placed in a QRTP after the end of the 30-day period that begins on the date a determination is made that the placement is no longer the recommended or approved. Administrative costs are still available for this child beyond the 30 period.

The term 'qualified residential treatment program' means a program that has a trauma-informed treatment model designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, can implement the treatment identified for the child by the assessment of the child required. In addition, has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state law, are on-site according to the treatment trauma informed model outlined here; and are available 24 hours a day and 7 days a week. The requirements do not require a QRTP to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.

In addition, the program to extent appropriate, and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program; facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child; documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained; provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and is licensed in accordance with this law.

In addition, the QRTP must be accredited by any of the following independent, not-for-profit organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), and any other independent, not-for-profit accrediting organization approved by HHS

The prohibition on federal payments does not prohibit federal payments for administrative expenditures incurred on behalf of a child placed in a child-care institution and for which payment is available.

Foster family home means the home of an individual or family that is licensed/approved by the state that meets the standards established for the licensing or approval; and in which a child in foster care has been placed in the care of an individual, who resides with the child and who has been licensed or approved by the state to be a foster parent. The home has been deemed capable of adhering to the reasonable and prudent parent standard; provides 24-hour substitute care for children placed away from their parents or other caretakers; and that provides the care for not more than six children in foster care.

The number of foster children that may be cared for in a home may exceed the numerical limitation at state option to allow a parenting youth in foster care to remain with the child of the parenting youth; to allow siblings to remain together; to allow a child with an established meaningful relationship with the family to remain with the family; or to allow a family with special training or skills to provide care to a

child who has a severe disability. This definition does not prohibit a foster parent from renting the home in which the parent cares for a foster child placed in the parent's care.

The term ***child-care institution*** means a private child-care institution, or a public child-care institution which accommodates no more than children, which is licensed by the state in which it is situated or has been approved by the agency of the state responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing. In the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions HHS shall establish in regulations.

The term continues to exclude detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

Assessment of children in QRTPs. For a child placed in a QRTP the following requirements apply for purposes of approving the case plan for the child and the case system review procedure for the child:

Within 30 days of the start of placement a qualified individual shall: assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by HHS; determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting would provide the most effective and appropriate level of care in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and develop a list of child-specific short and long-term mental and behavioral health goals.

The state shall assemble a family and permanency team for the child in accordance with the requirements listed here. The qualified individual conducting the assessment required shall work in conjunction with the family and permanency team for, the child while conducting and making the assessment.

The family and permanency team shall consist of all appropriate biological family members, relative, and fictive kin of the child, as well as, as appropriate, professionals who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy. In the case of a child who is 14 or older, the family and permanency team shall include the members the child selected in accordance with this section.

The State shall document in the child's case plan: the reasonable and good faith effort to identify and include all the individuals described here; all contact information for members of the team, as well as contact information for other family members and fictive kin who are not part of the family and permanency team; evidence that meetings of the team, including meetings relating to the assessment required are held at a time and place convenient for family; if reunification is the goal, evidence demonstrating that the parent provided input on the members of the family and permanency team; evidence the assessment required is determined in conjunction with the team; the placement preferences of the team relative to the assessment recognizes children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest; and if

the placement preferences of the team and child are not the placement setting recommended by the qualified individual conducting the assessment under this section, the reasons why the preferences of the team and of the child were not recommended.

In the case of a child who the qualified individual conducting the assessment determines should not be placed in a foster family home, the qualified individual shall specify in writing the reasons why the needs of the child cannot be met by the family of the child or in a foster family home.

A shortage or lack of foster family homes shall not be an acceptable reason for determining that the needs of the child cannot be met in a foster family home. The qualified individual also shall specify in writing why the recommended placement in a QRTP is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.

The term ***qualified individual*** means a trained professional or licensed clinician who is not an employee of the state child welfare agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State.

HHS may approve a state request to waive any requirement in this section upon a submission by the state, in accordance with criteria established by HHS that certifies that the trained professionals or licensed clinicians with responsibility for performing the assessments described shall maintain objectivity with respect to determining the most effective and appropriate placement for a child.

Within 60 days of a placement in a QRTP, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, shall consider the assessment, determination, and documentation made by the qualified individual conducting the assessment and determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a QRTP provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child and approve or disapprove the placement.

The written documentation and the determination and approval or disapproval of the placement in a QRTP by a court or administrative body under this section shall be included in the case plan for the child. As long as a child remains in a QRTP, the state child welfare agency shall submit evidence at each status review and each permanency hearing held with respect to the child:

- demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a QRTP provides the most effective and appropriate

level of care for the child in the least restrictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan;

- documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and
- documenting the efforts made by the state agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

In the case of any child who is placed in a QRTP for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or non-consecutive months), the state agency shall submit to HHS: the most recent versions of the evidence and documentation specified here; and the signed approval of the head of the child welfare state agency for the continued placement of the child in that setting.

The **state plan requirements** are amended to include the requirement that by inserting, '(vii) the procedures and protocols the state has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.'

The state plan is also amended with, '(37) includes a certification that, in response to the limitation imposed with respect to foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, the state will not enact or advance policies or practices that would result in a significant increase in the population of youth in the state's juvenile justice system.'

The **Court Improvement Program** is amended by inserting "shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are placed in settings that are not a foster family home,"

HHS shall conduct an evaluation of the procedures and protocols established by states in accordance with the requirements. The evaluation shall analyze the extent to which states comply with and enforce the procedures and protocols and the effectiveness of various state procedures and protocols and shall identify best practices. Not later than January 1, 2020, HHS shall submit a report on the results of the evaluation to Congress.

Government Accountability Office (GAO) shall evaluate the impact, on state juvenile justice systems of the limitation imposed under the restrictions on foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home. GAO shall evaluate the extent to which children in foster care who also are subject to the juvenile justice system of the state are placed in a facility under the jurisdiction of the juvenile justice system and whether the lack of available congregate care placements under the jurisdiction of the child welfare systems is a contributing factor to that result. By December 31, 2025, the GAO shall submit to Congress a report on the results.

AFCARS requirements are amended by inserting the following:

- with respect to each placement
 - the type of the placement setting, including whether the placement is shelter care, a group home and if so, the range of the child population in the home, a residential treatment facility, a hospital or institution providing medical, rehabilitative, or psychiatric care, a setting specializing in providing prenatal, post-partum, or parenting supports, or some other kind of child-care institution and if so, what kind
 - the number of children in the placement setting and the age, race, ethnicity, and gender of each of the children;
 - for each child in the placement setting, the length of the placement of the child in the setting, whether the placement of the child in the setting is the first placement of the child and if not, the number and type of previous placements of the child, and whether the child has special needs, or another diagnosed mental or physical illness or condition
 - the extent of any specialized education, treatment, counseling, or other services provided in the setting; and
 - separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement

The state plan is also amended by adding

“(D) provides procedures for any child care institution, including a group home, residential treatment center, shelter, or other congregate care setting, to conduct criminal records checks, including fingerprint-based checks of national crime information databases and checks described in subparagraph of this paragraph, on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, unless the state reports to HHS the alternative criminal records checks and child abuse registry checks the state conducts on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, and why the checks specified in this subparagraph are not appropriate for the State;”.

The **effective date of this section** with the limitations on placements not in a family foster home, definitions of foster family home and child care institution, assurance on nonimpact on Juvenile Justice, and assessment and documentation shall take effect on October 1, 2019 (FY 2020) but a state may request a delay in the effective date, HHS shall delay the effective date provided for the amount of time requested by the State, not to exceed 2 years. If a state asks for a delay the effective date is delayed the prevention services in the same timeframe.

The criminal records check provisions shall take effect on October 1, 2018

For **states with Title IV-E waivers** in effect on the date of enactment of this Act, the amendments made by this part shall not apply with respect to the state before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments are inconsistent with the terms of the waiver.

To support and retain foster families so they can provide quality family- based settings for children in foster care, HHS has, for fiscal year 2018, \$8,000,000 to make competitive grants to states, Indian tribes, or tribal consortia to support the recruitment and retention of high-quality foster families to increase their capacity to place more children in family settings, focused on states, Indian tribes, or tribal consortia with the highest percentage of children in non-family settings. The amount appropriated will remain available through fiscal year 2022.

ADDITIONAL IMPROVEMENTS UNDER IV-E and IV-B

Family based treatment. A child eligible for foster care maintenance payments under this section (Title IV-E) or who would be eligible for the payments if the eligibility were determined without regard to paragraphs Title IV-E eligibility (the link to AFDC), shall be eligible for the payments for a period of not more than 12 months during which the child is placed with a parent who is in a licensed residential family- based treatment facility for substance abuse, but only if:

- the recommendation for the placement is specified in the child’s case plan;
- the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and
- the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.
- With respect to children for whom foster care maintenance payments are made under section, only the children who are identified as a candidate for foster care shall be children with respect to whom foster care maintenance payments are made under this section

Kinship navigator programs. A 50 percent match is available to states for kinship navigator programs that HHS determines are operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices

The fifteen-month ***restriction on reunification services*** funding under Promoting Safe and Stable Families is modified to start on the date that the child returns home for reunification rather than when the child enters foster care.

REDUCING BUREAUCRACY AND UNNECESSARY DELAYS WHEN PLACING CHILDREN IN HOMES ACROSS STATE LINES

The ***National Electronic Interstate Compact Enterprise (NEICE)*** is expanded and a state plan shall provide that the state has in effect procedures providing for the use of an electronic interstate case

processing system but shall not apply to an Indian tribe, tribal organization, or tribal consortium that elects to operate a program under this part.

The purpose of this subsection is to facilitate the development of an electronic interstate case-processing system for the exchange of data and documents to expedite the placements of children in foster, guardianship, or adoptive homes across state lines.

A State that seeks funding under this subsection shall submit to HHS a description of the goals and outcomes to be achieved, which goals and outcomes must result in: reducing the time it takes for a child to be provided with a safe and appropriate permanent living arrangement across State lines; improving administrative processes and reducing costs in the foster care system; and the secure exchange of relevant case files and other necessary materials in real time, and timely communications and placement decisions regarding interstate placements of children; a description of the activities to be funded in whole or in part with the funds, including the sequencing of the activities; a description of the strategies for integrating programs and services for children who are placed across state lines; and other information HHS may require.

HHS can provide funds to a state and shall prioritize states that are not yet connected with the NEICE system and state that receive funds shall use the funding to support connecting with, or enhancing or expediting services provided under, the electronic interstate case-processing system referred to in paragraph

Not later than 1 year after the final year in which funds are awarded, the HHS shall submit to the Congress, and make available to the public by posting on a website, a report that contains the following information:

- How using the electronic interstate case-processing system developed pursuant to this section has changed the time it takes for children to be placed across state lines
- The number of cases subject to the Interstate Compact on the Placement of Children that were processed through the electronic interstate case-processing system, and
- the number of interstate child placement cases that were processed outside the electronic interstate case-processing system, by each State in each year
- The progress made by states in implementing the electronic interstate case-processing system
- How using the electronic interstate case-processing system has affected various metrics related to child safety and well-being, including the time it takes for children to be placed across State lines
- How using the electronic interstate case-processing system has affected administrative costs and caseworker time spent on placing children across state lines

HHS in consultation with the Secretariat for the Interstate Compact on the Placement of Children(ICPC) and the states, shall assess how the electronic interstate case-processing system developed could be used to better serve and protect children that come to the attention of the child welfare system, by:

- connecting the system with other data systems (such as systems operated by state law enforcement and judicial agencies, systems operated by the Federal Bureau of Investigation for the purposes of the Innocence Lost National Initiative, and other systems)
- simplifying and improving reporting regarding children or youth who have been identified as being a sex trafficking victim or children missing from foster care
- improving the ability of states to quickly comply with background check requirements

HHS shall reserve \$5,000,000 of available for fiscal year 2018 for Promoting Safe and Stable Families, Title IV-B, part 2, discretionary funds to carry out this implementation.

The **Regional Partnership Grants (RPGs)** are modified. The state child welfare agency and state agency for the substance abuse prevention and treatment block grant provided under the Public Health Service Act are mandatory partners for these grants. If the grant is to address serving children in out of home care, the Juvenile or Office of the Court that is most appropriate in that State.

If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this subsection, the Indian tribe or tribal consortium: may (but is not required to) include the state child welfare agency as a partner in the collaborative agreement; may not enter into a collaborative agreement only with tribal child welfare agencies (or a consortium of the agencies); and if the tribal grant includes children in out of home care it may include the appropriate tribal court.

Funding for RPGs is extended to 2021' and minimum grants available reduced to \$250,000 up to \$1 million. Semiannual reports not later than September 30 of each fiscal year and every six months after that shall be submitted to HHS.

Kinship licensing. Not later than October 1, 2018, HHS shall identify reputable model licensing standards with respect to the licensing of foster family homes. Not later than April 1, 18 2019, the state shall submit to HHS: whether the state licensing standards are in accord with model standards identified by HHS and if not, the reason for the specific deviation and a description as to why having a standard that is reasonably in accord with the corresponding national model standards is not appropriate for the state.

In addition, states will indicate whether the state has elected to waive standards established for relative foster family homes pursuant to waiver authority; a description of which standards the state most commonly waives, if the state has not elected to waive the standards, the reason for not waiving these standards; if the state has elected to waive standards specified, how caseworkers are trained to use the waiver authority and whether the state has developed a process or provided tools to assist caseworkers in waiving nonsafety standards per the authority provided to quickly place children with relatives; and a description of the steps the State is taking to improve caseworker training or the process, if any

The **state plan requirements regarding child fatalities** are amended with requirement "(19) document steps taken to track and prevent child maltreatment deaths by including: a description of the steps the state is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the state agency including gathering relevant information on the deaths from the relevant organizations in the state including entities such as the vital statistics department, child death

review teams, law enforcement agencies, offices of medical examiners, or coroners; and a description of the steps the state is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.

Extension of Title IV-B programs Child Welfare services (Title IV-B part 1) is extended from 2016 to 2021, funding for the Promoting Safe and Stable Families is extended to 2021. Funding is also extended for discretionary grants, the Court Improvement Program (CIP), the Regional Partnership Grants (RPGs), and funding for monthly caseworker visits by striking to 2021.

Changes and improvements in the John H. Chafee program include allowing states to increase eligibility from 21 to age 23 if a state extends foster care eligibility from 18 to age 21. The program is re-named by striking "INDEPENDENCE PROGRAM" and inserting "PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD"

To the extent that amounts paid to states under the CHAFEE program remain unspent at the end of the succeeding fiscal year, HHS may make the amounts available for redistribution in the second succeeding fiscal year among the states that apply for additional funds under this section. HHS shall redistribute the amounts made available for a fiscal year among eligible applicant states. Eligible applicant state means a state that has applied for additional funds for the fiscal year if HHS determines that the State will use the funds for the purpose intended under this section. The amount to be redistributed to each eligible state shall be based on the amount multiplied by the state foster care ratio. Any amount made available to a state shall be regarded as part of the allotment of the state for the fiscal year in which the redistribution is made.

The **education and training vouchers** are amended by increasing the age of eligibility from 23 to 26 but in no event may a youth participate in the program for more than 5 years (whether consecutive)

Not later than October 1, 2019, HHS shall submit to the House Ways and Means Committee and the Senate Finance Committee a report on **the National Youth in Transition Database** and any other databases in which states report outcome measures relating to children in foster care and children who have aged out of foster care or left foster care for kinship guardianship or adoption.

The report shall include: a description of the reasons for entry into foster care and of the foster care experiences, such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the National Youth in Transition Database and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17; a description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 to the National Youth in Transition Database.

Also required are benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans the executive branch will take to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care; **an analysis of the association between types of placement, number of**

overall placements, time spent in foster care, and other factors, and outcomes at ages 19 and 21; and an analysis of the differences in outcomes for children and youth at age 19 and 21 among states.

The REAL ID Act of 2005 is amended by requiring the states to provide “any official documentation necessary to prove that 12 the child was previously in foster care” to assist in providing the necessary documentation to qualify for Medicaid coverage to age 26.

The ***adoption and kinship incentive fund*** are extended to 2021.

The phase-out of the ***Adoption Assistance link to the 1996 AFDC eligibility*** standard is re-linked eligibility to the 1996 AFDC programs for children 2 or younger. The link to AFDC is now “2017 through 2023 age 2; and for 2024 age 2 or, in the case of a child for whom an adoption assistance agreement is entered on or after July 1, 2024, any age. In 2025 or thereafter any age. The effective date of the re-link shall take effect as if enacted on January 1, 2018.

Federal match for adoption assistance will be available for a child who will reach the age of 2 by the end of the fiscal year the adoption assistance agreement was signed. This covers the period of January 1, 2018 to June 30, 2024.

The Government Accountability Office (GAO) shall study the extent to which states are complying with the requirements in the 2008 the Fostering Connections to Success and Increasing Adoptions Act (Public Law 110–351) requiring states to reinvest state savings resulting from the gradual delink of adoption assistance from 1996 AFDC eligibility standard. The GAO shall submit the report to the Senate Finance Committee and the House Ways and Means of Committee.