**H. R. 5456, The Families First Prevention and Treatment Act**

*The bill amends part Title IV-B and Title IV-E of the Social Security Act to expand IV-E funding to provide some intervention services that can prevent foster care placements, restricts institutional placements, modifies the John Chaffee Independent Living Program, and reauthorizes and modifies Title IV-B programs part 1 and part 2.*

***TITLE I—INVESTING IN PREVENTION AND FAMILY SERVICES; TITLE II—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME; TITLE III—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES; TITLE IV—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP; TITLE V—TECHNICAL CORRECTIONS; and TITLE VI—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE***

**Title I PREVENTION AND FAMILY SERVICES AND PROGRAMS.**

States may draw Title IV-E funds for providing services or programs for a child considered a “candidate for foster care” and the parents or kin caregivers of the child when the need of the child, parent, or a caregiver for the services or programs are related to the safety, permanence, or wellbeing of the child or to preventing the child from entering foster care.

The term *child who is a candidate for foster care* means, a child who is identified in a prevention plan under this act as being at imminent risk of entering foster care (without regard to whether the child would be eligible for foster care maintenance payments, adoption assistance or kinship guardianship under the link to the 1996 AFDC eligibility) but who can remain safely in the child’s home or in a kinship placement as long as services or programs are provided to prevent the entry of the child into foster care.

The term does include a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

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
* In-home parent skill-based programs, that include parenting skills training, parent education, and individual and family counseling for not more than a 12-month period that begins on the date described by this act.

The child covered includes a child who is a *candidate for foster care* but who can remain safely at home or in a kinship placement with receipt of services/programs outlined here.

The child covered also includes a child in foster care *who is a pregnant or parenting foster youth*. Services are covered starting on the date on which a child is identified in a prevention plan maintained by the state.

The services/programs may be provided only if specified in advance in a *prevention plan* for the child and that includes these a written prevention plan for the child that meets the following requirements:

* + The prevention plan shall identify the foster care prevention strategy for the child: so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver; list the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and comply with such other requirements by HHS
	+ In the case of a child who is a pregnant or parenting foster youth the prevention plan shall: be included in the child’s case plan; list the services or programs to be provided to or on behalf of 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; describe the foster care prevention strategy for any child born to the youth; and comply with other requirements by HHS

The services or programs to be provided to or on behalf of a child are 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 trauma’s consequences and facilitate healing.

Services must meet a level or standard of *promising*, *supported*, or *well-supported* practice. General practice requirements for all services include the following:

* The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to 8 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 administrated 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.

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 1 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 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 1 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;
* A rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and
* Carried out in a usual care or practice setting; and
	+ The study described established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

A *well supported 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 studies that were:

* Rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;
* Rigorous random- controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and
* Carried out in a usual care or practice setting; and
	+ At least 1 of the *studies* described established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment.

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

The state shall collect and report to HHS information on the children for whom, or on whose behalf mental health and substance abuse prevention and treatment services or in-home parent skill-based programs are provided during a 12-month period beginning on the date the child is eligible:

* 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 a candidate for foster care.

*State plan requirements.* A state electing to provide services or programs shall submit to HHS a prevention services and programs plan that include the following:

* 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 and programs including through periodic risk assessments throughout the period in which the services and programs are provided. Re-examine the prevention plan maintained for the child with a re-examination of services provided if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.
* With respect to the services and programs specified, information on the specific promising, supported, or well-supported practices the state plans to use to provide the services or programs, 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 or programs, including how implementation of the services or programs 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 or programs;
* The target population for the services or programs; and
* How each service or program will be evaluated through a well-designed and rigorous process, which may consist of an on-going, cross-site evaluation approved by HHS.
* A description of the consultation that the state agencies responsible for administering the plans engage with other state agencies responsible for administering health programs, 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 here and their parents or kin caregivers.
* A description of how the state shall assess children and their parents or kin caregivers to determine eligibility for services or programs specified.
* A description of how the services/programs specified that are provided for or on behalf of a child and the parents or kin caregivers of the child 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 plan under part B.
* 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, including:
	+ Ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and
	+ A description of how the State 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.

* + A description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen.
* An assurance that the state will report to HHS information and data required with respect to the provision of services and programs specified including information and data necessary to determine the performance measures for the state.

*Evaluations*. A state may not receive a federal payment for a promising, supported, or well-supported practice unless the plan includes a well-designed and rigorous evaluation strategy for that practice. 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 included in in this act.

*HHS will measure the effectiveness of services*. Beginning with fiscal year 2021, and annually after, HHS shall establish the following prevention services measures based on information and data reported by states:

* The percentage of candidates for foster care for whom, or on whose behalf, the services or programs are provided 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 or 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, in-home parent skill-based programs, or kinship placement assistance, respectively, for, or on behalf of, each child.

HHS shall establish and annually update the prevention services measures:

* based on the median state values of the information required here for the then 3 most recent years; and taking into account state differences in the price levels of consumption goods and services using the most recent regional price parities published by the Bureau of Economic Analysis of the Department of Commerce or such other data as HHS determines appropriate.

HHS shall annually make available to the public the prevention services measures of each state.

*MOE.* States using prevention funding must maintain certain spending levels *Maintenance of Effort (MOE)* as a condition of qualifying. If a state provides services and programs the state foster care prevention expenditures for the fiscal year shall not be less than the amount of the expenditures for fiscal year 2014. The definition of state foster care prevention expenditures includes the federal and state funds spent under the Temporary Assistance for Needy Families (TANF) block grant; state and federal funding under Title IV–B part 1 and part 2; and federal Social Services Block Grant (SSBG).

The MOE also includes state expenditures for foster care prevention services and activities under any state program that is not described here. These state expenditures mean 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.

HHS shall require each state that elects to provide prevention services and programs to report the expenditures for fiscal year 2014. HHS shall specify the specific services and activities under each program referred to in this MOE definition.

A state that provides services and programs shall not use any state foster care prevention expenditures for a fiscal year for the state share of expenditures (matching funds).

The provision of services or programs to or on behalf of a child shall not be considered to be receipt of aid or assistance under the state plan under this part for purposes of eligibility for any other program established under the Social Security Act.

*Federal payments to states* under this act shall be provided:

Beginning in fiscal year 2020 (October 1, 2019) and before October 1, 2025, an amount equal to 50 percent (a 50% federal match rate) of the total amount expended for these services and programs under this act will be reimbursed. Funding for administrative costs and training would be matched at 50 percent.

Beginning in fiscal year 2026 (October 1, 2025) an amount equal to the Federal medical assistance percentage (known as the FMAP rate currently ranging from 50% to 83% based on state Medicaid formula) or 70 percent, in the case of the District of Columbia, of the total amount expended for the provision of services or programs specified under this act.

With respect to the payments 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 that would apply under the tribal FMAP.

HHS shall provide to states and to Indian tribes, tribal organizations, and tribal consortia, technical assistance regarding the provision of services and programs and shall disseminate best practices 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 best practice including culturally specific, or location- or population-based adaptations of the practices, to identify and establish a public clearinghouse of the practices that satisfy the requirements for the services defined in this act. The clearinghouse shall 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 may collect data and conduct evaluations with respect to the provision of services and programs that:

* reduces the likelihood of foster care placement;
* increases use of kinship care arrangements;
* improves child well-being.

HHS shall submit to the Senate Finance Committee and the House Ways and Means Committee periodic reports based on the provision of services and programs. HHS shall make the reports to Congress submitted under this paragraph publicly available. $1 million a year will be available for fiscal year 2016 and each fiscal year thereafter.

*Indian and Tribal Organizations* at the option of the tribe, organization, or consortium, services and programs specified in this act. 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 and programs in the form of services and programs that are adapted to the culture and context of the tribal communities served.

HHS shall establish specific performance measures for each tribe, organization, or consortium that elects to provide services and programs. The performance measures shall be consistent with the prevention services measures required for states.

*Foster Care payments for children with parents in a licensed residential family-based treatment facility* for substance use.

A child who is eligible for foster care maintenance payments or would be if not for the 1996 AFDC eligibility link 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 before the placement;
* 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.

*Kinship Navigator Programs funding through Title IV-E*

States are eligible for a 50 percent match for kinship navigator programs that meet the requirements under this act. HHS will determine if these navigator programs operated in accordance with promising, supported, or well-supported practices.

**Title I Subtitle B**

Under title IV-B, part 2, Promoting Safe and Stable Families (PSSF)is amended by altering the current “15 months” time limit on family reunification services. Current law limit this to start on the first day a child is in foster care generally means funds will not be available for very long once the child is reunified. Under this act in the case of a child who has been returned home, the services and activities can be provided during the 15-month period that begins on the date that the child returns home.

*Improvements to the Interstate Compact on the Placement of Children (ICPC).*

Not later than October 1, 2026, (FY 2027) states shall include the use of an electronic interstate case-processing system in implementation of the ICPC. In an effort to facilitate the development of an electronic inter-state 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 desires a grant under this subsection shall submit to HHS an application containing:

* A description of the goals and outcomes to be achieved during the period for which grant funds are sought, 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 grant 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.
* Such other information HHS may require.

Within 1 year after all grants are awarded HHS shall submit to 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 has changed the time it takes for children to be placed across state lines.
* The number of cases subject to the ICPC 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 ICPC and the states, shall assess how the electronic interstate case-processing system developed pursuant to the act could be used to better serve and protect children that come to the attention of the child welfare system,
* 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

HHS shall reserve $5,000,000 of the amount made available for fiscal year 2017 for grants under Title IV-B, part 1, Child Welfare Services for these grants.

*Amendments to the Regional Partnership Grants*. The following amendments are made to the regional partnership grants under Title IV-B part 2, PSSF. Regional partnership means a collaborative agreement (which may be established on an interstate, state, or intrastate basis) entered into include certain mandatory partners:

* The state child welfare agency that is responsible for the administration of the state plan under this Title IV-B, the State agency responsible for administering the substance abuse prevention and treatment block grant provided under part B of title XIX of the federal Public Health Service Act.
* If the partnership proposes to serve children in out-of- home placements, the Juvenile Court or Administrative Office of the Court that is most appropriate to oversee the administration of court programs in the region to address the population of families who come to the attention of the court due to child abuse or neglect.

At the option of the partnership, any of the following:

* An Indian tribe or tribal consortium.
* Nonprofit child welfare service providers.
* For-profit child welfare service providers.
* Community health service providers, including substance abuse treatment providers.
* Community mental health providers.
* Local law enforcement agencies.
* School personnel.
* Tribal child welfare agencies (or a consortia of the agencies)
* Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under a state plan approved under Title IV-B

If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this sub-section, 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; but may not enter into a collaborative agreement only with tribal child welfare agencies (or a consortium of the agencies); and may include tribal court organizations in lieu of other judicial partners.

The current minimum to maximum grant amount of $500,000 and not more than $1,000,000 is replaced with a range of $250,000 and not more than $750,000.

A grant awarded under this subsection shall be disbursed in 2 phases: a planning phase 1 (not to exceed 2 years); and an implementation phase. The total disbursement to a grantee for the planning phase may not exceed $250,000, and may not exceed the total anticipated funding for the implementation phase.

No payment shall be made for a fiscal year until HHS determines that the eligible partnership has made sufficient progress in meeting the goals of the grant and that the members of the eligible partnership are coordinating to a reasonable degree with the other members of the partnership. HHS shall evaluate current programs and outcomes HHS may request additional information needed to determine that the proposed activities and implementation will be consistent with research or evaluations showing which practices and approaches are most effective.

Not later than September 30 of each fiscal year in which a recipient of a grant is paid funds and every 6 months thereafter, the grant recipient shall submit to HHS a report on the services provided and activities carried out during the reporting period, progress made in achieving the goals of the program, the number of children, adults, and families receiving services, and such additional information as HHS determines is necessary. The report due not later than September 30 of the last such fiscal year shall include, at a minimum, data on each of the performance indicators included in the evaluation of the regional partnership.

*Reviewing and improving licensing standards for placement in relative foster care*.

Not later than October 1, 2017, HHS shall identify reputable model licensing standards with respect to the licensing of foster family homes. Not later than April 1, 2018, the state shall submit to HHS information addressing:

* 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;
* Whether the state has elected to waive standards established (under current Title IV-E foster Care provisions) for relative foster family homes (pursuant to waiver authority allowed) a description of which standards the state most commonly waives, and 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
* A description of the steps the state is taking to improve caseworker training or the process, if any.

*Requirement to have a statewide plan to prevent child abuse and neglect fatalities.*

State plan requirements are amended to direct states to outline the 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 state 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 of 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.

**TITLE II—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME**

*Section 201* creates LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES.

Unless in a foster family home or in a qualified residential setting states may not receive a maintenance payment for foster care for more than two weeks.

Maintenance payments are limited to a *“qualified residential treatment program*” (QRTP) as defined in this section, and/or a setting specializing in providing prenatal, post-partum, or parenting supports for youth, or in the case of a child who has attained 18 years of age, and/or a supervised setting in which the child is living independently.

For a child placed into a QRTP there must be an assessment completed within 30 days after the placement is made. If the assessment determines that the placement of a child in a QRTP is not appropriate, a court disapproves such a placement, 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 on behalf of the child 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 shall a state receive federal payments in a QRTP after the end of the 30-day period after the date a determination is made that the placement is no longer the recommended or approved placement for the child.

A QRTP includes:

* A trauma-informed treatment model that is 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, is able to implement the treatment identified for the child by the assessment of the child required under this section.
* 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 during business hours; and
	+ are available 24 hours a day and 7 days a week;
* 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 section and is 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 22 (COA).
	+ Any other independent, not-for- profit accrediting organization approved by HHS

The definition of *foster family home* means the home of an individual or family that is licensed or approved by the state in as a foster family home 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, and:

* the state deems capable of adhering to the reasonable and prudent parent standard;
* that provides 24-hour substitute care for children placed away from their parents or other care-takers; and
* provides the care for not more than 6 children in foster care.
	+ the number of foster children that may be cared for in a home may exceed the numerical limitation at the option of the state, for any of the following reasons:
		- 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.
		- To allow a family with special training or skills to provide care to a child who has a severe disability.
* The definition shall not be construed as prohibiting a foster parent from renting the home in which the parent cares for a foster child placed in the parent’s care.

*Child caring institution* means a private child-care institution, or a public child-care institution which accommodates no more than 25 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 as HHS shall establish in regulations.

As in current law, the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

The state’s highest court shall provide for the training of judges, attorneys and other legal personnel in child welfare cases on the 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.

*Juvenile justice*. The state must include in its state plan a certification that, in response to the limitation imposed under these new section with respect to foster care maintenance payments through QRTPs and new definitions regarding family foster care that 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 GAO shall evaluate the impact, if any, on state juvenile justice systems of the limitation imposed under this section. In particular, the 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. The report is due not later than December 31, 2023.

*Section 202* of this title outlines the requirements, assessments and documentation requirements under the QRTP.

In the case of any child who is placed in a QRTP the following requirements shall apply for purposes of approving the case plan for the child:

* Within 30 days of the start of each placement in such a setting, a qualified individual (as defined here) 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 from among the settings would provide the most effective and appropriate level of care for the child 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 of clauses below and the qualified individual conducting the assessment required under this shall work in conjunction with the family of, and permanency team for, the child while conducting and making the assessment. Further:

* + 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 has attained age 14, the family and permanency team shall include the members of the permanency planning team for the child that are selected by the child
	+ The state shall document in the child’s case plan—
		- the reasonable and good faith effort of the state to identify and include all such individuals on the family of, and permanency team for, the child;
		- all contact information for members of the family and permanency 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 family and permanency 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 from whom the child was removed provided input on the members of the family and permanency team;
		- evidence that the assessment required is determined in conjunction with the family and permanency team;
		- the placement preferences of the family and permanency team relative to the assessment and, if the placement preferences of the family and permanency team and child are not the placement setting recommended by the qualified individual conducting the assessment, 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 a 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

The term *‘qualified individual’* means a trained professional or licensed clinician who is not an employee of the state 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 waiver of this definition at the request of a state upon a submission by the state and in accordance with criteria established by HHS. The criteria by HHS outlines the trained professionals or licensed clinicians with responsibility for performing the assessments shall maintain objectivity with respect to determining the most effective 16 and appropriate placement for a child.

Within 60 days of the start of each placement in a QRTP a family or juvenile court or another court (including a tribal court) or an administrative body by the court, shall

* consider the assessment, determination, and documentation made by the qualified individual conducting the assessment
* 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, a

* approve or disapprove the placement.

The written documentation made and documentation of the determination and approval or disapproval of the placement in a QRTP by a court shall be included in the case plan for the child.

As long as a child remains placed in a QRTP the state 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;
* Documenting the efforts made by the state 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 shall submit to HHS

* The most recent versions of the evidence and documentation
* The signed approval of the head of the state agency for the continued placement of the child in that setting.

*Section 203* Outlines protocols to prevent inappropriate diagnosis.

State plan requirements are amended by adding: 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.

HHS shall conduct an evaluation of the procedures and protocols established by states in accordance with these requirements. The evaluation shall analyze the extent states comply with and enforce the procedures and protocols and the effectiveness of various procedures and protocols and shall identify best practices. Not later than January 1, 2019, HHS shall submit a report on the results to Congress.

*Section 204* creates additional data requirements and reporting. New data reporting includes:

* 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.

*Section 205* creates the effective dates.

In terms of the new definitions for the QRTP and Family Foster Homes the effective date is October 1, 2019 (FY 2020). In regarding to the remaining provisions including court training and data collection the effective dates are October 1, 2016 (FY 2017) with HHS ability to delay when state legislative action delays implementation.

**TITLE III—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES**

SUPPORTING AND RETAINING FOSTER FAMILIES FOR CHILDREN.

*Section 301*. This subsection provides $8 million in FY 2018 to be available through 2022 to support and retain foster families. HHS make competitive grants to states, Indian tribes and tribal consortia to recruit and retain high-quality foster family homes.

*Section 302* extends Title IV-B part 1, the Stephanie Tubbs Jones Child Welfare Services (CWS) set to expire on October 1, 2016 to October 1, 2021. The authorization level remains at $320 million annually but it currently receives $269 million in annual appropriations

This section extends Title IV-B part 2, the Promoting Safe and Stable Families Program (PSSF) which is set to expire on October 1, 2016 to October 1, 2021. This extension includes $345 million in mandatory funding as well as an authorization of discretionary funding of $200 million (currently appropriations for this discretionary funding is $59 million).

In addition, out of the $345 million in mandatory funds, $20 million is designated (extended) to promote monthly caseworker visits. It also designates $20 million to extend regional partnership grants (RPGs) to address family-based substance use treatment.

Separately this subsection also extends $20 million in funding of funding for state courts to address child welfare coordination also extended to October 1, 2021.

*Section 303* This subsection makes improvements to the Chafee program under Title IV-E. It changes the name from the John Chafee Foster Care Independence Program to the John H Chafee Foster Care Program for Successful Transition to Adulthood.

This subsection also allows states to use Chafee funds ($140 million annually) for transition services to youth up to age 23 (from the current age of 21) if the state has taken the option under Title IV-E to extend foster care to the age of 21 (states have had the option to extend foster care from age 19 to age 21 since the 2008 Fostering Connections to Success and Adoption Improvement Act).

In addition, states receive discretionary funding (now at $45 million annually) to provide higher education and training vouchers for youth transitioning from foster care. Youth may currently use these vouchers for up to age 23 if they were making progress in education and had been receiving a voucher by age of 21. This subsection makes improvements by allowing students to receive and be eligible for these vouchers to age 26. Under no circumstance can they receive vouchers for more than 5 years in total. It also expands eligibility to those young people who were in foster care at age 14. This part of an effort to assist in the adoptions of older youth.

HHS may re-distribute, after two years, Chafee transition and voucher funds to applying states and tribes if they have funds have gone unspent by other states and tribes. Currently such funds may revert to the Treasury.

Not later than October 1, 2017, HHS shall submit to the House Ways and Means Committee and the Senate Finance Committee 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.
* 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.
* An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among States.

This subsection also amends the past law, the ‘‘REAL ID Act of 2005’’ that requires that youth leaving care receive certain documents and information. States are to now include in this information any official documentation necessary to prove that the child was previously in foster care. This is intended to assist former foster youth, now eligible for Medicaid to age 26 under the Affordable Care Act (ACA), to have proof of foster care to access the Medicaid coverage.

**TITLE IV—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP**

This title extends the current incentive fund that provides awards to states based on increased adoptions as well as increases the number of subsidized guardianships from foster care. This incentive fund (expanded in 2014 to guardianships) was due to expire on October 1, 2016. This will extend the incentive fund to October 1, 2021.

**TITLE V—TECHNICAL CORRECTIONS FOR DATA EXCHANGE STANDARDS AND TO CLARIFY SERVICES TO CHILDREN UNDER FIVE**

This title re-writes a directive to HHS to craft data elements used under the reporting requirements under Title IV-B. This title now directs HHS along with the Office of Management and budget (OMB) set up a working group as part of this directive to develop these common data elements between the states in an effort to improve such data collection.

The data exchange standards required shall incorporate a widely accepted, nonproprietary, searchable, computer-readable formats, contain interoperable standards developed and maintained by intergovernmental partnerships, incorporate interoperable standards developed and maintained by Federal entities be consistent with and implement applicable accounting principles; be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and be capable of being continually upgraded as necessary.

Not later than 24 months after the date of the enactment of this section, HHS shall issue a proposed rule that identifies federally required data exchanges, includes specification and timing of exchanges to be standardized, and address the factors used in determining whether and when to standardize data exchanges; and specifies state implementation options and future milestones.

This title also amends requirements that states outline how they are addressing the development needs of all children under five through their Title IV-B programs not just those children under five and in foster care.

**TITLE VI—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE**

This title freezes the current gradual phase-out of the link of federal Title IV-E adoption assistance to the AFDC eligibility standard of 1996. As a result of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351; 122 Stat. 3975) policy was to gradually eliminate the link to federal adoption assistance funding for special needs adoptions to the 1996 AFDC program standards by age group. The phase out started in 2009 with children 17 through 18 and was decreased by two years

every year completely eliminating the link within ten years. On October 1, 2016 the de-link would apply to all children two and older. On October 1, 2017 the link to AFDC would be totally eliminated. This bill temporarily freezes the phase-out

This bill delays this final phase out of the link to April 1, 2019 for children two or older and totally eliminates the link on April 1, 2020.

In addition, the Government Accountability Office (GAO) will report on state reinvestment of savings resulting from increase adoption assistance. As a result of expanded federal funding for adoption assistance congress mandated that states re-invest savings from that expanded adoption assistance back into child welfare services.

The GAO will study the extent to which states are complying with these requirements. The Fostering Connections to Success and Increasing Adoptions Act of 2008 was later amended by the Preventing Sex Trafficking and Strengthening Families Act (Public Law 113–183) to strengthened the reinvestment requirements. The GAO will analyze the extent to which states are complying with the requirements including the requirement that states are to spend not less than 30 percent of the savings on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care. The GAO shall submit the report to the Senate Committee on Finance, the House of Representatives Committee on Ways and Means, and HHS.