



DATE: April XX, 2026

Behavioral Health Information Notice No: 26-XXX

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Behavioral Health Association
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators
California Hospital Association California Opioid Maintenance Providers
County Child Welfare Directors
Chief Probation Officers
Short-Term Residential Therapeutic Program Providers
Children's Crisis Residential Program Providers
Psychiatric Residential Treatment Facilities
Foster Family Agencies
Wraparound Providers
Behavioral Health Providers
Community Treatment Facilities
Tribes with an IV-E Agreement

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State of California

Gavin Newsom, Governor



California Health and Human Services Agency

SUBJECT: Medi-Cal Coverage of High Fidelity Wraparound (HFW) for Children and Youth

PURPOSE: To provide guidance regarding coverage of HFW pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate and in accordance with Assembly Bill (AB) 161 (Welf. & Inst. Code 16562, subd. (h)(1)(A)) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).

REFERENCE: California Welfare and Institutions (W&I) Code § [14184.400](#), [14184.102\(d\)](#) and 14184.402(i) [14184.400](#); W&I Code Sections [14059.5](#)

TABLE OF CONTENTS

BACKGROUND:.....	3
OVERVIEW OF BH-CONNECT.....	3
MEDICAID EPSDT MANDATE.....	4
POLICY:.....	4
OVERVIEW OF HFW.....	6
MEDI-CAL HFW POLICY MANUAL.....	8
FIDELITY ASSESSMENTS & FIDELITY DESIGNATION FOR HFW.....	9
USE OF CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) DECISION SUPPORT CRITERIA FOR YOUTH AGES SIX YEARS AND OLDER.....	10
MEDI-CAL HFW FOR YOUTH AGES 0-5 YEARS.....	15
MEDI-CAL CLAIMING.....	15
ADDITIONAL GUIDANCE ON CLAIMING FOR HFW WITH OTHER SMHS.....	23
MEDI-CAL PAYMENT FOR HFW AND MEDI-CAL MANAGED CARE PLAN (MCP) SERVICES.....	26
HFW AND JUVENILE JUSTICE SETTINGS.....	26
DOCUMENTATION.....	26
COMPLIANCE MONITORING.....	27

ENCLOSURE 1: MEDI-CAL SERVICE COMPONENTS FOR HFW MONTHLY RATE 28
ENCLOSURE 2: ENCLOSURE FOR MEMBER HANDBOOKS..... 30

BACKGROUND:

OVERVIEW OF BH-CONNECT

The [Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment \(BH-CONNECT\)](#) initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a five-year [Medicaid Section 1115 demonstration](#) and State Plan Amendments (SPAs) to expand coverage of evidence-based practices (EBPs) available under Medi-Cal, as well as complementary guidance and policies to strengthen behavioral health services statewide.¹

BH-CONNECT updates and clarifies existing Medi-Cal coverage of EBPs focused on children and youth, including HFW, to enable implementation consistent with national standards. This Behavioral Health Information Notice (BHIN) provides the minimum requirements all behavioral health plans (BHPs), inclusive of mental health plans and plans that also provide substance use disorder (SUD) services through an integrated contract,² must meet related to scope of coverage, medical necessity criteria, care delivery settings, provider qualifications, and claiming and payment for providing HFW under Medi-Cal.

¹ As defined by the [Agency for Healthcare Research and Quality](#), an EBP is a way of providing health care that is guided by a thoughtful integration of the best available scientific knowledge with clinical expertise. This approach allows the practitioner to critically assess research data, clinical guidelines, and other information resources in order to correctly identify the clinical problem, apply the most high-quality intervention, and re-evaluate the outcome for future improvement.

² HFW is covered through the Specialty Mental Health (SMHS) delivery system. For purposes of this BHIN, BHP refers to the entity that covers SMHS and is not intended to reference Drug Medi-Cal Organized Delivery System (DMC-ODS) benefits or plans. The Drug Medi-Cal State Plan program is also not included in the definition of BHP.

MEDICAID EPSDT MANDATE

All BHPs are required to cover HFW under the EPSDT mandate.³ The EPSDT mandate requires comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in full-scope Medi-Cal. Under EPSDT, states are required to provide all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under [the state's Medicaid State Plan](#).⁴ Furthermore, [federal guidance](#) from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition.⁵ Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are therefore medically necessary and covered as EPSDT services. Nothing in this BHIN limits or modifies the scope of the EPSDT mandate.

POLICY:

BHPs must cover HFW as an EPSDT service⁶ through the Specialty Mental Health Service (SMHS) delivery system, in accordance with this guidance and the accompanying Policy Manual which clarify the evidence-based practices required to cover and claim for HFW.

Effective July 1, 2026, in accordance with AB 161 (Welf. & Inst. Code 16562), which requires DHCS to implement "a case rate or other type of reimbursement" for HFW services, BHPs must claim for specified activities (see Enclosure 1) that all youth must receive as part of HFW using the updated payment model (hereafter, "the monthly HFW rate") described in this BHIN. BHPs must also cover and claim any additional medically necessary SMHS or Drug Medi-Cal (DMC)/Drug Medi-Cal-Organized Delivery System (DMC-ODS) services that are not covered through the monthly rate, and refer a youth to any non-specialty mental health service or Medi-Cal service that a youth needs as part

³ 42 C.F.R. Part 441, Subpart B; 42 U.S.C. §§1396a(a)(43) and 1396d(r)

⁴ See CMS State Health Official ([SHO Letter #24-005](#)).

⁵ [EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adults](#)

⁶ 42 C.F.R. Part 441, Subpart B; 42 U.S.C. §§1396a(a)(43) and 1396d(r)

of the model. BHPs must also coordinate with Medi-Cal Managed Care Plans (MCPs) to refer youth to any MCP-covered service (e.g., non- specialty mental health services, Caregiver Respite). Youth that are not enrolled in Medi-Cal managed care may access additional covered services through the Medi-Cal fee-for-service delivery system.

BHPs must consider the choice or preferences of Medi-Cal youth and caregivers when a youth is referred to or receiving Medi-Cal HFW services.

Together, the HFW monthly rate and the individualized array of SMHS and other Medi-Cal services comprise the “Medi-Cal HFW service package” outlined in Figure 1 below. The Medi-Cal HFW Service Package includes care coordination, psychosocial rehabilitation, crisis intervention, and peer support services delivered consistent with evidence-based standards for HFW, as well as other community-based services designed to meet the individualized needs of the youth and family.

Figure 1. Medi-Cal HFW Service Package

HFW Service Package	
HFW Monthly Rate	Services Billed/Claimed Outside of HFW Monthly Rate
<p>Encompasses services specified in Enclosure 1 when provided by the HFW team, as defined in California’s Medicaid State Plan:</p> <ul style="list-style-type: none"> » Targeted Case Management » Psychosocial Rehabilitation » Caregiver/Parent Peer Support Services » Crisis Intervention 	<ul style="list-style-type: none"> » Any SMHS, DMC or DMC-ODS service youth may need for which the BHP must provide or arrange⁷ » Any Medi-Cal Managed Care Service youth may need for which the BHP must refer consistent with MHP/MCP Memorandum of Understanding (MOU) requirements » Any Medi-Cal services covered in the Fee-for-Service delivery system, for youth not enrolled in Medi-Cal managed care

⁷ See [BHIN 26-002](#).

As described in the [BHSA County Policy Manual](#), counties are required to implement HFW as part of their Full Service Partnership (FSP) programs pursuant to the Behavioral Health Services Act (BHSA) beginning July 2026.⁸

BHPs shall ensure all Medi-Cal members under the age of 21 have access to HFW if determined medically necessary and clinically appropriate.

OVERVIEW OF HFW

HFW is a team-based, family-centered service for children and youth living with serious mental health or behavioral challenges. HFW is an intervention designed to help the youth stay at home with their families/caregivers, in school, and in the community. HFW is also designed to help the youth's family, caregivers, and natural supports understand the youth's needs and learn how to support them in navigating complex mental health and/or behavioral challenges. HFW organizes a collaborative planning process that brings together the youth and family/caregivers, natural supports, and involved providers to develop and carry out an individualized plan.⁹

Although wraparound services have been available in California for decades, studies have shown that certain practices garner best outcomes for youth.¹⁰ The work of the National Wraparound Initiative (NWI) has been to gather those practices into standards that are required by the evidence-based model, which is called "high fidelity" because it adheres to the evidence-based practice standards. As outlined in the [CA Wraparound](#)

⁸ HFW provided under FSP programs must meet all of the same standards as HFW delivered under Medi-Cal. Hereafter, references to "Medi-Cal HFW" apply to FSP/BHSA (see Section B.4.3 in the BHT Policy Manual for more information on alignment of HFW in FSP and Medi-Cal).

⁹ For information on natural supports, see [ACL 25-47/BHIN 25-027](#).

¹⁰ Youth participating in HFW have demonstrated improved outcomes including, improved behavior, mental health functioning, and reduced school absences and suspensions ([National Wraparound Initiative \(2017\)](#); [Bruns \(2008\)](#)). HFW is also linked to cost savings through reduced emergency room and inpatient psychiatric visits ([Olsen et al. \(2021\)](#); [Smith et al. \(2019\)](#)). In order to achieve these outcomes, the HFW program must have staff trained in HFW, outcomes monitoring, and demonstrated adherence to fidelity standards in line with the CA Wraparound Standards (see Section 2 of this manual).

[Standards](#)¹¹ HFW is delivered in accordance with ten principles of the National Wraparound Initiative (NWI) via four phases. Through these principles, HFW includes a family-centered, “anything necessary” approach to care for youth. HFW combines team-based intensive care coordination and facilitation with individualized and home- and community-based mental health services and supports tailored to meet the individualized needs of the youth. Many youth who benefit from HFW are often involved in multiple child-serving systems, like child welfare and/or juvenile probation.

The Child and Family Team (CFT) is an integral part of HFW. A CFT consists of a group of people (i.e., family, community, social worker, probation officer, Tribes when applicable¹², and practitioners from across the System of Care¹³) who are involved in supporting the youth and family to achieve their goals through developing and implementing an individualized plan of care. The youth and family¹⁴ are active members of the CFT and serve a key role in identifying other CFT members.¹⁵ All youth receiving HFW shall have a CFT, whether they are child welfare and/or juvenile probation involved or not. When a youth who receives HFW has a pre-existing CFT, the HFW staff become part of the CFT so there is only one team for the youth inclusive of the formal support systems a youth may need. The team works together to integrate required services and supports into a plan of care that aligns with the youth and family's goals and values, using individualized, strength-based planning. Hereafter throughout this BHIN, the term “HFW team” shall be used to describe the requirements associated with the make-up of practitioners operating within the context of the CFT.

¹¹ The CA Wraparound Standards align with the NWI HFW model. See [ACL 27-47/BHIN 25-047](#).

¹² See [ACL 22-73 for guidance on including Tribes in CFTs](#).

¹³ For information on the CA Children's System of Care, see [System of Care - California Health & Human Services](#) and [ACL 27-47/BHIN 25-047](#). The Children and Youth System of Care is informed by the implementation of [AB 2083](#), which requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that service children and youth in foster care who have experienced severe trauma.

¹⁴ A youth's caregivers may include, but is not limited to, a biological parent, adoptive parent, foster parent, kinship caregiver, legal guardian, or non-residential caregiver (e.g., a non-custodial parent) who shares caregiving responsibilities for the child.

¹⁵ See [ACL 25-47/BHIN 25-027](#), [ACL 22-35](#), and [ACL 22-73](#).

HFW is delivered in community-based settings, and, as necessary, to support continuity of care during transitional periods into and out of inpatient and residential settings. Additional details about the activities covered under Medi-Cal as part of the HFW monthly rate are included in Enclosure 1. As noted above, the HFW service package also includes an individualized array of SMHS as well as other Medi-Cal services that must be made available consistent with Medi-Cal coverage and care coordination guidance, and may be claimed outside of the monthly rate.

MEDI-CAL HFW POLICY MANUAL

This BHIN provides minimum requirements all BHPs must meet for providing HFW under Medi-Cal. The forthcoming HFW Policy Manual provides required operational and practice standards for the implementation of HFW. The Policy Manual includes information on program requirements, including:

- » Evidence-based service criteria for HFW;
- » HFW team structure and key functions;
- » The foundational requirements for counties to deliver HFW under Medi-Cal and BHSA;
- » Training, technical assistance, outcomes and fidelity monitoring; and
- » Data collection.

The HFW Policy Manual reflects expectations for service provision in alignment with current evidence and national (and CA Wraparound) standards. DHCS may periodically update the Policy Manual to clarify and reflect the latest guidelines for HFW in alignment with evolving evidence and national practice standards. DHCS will work with the HFW Center of Excellence (see additional information below) and other stakeholders on HFW Policy Manual updates and notify BHPs of any updates. BHPs must adhere to the standards set forth in the HFW Policy Manual in addition to the requirements in this BHIN.

The HFW Policy Manual is posted to the [BH-CONNECT webpage](#).

FIDELITY ASSESSMENTS & FIDELITY DESIGNATION FOR HFW

The HFW Policy Manual establishes training, technical assistance, fidelity monitoring and data collection standards for BHPs and behavioral health practitioners to implement HFW under Medi-Cal and the BHSA.

When implemented with fidelity to the evidence-based model, HFW has demonstrated robust outcomes among youth living with significant behavioral health needs.

Monitoring fidelity through regular fidelity assessments is a key component of HFW to ensure members are receiving the service as designed and to identify where improvements can be made.

DHCS has contracted with a HFW Center of Excellence (COE), the [Resource Center for Family-Focused Practice](#) (RCFFP) at UC Davis, to provide training, technical assistance, fidelity monitoring and data collection for HFW statewide.¹⁶ BHPs must work with the COE as described in this BHIN and in the Policy Manual to confirm that HFW provider sites are delivering HFW to fidelity. The HFW COE will conduct fidelity assessments as described in the HFW Policy Manual. HFW provider agencies and provider sites and associated fidelity requirements are described in the HFW Policy Manual.¹⁷

BHPs may claim for HFW for up to nine months before each provider agency completes a baseline fidelity assessment on behalf of their provider sites with the COE. For the BHP to claim for HFW on an ongoing basis after the initial nine-month period, provider sites must achieve and maintain Fidelity Designation, defined as meeting a specified fidelity threshold on their fidelity assessment conducted by the COE. There are three levels of Fidelity Designation:

¹⁶ DHCS also contracted with COEs to support implementation of Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Clubhouse Services. Additional information on these EBPs is available in BHIN 25-XXX and [BHIN 25-009](#) or subsequent guidance.

¹⁷ As described in the HFW Policy Manual, provider agencies are defined as the legal entity that holds administrative, fiscal, and compliance responsibility for the delivery of HFW services under contract with a county. A provider agency may operate one or more Medi-Cal certified service locations. HFW provider sites are defined as the operational unit within a HFW provider agency where HFW services are delivered under shared practice-level leadership, supervision, and accountability structures.

- » Baseline Fidelity Designation indicates a provider site has completed their baseline fidelity assessment;
- » Minimum Fidelity Designation indicates a provider site has completed their first fidelity assessment and meets the minimum fidelity threshold for HFW; and
- » Full Fidelity Designation indicates a provider site has completed their second fidelity assessment and meets the full fidelity threshold for HFW.

BHPs may claim Medi-Cal payment on an ongoing basis for provider sites that have achieved any of the three levels of Fidelity Designation. Specific fidelity thresholds required to achieve each Fidelity Designation level are described in the HFW Policy Manual. Fidelity Designation will be granted or renewed following each fidelity assessment. BHPs shall not continue to claim the HFW monthly rate for any provider site that loses its Fidelity Designation.

Additional details about the HFW COE, the fidelity assessment process, fidelity thresholds, and outcomes monitoring requirements that must be met to achieve Fidelity Designation are available in the HFW Policy Manual.¹⁸

USE OF CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) DECISION SUPPORT CRITERIA FOR YOUTH AGES SIX YEARS AND OLDER

DHCS is establishing HFW Decision Support Criteria (DSC) for youth ages six years and older in Medi-Cal and FSP, which shall be applied using CANS scores. The HFW DSC are a research-based tool/process intended to support clinical decision-making and statewide consistency in determination of need for HFW.

Once a CANS has been completed for a youth being assessed for HFW (consistent with [BHIN 25-035](#) and subsequent guidance), a licensed mental health professional (LMHP)^{19,20} must compare the completed CANS scoring against the HFW DSC to inform clinical decision-making about the appropriateness of HFW. LMHPs must recommend

¹⁸ DHCS will communicate to stakeholders and may adjust guidance if at any time DHCS is no longer able to make COE resources available free of charge.

¹⁹ For the purposes of this BHIN, an LMHP is defined on page 21 of [Supplement 3 to Attachment 3.1-A](#) of the California Medicaid State Plan.

²⁰ See [BHIN 24-023](#).

HFW for youth who meet the HFW DSC and BHPs must cover the service for those youth. In rare cases, an LMHP may choose to recommend HFW for a youth age six years or older who does not meet the HFW DSC, based on clinical judgment.²¹ The rationale for this recommendation must be clearly documented in the youth's clinical record.

BHPs shall monitor their providers to confirm that all youth for whom HFW will be claimed have received an assessment using the CANS. BHPs shall not require prior authorization for HFW or impose additional requirements that would delay referral or receipt of HFW services (the DSC is not a tool for prior authorization). BHPs must cover and facilitate access to HFW for youth who meet the HFW DSC. Figure 2 below outlines the process for using the DSC and the roles of the BHP and LMHPs/providers in this process.

²¹ See the HFW Policy Manual for an example edge case in which it may be appropriate to for an LMHP to recommend HFW when a youth does not meet the DSC.

Figure 2. Use of DSC to Recommend HFW for Youth Ages Six Years and Older and Roles of LMHPs/Providers and BHPs

Stage of DSC Process to Recommend HFW	LMHP/Provider Role	BHP Role
<p>1. Completing or Updating the CANS</p>	<p>After the CANS is completed or updated by an individual certified to do so, an LMHP must use the CANS to determine whether HFW is medically necessary and clinically appropriate for each youth referred for HFW.</p> <p>The HFW provider site is responsible for confirming that a CANS is completed or updated.</p>	<p>BHPs must monitor their providers to confirm that staff at HFW provider sites administer²² and update the CANS throughout the youth’s receipt of HFW, and that HFW provider sites have staff who are certified in accordance with BHIN 25-035 and subsequent guidance.</p>
<p>2. Administering the HFW DSC</p>	<p>Once a youth being assessed for HFW has a completed CANS, an LMHP must compare the completed CANS domain scoring against the HFW DSC (see Figure 3 below) to inform clinical decision-making about the appropriateness of HFW. An LMHP must review the HFW DSC in Figure 3 to make individualized determinations of clinical need for HFW. An LMHP can use a rubric based on Figure 3 to manually compare the</p>	<p>BHPs must monitor and train their providers so that an LMHP qualified to direct services as required in California’s Medicaid State Plan participates in the assessment process, reviews the HFW DSC as described at left, and</p>

²² Not all youth referred for HFW will have their CANS completed by a HFW provider site. Counties must make the CANS available for all youth referred for HFW in accordance with [BHIN 25-035](#). HFW provider sites must update CANS for youth for whom their CANS was completed by another individual/entity.

Stage of DSC Process to Recommend HFW	LMHP/Provider Role	BHP Role
	<p>required ratings outlined in the DSC against the youth’s completed CANS domain scores.</p> <p>Figure 3 depicts the HFW DSC. These ratings indicate that HFW is medically necessary and appropriate.</p>	<p>documents whether HFW is medically necessary and clinically appropriate.²³</p>
<p>3. Consideration of DSC and Confirmation that HFW is Medically Necessary and Clinically Appropriate</p>	<p>If a Youth Meets the HFW DSC in Figure 3: An LMHP recommends HFW.</p> <p>If a Youth Does Not Meet HFW DSC:</p> <p>In limited circumstances, an LMHP may still recommend HFW as medically necessary and clinically appropriate even if a youth does not meet the HFW DSC. DHCS expects that these edge cases in which an LMHP identifies and recommends HFW as a SMHS intervention but the youth does not meet HFW DSC will be limited. Please see the HFW Policy Manual for examples of these cases. Rendering LMHPs must still consider the youth’s CANS domain scoring in</p>	<p>If HFW is Medically Necessary and Clinically Appropriate for the Youth: BHPs must monitor and train their providers, and coordinate member care, as needed to ensure that all youth who meet HFW DSC are offered HFW. This may include proactive outreach to youth and families if they have not already been connected to a HFW provider. If a youth meets the HFW DSC, it is ultimately the youth and family’s decision as to whether they wish to receive HFW.</p> <p>If HFW is Not Medically Necessary and Clinically Appropriate for the Youth: For</p>

²³ The following clinicians who may direct services: a physician; a licensed or waived psychologist; a licensed, waived or registered social worker; a licensed, waived or registered marriage and family therapist; a licensed, waived or registered professional clinical counselor; a registered nurse (including a certified nurse specialist, or a nurse practitioner); or a licensed occupational therapist. See [California State Plan, Supp 3 to Att. 3.1-A](#) (page 2k).

Stage of DSC Process to Recommend HFW	LMHP/Provider Role	BHP Role
	the context of the HFW DSC to assess how closely the youth’s needs align with DHCS’ HFW DSC. For youth who do not meet the HFW DSC, a rendering LMHP that seeks to recommend this service should also engage the youth, family, and care team in making a clinical determination of need for HFW.	youth for whom an LMHP determines HFW is not clinically appropriate, BHPs must coordinate referrals for appropriate SMHS and NSMHS, consistent with current contractual requirements. BHPs remain responsible for grievances, appeals, and member noticing as needed, consistent with current guidance. ²⁴

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²⁴ See [BHIN 25-014](#).

Figure 3: High Fidelity Wraparound Decision Support Criteria Using CANS Tool

CANS Domain (with CANS Domain #, for reference)	Rating
Behavioral Emotional Needs (3.1) AND	At least one rating of 2 or 3
Caregiver Needs (3.5)	At least one rating of 2 or 3
AND AT LEAST 1 OF THE FOLLOWING:	
Risk Behavior (3.2) OR	At least one rating of 2 or 3 or Three or more ratings of 1
Life Functioning (3.3) OR	One rating of 3 or Two or more ratings of 2 or 3
Strengths Indicators (3.4)	Five or more ratings of 2 or 3

MEDI-CAL HFW FOR YOUTH AGES 0-5 YEARS

At the time of publication of this BHIN, DHCS has not established HFW DSC for youth ages 0-5 years old. Historically, BHPs have not been required to administer CANS for this age group; consequently, DHCS does not have CANS data with which to develop appropriate DSC. Youth ages 0-5 may receive Medi-Cal covered HFW when the service is deemed medically necessary and recommended by an LMHP acting within their scope of practice and authorized to direct services under the California Medicaid State Plan. Examples of factors an LMHP should consider when determining clinical appropriateness of HFW for this population are described in the HFW Policy Manual. After BHPs implement updates to CANS policy that include use of the CANS Early Childhood module, DHCS may consider implementing HFW DSC for this age group.

MEDI-CAL CLAIMING

BHPs will use the Short Doyle Medi-Cal claiming system to claim a monthly payment for specified activities (see Enclosure 1) for HFW for every youth receiving the service using the procedure code in Table 1 below. The HFW monthly rate covers **all** HFW service activities **provided by the HFW staff** outlined below, which are responsible for direct

services as well as indirect services, including fidelity coaching, clinical supervision, and community development. BHPs receive a county-specific HFW monthly rate for services that meet the requirements in this BHIN and the HFW Policy Manual. County-specific rates for behavioral health services, including HFW, are posted [here](#).²⁵

DHCS will submit a Medicaid SPA to pay for HFW using a monthly rate structure. The HFW monthly rate may not be claimed until the SPA is effective, and systems updates are in place. DHCS will notify BHPs and finalize this draft BHIN when this process is complete.

Additional details about claiming requirements for BH-CONNECT EBP, including HFW, are in the applicable Short-Doyle Medi-Cal billing manual.²⁶

Table 1. HFW Monthly Rate Claiming Details

Service	Rate Structure	CPT/HCPCS Code	Code Description
HFW	Monthly Rate	H2022	High-Fidelity Wraparound Services

The following are covered HFW **monthly rate service components**, which are defined in California's [Medicaid State Plan](#):

- » Targeted Case Management
- » Psychosocial Rehabilitation

²⁵ BHPs shall claim the established rates for HFW contained in the appropriate fiscal year's fee schedule for SMHS Outpatient rates. The fee schedules contain rates that DHCS reimburses BHPs for SMHS rendered to Medi-Cal members. BHPs negotiate rates with and reimburse individual network providers and are not required to reimburse network providers at the posted rates. Rates are developed using a county-wide average of direct and indirect costs and can be found here: [Medi-Cal Behavioral Health Fee Schedules](#).

²⁶ DHCS will submit a Medicaid SPA to pay for HFW using a monthly rate structure. The monthly rate for HFW may not be claimed until the SPA is effective, and systems updates are in place. DHCS will notify BHPs when this process is complete.

- » Caregiver/Parent Peer Support Services
- » Crisis Intervention

To meet the California Wraparound Standards, counties and providers must make available a set of roles as specified in [BHIN 25-027](#). The HFW monthly rate covers all of the direct service activities in Enclosure 1 provided by a facilitator, caregiver/parent peer partner, and family specialist to a youth. The HFW monthly rate also covers activities conducted by a HFW team supervisor and a fidelity coach,²⁷ clinical supervision from an LMHP, and a community developer.

Every HFW team under Medi-Cal and BHSA must also make available the following key functions: HFW Facilitation and Care Coordination, Care Planning and Documentation; CANS Updates; Crisis Support and Safety Planning; Strengths-Based Psychoeducation and Psychosocial Skills Coaching for the Youth; Parent/Caregiver Peer Support; Youth Peer Support; Referrals and Coordination; and Care Transition Support.

Team functions correspond to specified SPA service components as well as services claimed outside of the monthly rate. Additional information about team structure and functions is available in the HFW Policy Manual. The HFW team must work together to integrate required services and supports into a plan of care that aligns with the youth and family's goals and values.

Claiming guidance across all HFW team functions (in alignment with covered SPA authorities) is summarized in Figure 4 below. There must be at least one contact or encounter per month for the HFW monthly rate to be claimed. Beyond this, DHCS does not require a minimum number of contacts each month by a HFW team for the BHP to be claim the HFW monthly rate, acknowledging that a youth's needs will vary in intensity across phases of HFW. However, encounter data will be included in the claiming process and providers and BHPs must be prepared to document each encounter with the youth and family in the clinical record and report this data in accordance with applicable claiming guidance.²⁸

All Medi-Cal services not provided by HFW team must be claimed outside the HFW monthly rate. DHCS will provide additional information and technical assistance to help

²⁷ The fidelity coach is a function internal to the HFW provider agency and is separate from the fidelity oversight provided by the COE.

²⁸ [BHIN 23-068](#)

address questions about activities included in the HFW monthly rate and those that can be claimed separately.

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Figure 4: Claiming Guidance for HFW Service Components, Team Functions and Service Activities

SPA Service Component	HFW Team Functions Covered ²⁹	Claimed as Part of HFW Monthly Rate	Claimed Outside of HFW Monthly Rate (Non-Exhaustive)
Targeted Case Management	<ul style="list-style-type: none"> » HFW Facilitation and Care Coordination » Care Planning and Documentation » CANS Updates » Referrals » Care Transition Support 	<ul style="list-style-type: none"> » All activities provided by the facilitator and community developer » All indirect service activities including oversight, coaching, care transition support provided by the supervisor, fidelity coach, and clinician; administrative functions such as care plan documentation (including updates to the CANS) and review by the HFW team 	<ul style="list-style-type: none"> » Initial and ongoing full CANS administration while a youth is receiving HFW³⁰ (using H0031 (Mental Health Assessment by Non-Physician or H2000 (Comprehensive Multidisciplinary Assessment)). » LMHPs who are not part of the HFW team but who join the CFT in HFW team meetings (e.g., a youth’s therapist) may claim for time spent joining CFT/HFW team meetings (using Comprehensive Multidisciplinary Assessment, H2000 modifier HK). Youth peers who meet the qualifications for an OQP must also claim for CFT/HFW meeting time using this code.

²⁹ See HFW Policy Manual for more information on HFW team functions.

³⁰ See [BHIN-25-035](#) for details on required frequency of CANS administration while a youth is receiving SMHS.

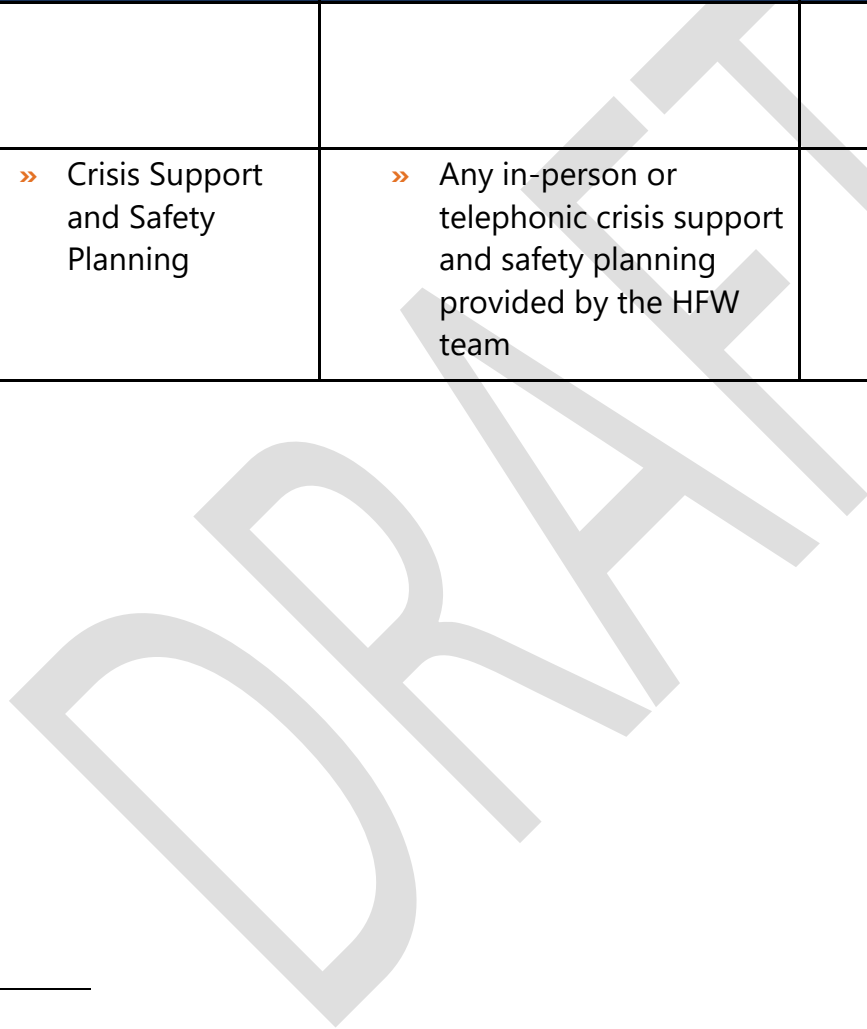
SPA Service Component	HFW Team Functions Covered ²⁹	Claimed as Part of HFW Monthly Rate	Claimed Outside of HFW Monthly Rate (Non-Exhaustive)
			<p>Youth peers who are certified Medi-Cal Peer Support Specialists must claim for CFT/HFW meeting time using Behavioral Health Prevention Education Service (H0025) or Self-Help/Peer Services (H0038).</p>
<p>Psychosocial Rehabilitation</p>	<p>» Strength Based Psychoeducation and Psychosocial Skills Coaching for the Youth</p>	<p>» All activities provided by the family specialist</p>	<p>» Additional IHBS identified within the HFW plan of care (and outside of the family specialist role responsibilities) must be claimed separately from the monthly HFW rate. Additional IHBS within the HFW plan of care may include service components defined in the 2018 Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries.</p> <p>» HFW teams must confirm that additional IHBS provided are complementary and not duplicative of HFW team functions.</p>

SPA Service Component	HFW Team Functions Covered ²⁹	Claimed as Part of HFW Monthly Rate	Claimed Outside of HFW Monthly Rate (Non-Exhaustive)
			<ul style="list-style-type: none"> » Additional therapeutic interventions³¹ not provided by the HFW team
Peer Support Services	<ul style="list-style-type: none"> » Parent/Caregiver Peer Support 	<ul style="list-style-type: none"> » All activities provided by the caregiver/parent peer partner activities 	<ul style="list-style-type: none"> » Youth peer partners not certified as Medi-Cal Support Specialists may claim for activities conducted outside of time spent on HFW team/CFT meetings as a part of HFW using the SMHS billing code for psychosocial rehabilitation (H2017) as an Other Qualified Provider as described in the HFW Policy Manual.³² Youth peer partners certified as Medi-Cal Peer Support Specialists may continue to claim for peer support services

³¹ As defined in [Supplement 3 to Attachment 3.1-A](#) to the [California Medicaid State Plan](#).

³² As described in the HFW Policy Manual, individuals serving in the role of caregiver/parent peer partner and youth peer partner on the HFW team may be certified as Medi-Cal Peer Support Specialists or meet Medi-Cal requirements for Other Qualified Providers. All caregiver/parent and youth peer partners must be employed by a HFW provider site meeting HFW Fidelity Designation and, like all HFW team members, must meet statewide HFW COE training requirements within established timelines. DHCS may update this guidance in the future to require Medi-Cal Peer Support Specialist certification for these individuals.

SPA Service Component	HFW Team Functions Covered ²⁹	Claimed as Part of HFW Monthly Rate	Claimed Outside of HFW Monthly Rate (Non-Exhaustive)
			using Behavioral Health Prevention Education Service (H0025) or Self-Help/Peer Services (H0038). ³³
Crisis Intervention	» Crisis Support and Safety Planning	» Any in-person or telephonic crisis support and safety planning provided by the HFW team	» Any crisis service (e.g., mobile crisis, or crisis residential) not provided by the HFW team must be claimed separately from the monthly HFW rate.



³³ See [BHIN-25-010](#).

ADDITIONAL GUIDANCE ON CLAIMING FOR HFW WITH OTHER SMHS

BHPs must provide or arrange for the provision of other medically necessary and clinically appropriate SMHS and DMC/DMC-ODS services as part of a youth's individualized Medi-Cal HFW service package. Additional SMHS and DMC-DMC-ODS services must be claimed separately from the monthly rate.

BHPs must ensure that additional SMHS and DMC/DMC-ODS services are complementary and not duplicative of the activities covered through the HFW monthly rate.

Non-exhaustive examples of additional SMHS that many youth may receive as part of the HFW service package, and for which the BHP must provide or arrange and that BHPs must claim separately from the HFW monthly rate include:

- » Any Crisis Service that is not provided by the HFW team³⁴, including but not limited to Crisis Intervention, Crisis Stabilization, or Mobile Crisis services,³⁵
- » SMHS Therapy and therapies such as Functional Family Therapy (FFT) or Multisystemic Therapy (MST)
- » Therapeutic Foster Care (TFC)
- » Day Treatment Rehabilitative and Day Treatment Intensive, only when services are not provided during the same hours of the day the HFW team is working directly with the youth
- » Youth Peer Support (see Figure 4 above)

In the event that a member³⁶ requires a transition to or from HFW to Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), or

³⁴ Telephonic crisis intervention is considered part of the HFW team responsibilities and the HFW team may also choose to provide in-person crisis intervention to the extent possible and as needed by the youth.

³⁵ Family Urgent Response System (FURS) may also be an applicable crisis support.

³⁶ In most cases, members receiving ACT, FACT, or CSC concurrently with HFW would be transitional age youth (TAY, ages 18-24). While it may be rare for a TAY to need concurrent ACT, CSC, and HFW, concurrent delivery may be appropriate to transition from one to another for up to three months (in most cases), as medically necessary and clinically appropriate.

Coordinated Specialty Care (CSC) for First Episode Psychosis, BHPs may claim for both services concurrently.

BHPs shall not claim for HFW concurrently with SMHS Targeted Case Management (TCM) or ICC. When either practitioners outside of the HFW team or who are not employed by the HFW provider (e.g., a youth's therapist) or a youth peer joins the youth's CFT, these practitioners may claim for time spent at HFW team meetings as specified in Figure 4.

MEDI-CAL PAYMENT FOR HFW FOR MEMBERS RECEIVING INPATIENT SPECIALITY MENTAL HEALTH SERVICES,³⁷ OR SERVICES IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs), COMMUNITY TREATMENT FACILITIES (CTFs), SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTPs), AND CHILDREN'S CRISIS RESIDENTIAL PROGRAMS (CCRP)

HFW is linked to cost savings through reduced emergency room and inpatient psychiatric visits.^{38,39} While HFW is intended to reduce the need for inpatient/residential care, sometimes these stays will be needed. HFW teams provide continuity of care and coordination of services while the youth is admitted to inpatient/residential care. HFW teams must coordinate with inpatient and residential care providers to support discharge planning. The choice or preferences of Medi-Cal youth and caregivers must be considered when a youth is referred to or enrolled in a Medi-Cal HFW program and admitted to inpatient/residential care.

HFW may be provided when a youth is receiving inpatient SMHS or is admitted to a PRTF for purposes of care coordination and discharge planning in the month of admission or the month of discharge. Therefore, BHPs may claim the HFW monthly rate during the months of admission and month of discharge from an inpatient or PRTF setting.

³⁷ Inpatient SMHS includes psychiatric inpatient hospital services, psychiatric inpatient hospital professional services, psychiatric health facility services, and psychiatric inpatient hospital services delivered in a psychiatric health facility.

³⁸ [Olson et al. \(2021\)](#)

³⁹ [Smith et al. \(2019\)](#)

For youth needing care in a CTF, STRTP, or CCRP, ongoing coordination by the HFW Facilitator and HFW team may be delivered to youth throughout the stay and to support the youth's transition home. For youth entering these programs with an existing HFW team/provider that is separate from staff responsible for care and supervision at these facilities, continued receipt of HFW from the same team can support continuity of care. In these cases, HFW may be claimed concurrently during stays in these facilities.

DHCS requires that delivery of HFW in these facilities exist with limitations to mitigate conflicts of interest for entities operating as both community-based HFW and inpatient SMHS, PRTF, STRTP, CTF, or CCRP providers, as the goal of providing HFW in these facilities is to support timely and effective care transitions back to home-based settings, and to reduce lengths of stay. Inpatient SMHS, PRTF, STRTP, CTF, or CCRP staff may not provide HFW; however, staff affiliated with parent organization of the facility operator but operating within the context of a HFW provider site may provide HFW to a youth in these facilities. Therefore, BHPs shall not claim for HFW concurrently while a youth is receiving inpatient SMHS or admitted to a PRTF, or residing in an STRTP, CTF, or CCRP under the following conditions:

- » The facility's direct care staff are providing HFW to the youth; and/or
- » The HFW facilitator is supervised by facility staff; and/or
- » The geographic location of the HFW provider site is the same as the facility in which the youth is admitted or placed.

Notwithstanding section 1830.225 of the California Code of Regulations, BHPs shall offer at least one alternative HFW provider when the BHP contracts for HFW services with the same organization that provides the youth's services in the inpatient, PRTF, CTF, CCRP, or STRTP so that the youth is not required to receive HFW provided by the same organization.⁴⁰

⁴⁰ Nothing in this BHIN supersedes section 1810.435 of Title 9 of the California Code of Regulations nor BHIN 25-013. BHPs must offer an appropriate range of services that is adequate to meet the needs for the anticipated number of members for the service area, including meeting the need for HFW. BHPs are required to cover care out-of-network when the BHP's network is insufficient.

MEDI-CAL PAYMENT FOR HFW AND MEDI-CAL MANAGED CARE PLAN (MCP) SERVICES

BHPs must also coordinate with Medi-Cal Managed Care Plans (MCPs) to refer youth to any MCP-covered service (e.g., non-specialty mental health services, Caregiver Respite) specified in the youth's plan of care. Youth who are not enrolled in Medi-Cal managed care may access additional covered services through the Medi-Cal fee-for-service delivery system. Medi-Cal members receiving HFW and enrolled in managed care may also concurrently receive Enhanced Care Management (ECM) or Complex Care Management (CCM). A member may be engaged with a HFW team through their BHP and with an ECM provider through their MCP. HFW teams must coordinate with ECM providers to confirm the services are complementary and not duplicative. ECM may be most appropriate for youth that have complex physical health needs as well as behavioral and social needs; it may not be indicated for every youth that is receiving HFW given the comprehensive care coordination that HFW teams provide.

HFW AND JUVENILE JUSTICE SETTINGS

It is important that youth in juvenile justice settings who received HFW prior to their incarceration continue HFW in the post-release period if needed. It is also important that youth who may meet criteria for HFW are assessed to identify whether HFW is medically necessary and clinically appropriate in the post-release period.

Under the CalAIM Justice Involved Reentry initiative, BHPs and correctional facilities are required to work in partnership to facilitate behavioral health links, which includes professional to professional clinical handoffs.⁴¹ Youth who are identified as needing BHP services will qualify for SMHS and require a behavioral health link.

DOCUMENTATION

Clinical records for youth receiving HFW must adhere to all Medi-Cal documentation requirements for SMHS as described in [BHIN 23-068](#).

⁴¹ Under the CalAIM Justice Involved Reentry initiative, behavioral health links facilitate the initiation or continuation of behavioral health treatment once individuals are released to the community.

April 14, 2026

COMPLIANCE MONITORING

BHPs are responsible for conducting monitoring of contracted providers for compliance with the terms of the BHP's contract with DHCS, including with policies outlined in this BHIN. DHCS will continue to carry out its responsibility to monitor and oversee BHPs and their operations as required by state and federal law. DHCS will monitor BHPs for compliance with the requirements outlined above, and deviations from the requirements may require corrective action plans. This oversight may include, but is not limited to, verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable state and federal laws, regulations, and the MHP contract. Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

BHPs must also update their 2026 member handbooks to notify members of HFW by either adding Enclosure 2 of this BHIN as an insert to their handbook or incorporating the information in Enclosure 2 to the "Additional Information About Your County" section within their handbook within 90 days from the publication of this BHIN. BHPs must send a Notice of Significant Change to each member at least 30 days before the effective date of the handbook.⁴² For additional information regarding the Notification of Significant Change delivery method requirements, please reference [BHIN 24-034](#) or any subsequent guidance issued by DHCS.

Please contact BH-CONNECT@dhcs.ca.gov for questions regarding this BHIN.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief

Medi-Cal Behavioral Health – Policy Division

Enclosures (2)

⁴² Title 42, CFR, Part 438.10(g)(4)

ENCLOSURE 1: MEDI-CAL SERVICE COMPONENTS FOR HFW MONTHLY RATE

The county-based monthly rate for HFW is paid for the following service components as those components are defined in [Supplement 1 to Attachment 3.1-A](#) and [Supplement 3 to Attachment 3.1-A](#) to the [California Medicaid State Plan](#):

Targeted Case Management: Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following service components:

- » Comprehensive Assessment and Periodic Reassessment of Individual Needs, to determine the need for any medical, educational, social or other services.
- » Development (and Periodic Revision) of a Specific Care Plan that is based on the information collected through the assessment.
- » Referral and Related Activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
- » Monitoring and Follow-up Activities means activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Peer Support Services: Services that are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

Peer support services include one or more of the following service components:

- » Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- » Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
- » Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Psychosocial Rehabilitation: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation

includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These therapeutic interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education and/or psychoeducation. Psychoeducation assists members to recognize the symptoms of their mental health condition to prevent, manage or reduce such symptoms.

Crisis Intervention: An unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

ENCLOSURE 2: ENCLOSURE FOR MEMBER HANDBOOKS

Additional Specialty Mental Health Services Available:

HIGH FIDELITY WRAPAROUND (HFW):

- » HFW is a service that helps youth with serious behavioral health needs. Youth who need HFW may also be served by foster care, child welfare, or juvenile justice.
- » The goal is to help the youth feel better, stay connected to school, make positive choices, and develop skills needed to thrive in their community. HFW also helps the youth's family and caregivers understand the youth's needs and learn how to support them and tailors services and supports based on the youth's needs.
- » HFW is a structured team-based process and is provided through a Child and Family Team (CFT), which is centered on family voice and choice and strengths, and includes people who are involved in the youth and family's life. Together, they make a care plan to help the youth reach their goals.