HIGH FIDELITY WRAPAROUND (HFW) CONCEPT PAPER

Key Elements of DHCS Proposal to Align Medi-Cal Service Requirements with National Wraparound Initiative Standards

July 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CONTENTS

INTRODUCTION AND PURPOSE

California is transforming and modernizing behavioral health services delivery to improve health care quality, access, and outcomes for Californians. Central to this effort is Behavioral Health Transformation (BHT), inclusive of the Behavioral Health Bond and the Behavioral Health Services Act (BHSA). BHT complements California's other major behavioral health initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 demonstration. BH-CONNECT will strengthen and expand the continuum of care for Medi-Cal members living with significant behavioral health conditions by improving access to an array of community-based, evidence-based interventions and investing in behavioral health quality improvement and workforce development.

Children and youth with behavioral health needs, particularly those involved in the child-welfare system,[1] are a population of focus for BHT as well as BH-CONNECT. High Fidelity Wraparound (HFW) is a team-based, family-centered[2] model **recognized nationally as the gold standard for preventing out-of-home placement for youth living with significant behavioral health needs and often involved in multiple child-serving systems.** Through BHT and BH-CONNECT, the Department of Health Care Services (DHCS), in close collaboration with the California Department of Social Services (CDSS), seeks to expand access to evidence-based HFW statewide. **Through statewide HFW implementation, DHCS aims to meet the goals of delivering care to California's youth living with significant behavioral health needs in the least restrictive environment, and to address the needs of youth and their families.**

As part of BH-CONNECT, DHCS is updating and clarifying existing Medi-Cal coverage of evidence-based practices (EBPs) focused on children and youth, including HFW. Although county Behavioral Health Plans (BHPs)[3] cover Wraparound services in Medi-

[1] Throughout this concept paper, references to youth "involved in the child-welfare system" are inclusive of youth placed in foster care by juvenile probation departments.
[2] For the purposes of this concept paper, "family" is defined as anyone who is providing care and supervision for the youth (e.g., biological family, caregivers, chosen family, and/or individuals who love and support each other like a family might).
[3] Only mental health plans (MHPs) are required to provide HFW, so Drug Medi-Cal Organized Delivery System (DMC-ODS) plans are not referenced in the definition of BHPs.

Cal now,[4] programs may not provide the service to fidelity with the nationally recognized EBP. Beginning July 1, 2026, and in accordance with Assembly Bill (AB) 161 and BH-CONNECT, DHCS will align the Medi-Cal HFW service requirements with national practice standards and implement a corresponding updated payment model within Medi-Cal SMHS.[5]

As described in the BHSA County Policy Manual, counties must also implement HFW under the Full Service Partnership (FSP) program beginning in July 2026.[6] To ensure alignment across the county behavioral health delivery system and efficiency in payment, FSP HFW program requirements under BHSA will align closely with requirements for Medi-Cal HFW.

In this concept paper, DHCS describes and seeks comment on its initial vision for Medi-Cal HFW payment and monitoring policies and associated updated standards for service delivery in both Medi-Cal and BHSA, in alignment with national standards and state best practices. Importantly, these components are subject to revision based on feedback from stakeholders. DHCS will refine policies through the end of Calendar Year (CY) 2025, informed by stakeholder feedback, and plans to release Medi-Cal HFW policy guidance in early CY 2026. As an immediate next step, DHCS invites the public to comment on the concepts presented in this paper and provide responses to the specific questions for stakeholder input that are noted throughout. **Comments are due by 5:00 p.m. PT, August 21, 2025. Comments may be submitted**

[4]Intensive Care Coordination (ICC) is an SMHS that BHPs are obligated to provide to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet medical necessity criteria (BHIN 21-058). In addition, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, 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 Plan. Nothing in this concept paper limits or modifies the scope of the EPSDT mandate.

[5] AB 161, which establishes a tiered case rate structure for California foster care, specifies that DHCS will implement "a case rate or other type of reimbursement" for HFW as a Medi-Cal SMHS for members under 21 years of age (Welf. & Inst. Code 16562, subd. (h)(1)(C)). In this concept paper, DHCS will use the term "payment model" to describe DHCS' proposed requirements, claiming procedures, and rate methodologies designed to support fidelity implementation.

[6] Welf. & Inst. Code 5887(a)(2)

to BH-CONNECT@dhcs.ca.gov with the subject line "Comments on Proposed Medi-Cal HFW Service Requirements Aligned with National Practice Standards."

Policy Development Next Steps

Following this public comment period, DHCS will refine policies through the end of CY 2025 informed by stakeholder feedback and plans to release Medi-Cal HFW policy guidance in early CY 2026. Milestones listed below will be described in further detail within this section.

Timing	Milestone
July 2025	» Release of Family First Prevention Services Act (FFPSA) Part IV Aftercare ACL 25-47/BHIN 25-027 regarding California's implementation of FFPSA Part IV family-based aftercare services requirements, which build upon established processes and requirements under the CA Wraparound Standards.
August 2025	» Medi-Cal HFW Concept Paper public comment.
Late 2025 – Early CY 2026	» Draft Medi-Cal HFW Guidance public comment.
Early CY 2026	» Release of final Medi-Cal HFW Guidance.
July 2026	» Payment and Monitoring Policies for HFW in Medi-Cal go live. » HFW service requirements for BHSA FSPs take effect.
July 2027	» CDSS Immediate Needs Program and Permanent Foster Care Rate Structure payments go-live.[7,8] » Within 12 months of the effective date of Payment and Monitoring Policies, initial Medi-Cal HFW fidelity monitoring assessments for Medi-Cal fidelity standards begin for HFW providers.

[7] CDSS. (n.d.). Implementation of the Tiered Rate Structure.

[8] The Immediate Needs Program will offer a range of coordinated services and support for youth in foster care, as a component of the Tiered Rate Structure outlined in Section 11461(h) and guided by the Integrated Practice CANS (IP-CANS) tool. The Immediate Needs Program helps create and carry out whole-child care plans. These plans build on existing assessments, planning tools, and team-based approaches, all following a clearly defined model of care.

BACKGROUND AND DHCS PROPOSAL TO ALIGN MEDI-CAL HFW SERVICE REQUIREMENTS WITH NATIONAL PRACTICE STANDARDS

Background

The Evolution of HFW

The term "Wraparound" originated in the late 1970s to describe grassroots efforts to provide individualized, comprehensive, community-based care for youth with complex behavioral health needs. The Wraparound model included the creation, implementation, and monitoring of an individualized, community-based, comprehensive care plan driven by the needs of the youth and family.[9] The Wraparound model was developed as a response to service models that have historically (1) separated youth from their families for treatment in residential facilities, and/or (2) added more services and providers without adequate coordination and individualization to identify symptoms and meet the increasing needs of youth.

In the late 1990s, a group of family advocates, providers, and researchers came together to more clearly define the goals and key components of Wraparound, as there was not yet a way to ensure quality across programs or establish a Wraparound evidence-base.[10,11] Wraparound was further standardized in the early 2000s when the National Wraparound Initiative (NWI)* began developing the HFW model and expanding research on HFW's efficacy to establish

*NWI is a national organization that "has worked to promote understanding about the components and benefits of care coordination using the [HFW] Practice Model, and to provide the field with resources and guidance that facilitate high quality and consistent [HFW] implementation."

-NWI

[9] National Wraparound Initiative. (n.d.). History of Wraparound and the National Wraparound Initiative.
[10] VanDenBerg, J., Bruns, E., & Burchard, J. (2003). History of the Wraparound Process. Focal Point: A National Bulletin on Family Support and Children's Mental Health: Quality and fidelity in Wraparound, 17(2), 4-7
[11] National Wraparound Initiative. (n.d.). History of Wraparound and the National Wraparound Initiative.

a basis for service delivery standards. Over the past decade, NWI has engaged national experts to continue to define a standardized practice model, and today, a growing body of research has emerged associating HFW with improvements in mental health, living environment, and social functioning.[12,13]

The research highlights the importance of adhering to defined Wraparound standards, reflecting that high fidelity to these standards is directly correlated with improved outcomes for young people, including behavior, mental health functioning, caregiver satisfaction, and reduced school absences and suspensions.[14,15] HFW is also linked to cost savings through reduced emergency room and inpatient psychiatric visits.[16,17] In order to achieve these outcomes, the HFW program must have staff trained in HFW, outcome monitoring, and demonstrated adherence to fidelity standards in line with NWI recommendations.[18]

What Does HFW Entail?

HFW provides a comprehensive, holistic, evidence-based, youth and family-driven process for responding when youth experience significant mental health or behavioral

[12] Olson et al. (2021). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 60(11), 1353-1366.
[13] Bruns, E. (2015). Wraparound is worth doing well: An evidence-based statement. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative.
[14] National Wraparound Initiative, Wraparound Basics: Frequently Asked Questions
[15] Bruns, E. (2008). The evidence base and wraparound. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.
[16] Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: a meta-analysis. *Clinical Child and Family Psychology Review*, 12(4), 336–351.
[17] Smith, W., Sitas, M., Rao, P., Nicholls, C., McCann, P., Jonikis, T., ... & Waters, F. (2019). Intensive community treatment and support "Youth Wraparound" service in Western Australia: A case and feasibility study. *Early Intervention in Psychiatry*, *13*(1), 151-158.
[18] What constitutes an "EBP" is debated in the field as there is no one source of truth for this title. The California Evidence-Based Clearinghouse for Child Welfare recognizes wraparound (not HFW), and ICC using HFW facilitation, as practices supported by promising research evidence.

challenges, including children and youth involved in multiple youth-serving systems.[19] HFW is a team-based EBP that includes an "anything necessary" approach to care for youth with the most intensive behavioral health challenges, and is the most frequently used EBP to support this population.[20]

HFW is intended to simplify the lives of the youth and family and increase their chances of resiliency and healing in the community by:

- Centering care and service planning within the context of a Child and Family Team (CFT), guided by a trained professional facilitator, led by the voice of the youth and their caregiver(s).
- Developing a simple, individualized, time-limited plan of care with a structured, creative, and individualized set of strategies that are effective and relevant to the youth and their family.
- Empowering the youth, family, and natural supports to develop sustainable strategies that allow the youth to remain in school and in the community.[21]
- Improving caregivers' ability and confidence to identify and address the youth's needs.

Wraparound History in California

California has operated its own variation of "Wraparound," known as "CA Wraparound" for nearly 30 years. Existing CA Wraparound programs originated from the collaborative work between California's child welfare system, Medi-Cal, and the persistent efforts of

[19] Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process.

[20] Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles (SAMHSA Publication No. PEP19-04-01-001). U.S. Department of HHS.

[21] NWI defines natural supports "individuals within a youth or family's social network that provides consistent and/or meaningful support above and beyond any formal organizational ties and without remuneration" (Coldiron, J. S., Bruns, E., Hensley, S., & Paragoris, R. (2016). Wraparound implementation and practice quality standards. National Wraparound Initiative).

stakeholders and advocates.[22] CA Wraparound has established a strong foundation, via the CA Wraparound Standards, for an evidence-based approach to the delivery of HFW statewide.

In 1997, CA Wraparound was established through Senate Bill 163 to allow counties the option to provide Wraparound to youth with child welfare involvement, with the goal of supporting reunification, timely exits to permanency, and placement in the least restrictive environment. Although child welfare-involved youth were the initial legislative focus for CA Wraparound, providers now deliver CA Wraparound to both child welfare and non-child-welfare involved youth. At this point in time, CA Wraparound is delivered across the state, with varying levels of fidelity. **Medi-Cal can be and is billed for components of CA Wraparound for eligible members, but there is no guidance as to how BHPs are expected to comprehensively claim for multiple components of the service nor how fidelity of the service model will be assured statewide**.

Over the past 20 years, as Wraparound research has evolved nationally and in California, CA Wraparound has also been evolving. In recent years, recognizing this evolution, CDSS has invested in promoting fidelity to the HFW model for the youth they serve, working with the CA Wraparound stakeholders to ensure that CA Wraparound standards are aligned with the NWI's principles and standards. CDSS and DHCS have since collaborated with the County Behavioral Health Directors Association of California, the County Welfare Directors Association of California, the Chief Probation Officers of California, Tribes, county child welfare agencies, probation departments, BHPs, current CA Wraparound providers, current and former foster youth, caregivers, and other system partners in the development of these standards and requirements, to develop a unified CA HFW Model, which is based on the CA Wraparound Standards.[23]

DHCS and CDSS Joint Commitment to a Statewide CA HFW Model With Fidelity to National Standards

DHCS and CDSS seek to align efforts and ensure that all qualifying youth who need HFW have access to the full evidence-based service model. DHCS and CDSS

[22] Katie A. et al. v. Diana Bonta et al. (the "Katie A. Litigation"), filed July 18, 2002, in the U.S. District Court for the Central District of California, case no. 02-05662. The Katie A. Litigation settlement requires the provision of medically necessary Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC).

[23] UC Davis. (n.d.). California Wraparound Standards.

are collaborating across several efforts to minimize duplication and administrative complexity and align the HFW requirements applicable to FFPSA Part IV aftercare, Medi-Cal, the Immediate Needs program, and BHSA FSPs with the nationally recognized model of HFW. This model will be known as the CA HFW Model.

DHCS Proposal to Align Medi-Cal and FSP HFW Service Requirements With National Practice Standards

DHCS recognizes that there has never been guidance issued that explicitly describes the requirements for service provision and payment of HFW in Medi-Cal.[24] Consistent with AB 161, which requires DHCS to implement "a case rate or other type of reimbursement"[25] for HFW as a Medi-Cal SMHS for members under 21 years of age, DHCS plans to issue such guidance in early 2026, after taking into account stakeholder feedback on this concept paper.

As more young people receive HFW, DHCS expects to see improved outcomes among youth and families living with significant behavioral health needs, including improved school, community, and interpersonal functioning, reduction in inpatient/emergency department admission for behavioral health visits, and increased caregiver confidence (for all proposed expected outcomes, see the Appendix). These outcomes align with the outcomes expected in other states' HFW programs and in the current CA Wraparound Standards, and with the goals and desired outcomes of other DHCS behavioral health initiatives including statewide behavioral health goals developed as part of the BHSA, the populations of focus prioritized in both BHT and BH-CONNECT, and BH-CONNECT Incentive Program measures (see the Appendix).

The remainder of this concept paper is devoted to describing the preliminary vision for updated Medi-Cal and FSP HFW service requirements.

[24] All counties are currently required to provide HFW under the EPSDT mandate. As such, BHPs currently bill the components of the HFW model through existing SMHS.
[25] Welf. & Inst. Code16562, subd. (h)(1)(C)

MEDI-CAL AND BHSA SERVICE REQUIREMENT UPDATES TO ALIGN WITH NATIONAL STANDARDS

As detailed above, BHPs may use existing Medi-Cal benefits and procedure codes to cover many components of the HFW service model for eligible members, but there is no guidance as to how BHPs are to comprehensively claim the multiple components of the service model. DHCS proposes to develop a new Medi-Cal payment model that will cover a Medi-Cal HFW core group of services. The new payment model would cover a core group of Medi-Cal services that providers must provide to *all* Medi-Cal youth receiving HFW. Additional services and supports specific to each youth's individualized needs will also be made available for high-fidelity service delivery; these services will be covered either through Medi-Cal or other funding sources. In billing for these services, the HFW model must be provided to fidelity.

The following sections of this concept paper describe:

- The core group of HFW services to be covered through a new payment model, as well as additional Medi-Cal/non-Medi-Cal services often needed by the children and youth served by HFW;
- How a standardized decision support criteria (DSC) will be used to identify youth for whom HFW is clinically appropriate;
- The HFW team structure and HFW staff, as well as practitioner qualifications and case ratios for each HFW practitioner;
- How HFW will interact with Intensive Care Coordination (ICC) and how HFW might integrate into the broader Medi-Cal care continuum;
- The intent to establish a HFW Center of Excellence (COE) to administer training, fidelity assessments and monitoring, and ongoing technical assistance to BHPs and practitioners.

In future guidance, DHCS will establish specific service standards consistent with national and state best practices (including the CA Wraparound Standards established in ACL 25-47/BHIN 25-027) which will be subject to COE oversight and monitoring.

CA HFW Model Service Components

HFW includes four phases and associated key activities, with flexibility to align services and supports with youth and family-identified strengths and needs.[26]

About Child and Family Teams (CFTs):

A CFT is a group of people who are involved in supporting the youth and family to achieve their goals and successfully transition out of the formal child and family systems of care.[27] The youth and family are active members of the CFT and serve a key role in identifying other CFT members.

Individuals working as part of the CFT each have their own roles and responsibilities, but they work together as members of an integrated team to plan, implement, refine, and transition services, consistent with DHCS and CDSS CFT requirements.

The CFT is an integral part of HFW, supporting the youth and family by guiding the HFW process and participating in HFW plan of care implementation and is intended to be inclusive of multiple formal support systems a youth may need, as well as the community-based and natural supports surrounding a family.[28,29,30,31]

All youth needing HFW have a CFT, whether they are child welfare involved or not.

For a description of the relationship between the CFT and HFW staff, see HFW Team Functions and Staffing section.

» **1: Engagement and Team Preparation** – Initial contact between the HFW staff, youth, and family to introduce the HFW process, identify CFT members (if one

[26] Walker, J. S., Bruns, E. J., & The National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process.

[27] Transition is defined as the process of moving from formal services and supports to natural supports and out of HFW.

[28] Olson et al. (2021). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents.

[29] National Wraparound Implementation Cetner. (n.d.). Key Elements of the Wraparound Process.

[30] Donnelly, T., Coviello, K., Estep, K., & Walker, J. (2024). The Wraparound Process User's Guide: A Handbook for Families. Portland, OR: National Wraparound Initiative, Portland State University.

[31] While every youth receiving HFW will have a CFT, not every youth with a CFT will be engaged in HFW.

doesn't already exist), address immediate needs, and discuss the youth and family's needs and strengths.

» **2: Plan Development** – During this phase, the CFT develops an individualized plan of care that reflects the child or youth and family's needs, strengths, and strategies to build shared vision among the CFT.

» **3: Plan Implementation** – During this phase, the CFT meets to review and update the individualized plan of care, crisis and safety plan, and transition plan, gradually shifting responsibility from the HFW team to the family and natural supports.[32]

» **4: Transition** – During this phase, the CFT meets to prepare the youth and family for transitioning out of HFW, continuing to shift responsibility to the family and natural supports. CFT organizes one closing ceremony at the end of HFW, celebrating success to facilitate a positive transition in a way that is meaningful to the child or youth and family.

Additionally, there are ten principles intended to serve as a foundation for understanding the HFW philosophy, which experts describe as keeping youth **"at home, in school, and out of trouble."**[33]

HFW Principles

1. Family Voice and Choice
2. Strengths Based
3. Individualized
4. Natural Supports
5. Community-Based
6. Culturally Respectful and Relevant
7. Team-Based
8. Collaboration
9. Outcome-Based
10. Persistence

DHCS intends to identify a core group of Medi-Cal services ("Medi-Cal HFW core group of services") that *all* Medi-Cal youth will receive under the payment model. Consistent

[32] Empowering and promoting the long-term resilience of the family and natural support are central to the HFW theory of change.
[33] Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

with the HFW model, other formal supports must be available to youth and caregivers based on the youth and family's individualized needs. **DHCS will require that youth receive any Medi-Cal service determined clinically appropriate and necessary**, including, but not limited to, the core group of services, as well as any other family or community support that the team deems necessary for the youth's success. Note that while the core group of services will be covered as SMHS, youth who would benefit from specialty substance use disorder treatment can and should receive services covered under Drug Medi-Cal or the Drug Medi-Cal Organized Delivery System. Supports that cannot be covered through Medi-Cal can be obtained through "flexible funds" provided by sources other than Medi-Cal.

CA HFW Model Youth and Family-Centered Service Components

Medi-Cal HFW Core Group of Services	Additional Services Through Medi-Cal (Non-Exhaustive, Including Medi-Cal MCP Services)	Non-Medi-Cal Supports
» **HFW Facilitation and Coordination** » **Child Adolescent Needs and Strengths (CANS) Administration** » **Individualized Care Planning, including Safety and Crisis Planning** » **Caregiver Peer Support**	» Additional Assessments (e.g., Psychological and Neuropsychological Testing) as needed » 24/7 Support (i.e., Mobile Crisis Services) » Intensive Home-Based Services (IHBS), and therapies like Multisystemic Therapy (MST) and Functional Family Therapy (FFT) » Youth Peer Support » Caregiver Respite (Medi-Cal Managed Care) » Activity Funds	As needed, access to non-Medi-Cal supports and resources may be covered through alternative funding sources (e.g., via flexible funds). Resources available will vary by community.[34] *See the descriptions below.*

Description of Medi-Cal HFW Core Group of Services:

The composition of the Medi-Cal HFW core group of services is consistent with NWI principles and standards, other state Medicaid approaches, and CA Wraparound Standards. The following activities comprise the Medi-Cal HFW core group of services,

[34] As outlined in the HFW staff descriptions in the HFW Team Function and Staffing section, the Community Developer may also find local sources of support that are free or covered via other means.

which reflect the team functions *(outlined in HFW Team Function and Staffing section below)* and four phases of HFW:

- **HFW Facilitation and Coordination** – The initiation of, care planning for, and coordination of HFW for youth and their families. The HFW Facilitator in cooperation with the youth and caregiver works with a CFT to help the youth and family understand the CFT function and HFW process, identify immediate safety needs, develop and coordinate activities within an individualized plan of care, and establish coordination across involved child serving systems (e.g., mental health, child welfare, juvenile justice, schools, and courts) and community agencies.
- **Needs Assessment and Documentation** (CANS) – Assessments to identify the youth and family needs and strengths. The HFW staff will administer the CANS assessment and use it as a service planning tool with the CFT throughout HFW delivery to inform the individualized care plan and update it as necessary.
- **Individualized Care Planning, including Safety and Crisis Planning** – An individualized written plan to identify what the child or youth and their family need with respect to care coordination, transition planning, and connections to natural supports based their needs and preferences. The individualized plan of care includes a safety plan that identifies safety needs, risks factors for a crisis, and proactive strategies to avert and respond to crisis, while at the same time ensuring access to 24/7 crisis response as a backup.
- **Caregiver Peer Support** – Direct support to caregivers provided by Caregiver Peer Support Specialists who are part of the CFT. Peer Support helps caregivers understand and navigate the HFW process, improving their understanding of the youth's needs, and responding to the youth in ways that improve their outcomes.

The core Medi-Cal services will be accounted for in the Medi-Cal payment model, in accordance with AB 161, which specifies that DHCS will implement "a case rate or other type of reimbursement" for HFW as a Medi-Cal SMHS for members under 21 years of age.

Descriptions of Potential Youth Needs for Additional Services Through Medi-Cal (Non-Exhaustive)

- **Additional Assessments** – The HFW staff may need to refer a child or youth for additional assessment(s) (e.g., psychological and neuropsychological testing) by a licensed clinician to identify youth and family needs and strengths, as well as for other specialized supports.
- **IHBS** – Youth receiving HFW may need additional individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a

youth's functioning. IHBS activities support the engagement and participation of the youth and their significant support persons in a range of strength-based interventions. In addition, IHBS activities help the youth develop skills, such as emotional regulation[35] and can include additional therapeutic care (e.g., MST, FTT) delivered by a licensed mental health professional outside of the HFW team.

- **Youth Peer Support** – Youth living with significant behavioral health needs receiving HFW may benefit from direct support from a peer with lived experience in the child welfare, juvenile probation, or children's behavioral health system.[36]
- **Caregiver Respite** – Caregivers of youth receiving HFW may need short-term relief from addressing the significant behavioral health needs of the youth. Respite is part of a suite of Medi-Cal Community Supports available to Medi-Cal Managed Care Plan (MCP) members. For more information, see the Community Supports Policy Guide.
- **Activity Funds** – Youth involved in the child welfare system living with significant behavioral health needs may benefit from activities and items that encourage forms of expression beyond traditional therapies to support their inclusion in the community and promote improved physical and behavioral health outcomes. The BH-CONNECT Activity Funds Initiative covers some or all of the cost of these activities and items for eligible members.

"[HFW] is best implemented in the context of a community-based system of care…This means that [the HFW team] needs to ensure that a wide array of supports and interventions are considered and developed…and include a blend of [Medicaid and non-Medicaid] services and supports."

- NWI

Other Non-Medi-Cal Supports (via Flexible Funds)

In line with the "anything necessary" approach, ensuring timely access to non-Medi-Cal supports and resources outlined in the youth's HFW individualized plan of care will be required under the CA HFW model. As outlined in the HFW staff descriptions in the HFW Team

[35] DHCS. (2018). Medi-Cal manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries (3rd ed.).

[36] Per W&I Code 14045.15, Medi-Cal Peer Support Specialist must be at least 18 years of age to be certified. This does not preclude Medi-Cal Peer Support Specialists from working with youth or transitional-age youth (Medi-Cal-Peer-Support-Services-Specialist-Program-Frequently-Asked-Questions)

Function and Staffing section below, the Community Developer may also find local sources of support that are free or covered via other means.

When a need identified by the CFT is not Medi-Cal covered, flexible funds[37] must be made available to the CFT to meet youth and family needs as well as no cost community-based supports identified by the Community Developer *(a HFW staff role described in more detail below)*. These can be used for non-traditional purposes,[38] and may be covered through multiple funding sources, including, but not limited to:

- **BHSA FSP Funds**[39] – Counties may use BHSA FSP funding for any HFW service components not otherwise covered through Medi-Cal or through other funding sources. FSP will be an important source of funding for flexible funds.
- **Child Welfare Realignment Funds** – Funds may be used to support the provision of HFW for child welfare-involved youth.[40]
- **FFPSA Part IV Aftercare Allocations** – Funds may be used to support provision of six months of aftercare services utilizing the CA HFW model for foster youth who are stepping down from an STRTP or Community Treatment Facility to a family-based setting.
- **Foster Care Tiered Rate Structure Immediate Needs Funding** – Funds may be used to support the provision of HFW for youth qualifying for the Immediate Needs Program. CDSS will issue guidance in the future on the IN Program.

For other potential funding sources to support youth and families receiving HFW, see CDSS California Wraparound Funding Matrix.

[37] As noted in ACL 25-47/BHIN 25-027, the HFW Program ensures the requirements of any single funding source (e.g., BHSA, Title IV-E, CalWORKs, etc.) shall not limit the availability of flexible funding or the resources developed to meet the needs of the youth, families, Tribes and communities served by HFW.
[38] Flexible funds processes are defined by written policies that address how funds are accessed, tracked, and managed, and include a process for accessing funds quickly for emergencies.
[39] Pursuant to the BHSA, county FSP programs must implement HFW beginning in July 2026.
[40] Welf. & Inst. Code 16562, subd. (h)(1)(C)

For Stakeholder Input:

- What is your feedback on DHCS's proposed Medi-Cal HFW core group of services? Is there anything missing?
- How are flexible funds accessed currently?
- What inputs and assumptions should DHCS consider when developing the Medi-Cal payment model?

How a Youth Qualifies for HFW

Context: HFW Decision Support Criteria (DSC) Across State HFW Programs

States implementing HFW typically use standardized criteria and a decision rubric to support providers, referral partners, and plans to better identify youth and families who would benefit from HFW. The CANS is the most commonly deployed tool used to define these criteria under the term "decision support criteria" (DSC).

DSC: A standardized set of criteria to inform whether a youth and their family require the intense level of support provided by HFW.

CANS as the Basis for the HFW DSC

The CANS is an open domain tool for use in multiple youth-serving systems that assesses the needs and strengths of youth, adolescents, and their families. It is a flexible and evolving tool that supports open discussion and collaborative decision-making regarding care coordination and planning, levels of care, services, and placement (if applicable). [41] CDSS worked with the Praed Foundation to apply a machine learning approach called Latent Class Analysis (LCA) to group welfare-involved children and youth based on common needs and strengths from the Integrated Practice CANS (IP-CANS).[42] The LCA serves as the basis for the decision support model for the new Foster Care Tiered Rate Structure.

[41] For more information on CANS scoring and identification of needs and strengths, see Praed Foundation - CANS.

[42] CDSS's IP-CANS includes the core 50 items of the CANS, the ability to assess up to four caregivers, and the 12- item "CANS Potentially Traumatic/Adverse Childhood Experiences" domain.

Drawing on the CANS, DHCS will implement a uniform decision support tool for Medi-Cal and FSP HFW that can be used by providers. The support tool can help streamline referral processes across BHPs and Child Welfare agencies to better serve youth in SMHS, including those involved in the child welfare system. This is consistent with DHCS and CDSS's longstanding collaboration to further align behavioral health and child welfare use of CANS under BH-CONNECT, CDSS' Foster Care Rate Structure, and AB 161, to reduce duplicative assessments and promote consistent procedures across the agencies serving the same individuals.

DHCS also plans to work with the Praed Foundation to develop HFW CANS DSC consistent with other state approaches.[43]

Preliminary Vision: How the DSC and CANS Will Support Proactive Identification and Authorization for HFW

Timely access to HFW is critical. By adopting standardized DSC for statewide use by Medi-Cal and FSP HFW providers and BHPs, DHCS aims to support proactive identification and referrals of youth who meet SMHS access criteria. In the absence of DSC, there is a much greater risk of "missing" young people who would benefit from the model. Standardized DSC for HFW also help to reduce variation in access policies and procedures across counties, as well as to expedite clinical decision-making, as many states use their HFW DSC as the basis for medical necessity criteria for HFW. As such, the CANS assessment, completed by a credentialed provider, will inform eligibility for HFW.

DHCS will continue to design and describe the HFW DSC in greater detail in future Medi-Cal guidance. At a high level, DHCS currently proposes the following process to authorize an eligible youth for HFW, incorporating the CANS-based DSC:

- **Step 1: Referral partners submit a referral for the youth to be assessed for HFW.** A wide range of entities can refer young people and families to HFW, including but not limited to caregivers, pediatric providers, schools, behavioral health providers, BHPs, Managed Care Plans (MCPs), county child welfare agencies, Tribes, and others. These entities can refer a youth directly to a BHP-operated or BHP-contracted provider or county child welfare service provider capable of assessing the youth pursuant to Step 2; a referral to the BHP is permitted but not required.

[43] CDSS and other states are currently working with a team led by John Lyons, the creator of the CANS, to develop CANS-based DSC for the determination of need for HFW.

- **Step 2: Youth is assessed via the CANS by a certified CANS assessor (who may not be a clinician),[44] or a recent CANS is used, if appropriate**, and the CANS is submitted through the HFW DSC data system (in some cases, if a recent CANS already exists, the data could be used for this purpose, i.e., reassessment is not necessarily required). DHCS will clarify in future guidance the operational and system requirements for this submission process, which will align closely with existing processes defined in ACL 25-47/BHIN 25-027. In future guidance, DHCS will also describe how referral partners, HFW providers, and BHPs can collaborate in this process, and any associated timeliness requirements. Any individual or entity performing an initial CANS assessment, including the BHP, may immediately utilize the HFW DSC data system as described in Step 2.
- **Step 3. The DSC provides a recommendation for the youth to receive HFW based on their identified needs in the CANS.** If the youth meets criteria for HFW through the DSC, any clinician who is a behavioral health professional qualified to direct services as required in California's Medi-Cal state plan can confirm that **HFW is an appropriate service** based on DSC/CANS results.[45,46] If the clinician confirming that HFW is an appropriate service based on the DSC/CANS results is not part of the HFW provider, then the clinician will ensure the youth is referred to an HFW provider. The HFW provider confirms that they will take the referral. The HFW provider then begins to engage the youth and caregivers in the HFW process. If the provider will not take the referral for any reason, the HFW provider must inform the BHP, and the

[44] A primary goal of CANS alignment is to ensure that county child welfare agencies, county juvenile probation agencies, county behavioral health delivery systems and behavioral health providers administer the same CANS tool in an aligned way.

[45] If the initial determination is that HFW is not recommended for the youth, the youth and caregiver may appeal this decision. Consistent with federal and state law, Medi-Cal members are entitled to notice of adverse benefit determinations when a mental health plan makes a decision to deny, limit, reduce, delay or end services, including a request for HFW that is denied. Members may appeal if they do not agree with the decision and if the adverse benefit determination is upheld, Members may request a State Fair Hearing, which is an independent review conducted by an administrative law judge to ensure Members receive the behavioral health services they are entitled to under the Medi-Cal program (DHCS Behavioral Health Member Handbook Template). See also DHCS BHIN 25-014 and Enclosures.

[46] Once the initial determination has been made that HFW is an appropriate service for the youth, BHPs may not impose additional requirements, criteria, or reviews of this determination that would delay a referral to a HFW provider or initiation of HFW to the youth if a HFW provider is already engaged with the youth.

BHP will work with the referral source to find another provider who will take the referral.

- **Step 4: Communication of initial determination to youth and their family, referring entity/CANS assessor (if the clinician making the recommendation is not the same entity), and placing/child welfare agency (for welfare-involved youth) and the BHP.** If a youth qualifies for HFW, it is ultimately the youth/family's decision as to whether they wish to receive HFW.

For Stakeholder Input:

» Do you support the concept of using CANS to develop statewide, standardized DSC for HFW? What elements of the HFW DSC need further clarification?

» How can DHCS develop referral standards that support the proposed HFW process? How could the DSC be used to more proactively identify and facilitate timely access?

HFW Team Functions and Staffing

According to national and state best practices, a HFW team consists of the youth and family, natural supports, and HFW Facilitator and other paid HFW staff.

Medi-Cal HFW Staff: Each youth receiving HFW has paid supports alongside natural supports, with the youth and their caregiver(s)/family/Tribe, in the case of an Indian child, sitting at the head of this team. The Medi-Cal HFW staff consists of the paid supports staffed by the HFW provider to provide the HFW core set of services to the youth. The role of each member of the Medi-Cal HFW staff is described further below.

<table>
<tr><th colspan="2">CFT</th></tr>
<tr><td>» The youth and family
» Tribes in the case of an American Indian youth
» Natural supports approved by the youth and family and participate in the HFW plan of care implementation (e.g., caregivers, friends, chosen family)
» Representatives from other systems/services (e.g., Probation Officer, social worker, coach, teacher, Multisystemic Therapy provider) as appropriate and approved by the youth/ family</td><td>Medi-Cal HFW Staff
(Part of the CFT)
» HFW Facilitator
» Caregiver Peer Partner
» HFW Supervisor
» Licensed Clinician
» Community Developer</td></tr>
</table>

When a youth and family have HFW, the HFW Staff become part of the CFT ensuring there is one team for the youth and family that is inclusive of multiple formal support

systems (see above) a youth may need, as well as community-based and natural supports.[47]

HFW Staff Functions

The HFW staff is responsible for delivering HFW and performing the following eight functions, which encompass the Medi-Cal HFW core group of services:

1. Facilitation and Team Communication	5. Child/Youth and Family Support
2. Assessment, Care Planning and Documentation, Reassessment	6. Team Oversight, Training, and Fidelity Monitoring
3. Crisis Stabilization and Safety Planning	7. Clinical Supervision and Oversight
4. Care Coordination, Referrals, System of Care Linkages	8. Care Transition Support

Many of these HFW team functions overlap and can be performed by the same individual.[48] Consistent with DHCS's Comprehensive Quality Strategy and MHP contract requirements,[49] teams are expected to delivery culturally responsive care and observe National CLAS Standards, which describe a framework to deliver services that are culturally and linguistically appropriate and respectful, and that respond to individuals' cultural health beliefs, preferences and communication needs.

[47] CDSS. (n.d.). Child and Family Teams Resources.
[48] The proposed HFW staff model largely reflects the CA Wraparound Standards, which state that "[HFW] staff consists of individuals with specific roles *(which can be overlapping),* each with a distinct purpose designed to assist youth, caregivers and the CFT to engage in and move through the stages of the [HFW] process."
[49] MHP Contract Exhibit A, Attachment 7: "The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (42 C.F.R. § 438.206(c)(2).

HFW Staff Descriptions and Preliminary Practitioner Qualifications

DHCS proposes a staffing model that has five different roles for team members. To receive Medi-Cal reimbursement for HFW, each staff member must be a qualified SMHS practitioner type (with the possible exception of the Community Developer role, as described in the table below).[50] When developing Medi-Cal rates for BHPs, DHCS will make informed assumptions about the SMHS practitioner types most likely to perform these roles. However, DHCS does not propose to require that all roles be held by specific practitioner types

DHCS will establish staffing ratios for key functions, consistent with the evidence-based model. There will be no caseload requirement per team but rather, ratios of staff to deliver high fidelity care, as explained in the table.

HFW Staff Role	Description and Staffing Ratio (As Applicable)	Preliminary Practitioner Qualifications
HFW Facilitator	Works with the youth and family to identify CFT members and leads the HFW team to develop and implement the youth/family's HFW plan of care in the context of the CFT. Works with the youth and their caregiver(s) to develop ownership of and be prepared to manage their own plan at transition. **Each HFW Facilitator is expected to serve ten youth and families.**	May hold a combination of education (H.S., AA, BA, MA) and/or experience that prepares them to perform the role, including the ability to provide care coordination and lead a CFT. May be a licensed, or non-licensed, SMHS practitioner.

[50] DHCS. (2024, December). California State Plan Supplement 3 To Attachment 3.1-A.

HFW Staff Role	Description and Staffing Ratio (As Applicable)	Preliminary Practitioner Qualifications
HFW Supervisor	Responsible for the recruitment, selection, training, coaching and management of the members of the HFW team who provide direct services to youth and families. Ensures that team members follow the HFW process with fidelity. The Supervisor will work with members of the team, but not necessarily directly with the youth and their family except during formal CFT meetings.[51] **Each HFW Supervisor is expected to work with eight HFW Facilitators.**	Must have a BA or MA level education, or equivalent combination of education and experience. May be a licensed, or non-licensed, SMHS practitioner.

[51] CFT meeting is a collaborative, strengths-based planning process that brings together the youth and their family, natural supports, and professionals from various systems to develop and monitor a unified, culturally responsive plan of care. CFT meetings occur regularly and during key transitions. If the youth and family are receiving HFW, every CFT team meeting should also be a HFW team meeting.

HFW Staff Role	Description and Staffing Ratio (As Applicable)	Preliminary Practitioner Qualifications
Caregiver Peer Partner	Directly supports and engages caregivers new to the HFW process, such as by educating them about how the CFT works, as well as by identifying shared values and experiences that they have in common with the caregiver receiving HFW. Supports caregivers to understand their youth's behaviors and to try new approaches to caregiving. Caregiver Peer Support is integral to ensuring HFW delivery is youth and family-driven. **Each Caregiver Peer Partner is expected to work with eight youth/families.**	Must be a Peer Support Specialist with lived experience (past or present) raising a youth living with significant behavioral health needs, involved with child welfare, and/or involved with the juvenile justice system. Must have a current state-approved certification as a Medi-Cal Peer Support Specialist and must meet all other applicable state requirements, including ongoing continuing education requirements.[52,53,54]

[52] For Peer Support Services components, refer to BHIN-25-010.

[53] DHCS guidance clarifies under SPA 22-0024, and according to CMS' Clarifying Guidance on Peer Support Services Policy, that Peer Support Services are available to parents/legal guardians of beneficiaries 17 years of age and younger when the service is directed exclusively toward the benefit of the beneficiary.

[54] Caregiver Peer Partners must secure CalMHSA Medi-Cal Peer Support Specialist certification. DHCS does not typically require Medi-Cal Peer Support Specialists who work in a specialization (e.g., caregiver peer) to complete specialization training before providing Medi-Cal Peer Support Services (Medi-Cal Peer Support Services Specialist Program - FAQs). For HFW, specialization training may be recommended or required (e.g., National Federation of Families Family Peer Specialist Certification).

HFW Staff Role	Description and Staffing Ratio (As Applicable)	Preliminary Practitioner Qualifications
Licensed Clinician *Note: As with other HFW staff roles, the Licensed Clinician may be directly employed by the HFW provider or through a contracted entity.*	Supports non-clinical staff in providing engagement and clinical consultation to possible intensive interventions (e.g., crisis management), and assessments for youth and families and works with the HFW Supervisor, who assures that the staff are timely and collaborative. Both the Licensed Clinician and the HFW Supervisor are present for HFW staff oversight; they help to ensure adequate training and play an important role in fidelity monitoring.[55] **The licensed clinician is not a therapist for the youth. Each Licensed Clinician is expected to consult with and support four HFW teams.**	Must be a licensed SMHS practitioner (e.g., Psychiatrist, Nurse Practitioner, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, or Licensed Marriage and Family Therapist).

[55] The Licensed Clinician can also supervise team members who are pre-licensed professionals (e.g., AMFT, ASW APCC) and seeking individual licensure in accordance with CA state licensure requirements and provide the team with education utilizing Evidence-Based-Practices to foster specialized treatments such Trauma Focused Cognitive Behavioral Therapy (TF-CBT), MST, and substance use disorder treatment.

HFW Staff Role	Description and Staffing Ratio (As Applicable)	Preliminary Practitioner Qualifications
Community Developer	An ancillary staff role to support the HFW staff in identifying and facilitating coordination of community resources.[56] Identifies natural supports for the young person or their family (e.g., recreational programs, neighborhood and civic organizations, etc.). This role allows other HFW staff (e.g., the HFW Facilitator) to spend more time directly serving the youth and family and less time locating services in the community.	Must have a BA or MA level education, or equivalent combination of education and experience with identifying community resources and addressing health-related social needs (including Medi-Cal Community Supports). DHCS is considering the option for this role, which typically supports the HFW staff rather than providing direct support or care to the youth and family, to be performed as part of external technical assistance, e.g., a COE.

[56] Ohio and Illinois Medicaid HFW staffing models include the Community Developer role.

Note: The HFW Fidelity Coach[57] is an additional role defined under the CA Wraparound Standards. As noted above, team members like the HFW Supervisor must play a role in coaching the team to deliver HFW with fidelity. There are also distinct fidelity training and monitoring functions which DHCS proposes to be incorporated into a HFW COE. **In other words, DHCS envisions that both HFW staff members and an external training and technical assistance will take part in supporting high fidelity service delivery and is seeking stakeholder comment on whether this role should be preserved a distinct role within the HFW staff.**

For Stakeholder Input:

- What additional practitioner qualifications (e.g., education, training, experience), if any, should DHCS consider for each HFW staff role?
- Are the proposed HFW team ratios appropriate? If not, please suggest the appropriate staff ratios.
- Do you foresee barriers to ensuring access to certified Caregiver Peer Partners?
- Does a HFW provider require a HFW Fidelity Coach role, consistent with the current CA Wraparound Standards? What is your feedback on DHCS's proposal to assign some fidelity coaching functions to an external COE (while acknowledging that HFW team members must play a role in assuring fidelity as well)?

Interaction With Existing SMHS and Medi-Cal MCP Care Management Services

Intensive Care Coordination (ICC) and HFW

In 2013, DHCS implemented ICC in Medi-Cal. ICC is an SMHS Targeted Case Management (TCM) service that facilitates the assessment of, care planning for, and coordination of services. The Medi-Cal Manual for ICC, IHBS, and TFC for Medi-Cal Beneficiaries (Third Edition) provides information and guidelines for the delivery of ICC. ICC was implemented in response to litigation[58] that sought to provide access to high-

[57] CDSS, CA Wraparound Standards Toolkit

[58] Katie A. et al. v. Diana Bonta et al. (the "Katie A. Litigation"), filed July 18, 2002, in the U.S. District Court for the Central District of California, case no. 02-05662. The Katie A.

intensity community-based services to youth who were both SMHS and child welfare involved.

As currently implemented in California, ICC functions as a form of Wraparound. Notably, ICC does not require fidelity to an evidence-based model, as the evidence base was still emerging when ICC was introduced in 2013. Based on state best practices and recent research, HFW represents an updated and evidence-based approach to delivering ICC, centering the role of the CFT in service planning, empowering the CFT to lead care delivery, and adhering to fidelity standards[59] as the gold standard of implementing the CFT process. This aligns with the original intent of implementing ICC in CA following the Katie A. Litigation.

> "ICC provides a general framework for the [HFW] intervention without a specific practice model. As a result, many communities across the country have chosen to implement [HFW] as their approach to ICC."
>
> - Substance Abuse and Mental Health Services

To improve the effectiveness of ICC, DHCS proposes to update the way that ICC is delivered by requiring adherence to the evidence-based way of delivering the service—by providing HFW facilitation. In other words, SMHS ICC will become HFW Facilitation.

In addition, DHCS intends to explicitly offer to youth receiving ICC the ability to automatically qualify for HFW, effectively "grandfathering" any youth who is receiving ICC into HFW.

Interaction With Other Medi-Cal SMHS

Other Medi-Cal SMHS may interact and overlap with HFW. While most services may be provided concurrently (members may be enrolled in/receive both programs/services at the same time), some services may be duplicative, and members may not receive both HFW and some SMHS at the same time. SMHS that may and may not be delivered concurrently with HFW are outlined below.

Litigation settlement requires the provision of medically necessary Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TCS) – often referred to as "Katie A. Services."

[59] SAMHSA. (2019). Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles.

Youth who do not need HFW but could benefit from "lighter touch" behavioral health case management services could still receive covered SMHS TCM as appropriate.[60] During the Transition Phase of HFW, it is especially important that the HFW team plan for the range of supports and care coordination needs that persist beyond HFW as a glidepath towards improved functioning in the community.

SMHS	Preliminary Overlap Policy with HFW
IHBS	Allowed concurrently.
Day Treatment Rehabilitative	Allowed concurrently so long as they are not provided during the same hours of the day as HFW is being provided to the youth.
Day Treatment Intensive	
Group Therapy	
Therapeutic Behavioral Services	Allowed concurrently so long as they are provided by different, individual, qualified practitioners, to or on behalf of the same member.
Mental Health Services	Allowed concurrently.
Therapeutic Foster Care (TFC)	Allowed concurrently.
MST	Allowed concurrently.
FFT	
Assertive Community Treatment (ACT)	Allowed concurrently for transitional age youth, or TAY* in the event that an individual needs ongoing support from the HFW staff while transitioning to ACT. Outside of a transition period, receipt of both of these models/services at the same time would be duplicative. *Note: This will be defined further in Medi-Cal guidance*.
Inpatient, Residential, and Psychiatric Health Facility Services	Allowed concurrently to promote continuity of care and discharge planning. *Note: This will be defined further in Medi-Cal guidance*.

[60] Youth can also receive care management services provided by the Medi-Cal managed care plans (MCPs).

SMHS	Preliminary Overlap Policy with HFW
Mobile Crisis Services, Crisis Stabilization, and Crisis Intervention	Allowed concurrently. Crisis Stabilization may be provided concurrently so long as it is not provided during the same hours of the day as HFW is being provided to the youth. *Note: This will be defined further in Medi-Cal guidance*.
SMHS TCM	May not be provided concurrently
Coordinated Specialty Care (CSC) for First Episode Psychosis	Allowed concurrently for transitional age youth, or TAY* in the event that an individual needs ongoing support from the HFW staff while transitioning to CSC. Outside of a transition period, receipt of both of these models/services at the same time would be duplicative. *Note: This will be defined further in Medi-Cal guidance*.

*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, as medically necessary and clinically indicated.

**DHCS. (2024, December). BH-CONNECT Evidence-Based Practices Policy Guide.

DHCS proposes that claiming for HFW is allowed in all places of service. DHCS will outline standards for receipt of SMHS when a youth is transitioning from a juvenile setting in forthcoming policy guidance.[61]

HFW and Other SMHS in Context of the Medi-Cal Continuum of MCP Care Management Services

HFW is part of a continuum of services available through Medi-Cal to support youth living with behavioral health needs. DHCS intends to provide more details on how Medi-Cal HFW relates to other community-based services in the future.

In July 2023, DHCS implemented ECM services for children and youth, which serves as the highest level of care management services in managed care. Medi-Cal MCPs also provide Complex Care Management (CCM) and Basic Population Health Management (BPHM) services, including care coordination, under Population Health Management (PHM), a cornerstone of CalAIM. SMHS provides TCM.

DHCS will need to determine how MCP care management services interact, whether they are allowed concurrently with SMHS, and provide guidance as to how to choose

[61] DHCS. (2023, October). Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative.

one of these services as a stepdown service post HFW, as needed. Current Medi-Cal policy guidance states that it is important for MCPs, BHPs, and providers to ensure the non-duplication of care management services but does not specify how to do so. For example, in the current ECM Policy Guide (including for CA Wraparound, ACT, ICC and others) guidance specifies that ECM may be provided concurrently with these care management services.[62]

For Stakeholder Input:

- What standards are currently used to determine the appropriateness of referring a youth to HFW versus relying on other care management services? Are these standards applied consistently?
- Do some children receiving HFW need an MCP care management service, such as ECM, to assist with coordination of physical health care services—particularly if they have complex physical health needs—or is this duplicative?
- What lessons from the field can be shared about the value of concurrent use of HFW alongside MCP care management models (e.g., use cases, and service delineation)?

Fidelity, Quality, and Oversight

Overview

Studies suggest that adherence to and monitoring of fidelity to the HFW evidence-based model are key components of successful HFW implementation and subsequent improved outcomes among youth.[63,64,65] Best practice states that while monitoring fidelity is a necessary component of quality oversight, there is a need for accompanying quality measurement to determine if HFW is effective and meeting its intended outcomes. DHCS is planning a robust approach to oversight, quality measurement (to assess if the services meet their intended outcomes, with corresponding data sources),

[62] See the CalAIM Enhanced Care Management Policy Guide (2024, August) and BH-CONNECT Evidence-Based Practice Policy Guide (2024, December)
[63] Bruns, E. (2008). The evidence base and wraparound.
[64] Bruns et al. (2014). Effectiveness of wraparound versus case management for children and adolescents: Results of a randomized study.
[65] Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: a meta-analysis.

and a fidelity monitoring strategy to refine and improve the fidelity of the practice model. These requirements will be further developed and detailed in future Medi-Cal guidance.

Preliminary DHCS Monitoring and Oversight of HFW With a Center of Excellence (COE)

Building upon existing processes underway to implement the CA HFW Model under FFPSA aftercare as outlined in ACL 25-47/BHIN 25-027, DHCS seeks to establish a COE to support the implementation of the CA HFW Model. The COE will administer provider training, fidelity assessments and monitoring, and ongoing technical assistance to BHPs and practitioners consistent with EBPs outlined in BH-CONNECT and BHT. The extent of monitoring and oversight activities conducted by the COE are subject to funding availability.

CA Context: Fidelity and Outcomes

CDSS is partnering with UC Davis and the NWI's Wraparound Evaluation and Research Team (WERT) to pilot a statewide Continuous Quality Improvement (CQI) approach with existing CA Wraparound programs. In partnership with CDSS, DHCS will complement and build upon existing work underway to refine the CQI and monitoring of HFW under Medi-Cal, in large part through the role the COE will serve in supporting providers and BHPs with implementing the HFW model. As noted at the beginning of this paper, DHCS and CDSS recently published guidance on requirements for HFW delivered as FFPSA aftercare services; DHCS and CDSS intend to collaborate to ensure there are consistent standards and requirements for CA HFW in the context of Medi-Cal, BHSA, and FFPSA aftercare.

Aligned with NWI fidelity indicators, Wraparound leaders in California developed fidelity indicators with UC Davis Resource Center for Family Focused Practice and NWI's WERT to ensure youth and families receive the HFW model as informed by NWI's fidelity index:

HFW Fidelity Indicators	
» Timely Engagement and Planning » Led by Youth and Families » Strength-Based » Needs Driven » Individualized » Use of Natural and Community-Based Supports	» Culturally Respectful and Relevant » High-Quality Team Planning and Problem Solving » Outcomes Based Process » Persistence » Transitions as Part of HFW Phase Four

For information on the national context of team oversight and fidelity tools, please see the Appendix.

Consistent with other EBPs under BH-CONNECT and BHSA,[66] DHCS is developing a process for providers to become approved to provide HFW under the new Medi-Cal payment model. This process will be called HFW Medi-Cal Fidelity Designation. Medi-Cal HFW teams will be required to meet fidelity requirements specified by DHCS for the BHP to claim Medi-Cal payment for HFW. Therefore, fidelity assessments will be conducted by a COE on a regular cadence.

The expected outcomes outlined below are aligned with those detailed in ACL 25-47/BHIN 25-027 in the context of FFSPA Part IV aftercare. DHCS and CDSS will continue to collaborate to refine the outcomes and data sources used to evaluate the effectiveness of HFW in the following areas, in partnership with the HFW COE.

HFW Expected Outcomes	
» Youth and Family Satisfaction » Improved School Functioning » Improved Functioning in the Community » Improved Interpersonal Functioning » Increased Caregiver Confidence	» Stable and Least Restrictive Living Environment » Reduced Justice Involvement » Reduction in Inpatient, Emergency Department Admission for Behavioral Health Visits » Reduction in Crisis Visits » Positive Exit from HFW

[66] Such as ACT and CSC (see BHIN 25-009 for ACT and CSC fidelity requirements).

These outcomes align with other states' HFW programs and DHCS behavioral health initiatives, including statewide behavioral health goals (outlined in the BHSA County Policy Manual, Section E.6.1), BHT/BH-CONNECT priority populations, and BH-CONNECT Incentive Program measures (see the Appendix).

For Stakeholder Input:

- What is an appropriate timing of an initial fidelity assessment? Cadence of ongoing fidelity assessments by the COE?
- What specific measures and/or data sources should be captured as part of the continuous quality improvement (CQI) approach to measure the outcomes described above?

CONCLUSION AND NEXT STEPS

DHCS will implement HFW within SMHS to deliver evidence-based, consistent, community-based care to high-needs youth. To achieve this, DHCS will align Medi-Cal HFW service requirements with modern national practice standards, as well as existing standards for CA Wraparound,[67] align policy and implementation support with HFW requirements under BHSA, and implement a corresponding payment model and monitoring policies within Medi-Cal SMHS.[68] DHCS is seeking input from a broad range of stakeholders on the concepts presented in this paper.

As an immediate next step, DHCS invites the public to comment on this draft concept paper. See a compiled list of Stakeholder Questions in the Appendix below. **Comments are due by 5 p.m. PT, August 21, 2025. Comments may be submitted to BH-CONNECT@dhcs.ca.gov** with the subject line "Comments on Proposed Medi-Cal HFW Service Requirements Aligned With National Practice Standards."

[67] ACL 25-47/BHIN 25-027, Appendix, CA Wraparound Standards
[68] Welf. & Inst. Code 16562, subd. (h)(1)(C)

APPENDIX

Summary of Questions for Stakeholder Input

1. What is your feedback on DHCS's proposed Medi-Cal HFW core group of services? Is there anything missing?
2. How are flexible funds accessed currently?
3. Do you support the concept of using CANS to develop statewide, standardized DSC for HFW? What elements of the HFW DSC need further clarification?
4. How can DHCS develop referral standards that support the proposed HFW process? How could the DSC be used to more proactively identify and facilitate timely access?
5. What additional practitioner qualifications (e.g., education, training, experience), if any, should DHCS consider for each HFW staff role?
6. Are the proposed HFW team ratios appropriate? If not, please suggest the appropriate staff ratios.
7. Do you foresee barriers to ensuring access to certified Caregiver Peer Partners?
8. Does a HFW provider require a HFW Fidelity Coach role, consistent with the current CA Wraparound Standards? What is your feedback on DHCS's proposal to assign some fidelity coaching functions to an external COE (while acknowledging that HFW team members must play a role in assuring fidelity as well)?
9. What standards are currently used to determine the appropriateness of referring a youth to HFW versus relying on other care management services? Are these standards applied consistently?
10. Do some children receiving HFW need an MCP care management service, such as ECM, to assist with coordination of physical health care services—particularly if they have complex physical health needs—or is this duplicative?
11. What lessons from the field can be shared about the value of concurrent use of HFW alongside MCP care management models (e.g., use cases, and service delineation)?
12. What is an appropriate timing of an initial fidelity assessment? Cadence of ongoing fidelity assessments by the COE?
13. What specific measures and/or data sources should be captured as part of the continuous quality improvement (CQI) approach to measure the outcomes described above?

Alignment with Statewide Behavioral Health Goals:

HFW Expected Outcomes	Statewide Behavioral Health Goals	
Youth and Family Satisfaction	Goals for Improvement	Quality of Life, Care Experience
Improved School Functioning		Social Connection, Engagement in School
Improved Functioning in the Community		Social Connection, Engagement in Work (as applicable)
Improved Interpersonal Functioning		
Stable and Least Restrictive Living Environment	Goals for Reduction	Homelessness, Institutionalization, Removal of Children from Home
Reduced Justice Involvement		Justice-Involvement
Reduction in Inpatient, Emergency Department Admission for Behavioral Health Visits		Untreated BH Conditions, Suicides, Overdoses, Institutionalization
Reduction in Crisis Visits		
Increased Caregiver Confidence	*These measures are more specific to the HFW model than Statewide Behavioral Health Goals. DHCS will discuss how to monitor these outcomes in Medi-Cal guidance.*	
Positive Exit from HFW		

BH-CONNECT Incentive Program Measures

BH-CONNECT supports a $1.9 billion incentive program (the Access, Reform and Outcomes Incentive Program) to reward participating BHPs for demonstrating improvements in access to behavioral health services and outcomes among Medi-Cal members living with significant behavioral health needs. BH-CONNECT Incentive Program includes a measure on increased utilization of HFW, as well as several measures intended to improve access to and efficacy of HFW delivery. DHCS intends to work with the HFW COE to refine additional measures which may be relevant to HFW.

BH-CONNECT Incentive Program Measure Areas[69]
Area of Focus: Improved Access to Specialty Behavioral Health Services
1. Improve Penetration and Engagement in Specialty BH Services *(within DMC-ODS delivery system)*
2. Improve Performance on Timely Access Standards for Specialty BH Services
3. Increase Utilization of EBPs for Adults (ACT, Forensic ACT (FACT), CSC, Individual Placement and Support (IPS) Supported Employment, Community Health Worker Services, Peer Support Services, Clubhouse Services)
4. Increase Utilization of EBPs for Children, Youth and Adolescents (HFW, MST, PCIT, FFT, Parent-Child Interaction Therapy (PCIT))
5. Increase Utilization of ECM)
Area of Focus: Improved Health Outcomes and Quality of Life
6. Pharmacotherapy for Opioid Use Disorder (POD) *(within DMC-ODS delivery system)*
7. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
8. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
9. Improve Patient-Reported Quality of Life (QOL)
10. Improve Health Outcomes and QOL Among Members Receiving ACT, CSC, and IPS Supported Employment (ED Visits, Hospital Admissions, Homelessness, Justice Involvement, School/Work Involvement, QOL)
Area of Focus: Targeted Behavioral Health Delivery System Reforms
11. Receive Approval of Plan to Address County-Specific Behavioral Health Delivery System Gaps
12. Reduce County-Specific Quality Improvement Gaps Identified in National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organizations (MBHO) Assessment (follow-up submissions related to NCQA MBHO assessment gap-filling plan)
13. Demonstrate Improved Data Sharing for the Behavioral Health Population
14. Improve Identification and Outreach to Member Population Eligible for Specialty BH Services
15. Increase Capacity to Deliver Crisis Services

[69] Centers for Medicare and Medicaid Services. (2025, January). Access, Reform and Outcomes Incentive Program Protocol. (121-130).

Fidelity, Quality, and Oversight

National Context: Team Oversight and Fidelity Tools

Several fidelity and implementation support tools will inform the Medi-Cal monitoring approach. NWI's Wraparound Fidelity Assessment System (WFAS) has constructed tools used to regularly assess fidelity through multiple methods, including team observations, documentation reviews, and/or youth, family, and HFW team member surveys.

States use national guidelines to monitor fidelity to the practice model, including the use of fidelity monitoring tools. The WERT is the "accountability wing" of NWI. WERT develops and disseminates evaluation measures that support HFW implementation such as the WFAS, a multi-method approach to assessing the quality and fidelity of HFW. WFAS instruments include surveys of multiple stakeholders, a team observation measure (TOM), a document review measure, and an instrument to assess the level of community and system support for HFW as follows:

- Wraparound Fidelity Index, Brief Version (WFI-EZ): evaluates HFW implementation fidelity, caregiver and youth satisfaction, and family outcomes.
- Team Observation Measure (TOM), Version 2.0: evaluates the quality of CFT meetings across seven domains using 36 indicators to provide a comprehensive fidelity score.
- Document Assessment and Review Tool (DART): evaluates the family's HFW experience over time using 51 items across ten domains based on various documentation.
- Community Supports for Wraparound Inventory (CWI): measures local system support for HFW, providing a quantitative profile across multiple domains for identifying strengths and challenges, and monitoring improvements over time.
- Wraparound Structured Assessment and Review (WrapSTAR): evaluates a site's HFW implementation strengths and needs by combining various assessment tools for a comprehensive approach to quality improvement and accountability.