Civil SERVICE COMMISSION
CITY AND COUNTY OF SAN FRANCISCO

CIVIL SERVICE COMMISSION REPORT TRANSMITTAL (FORM 22)

Refer to Civil Service Commission Procedure Number Two for Instructions on Completing and Processing this Form

1. Civil Service Commission Register Number: _____ - _____ -

2. For Civil Service Commission Meeting of: May 4, 2026

3. Check One: Ratification Agenda

   Consent Agenda

   ☒ Regular Agenda

   Human Resources Directorσ Report

4. Subject: Personal Services Contract PSC 0005086 – 24/25

5. Recommendation: Adopt the report

6. Report prepared by: Mirna Palma Telephone number: 415-416-7256

7. Notifications: **(See attached a list of the persons to be notified per IV. Commission Report Format**

8. Reviewed and approved for Civil Service Commission Agenda:

   Human Resources Director:

   Date:

9. Submit the original time-stamped copy of this form and person(s) to be notified (see Item 7 above) along with the required copies of the report to:

   Executive Officer
   Civil Service Commission
   25 Van Ness Avenue, Suite 720
   San Francisco, CA 94102

10. Receipt-stamp this form in the ACSC RECEIPT STAMP≅ box to the right using the time-stamp in the CSC Office.

CSC RECEIPT STAMP

Attachment

Contact information for notifications:

Department of Human Services, Trent Rhorer, trent.rhorer@sfgov.org
Department of Human Resources, Carol Isen, carol.isen@sfgov.org
Department of Human Services, Daniel Kaplan, daniel.kaplan@sfgov.org
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SAN FRANCISCO
HUMAN SERVICES AGENCY

Department of Benefits and Family Support

Department of Disability and Aging Services

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San Francisco, CA
94120-7988
www.SFHSA.org

Date: May 4, 2026

To: Kate Favetti, President, Civil Service Commission
Sandra Eng, Executive Director, Civil Service Commission
Members of Civil Service Commission

From: Mirna E. Palma, Talent Acquisition, Assessments and Classification Manager

RE: Request for a Feasibility Study on Personnel Services Contract 0005086

Background

On April 7, 2025, the Human Services Agency (HSA) presented Personal Services Contract 0005086 – 24/25 to the Civil Service Commission for Wraparound Program services delivered by a community-based organization (CBO). During the meeting, Commission President Kate Favetti requested additional information regarding the scope of services and whether these duties could be feasibly performed by existing City classifications to bring the work in-house.

Wraparound is a state-authorized program established under Senate Bill (SB) 163 (1997), codified in Welfare & Institutions Code §§ 18250–18258. The Legislature authorized counties to develop expanded family-based service alternatives to group home care, including individualized "wrap-around" services built on child and family strengths and tailored to unique, changing needs. The statute's intent is to provide service alternatives that keep children in home and community settings rather than institutional placement. [1] [2]

California's High Fidelity Wraparound model requires adherence to four phases (Engagement, Plan Development, Implementation, Transition) and ten principles (Family Voice & Choice; Strengths-Based; Individualized; Natural Supports; Community-Based; Culturally Respectful and Relevant; Team-Based; Collaboration; Outcomes-Based; Persistence) to ensure

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consistent quality and outcomes statewide. These practice elements depend on mobility, flexibility, and strong community presence and partnerships.

State guidance identifies the Integrated Practice , Child and Adolescent Needs and Strengths (IP-CANS) as the tool for assessment and care planning within California Wraparound, and clarifies that county Wraparound programs are administered and managed at the county level, with services being delivered by community-based organizations.

Scope of Work

The Wraparound program's goal is to deliver individualized, community-based support that prevents placement into higher levels of care and maintains youth in stable home or family environments. Our community partner operates in neighborhoods and community spaces where families live and gather, these settings reduce barriers to engagement, increase consistent participation, and enable early intervention.

Family Children Services (FCS) provides administrative oversight of the Wraparound program. A Monthly Oversight Committee monitors fidelity to the state model, quality and effectiveness of service, outcome trends, and the identification of community resources, and incorporates input from youth, families, natural supports, and Native American tribes (as applicable) which are elements required by Wraparound's principles and team-based design [3]

Services provided under this contract include:

- Providing intensive case management to include crisis intervention and management on a 24-hour basis, seven (7) days a week.
- Timely engagement (first contact within 10 days; Plan of Care within 30 days)
- Coordinating, selecting, and convening the Family Team meetings and facilitating the program planning process, i.e., individualized, family-centered, strength-based, and needs driven.
- Solidifying wraparound and mental health services from a network of providers and completing appropriate service authorizations and agreements. (These professionals are specialized and trained in unique Wraparound methods and approaches to ensure effectiveness and efficiency in the de[i]livery of services).

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- Providing services to the family in their home setting, these require intensive and frequent visits, often within a 90-mile radius
- Developing, coordinating, and providing formal and informal support and services, such as home-based and community-based, provided by professional and non-professionals.
- Collaborating with Tribal partners when serving a Native American child.
- Ensuring the family can move toward independence through natural supports over time

Wraparound services incorporate several City and County of San Francisco Departments/Agencies, such as the Department of Public Health (DPH), the Juvenile Probation Department (JPD), and the Human Services Agency (HSA). DPH has contracted services through the same CBO as HSA does, this gives our youth and their families better access to services from both departments.

Feasibility Analysis

HSA evaluated statutory requirements, statewide standards, staffing resources, operational capacity, and fiscal implications. Based on these factors, it is not feasible to deliver Wraparound internally.

SB 163 authorizes counties to use funding flexibly to develop family-based service alternatives to group home care, including individualized Wraparound services tailored to child and family needs in home and community settings. This legislative intent emphasizes community-rooted, family-driven supports that differ from traditional government delivery structures [1] [2]. We conducted a survey of all nine Bay Area counties and found that they all nine counties outsource Wraparound services.

California's Wraparound framework requires adherence to statewide standards, tools (IP-CANS), and fidelity practices; providers must be certified to deliver services under the High Fidelity Wraparound model, these requirements provided via state guidance (e.g., ACL 25-47/BHIN 25-027) and county plan/provider certification processes. Building this certification capacity in-house would impose significant training, and implementation costs and lengthy implementation timelines.[5] [4]

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FCS is currently facing a 24% vacancy rate, persistent recruitment and retention challenges in permanent civil service classifications, budget constraints as well as on-going workforce reductions. Building up a new, intensive 24/7 field program within this environment is not feasible. Additionally, meeting Wraparound certification and training requirements would add material costs that are unfunded at this time. [5]

Wraparound requires 24-hour availability, evening/weekend/overnight coverage, rapid crisis response in the field, and frequent travel across a 90-mile radius. While HSA operates a 24-hour hotline and some on-call functions, we do not currently provide individualized, 24-hour, community-based services, and recruiting to sustain those shifts would be difficult. The Wraparound principles and phases necessitate consistent community presence, team facilitation, and inclusion of natural supports, all of which are more feasibly provided by a CBO embedded in the community [3] [6]

The cost associated with bringing Wraproud in-house would increase in the form of premium pay for non-standard shifts, significant new overhead cost (office space, vehicles, supervision as well as training and certification costs to comply with Wraparound standards and guidance. [5]

Partnering with a qualified CBO allows us to maintain service continuity during ongoing budget constraints, in addition to maintaining fidelity to statewide standards and practices, and to have an embedded community presence and partnerships and the ability to scale and respond rapidly to field conditions and crisis needs, capabilities aligned with California's model and guidance [4] [3]

Given state statutory intent (SB 163), the requirements of California's High Fidelity Wraparound Standards, current staffing constraints, operational demands, and fiscal impacts, bringing Wraparound services in-house is not feasible. Partnering with a certified community-based organization (CBO) is the approach contemplated by California's Wraparound framework to ensure youth receive flexible, culturally responsive, and community-driven services

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that counties administer and oversee but are not structurally equipped to deliver within HSA at high fidelity. [1] [2] [3] [4]

Therefore, HSA requests approval of this feasibility analysis and continued authorization to contract for Wraparound services under Personal Services Contract 0005086.

References

1 SB 163 (1997) – Chaptered Bill Text (WIC §§ 18250–18258): California Legislative Information PDF
2 California High Fidelity Wraparound County Plan Approval and Provider CertificationCDSS California Wraparound Program & IP-CANS: cdss.ca.gov/inforesources…/wraparound
3 California High Fidelity Wraparound Approval/Certification | Continuing and Professional Education | Human Services
4 California Department of Health Care Services ACl 25 47 BHIN 25 027
5 Wraparound Background History www.cdss.ca.gov/inforesources/cdss-programs/foster-care/wraparound/background-history
6 Medical High Fidelity Wraparound Concept Paper https://www.dhcs.ca.gov/Documents/ACL-25-47-BHIN-25-027.pdf

REFERENCE 1

Senate Bill No. 163

CHAPTER 795

An act to amend Sections 18250, 18251, 18252, 18253, 18254, 18255, 18256, and 18257 of, to amend the heading of Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 of, and to add Sections 18253.5 and 18256.5 to, the Welfare and Institutions Code, relating to public social services.

[Approved by Governor October 8, 1997. Filed with Secretary of State October 9, 1997.]

LEGISLATIVE COUNSEL'S DIGEST

SB 163, Solis. Children: wrap-around services.

Existing law creates the Aid to Families with Dependent Children-Foster Care program, under which a combination of federal, state, and county funds are used to provide reimbursement to families and facilities providing foster care to eligible children.

Existing law also requires each county to provide child welfare services.

Existing law also provides, until July 1, 2001, for the establishment in Santa Clara County, at the county's option, of a pilot project to continue the provision of intensive wrap-around services, as defined, to eligible children in foster care or at imminent risk of this placement. These provisions would be repealed on January 1, 2002.

This bill would, instead, permit each county to participate in this pilot project, if approval for the county's participation is given by the State Department of Social Services, and would make various other changes in these pilot project provisions.

The bill would also extend the operative date of these provisions until October 1, 2003, and the date of their repeal until April 1, 2004.

The people of the State of California do enact as follows:

SECTION 1. The heading of Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 of the Welfare and Institutions Code is amended to read:

CHAPTER 4. COUNTY WRAP-AROUND SERVICES PILOT PROJECT

SEC. 1.5. Section 18250 of the Welfare and Institutions Code is amended to read:

18250. (a) It is the intent of the Legislature that all counties be authorized to provide children with service alternatives to group home care through the development of expanded family-based

services programs. These programs shall include individualized or "wrap-around" services, where services are wrapped around a child living with his or her birth parent, relative, adoptive parent, licensed or certified foster parent, or guardian. The wrap-around services developed under this section shall build on the strengths of each eligible child and family and be tailored to address their unique and changing needs.

(b) It is further the intent of the Legislature that the pilot project include the following elements:

(1) Making available to the county the state share of nonfederal reimbursement for group home placement, minus the state share, if any, of any concurrent out-of-home placement costs, for children eligible under this chapter, for the purpose of allowing the county to develop family-based service alternatives.

(2) Enabling the county to access all possible sources of federal funds for the purpose of developing family-based service alternatives.

(3) Encouraging collaboration among persons and entities including, but not limited to, parents, county welfare departments, county mental health departments, county probation departments, county health departments, special education local planning agencies, school districts, and private service providers for the purpose of planning and providing individualized services for children and their birth or substitute families.

(4) Ensuring local community participation in the development and implementation of wrap-around services by county placing agencies and service providers.

(5) Preserving and using the service resources and expertise of nonprofit providers to develop family-based and community-based service alternatives.

SEC. 2. Section 18251 of the Welfare and Institutions Code is amended to read:

18251. As used in this chapter:

(a) "County" means each county participating in an individualized or "wrap-around" pilot project.

(b) "County placing agency" means a county welfare or probation department, or a county mental health department with respect to those children placed pursuant to Section 7572.5 of the Government Code.

(c) "Eligible child" means a child who is any of the following:

(1) A child who has been adjudicated as either a dependent or ward of the juvenile court pursuant to Section 300, 601, or 602 and who would be placed in a group home licensed by the department at a rate classification level of 12 or higher.

(2) A child who would be voluntarily placed in out-of-home care pursuant to Section 7572.5 of the Government Code.

(3) A child who is currently, or who would be, placed in a group home licensed by the department at a rate classification level of 12 or higher.

(d) "Wrap-around services" means community-based intervention services that emphasize the strengths of the child and family and includes the delivery of coordinated, highly individualized unconditional services to address needs and achieve positive outcomes in their lives.

(e) "Service allocation slot" means a specified amount of funds available to the county to pay for an individualized intensive wrap-around services package for an eligible child. A service allocation slot may be used for more than one child on a successive basis.

SEC. 3. Section 18252 of the Welfare and Institutions Code is amended to read:

18252. Each county shall, at the county's option, develop a county plan for intensive wrap-around services and monitor the provision of those services in accordance with the plan. This plan shall be submitted to the department for informational purposes. Where a county operates both systems of care under the Children's Mental Health Services Act, Part 4 (commencing with Section 5850) of Division 5, and wrap-around services, these plans shall be coordinated. Each county's plan shall include all the following elements:

(a) A process and protocol for reviewing the eligibility of children and families for service and for monitoring accessibility and availability of service to the targeted population. Children shall be determined as eligible for wrap-around services pursuant to subdivision (c) of Section 18251, except that:

(1) Once a child is determined to be eligible for wrap-around services under this chapter, he or she shall remain eligible for the time period specified in his or her individualized services plan.

(2) A child and family participating in a family maintenance services program as described in Section 16506 and the wrap-around services program, shall not be subject to the time limitations specified in Section 16506.

(b) A process to accept, modify, or deny proposed individualized service plans for eligible children and families.

(c) A process for parent support, mentoring, and advocacy that ensures parent understanding of, and participation in, wrap-around services programs.

(d) A planning and review process to support and facilitate the following principles in delivering intensive wrap-around services to eligible children and families:

(1) Focusing on an individual child and family through the creation of service plans designed specifically to address the unique needs and strengths of each child and his or her family.

(2) Providing services geared toward enabling children to remain in the least restrictive, most family-like setting possible.

(3) Developing a close collaborative relationship with each child's family in the planning and provision of wrap-around services.

(4) Conducting a thorough, strengths-based assessment of each child and family that will form the basis for the development of the individualized intervention plan.

(5) Designing and delivering services that incorporate the religious customs, and regional, racial, and ethnic values and beliefs of the children and families served.

(6) Measuring consumer satisfaction to assess outcomes.

(e) Written interagency agreements or memorandums of understanding between the county departments of mental health, social services, and probation that specify jointly provided or integrated services, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services.

SEC. 4. Section 18253 of the Welfare and Institutions Code is amended to read:

18253. Each county shall ensure that an evaluation of the pilot project is conducted to determine the cost and treatment effectiveness of outcomes such as family functioning and social performance, preventing placement in more restrictive environments, improving emotional and behavioral adjustments, school attendance, and academic performance for eligible children. Systems of care outcomes shall be included to the extent they are applicable to the target population.

SEC. 5. Section 18253.5 is added to the Welfare and Institutions Code, to read:

18253.5. Each county shall ensure that staff participating in the pilot projects have completed training provided or approved by the department, on providing individualized wrap-around services.

SEC. 6. Section 18254 of the Welfare and Institutions Code is amended to read:

18254. (a) Reimbursement rates for intensive wrap-around services, under this pilot project, shall be based on the average cost of rate classification levels 12 to 14, inclusive, in each county, minus the cost, if any, of concurrent out-of-home placement of those children.

(b) The annual maximum limit on funding available for the pilot project authorized by this chapter shall be based on the average cost, determined pursuant to subdivision (a), for the number of service allocation slots assigned to each county.

(c) The department shall reimburse each county, for the purpose of providing intensive wrap-around services, up to 100 percent of the state share of nonfederal funds, to be matched by each county's share of cost as established by law, and to the extent permitted by federal

law, up to 100 percent of the federal funds allocated for group home placements of eligible children, at the rate authorized pursuant to subdivision (a).

(d) State and, to the extent permitted by federal law, federal foster care funds shall remain with the administrative authority of the county welfare department, which may enter into an interagency agreement to transfer those funds, and shall be used to provide intensive wrap-around services.

(e) General Fund costs for the provision of benefits to eligible children pursuant to subdivision (c) of Section 18251 at rates authorized by subdivision (a) through the pilot project authorized by this chapter shall not exceed the costs which would otherwise have been incurred had the eligible children been placed in a group home.

SEC. 7. Section 18255 of the Welfare and Institutions Code is amended to read:

18255. This pilot project may be extended to any county that applies to, and is granted approval, by the department. The number of service allocation slots assigned to each county shall be determined by each county and approved by the department.

SEC. 8. Section 18256 of the Welfare and Institutions Code is amended to read:

18256. Each county shall evaluate its pilot project, prepare interim and final evaluations, and submit them to the appropriate committees of the Legislature and to the department. The interim report shall be submitted not later than six months following the start of the third year of the pilot project. The final report shall be submitted not later than six months following the end of the five-year pilot project. These reports shall assess the effectiveness of the pilot project authorized by this chapter. The reports shall include, but need not be limited to, all of the following:

(a) The effectiveness of the project in reducing the level of out-of-home services required, and in reducing the average length of stay in out-of-home care.

(b) A comparison of the cost of placement and services for children in the pilot project with the average cost of out-of-home placement for the same number of children.

(c) The effectiveness of the pilot project in assisting children and families in attaining their service goals.

SEC. 9. Section 18256.5 is added to the Welfare and Institutions Code, to read:

18256.5. At the end of a county's pilot project, in order to prevent disruption to the child, each child remaining in the pilot project shall continue to receive all planned services specified in the child's individualized services plan until his or her case is closed.

SEC. 10. Section 18257 of the Welfare and Institutions Code is amended to read:

18257. This chapter shall become inoperative on October 1, 2003, and, as of April 1, 2004, is repealed, unless a later enacted statute, that becomes operative on or before April 1, 2004, deletes or extends the dates on which it becomes inoperative and is repealed.

O

REFERENCE 2

CDSS Social Services

California Wraparound

California High Fidelity Wraparound is a collaborative, family-centered approach to support children and youth with complex needs. It is designed to provide personalized, community-based services in an environment where healing and growth can take place. It aims to deliver comprehensive, coordinated care by creating a team with youth, families, natural supports, professionals, and other community resources who engage in the development and implementation of a plan of care. The team develops a plan of care based on the Integrated Practice - Child and Adolescents Needs and Strengths (IP-CANS). The IP-CANS is the building block that leads to the development and identification of specific strategies. The plan of care reflects the child and family's culture and preferences. The plan is flexible and is designed to build on the strengths of the individual and their family, rather than focusing solely on their deficits. High Fidelity California Wraparound aims to provide a more holistic and effective alternative to traditional, often more fragmented in-service models, promoting better outcomes for individuals with significant needs. It is intended to allow children to grow up in a safe, stable, permanent family environment.

Please note that California County Wraparound Programs are administered and managed at the county level, not by the state. Each county determines program operations, service access, and referral processes. For county specific questions, please contact your County Wraparound Coordinator.

Eligibility for Wraparound is outlined in Welfare and Institutions Code (WIC) 18250–18258, which establishes the statutory framework for California's High Fidelity Wraparound program.

Announcing the release of the ACL 25-47/BHIN 25-027 Aftercare Utilizing the High Fidelity Wraparound Model letter!

This letter includes the CA Wraparound Standards as the foundation for the High Fidelity Wraparound Model and establishes requirements for County Approval and Provider Certification.To assist with the implementation of these requirements please explore the CA

CDSS Social Services

essential resources together in one convenient place. Whether you're new to the process or ready to dive in, it's the perfect starting point.

- Visit the CA HFW County Plan Approval and Provider Certification webpage

Partnership Spotlight: UC Davis Resource Center for Family-Focused Practice (RCFFP)

The RCFFP is contracted by the California Department of Social Services to provide facilitation, technical assistance, and training to support High Fidelity Wraparound across the state. In addition, they are partners in developing Wraparound trainings, resources, and other aspects of California High Fidelity Wraparound. Please use the link below to access technical assistance through the RCFFP.

- Technical Assistance

CA High Fidelity Wraparound Standards

High Fidelity Wraparound County Plan Approval and Certification Portal

CA High Fidelity Wraparound Toolkit

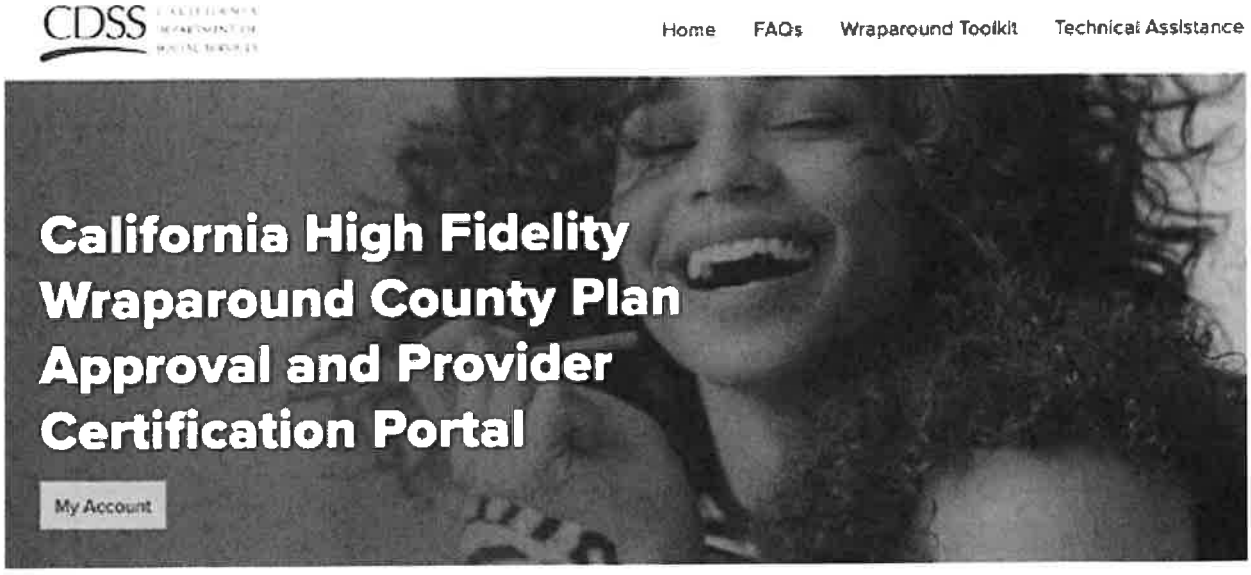
CDSS Social Services

Networking and Meetings

Webinars

California Wraparound Certification Portal

Here, you will find essential resources, including upcoming webinars, technical assistance opportunities, FAQs, and training guidance, which are designed to help you navigate approval and certification. In partnership with CDSS, the UC Davis RCFFP is committed to addressing your unique needs and providing the tools and support necessary to achieve High Fidelity Wraparound implementation success.



California High Fidelity Wraparound Technical Assistance (TA) System

Whether you are navigating the ins and outs of the California High Fidelity Wraparound (CA-HFW) County Approval or the Provider Certification process, you don't have to do it alone. The California Department of Social Services (CDSS), in partnership with the UC Davis Resource Center for Family-Focused Practice (RCFFP), offers a flexible and responsive Technical

CDSS Social Services

The TA system is built to provide a range of supports that empower counties, providers, and system partners to align with California's Wraparound Standards and fidelity expectations.

CALIFORNIA Wraparound

Save the dates!

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PARTNERSHIPS FOR WELL-BEING

📍 June 10–12, 2026

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Contact Us

CDSS Social Services

System of Care Branch-Wraparound & Integrated Practice Support Unit

744 P Street, MS 8-3-570
Sacramento, CA 95814
(916) 651-2752
- **Email**: WraparoundQuestions@dss.ca.gov

CDSS Program Consultants & County Coordinators

County Wraparound Coordinators

Key local contacts who oversee Wraparound implementation and coordination within each county. They serve as the primary point of contact for program logistics, collaboration, and system-level support.

CDSS Program Consultants

State-level consultants from the California Department of Social Services (CDSS) who provide oversight, technical assistance, and policy guidance related to Wraparound programs.

High Fidelity Wraparound Policy Letters

CA High Fidelity Wraparound Statute

- California Welfare and Institutions Code 18250–18258
- Welfare and Institutions Code 4096.6

Wraparound Evaluation and Research Team (WERT) using the Wraparound Fidelity Assessment System (WFAS)

- WERT home page
- WERT Wrap Stat Webinar
  This presentation by Eric J. Burns and Marianne Kellogg from the Wraparound Evaluation and Research Team at the University of Washington describes in detail the opportunities that the WFAS program can provide in evaluating fidelity in Wraparound programs.
- PowerPoint Presentation
- Wraparound Fiscal Matrix

Wraparound services paid by the Adoption Assistance Program (AAP)

- ACL 24-66 AAP Wraparound Policy Letter

CDSS Social Services

(includes AAP eligible nonminors).

ACL 24-66 Q&A document

Visit the AAP Website

- **Email:** AAP@dss.ca.gov

Resources

- Child and Family Teams
- Child and Family Teams: Tribal Engagement Guide
- Complex Care
- Early Childhood and Child Welfare
- Family Finding
- Family First Prevention Services Act (FFPSA)
- Integrated Core Practice Model (ICPM)
- Integrated Practice – Child and Adolescent Needs and Strengths (IP-CANS)
- Kinship Care
- National Wraparound Initiative (NWI)
- Office of Tribal Affairs (CDSS)
- Peer Partners
- Safety Organized Practice (SOP) Toolkit
- Wrapround Evaluation and Research Team (WERT)
- Wraparound Theory of Change

REFERENCE 3

California High Fidelity Wraparound Approval/Certification

Wraparound Toolkit Menu

This section is dedicated to supporting California High Fidelity Wraparound County Plan Approval and Provider Certification. Here, you will find essential resources, including upcoming webinars, technical assistance opportunities, FAQs, and training guidance, which are designed to help you navigate approval and certification. In partnership with CDSS, the UC Davis RCFFP is committed to addressing your unique needs and providing the tools and support necessary to achieve High Fidelity Wraparound implementation success.

The California High Fidelity Wraparound County Plan Approval and Provider Certification is based on the California Wraparound Standards and is a part of California's vision that evidence-based High Fidelity Wraparound services be provided statewide to all youth who need them, under the CA High Fidelity Wraparound Model.

Portal Resources and Instructions

Creating a Profile

In order to create a profile in the Portal, you will be asked to provide information about your organization. View the links below for a detailed list. This information will be used for tracking purposes only and will not be considered in determining approval/certification status. Please remember, one profile and submission per county or provider- multiple entries from the same organization will not be accepted.

Resources for Portal Submission

Looking for resources on how to complete your submission in the Portal? These documents offer additional examples to help counties and providers submit clear, complete and verifiable information that demonstrates both implementation of and fidelity to the California HFW Standards.

Resources for County Plan Approval and Provider Certification Portal Submissions

County Information Required for Profile Creation (Download as PDF)

Provider Information Required for Profile Creation (Download as PDF)

Portal Instructions

Looking to plan ahead before creating a profile in the Portal? You can now download the instructions as a PDF. Once you log in, the Portal has these instructions, plus additional resources, available on every page by clicking the information and resources tabs on the right side of the webpage.

County Approval and Provider Certification Standards and Requirements

Preview the Portal requirements by downloading a PDF copy of the California High Fidelity Wraparound County Approval and Provider Certification Standards and Requirements. Please note that this document is for reference only (all submissions must be made in the Portal).

High Fidelity Wraparound Policy Letters

Access the letters associated with Approval/Certification including ACL 25-47/BHIN 25-027 and all of the All County Letters, Fiscal Letters and Resources related to FFPSA Part IV and Wraparound Implementation on the CDSS High Fidelity Wraparound Policy Letters page.

Wraparound Approval/Certification Webinars

The Wraparound Approval/Certification Webinar series is designed to overview the Portal and provide guidance on navigating submission, meeting approval or certification requirements, and implementing best practices in High Fidelity Wraparound. Whether you're new to approval and certification or seeking clarification on specific points, these recorded webinars will be on hand to assist you in achieving approval or certification and enhancing your Wraparound services.

Technical Assistance (TA) Office Hours for High Fidelity Wraparound

The Technical Assistance (TA) Office Hours have been designed to provide direct support and answers to your most pressing questions. These sessions offer an open forum where participants can seek guidance on a variety of certification and approval topics from navigating the approval process, meeting certification requirements, and implementing High Fidelity Wraparound. Whether you're new to the process or seeking clarification on specific points, our team of experts will be on hand to help you successfully achieve your goal of plan approval or provider certification and enhance your California High Fidelity Wraparound delivery.

Individualized Technical Assistance and Consultation

Support from the CDSS and the UC Davis RCFFFP is available to counties and providers at any point along their approval/certification journey in the form of technical assistance and consultation.

Looking for help logging into the portal or having issues with your portal account? Email calwrapcert@ucdavis.edu for support.

Developing a Wrapround Training Plan

As part of approval and certification, providers and counties will need to submit documentation demonstrating a High Fidelity Wraparound training plan. The Training Wraparound section of this Toolkit has tools and resources available to assist in developing a training plan as well as access to the State Standardized Foundational Wraparound training materials located on the UC Davis website.

Frequently Asked Questions (FAQs)

The FAQs section is a go-to resource for answers to the most common questions about state requirements, CA Wraparound Standards, approval and certification and the Portal.

List of Certified Providers

To assist counties with contracting, and families with finding certified providers in their area, a list of certified providers will be posted to this website. The list will be updated as providers successfully complete the certification process- check back often for updates!

REFERENCE 4

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

GAVIN NEWSOM
GOVERNOR

CDSS
JENNIFER TROIA
DIRECTOR

July 8, 2025

ALL COUNTY LETTER NO. 25-47
BEHAVIORAL HEALTH INFORMATION NOTICE NO. 25-027

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS
ALL COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS
ALL SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM PROVIDERS
ALL FOSTER FAMILY AGENCIES
ALL WRAPAROUND PROVIDERS
ALL BEHAVIORAL HEALTH PROVIDERS
ALL COMMUNITY TREATMENT FACILITIES
TRIBES WITH AN IV-E AGREEMENT

CC: COUNTY WELFARE DIRECTORS ASSOCIATION OF CALIFORNIA
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CHIEF PROBATION OFFICERS OF CALIFORNIA
ALL FEDERALLY RECOGNIZED TRIBES
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES

SUBJECT: FAMILY FIRST PREVENTION SERVICES ACT PART IV AFTERCARE SERVICES UTILIZING CALIFORNIA'S HIGH FIDELITY WRAPAROUND MODEL

REFERENCE: FAMILY FIRST PREVENTION SERVICES ACT, PART IV; BIPARTISAN BUDGET ACT OF 2018, PUBLIC LAW 115-123; ASSEMBLY BILL (AB)161 (CHAPTER 46, STATUTES OF 2024); AB 153 (CHAPTER 86, STATUTES OF 2021); AB 2083 (CHAPTER 815, STATUTES OF 2018); SENATE BILL 187 (CHAPTER 50, STATUTES OF 2022); FAMILY (FAM) CODE SECTION 7900, ET SEQ.; FAM CODE SECTION 7911.1; HEALTH AND SAFETY CODE (HSC) SECTION 1502; HSC SECTION 1530.90; HSC SECTION 1562.01; WELFARE AND INSTITUTIONS CODE (WIC) SECTION 706.6; WIC SECTION 5851; WIC SECTION 4096.6; WIC SECTION 11400; WIC SECTION 16501; WIC SECTION 16521.6; WIC SECTION 16560; WIC SECTION 16562; ALL COUNTY LETTER (ACL) 08-66; ACL 18-81;

ACL 24-18; ACL 21-116/ BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN) 21-061; ALL COUNTY INFORMATION NOTICE (ACIN) I-52-15; ACIN I-07-23; ACIN I-73-21/BHIN 21-055; ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL) NO: 12-12; ACWDL NO: 21-28; BHIN 21-062; COUNTY FISCAL LETTER (CFL) 20/21-94; CFL 21/22-36; CFL 21/22-57; CFL 23/24-30; CFL 24/25-30

PURPOSE

The purpose of this California Department of Social Services (CDSS) All County Letter (ACL) and Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) is to establish the statewide minimum standards to be certified to provide family-based aftercare services. This ACL/BHIN provides information to county child welfare agencies, juvenile probation departments, Tribes, county Mental Health Plans (MHPs), Wraparound providers, Short Term Residential Therapeutic Programs (STRTPs), Community Treatment Facilities (CTFs) and out-of-state residential facilities[1] regarding California's implementation of the Family First Prevention Services Act (FFPSA) Part IV aftercare requirements.

To become a certified provider of aftercare services, providers must agree to use the California High Fidelity Wraparound Model ("CA HFW Model"), approved by the CDSS and based on the updated California Wraparound Standards (CA Wraparound Standards).

The DHCS and CDSS continue to collaborate to minimize duplication and administrative complexity and align the High Fidelity Wraparound (HFW) requirements applicable to family-based aftercare, Medi-Cal, the Immediate Needs program, and Behavioral Health Services Act (BHSA) Full Service Partnerships (FSPs). This and future guidance will build upon established processes and requirements under the CA Wraparound Standards. This ACL/BHIN is tailored specifically to family-based aftercare services and the CA Wraparound Standards may be subject to change to ensure alignment with Medi-Cal, the Immediate Needs program, and BHSA FSPs requirements.

[1]Per ACIN I-07-23, out-of-state residential facility placement requirements were updated and all out-of-state residential facilities were decertified as of January 1, 2023, unless those placements fell within certain exceptions described in ACIN I-07-23.

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BACKGROUND

The FFPSA was signed into federal law as part of the Bipartisan Budget Act of 2018, Public Law 115-123, on February 9, 2018. To achieve compliance with this federal law, California passed Assembly Bill (AB) 153 (Chapter 86, Statutes of 2021), which established the requirements for county child welfare agencies, probation departments, and MHPs, in consultation with the local Interagency Leadership Teams (ILTs) established pursuant to Welfare and Institutions Code (WIC) Section 4096.6, to jointly provide, arrange for, or ensure the provision of six months of aftercare services to youth upon their discharge from placement in an STRTP, CTF, or an out-of-state residential facility,[2] to a family-based setting on or after October 1, 2021.[3] Equally, this letter provides foundational guidance pursuant to WIC section 16560(e) upon which further forthcoming guidance will rely to establish the Standards of care and certification requirements for the Immediate Needs Program established in WIC section 16562, applicable upon implementation of the Tiered Rate Structure adopted in AB 161 (Chapter 46, Statutes of 2024).

STRTP and CTF providers are required to provide for, arrange for the provision of, or assist in the development of an individualized family-based aftercare support plan, developed pursuant to WIC Section 4096.6.[4] The aftercare support plan must identify necessary supports, services, and treatment to be provided for at least six months post-discharge as youth transition from an STRTP, CTF, or an out-of-state residential facility[1] to a family-based setting.[5]

Previously, CDSS and DHCS issued ACL 21-116/BHIN 21-061, which informs county child welfare agencies, juvenile probation departments, county MHPs, and providers, including STRTPs and those delivering Wraparound services, about California's implementation of the FFPSA Part IV requirements for family-based aftercare support. The CDSS issued County Fiscal Letter (CFL) 21/22-36; CFL 21/22-57; CFL 23/24-30; and CFL 24/25-30 regarding funding allocations and claiming instructions, and DHCS issued BHIN 21-062, which provides guidance to MHPs on claiming for FFPSA Qualified Individual (QI) and aftercare costs.

For the purposes of this ACL/BHIN, "family" is defined as anyone who is providing care and supervision for the youth.

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[2] Per ACIN I-07-23, out-of-state residential facility placement requirements were updated and all out-of-state residential facilities were decertified as of January 1, 2023, unless those placements fell within certain exceptions described in ACIN I-07-23.
[3] Health & Safety Code (HSC) §§ 1562.01(d)(2)(C)(vii)(I)(ib) & 1530.90(c)(2)(E)(i)(II); Welf. & Inst. Code (WIC) §§ 706.6 (d)(3), 4096.6, 16501(a)(4)(A)(III) & 16501.1(d)(2).
[4] HSC §§ 1652.01(d)(2)(C)(vii)(I)(ib) & 1530.90(c)(2)(E)(i)(II).
[5] Family-based setting is defined in ACL 21-116/BHIN 21-061.

DEFINITIONS

CA HFW Model
California's model of High-Fidelity Wraparound (HFW), based on the California Wraparound Standards, which is the designated model for the aftercare services requirement.

HFW is a team-based evidence-based practice that includes an "anything necessary" approach to care for youth and families with the most intensive mental or behavioral health challenges.

CA HFW model aligns with the national evidence-based practice model for HFW that provides a comprehensive, holistic, youth and family-driven way of responding when youth experience significant mental health challenges, in addition to other identified needs, often involving multiple child-serving systems.

CA Wraparound Standards
A set of Standards to ensure quality, high fidelity, and consistent practices for the provision of HFW in California. The CA Wraparound Standards in this ACL/BHIN are based on the national evidence-based practice model and will be used to implement the CA HFW model and supersede the CA Wraparound Standards contained in ACIN I-52-15.

Child and Family Team/HFW Team
When a youth and family have HFW, the HFW Staff become part of the Child and Family Team (CFT) ensuring there is one team for the youth and family that is inclusive of multiple formal support systems (i.e. education, Tribes, behavioral health, regional center, etc.) a youth may need, as well as community-based and natural supports. The team works together to incorporate mandates from system partners into the Plan of Care by collaboratively integrating required services and supports into the plan in a way that aligns with the family's goals and values, ensuring compliance while maintaining individualized, strength-based planning.

CFT Meeting/HFW Team Meeting
When a youth and family are receiving HFW, the HFW staff become part of the CFT meetings that fulfill the statutory meeting requirements of ACL 22-35 and ACL 22-73. Additionally, the HFW Team meets more often than the CFT requirements described in ACL 22-35 and ACL 22-73 to plan and implement the HFW process (referred to as "the HFW Team meeting" in this letter). Due to the frequency of HFW team meetings, not all CFT members are required to attend every HFW Team meeting. However, the HFW team ensures all CFT members stay informed and connected to the discussions within the HFW team meetings.

Plan of Care
A plan tailored to each youth and family based on their specific needs and goals. The plan should be strengths-based, needs-driven, culturally relevant to the family and integrates the California Integrated Practice – Child and Adolescent Needs and Strengths (IP-CANS). The plan should identify specific, incremental steps that move the youth and family toward their specific goals and away from involvement with child welfare or probation agencies. The roles and responsibilities of each team member should be identified in the plan. The plan should address needs across life domains and include strategies to meet the needs and include the Tribe in the case of an Indian child.

Community Leadership Team
A cross system team convened at the county level that provides leadership of the HFW program in the form of a formal collaborative structure that includes empowered leaders from child serving systems, community agencies and community representatives. Counties ensure formal communication structures are established between Community Leadership Teams and Interagency Leadership Teams (ILTs) pursuant to WIC Section 5851. Relevant child serving agencies (e.g., mental health, child welfare, juvenile justice, schools, and courts) participate actively and "buy in" to the HFW program. The representatives must be able to collectively take responsibility for task oversight, have relevant expertise with representatives that are able to participate in decision making, and the authority to make decisions that are followed in terms of program design. Potential team members include:
» Families
» System Partners
» Tribal Representatives
» Community Representatives
» Business leaders
» Cultural Leaders

Cost Savings
Unspent child welfare assistance payment funds that would have been spent to place a child in a more restrictive setting had HFW not been available.

Family Engagement
A strengths-based approach to partnering with youth and families in making decisions, setting goals and achieving desired outcomes. The goals are intended to ensure youth and families are active and influential participants in identifying their needs and finding solutions to their unique and personal issues and concerns.

Family Voice and Choice
Perspectives of the youth, family, and Tribes, in the case of an Indian child, are intentionally elicited and prioritized during all phases of the CA HFW model. Planning is grounded in these perspectives, and the team strives to provide options and choices such that the Plan of Care reflects family values and preferences.

Flexible Funds
Non-Medi-Cal funding made available to each HFW team to meet needs identified in the Plan of Care. Funds can be used for activities, services and supports that are not covered by Medi-Cal. Flexible funds processes are written policies that address how funds are accessed, tracked, and managed, and include a process for accessing funds quickly for emergencies. Flexible funds may be funded by sources including but not limited to, Full Service Partnership (FSP), child welfare realignment, FFPSA Part IV aftercare allocations, private philanthropy, or other county funds.

Foster Care Tiered Rates Structure (TRS) Immediate Needs (IN) Program
The Immediate Needs (IN) Program established in WIC Section 16562 will offer a range of coordinated services and support for youth in foster care, as a component of the TRS outlined in WIC Section 11461(h) and guided by the 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.
The CA HFW Model will be a core component of the TRS IN Program.

Life Domains
Aspects or areas of a person's life that may be addressed in the Plan of Care. Every Plan of Care shall include interventions meant to address issues in one or more life domains. Life domains include safety, family, a place to live, school, work, emotional well-being, culture, spiritual beliefs, Tribal connection, social/fun, legal, medical health, mental health, developmental health, finances, relationships, and independent living skills.

Natural Supports
Individuals and resources who are not connected with formal systems and are accessible to a youth and family through normal means, i.e., friends, neighbors, relatives, community groups, and others. The HFW team actively seeks out and encourages the inclusion of natural supports in the HFW process and draws from family members' own networks of interpersonal and community relationships. The HFW team must encourage the family to consider engagement and inclusion of natural supports.

SB 163
Wraparound was initially established in California pursuant to SB 163 (Chapter 795, Statutes of 1997), which created a mechanism to fund Wraparound in California through the child welfare system. Specifically, SB 163 allowed California counties to develop a Wraparound program using state and county Aid to Families with Dependent Children - Foster Care (AFDC-FC) funding. This legislation permitted counties to use the funding for planning and service delivery instead of for placing youth in high-level group homes. As such, the Wraparound program model funded by SB 163 is considered to be the HFW model described within this ACL/BHIN, as HFW programs funded through SB 163 processes and FFPSA Part IV aftercare

allocations both ensure alignment with the HFW Standards described within this ACL/BHIN.

Transition
The process of moving from formal services and supports to natural supports and out of HFW.

OVERVIEW OF THE PROVISION OF AFTERCARE SERVICES UTILIZING CALIFORNIA'S HIGH FIDELITY WRAPAROUND MODEL

Pursuant to WIC Section 4096.6(b)(4), within 12 months from the date of this letter, county child welfare agencies, probation departments, and MHPs, in consultation with local ILTs shall jointly provide, arrange for, or ensure the provision of at least 6 months of aftercare services for foster youth who are stepping down from an STRTP and CTF utilizing the CA HFW model, consistent with the CA Wraparound Standards.

Tribes, local Indian Health Centers, Tribal organizations, and their consortia may also become certified to provide aftercare services utilizing the CA HFW model for the Tribal communities they serve.

The CDSS and the DHCS collaborated with county child welfare agencies, probation departments, MHPs, Tribes, Wraparound providers, current and former foster youth, caregivers and other system partners in the development of the CA HFW model and requirements, which are consistent with the updated CA Wraparound Standards.

For more information, visit the CA Wraparound Standards Toolkit, the CDSS Wraparound webpage, the UC Davis Resource Center for Family Focused Practice (RCFFP) webpage, or email WraparoundQuestions@dss.ca.gov.

Alignment of the CA HFW Model Across Aftercare, Medi-Cal, the Behavioral Health Services Act, and the Immediate Needs Program

The CDSS and DHCS intend that evidence-based HFW services be provided statewide to all youth who need them, under the CA HFW Model. The departments continue to collaborate closely, seeking to minimize duplication and administrative complexity, and align HFW requirements in the context of aftercare, Medi-Cal, BHSA FSPs, and the Immediate Needs program. As such, this guidance may be updated to support continued alignment and clarify expectations for consistent implementation.

Pursuant to the BHSA, DHCS is also formally implementing HFW as the children and youth level of care within the FSP program. FSP programs are comprised of required and allowable services and must make required services (e.g., HFW) available as a condition of receiving BHSA funding. According to the BHSA County Policy Manual,

counties must implement HFW beginning in July 2026. To ensure alignment across the county behavioral health delivery system, HFW FSP program requirements under BHSA will align closely with the Medi-Cal HFW requirements. Eligibility criteria for BHSA services are aligned with Medi-Cal Specialty Mental Health Services (SMHS) access criteria. However, it is important to note that BHSA eligible populations are not required to be enrolled in the Medi-Cal program.

HFW in Medi-Cal and the Foster Care Tiered Rate Structure

For HFW activities that can be covered under Medi-Cal, Federal Financial Participation (FFP) shall only be available if all federal and state requirements are met and the service is medically necessary, regardless of the six months post-discharge requirement. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate (42 C.F.R. Part 441, Subpart B; 42 U.S.C. §§1396a(a)(43) and 1396d(r)) 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 such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services. Nothing in this ACL/BHIN limits or modifies the scope of the EPSDT mandate under Medi-Cal.

The DHCS will publish payment and monitoring policies for a Medi-Cal payment model for HFW, effective July 1, 2026. Until that time, medically necessary HFW services must continue to be covered through existing Medi-Cal benefits. The new Medi-Cal payment model is in development and will be described in future guidance.

The CA Wraparound Standards are evolving and are subject to change over time. DHCS and CDSS intend that the CA Wraparound Standards for FFPSA Part IV family-based aftercare and forthcoming Medi-Cal HFW guidance will align. There may be necessary changes to the CA Wraparound Standards as updated Medi-Cal HFW payment and monitoring policies are implemented in July 2026. The departments will also continue to collaborate if the Foster Care Tiered Rate Structure Immediate Needs program results in additional changes to the CA Wraparound Standards.

Timeline of Key County and Provider Requirements and Milestones Under FFPSA Part IV Aftercare and Under Medi-Cal

Within 12 months from the release date of this BHIN/ACL	• County child welfare agencies, probation departments, and MHPs jointly submit an updated county plan for family-based aftercare services using the CA HFW Model consistent with the CA Wraparound Standards via the High Fidelity Wraparound County Plan Approval and Provider Certification Portal (Portal). • FFPSA Part IV aftercare counties and providers demonstrate compliance with the CA HFW Model consistent with the CA Wraparound Standards via Portal submissions. To achieve county approval and certification for providers, all the items in the Portal must be completed in its entirety. • Certification via the Portal as an aftercare provider is the first step in being certified as a HFW provider for FFPSA Part IV family-based aftercare, and then later as a provider of Immediate Needs services.
July 2026	• Payment and Monitoring Policies for HFW in Medi-Cal go live. • HFW requirements for BHSA FSPs take effect.
July 2027	• CDSS Immediate Needs Program and Permanent Foster Care Rate structure payments are expected to go-live. • 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 Medi-Cal HFW providers.

HIGH FIDELITY WRAPAROUND COUNTY PLAN APPROVAL AND PROVIDER CERTIFICATION PORTAL

Pursuant to WIC 4096.6(d)(2), within 12 months from the date of this ACL/BHIN, county child welfare agencies, probation departments, and MHPs must jointly submit an updated county plan for family-based aftercare services to the CDSS that is consistent with the attached CA Wraparound Standards. County plans must be submitted through the High Fidelity Wraparound County Plan Approval and Provider Certification Portal (Portal), as described below.

Pursuant to WIC 4096.6 (c)(1)(B), the CDSS and the DHCS have established a process by which a provider of family-based aftercare services shall be certified to provide HFW. Providers planning to deliver county contracted aftercare services must utilize the CA HFW Model in alignment with CA Wraparound Standards pursuant to WIC 4096.6(c)(1)(A).

The 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. Requirements for Medi-Cal provider enrollment, and for SMHS provider certification as overseen by county Behavioral Health Plans (BHPs[6]), are distinct from requirements for Medi-Cal Fidelity Designation, which will be further described in future guidance.

The DHCS and CDSS intend to collaborate closely and minimize duplication and administrative complexity. The two Departments will seek to maximize alignment of the procedures that providers must follow to become approved to provide HFW as family-based aftercare, as a Medi-Cal service through BHSA FSPs, and through the Immediate Needs program.

For the purposes of this ACL/BHIN, the HFW county plan approval and provider certification process are limited to the FFPSA Part IV aftercare requirements pursuant to WIC 4096.6 and does not relate to the HFW Medi-Cal Fidelity Designation process.

To review and approve county plans and certify providers, the CDSS has established the Portal. The Portal is an online system that contains each of the CA Wraparound Standards and requirements with a corresponding text field in which the county or provider shall describe the practices it is implementing to meet each Standard and a corresponding field in which the county or provider shall upload supporting documents. Examples of supporting documentation include relevant provider contracts, policies and procedures, manuals, desk guides, training plans, and any other documents that demonstrate how the county or provider will meet each Standard. To achieve county approval and certification for providers, all items in the Portal must be completed.

Items within the Portal can be saved and revisited over time. Counties and providers should begin completing the items in the Portal as soon as possible for providers to achieve certification to contract with counties. Technical assistance is required until county approval and certification are achieved. Full instructions for the Portal are included in Appendix E to this ACL/BHIN.

County Approval Process

Pursuant to WIC 4096.6, within 12 months from the date of this ACL/BHIN, county child welfare agencies, probation departments, and MHPs must jointly submit an updated plan to the CDSS through the Portal, that is consistent with the attached CA Wraparound Standards. CDSS or its designee, the UC Davis RCFFP, will conduct

[6] To deliver and receive Medi-Cal payments for SMHS, providers must enter into a contract or payment agreement with a county BHP. The BHP is then responsible for additional oversight of its contracted providers consistent with the terms of its Medi-Cal contract.

reviews and approvals of county plans for the provision of aftercare utilizing the CA Wraparound Standards.

1. Counties must complete the Portal requirements no later than 12 months from the release date of this ACL/BHIN. However, counties are highly encouraged to start completing requirements in the Portal as soon as possible.

2. Within 90 days of submission, the county will be notified through email of a plan approval or the need to provide additional information and/or corrections. A county must demonstrate compliance with the CA Wraparound Standards to receive approval.

3. If the county is not able to demonstrate compliance with all Standards, then counties must participate in technical assistance until the county's plan is approved.

4. Counties who contract with providers shall describe how the county holds all contracted providers accountable for meeting each Standard requirement. Counties shall identify where in their supporting documentation the provider is tasked with meeting the Standard and how the county oversees and supports the provider.

5. All 58 counties submit a unified plan with the approval of the MHP, child welfare and probation departments. Each county submits one plan, including counties who are contracting with a provider.

As indicated above, CDSS or its designee will review submissions and issue county plan approvals and provider certifications. Counties shall submit plan updates for approval through the Portal for any significant changes to a program policy, practice, funding, contract, or workforce changes. Counties planning to meet the aftercare requirement for HFW via contracts with providers shall ensure that the providers have obtained certification via the process described below.

Provider Certification Process

Providers planning to deliver county contracted aftercare services utilizing the CA HFW model must obtain provider certification. If a contracted provider is not certified, the provider's contract may be subject to corrective action and/or termination by the county.

1. Providers must complete the Portal requirements currently set forth by the CDSS, which include uploading supporting documents. Because counties are required to contract with certified providers within 12 months from the date of this ACL/BHIN, providers who have or are planning to have a contract with a county for the provision of aftercare services utilizing the HFW model should obtain certification as soon as possible.

2. Providers are required to submit one unified plan, regardless of the number of locations or counties in which they operate.

3. Within 90 days of submission, the provider, and any counties with which they have contracts, will be notified of an incomplete submission or certification.

4. If the provider does not meet the requirements to receive certification, then they cannot perform aftercare services. In the case the provider does not meet the requirements to receive certification, the provider can participate in technical assistance until they demonstrate required certification Standards. The CDSS or its designee will also notify any counties with whom the provider has a contract about the provider not being certified and their participation in technical assistance.

5. Counties shall only contract with providers that are certified.

6. Providers must apply for recertification through the Portal every three years from their initial certification date. Providers who do not renew their certification by their required recertification date will lose their certification.

7. Providers may be decertified by the CDSS or its designee, based on criteria that will be developed in forthcoming guidance. CDSS and DHCS will work collaboratively to develop the decertification process.

8. If the provider is decertified by CDSS or its designee, the contracting county and provider will be notified within 48 hours of determining the status of the provider. The provider and contracting county must develop transition plans to support continuity of care for the youth.

Certification
The CDSS or its designee, determines certification when all CA Wraparound Standards are met by the provider, and they have successfully completed all Portal requirements. As noted above, DHCS is developing the process for HFW Medi-Cal Fidelity Designation and will provide additional guidance at a later date.

Incomplete
"Incomplete" status is determined by CDSS or its designee, when all CA Wraparound Standards have not been met. In this case, the provider can request technical assistance to support their improvement process.

Recertification
The CDSS requires that providers must apply for recertification via the certification process described above every three years from the providers' certification date.

Providers initial certification will be saved in the Portal and must be updated and resubmitted. Providers who do not renew their certification every three years will be considered "Not Certified" until all certification requirements are met and a Notice of Recertification from the CDSS or its designee is provided. Written notice to the provider, and any counties with whom the provider has a contract, will be provided 60 days prior to the recertification deadline.

Decertification
Providers may be decertified by the CDSS or its designee based on criteria that will be developed in forthcoming guidance.

Due Process
Providers who do not receive certification or who are decertified by the CDSS or its designee may request a second level review. To request a second level review, providers must coordinate with CDSS or its designee to understand the reason for not receiving certification and request a second level review and determination from the CDSS by emailing WraparoundQuestions@dss.ca.gov. CDSS will provide a determination via written communication of its second level review within 30 calendar days of the request from the provider. Any counties with whom the provider has a contract will also be included in the notification from CDSS of its second level review determination. The decision from the second level review shall serve as the final decision for certification.

COUNTY REQUIREMENTS

Counties shall develop their aftercare services utilizing the CA HFW model in consultation with the local ILT consistent with Children's System of Care and the Integrated Core Practice Model (ICPM). Counties shall include county child welfare agencies, probation departments, MHPs and Tribes, as applicable, and other representatives of the county ILT, as is determined relevant for each county.

In the case of an Indian child, the county child welfare agency, probation department, and MHP must consult with the Indian child's Tribe in the coordination of aftercare services pursuant to the SOC Memorandum of Understanding. In addition, aftercare services must be culturally relevant in accordance with ACL 24-18. Examples of culturally relevant services may include: healing circles, powwows, parenting programs, etc. Counties should also consider contracting for aftercare services utilizing the CA HFW model with Tribes, local Indian Health Centers, Tribal organizations and their consortia to meet the needs of the Indian children and Tribal communities they serve.

Counties shall require, through their contracts, that providers obtain certification within 12 months of the date of this ACL/BHIN and maintain certification or be subject to corrective action.

If the youth is stepping down from an STRTP or CTF that is a HFW provider, the county should prioritize these entities as the HFW provider of the aftercare services to promote continuity of care.

Counties must participate in technical assistance provided by the CDSS or its designee to address the policies and practices required to meet the CA Wraparound Standards until the county's plan is approved.

Transition Documentation in Child Welfare Case Plan

The FFPSA requires that a youth transitioning from an STRTP, CTF, or out-of-state residential facility[7] has a thorough transition plan. Additionally, pursuant to WIC 706.6(d)4(E) and WIC 16501.1(d)(2)(F), prior to discharge from an STRTP or a CTF, the placing agency must include in the youth's case plan a description of the type of in-home or institution-based services to encourage the safety, stability, and appropriateness of a transition to the next placement, including the recommendations of the CFT. To appropriately plan for the youth's transition, and in accordance with the Mental Health Program Approval STRTP Regulations Version 2 Section 15 and CDSS STRTP Interim Licensing Standards (ILS) Version 5 Section 87068.22(c)(5), an STRTP must develop the youth's transition plan while involving the youth and/or the person(s) identified by the court as authorized to make decisions about the youth, and the CFT. The transition plan shall be individualized for the youth and their family as they work towards stability and permanency. To support this individualization, case plans should include the outcomes of the CFT meetings, recommendations from the QI's assessment report, as well as a transition plan addressing aftercare services and supports.

Child Welfare Services/Case Management System Documentation

Requirements for documentation of HFW services in the Child Welfare Services/Case Management System (CWS/CMS) were initially established in ACL 08-66 and further developed in ACL 21-116/BHIN 21-061, which states that beginning on October 1, 2021, all counties must document any currently open or future child welfare or probation cases, including in-home, out of home, voluntary, and court ordered cases, with youth who are receiving Wraparound services (without regard to the funding source of the services), including family-based aftercare services, using the Special Project Code (SPC): 'S-Wraparound Program'. The data entry requirements pertain to all counties without regard to which agency holds the Wraparound contract (e.g., county child welfare, probation department, and/or MHPs). For additional support and information about data entry, please see ACL 21-116/BHIN 21-061, Attachment B, and consult with

[7] Per ACIN I-07-23, out-of-state residential facility placement requirements were updated and all out-of-state residential facilities were decertified as of January 1, 2023, unless those placements fell within certain exceptions described in ACIN I-07-23.

the assigned county CWS/CMS Single Point of Contact (SPOC) and Office of Systems Integration (OSI) CWS/CMS System Support Consultant (SSC).

If a family declines HFW services, there is no requirement to enter the SPC into CWS/CMS. However, the child welfare caseworker or probation officer must engage with the family and the child's Tribe, in the case of an Indian child, explain the services and benefits of the program, and document these engagement efforts in the CWS/CMS Contact Notebook. These instructions also pertain to families that choose to terminate aftercare services prior to the six-month timeframe.

These statutory requirements must have been implemented by October 1, 2021, to ensure that otherwise federally eligible youth placed in an STRTP, a CTF, or an out-of-state residential facility[8] will be eligible for Title IV-E funding during their placement.

Non-Dependency/Voluntary Placement Cases

Federal and state policies do not limit aftercare requirements exclusively to open dependency and probation foster care cases. Thus, counties and providers must provide aftercare services utilizing the HFW model for youth who are voluntarily placed into STRTPs, CTFs, and out-of-state residential facilities and are transitioning to a family-based setting.

Out-Of-Home Placements Paid by the Adoption Assistance Program

FFPSA Part IV aftercare requirements only apply to youth in foster care and do not apply to an adopted youth eligible for the Adoption Assistance Program (AAP). Counties may support adoptive parents receiving AAP benefits on behalf of their youth in identifying certified HFW providers, as necessary. In addition, the Portal is available for certification of, but not required for, providers exclusively utilizing AAP funds for Wraparound services. For more information on AAP policies and practices regarding HFW, please email the AAP mailbox at AAP@dss.ca.gov.

Transition To An Out-Of-State Family-Based Placement

If a youth is placed in an out-of-state family-based setting by a Title IV-E agency, the requirement of aftercare services still pertains. The county placing agency must follow the Interstate Compact on the Placement of Children (ICPC) process. In the case of an Indian child, the child welfare agency must engage and collaborate with the Tribe to identify culturally appropriate aftercare services. The county placing agency must work

[8] Per ACIN I-07-23, out-of-state residential facility placement requirements were updated, and all out-of-state residential facilities were decertified as of January 1, 2023, unless those placements fell within certain exceptions described in ACIN I-07-23.

with the receiving state to coordinate aftercare services. The aftercare services allocation to county child welfare and probation agencies described in CFL 21/22-36 is available for aftercare services provided out of state.

Pursuant to California Code Regulations Title 9, § 1810.355, subdivision (b) MHPs shall not be responsible to provide or arrange and pay for out-of-state Specialty Mental Health Services (SMHS) except when it is customary practice for a California beneficiary to receive medical services in a border community outside the state.

For more information about Medicaid eligibility for youth in foster care and placed out of state, please see All County Welfare Directors Letter No: 12-12 and All County Welfare Directors Letter No: 21-28.

Funding

County child welfare agencies and probation departments in consultation with their local ILT, must coordinate to ensure funding is leveraged to provide at least six months of aftercare services under their shared responsibility and pursuant to WIC Section 4096.6. Per CFL 21/22-36 and CFL 24/25-30[9], funding for aftercare services was allocated to placing agencies for six months per youth plus an additional month for engagement, transition-planning, and relationship-building with an STRTP, CTF, or an out-of-state residential facility prior to the youth's discharge. The funding can be utilized on a variety of activities as described in CFL 21/22-36. The statutory requirements in WIC Section 4096.6 must be implemented to ensure that otherwise federally eligible youth placed in an STRTP, CTF, or an out-of-state residential facility[10] will be eligible for Title IV-E funding during their placement.

In addition to the funding described above, counties are encouraged to utilize other funding sources to continue provision of HFW beyond the six-month aftercare requirement and offer HFW to youth and families who may not be eligible for FFPSA Part IV aftercare, but who may benefit from HFW, if the youth meets eligibility criteria for the service.

Medi-Cal payment may be available for family-based aftercare services if all federal and state requirements are met and the treatment is medically necessary. As described above, HFW is already a Medi-Cal covered service, and DHCS anticipates providing guidance for counties and providers regarding HFW in Medi-Cal, including claiming procedures and rate methodology that will take effect July 1, 2026.

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[9] Subject to final state budget appropriations, a CFL will be issued for FY 2025-26 allocations to placing agencies.

[10] Per ACIN I-07-23, out-of-state residential facility placement requirements were updated, and all out-of-state residential facilities were decertified as of January 1, 2023, unless those placements fell within certain exceptions described in ACIN I-07-23.

For comprehensive claiming instructions for current Wraparound programs, not including funds allocated for the implementation of FFPSA Part IV aftercare services, please see CFL 20/21-94. Technical assistance regarding options to leverage and coordinate funds between systems may be requested by emailing WraparoundQuestions@dss.ca.gov.

STRTP PROVIDER REQUIREMENTS

The STRTP shall provide, arrange for the provision of, or assist in developing an individualized family-based aftercare support plan. In the development of the aftercare support plan, the STRTP, CFT and HFW county or provider shall review and include, as appropriate, the QI recommendations. The planning for a youths' transition from an STRTP begins when the youth is initially placed in an STRTP, and as the CFT begins actively preparing for the youths' transition from the STRTP, the STRTP should also participate and support coordination of and assist with the youths' transition from the STRTP to the subsequent placement (WIC 16501(a)(4)). The STRTP will coordinate with the HFW county or provider.[11][12][13] In some circumstances, the STRTP might be certified to provide aftercare services.[14][15] This coordination is vital to ensure the continuity of care and supports the youth's successful reintegration into a family-based setting.[16][17]

COMMUNITY TREATMENT FACILITY PROVIDER REQUIREMENTS

CTFs shall provide, arrange for the provision of, or assist in developing an individualized family-based aftercare support plan as a youth moves from CTF placement to a family-based setting, a permanent living situation, or to a transitional housing program.[18]

In the development of the aftercare support plan, the CTF, Child and Family Team, and HFW county or provider should review and include, as appropriate, the QI's recommendations. As the Child and Family Team begins actively preparing for the youth's transition from the CTF, the CTF should also assist with the youth's transition to the subsequent placement by coordinating with the HFW county or provider. In some circumstances, the provider offering the aftercare services could be the CTF provider.

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[11] All County Letter (ACL) 21-116
[12] Welfare & Institutions Code (WIC) § 4096.6
[13] Welfare & Institutions Code (WIC) 4096
[14] Health & Safety Code (HSC) 1562.01
[15] STRTP Interim Licensing Standards (ILS), V5, § 87022.1
[16] STRTP Interim Licensing Standards (ILS), V5, § 87022
[17] Welfare & Institutions Code (WIC) 16553
[18] HSC Section 1530.90(c)(2)(E)(i)(II) and WIC Section 16501.1(d)(2)(F)(ii)

For questions or additional guidance regarding the information in this letter, contact the CDSS Integrated Practice and Resource Development Section at WraparoundQuestions@dss.ca.gov and the DHCS at FFPSA@dhcs.ca.gov.

Sincerely,

Original Document Signed By

ANGIE SCHWARTZ
Deputy Director
Children and Family Services Division
California Department of Social Services

Original Document Signed By

PAULA WILHELM
Deputy Director
Behavioral Health
Department of Health Care Services

Attachments

APPENDIX A

California Wraparound Standards

The **CA Wraparound Standards** are a set of Standards that have been updated to reflect expectations concerning implementation of the CA HFW Model to ensure quality, high fidelity, and consistent practices related to the development, implementation, and support of the CA HFW Model. The CA Wraparound Standards were updated, pursuant to WIC Section 4096.6, to meet minimum requirements for implementation of the CA HFW Model for the purpose of providing aftercare. They supersede the Wraparound Standards contained in ACIN I-52-15.

As described in this ACL/BHIN, DHCS is in the process of reviewing these Standards to determine how to best align Medi-Cal and BHSA guidance with CDSS policies and the practices and timeframes from the National Wraparound Initiative. DHCS and CDSS retain the right to continue to update these Standards in future guidance.

The CA Wraparound Standards establish the principles, phases, and key elements that are required for the CA HFW model. These Standards were created to ensure high fidelity practices in direct service delivery with youth and families, including Tribes in the case of an Indian child. Integrated Core Practice Model (ICPM) practice behaviors are based on the Wraparound principles and are aligned with the CA Wraparound Standards. High fidelity is defined as adherence to the four phases and ten principles of the CA HFW Model. These Standards set forth practice elements that are necessary to achieving high fidelity, which in-turn promotes the achievement of consistent positive outcomes for youth and families participating in HFW throughout California.

CA HFW Model 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. Outcomes-Based
10. Persistence

Wraparound Phases:

1. Engagement
2. Plan Development
3. Implementation
4. Transition

The CA Wraparound Standards are organized into the following domains:

I. Fidelity Indicators and Expected Outcomes
   1. Fidelity Indicators
   2. Expected Outcomes

II. Operationalization of the Four Phases
   3. Engagement
   4. Plan Development
   5. Implementation
   6. Transition

III. Facilitative Organizational Supports/System Standards
   7. HFW Program and Community Leadership
   8. Fiscal
   9. Workforce Development and Human Resource Management
   10. Utility-Focused Data and Outcomes Processes

I. FIDELITY INDICATORS AND EXPECTED OUTCOMES

OVERVIEW
The Fidelity Indicators and Expected Outcomes section contains Standards to ensure youth and families receive the CA HFW model according to the Ten Principles of HFW and that programs are actively evaluating their effectiveness in achieving the types of outcomes routinely associated with HFW model implementation. These fidelity indicators and outcomes are simultaneously practice Standards to be implemented and data points to be tracked and evaluated (as outlined in Standard 10.1).

1. Fidelity Indicators:

1.1 Timely Engagement and Planning. HFW staff engages families early and often, including Tribes in the case of an Indian child. First contact with families is made as soon as possible, but no later than 10 calendar days after referral; teams complete a Plan of Care within 30 calendar days; teams review the plan

within the context of a HFW team meeting at least every 30-45 calendar days; teams update the Plan of Care and distribute to all team members at least every 90 days and more often as needed.

1.2 **Led by Youth and Families.** The HFW team prioritizes the youth and family's perspectives and voices in developing and modifying the mix of strategies and supports to ensure the best fit with their preferences. The youth and family's values, culture, expertise, capabilities, interests, and skills are elicited, fully understood, and celebrated. They are viewed as critical to a successful process and are the basis for decision making and problem-solving. In the case of an Indian child, the HFW team prioritizes the perspectives and voices of the youth, family and Tribe. Tribes, in the case of an Indian child, must be an equal voice on the HFW team. (Principle 1: Family Voice and Choice)

1.3 **Strength-Based.** Functional strengths of the youth, the family, all team members, and the family's community are collectively reviewed and utilized throughout the HFW process. Identified strengths are functional in nature and drive decision making and service planning. Team members remain focused on solutions, rather than dwelling on negative events. The Integrated Practice-Child and Adolescents Needs and Strengths (IP-CANS) is critical and required for strengths identification. (Principle 2: Strength-Based)

1.4 **Needs Driven.** HFW services and supports are focused on addressing the high priority underlying needs of the youth, as well as their family members. Needs statements refer to the underlying reasons why problematic situations or behaviors are occurring, not simply stated as deficits, problematic behaviors, or service needs. The HFW process continues until needs are sufficiently met. The IP-CANS is critical and required for needs identification.

1.5 **Individualized.** The HFW team is committed to finding creative, highly individualized strategies that are customized to match each youth and family's needs, strengths, values, culture, preferences and reduces harm over time. The HFW plan is uniquely tailored to fit the family and capitalize on the assets of their community and informal networks and in the case of an Indian child, the Tribe. (Principle 3: Individualized)

1.6 **Use of Natural and Community Based Supports.** Natural supports are integral team members. HFW teams are strengthened by the contributions of natural supports. HFW teams prioritize strategies in the Plan of Care that utilize natural supports, and that take place in the family's community, to reduce reliance on formal supports while fostering sustainability within youth and family's community. (Principles 4, 5: Natural Support, Community Based)

1.7 **Culturally Respectful and Relevant.** HFW teams recognize that a family's traditions, values, and heritage are sources of great strength. HFW teams use strategies that are relevant to and respectful of the youth and family's culture, including Tribes in the case of an Indian child. HFW teams work to connect families with individuals and organizations that provide culturally relevant support after the family transitions from formal HFW services. (Principle 6: Culturally Respectful and Relevant)

1.8 **High-Quality Team Planning and Problem Solving**. HFW teams are comprised of formal and natural supports across all Children's System of Care partners who work together to develop, implement, and monitor the individualized Plan of Care that meet the unique needs of the youth and family. All team members take ownership over their assigned tasks and collaborate to meet the youth and family's needs. Teams experience optimism, commitment, and energization. (Principles 7, 8: Team Based, Collaboration)

1.9 **Outcomes Based Process**. The HFW team monitors the success of the Plan of Care—including progress toward meeting needs, strategy implementation, and task completion. These are measured objectively, reviewed routinely, and used to inform changes to the Plan as needed. Needs statements are linked to measurable outcomes and data from standardized instruments including the IP-CANS and are integrated into the planning process. (Principle 9: Outcomes-Based)

1.10 **Persistence**. The HFW team views setbacks and challenges not as evidence of a youth, or family failure, but as an indicator of a need to revise the Plan. The HFW team is committed to implementing a Plan that reflects the HFW Principles, even in the face of limited system capacity. (Principle 10: Persistence)

1.11 **Transitions as part of the Fourth Phase of HFW.** Transitions are planned for in advance and celebrated with full youth and family participation. Transitions only happen when the youth and family have had their needs met, not due to an adverse event or an administrative requirement.

2. Expected Outcomes:

Policies, procedures, and data processes *(for example, IP-CANS, satisfaction surveys, use of the Wraparound Fidelity Index (WFI), Team Observation Measure (TOM), Document Assessment Review Tool (DART), quality assurance phone calls, post HFW team meeting verbal feedback or feedback forms,*

documentation review, etc.) ensure that the HFW program is routinely evaluating its effectiveness in the following areas (in compliance with Standard 10.2 Evaluation Metrics and Outcomes):

2.1 **Youth and Family Satisfaction.** Youth and families are satisfied with their HFW experience and their progress. Policies and procedures are in place to record and evaluate youth and family satisfaction with their HFW experience. In the case of an Indian child, the Tribe is satisfied with the HFW experience. Policies and procedures are in place to evaluate the Tribe's satisfaction with their HFW experience.

2.2 **Improved School Functioning.** Youth experience improved educational and vocational functioning as a result of their involvement in HFW. They have more consistent attendance, are participating at or above grade level or according to their educational plan, and/or are developing needed vocational experience.

2.3 **Improved Functioning in the Community.** Youth experience improved functioning in the community as a result of their involvement in HFW. Policies and procedures are in place to record and evaluate the level of justice involvement and engagement with community activities.

2.4 **Improved Interpersonal Functioning.** Youth and their families experience improved interpersonal functioning as a result of their involvement in HFW. There is less stress and strain at home attributed to them and they are able to develop or maintain positive family relationships and friendships.

2.5 **Increased Caregiver Confidence.** Families have access to effective needed services and supports. Caregivers feel increased confidence in their ability to manage future problems and they know how to find and access services and effectively address crises.

2.6 **Stable and Least Restrictive Living Environment.** Youth experience permanency and stability in their community-based living situation. Youth do not experience a new placement in an institution (such as detention, psychiatric hospital, treatment center, or STRTP) and/or have not moved between residential settings.

2.7 **Reduction in Inpatient, Emergency Department Admission for Behavioral Health Visits.** Youth experience stability with regard to their behavioral health, necessitating fewer or no visits to the hospital.

2.8 Reduction in Crisis Visits. Youth and natural supports are able to avert most crises and manage most impending crises without professional support.

2.9 Positive Exit from HFW. Youth and their families exit HFW based on stabilization and adequate progress in meeting needs; youth and families are not discharged from HFW due to an adverse event.

II. OPERATIONALIZATION OF THE FOUR PHASES

The Operationalization of the Four Phases section contains Standards to ensure high fidelity practices in direct service delivery with youth and families, including Tribes. This section defines the program and practice elements that are necessary to achieving high fidelity according to the Four Phases of HFW. The Standards are organized into four sections: Engagement, Plan Development, Implementation, and Transition.

3. Engagement

3.1 Orientation. The HFW team orients youth and families to the HFW process, including explaining the HFW principles and phases, addressing legal and ethical considerations, and explaining the role of each member on the team including the family's role and the role of natural supports and Tribes in the case of an Indian child.

3.2 Safety and Crisis Stabilization. The HFW team addresses pressing needs and concerns so that the family and team can focus on the HFW process. If immediate response is necessary, the HFW team formulates a plan for immediate intervention and stabilization, including development of a crisis plan and ensures access to 24/7 crisis response when needed.

3.3 Strengths, Needs, Culture and Vision Discovery. The HFW team facilitates conversations and activities with the youth and family to identify individual and family strengths, needs, culture, and their vision for a better future. The facilitator prepares a summary document to clearly communicate strengths, needs, culture and vision to all team members, to orient new team members as they are added to the process, and to support the initial plan development process.

3.4 Engage all Team Members. The HFW team engages the participation of team members across all Children's System of Care partners (including formal, natural supports, and Tribes, in the case of an Indian child), who care about and can aid the youth and family. The HFW team encourages and facilitates their active participation by clarifying their roles and responsibilities on the

team. The facilitator intentionally engages the team in activities to ensure a positive and collaborative team culture.

3.5 Arrange Meeting Logistics. The HFW team ensures that meetings take place at a time and in a location that is convenient and accessible to all team members with priority given to family needs and family voice and choice, taking into consideration family schedules, culture, and history of trauma, and ensuring equitable access for all youth and families. The HFW team plans for and arranges meeting logistics such as transportation, interpretation, telehealth capability, etc.

4. Plan of Care Development

4.1 Develop and Document Team Agreements, Additional Strengths, and Team Mission. Building upon the activities completed during engagement, the facilitator leads the team in:

(1) developing formal agreements on how the team will engage during meetings and make decisions,

(2) identifying and documenting additional strengths of the youth, family, other team members, and the community, and

(3) creating a team mission statement that defines the overall purpose of the HFW team in alignment with the family vision.

4.2 Describe and Prioritize Needs, Develop Goals, and Assign Strategies. The facilitator guides the team in reviewing needs identified during engagement, adding any additional needs, and prioritizing them. The HFW team uses the prioritized needs to develop specific, measurable goals and outcomes. The facilitator engages the team in brainstorming multiple creative strategies to meet the prioritized needs, goals, and outcomes before selecting strategies and assigning responsibility in the form of action items.

4.3 Develop an Individualized Plan of Care. The HFW team develops a comprehensive initial Plan of Care that is based on the prioritized needs, goals, and strategies of the family and youth. This is accomplished via a high-quality team process across all Children's System of Care partners, including the Tribe in the case of an Indian child, that elicits multiple perspectives, builds trust and shared vision amongst team members, and demonstrates the HFW principles. The facilitator leads the team to ensure:

(1) The Plan of Care is in alignment with the family vision and team mission statement and is based on the strengths, needs, and culture of the youth and family.

(2) The Plan of Care addresses needs across multiple life domains and Children's System of Care partners as identified and prioritized by the HFW team.

(3) Strategies and action items are clearly documented and include who is responsible for each strategy/action item, due dates are established, and each team member understands their role. Strategies are culturally relevant and include a balance of formal services, natural supports, and community and family resources, with greater reliance on natural supports over time.

(4) The Plan of Care includes an array of services and supports that are well-coordinated across Children's System of Care partners, tailored to meet the youth and family's individual needs, and delivered in the community in which the youth and family live, with priority given to family needs and family voice and choice, taking into consideration family schedules, culture, and history of trauma and ensuring access for all youth and families.

(5) Natural supports and sustainable community resources are included in the Plan, or the Plan includes strategies to identify and develop community and natural supports before the youth and family transition out of the HFW Program.

(6) Transition from formal services is graduated; plans set benchmarks for transitioning to less restrictive, less intrusive, and less formal services throughout the HFW Process, taking into consideration the ability of families to move through the process at their own pace.

4.4 Develop a Crisis and Safety Plan. The facilitator leads the team in developing a crisis and safety plan that identifies and prioritizes safety needs, potential risk and crisis situations, as well as highly individualized proactive and reactive strategies for the youth, family, and team members to respond effectively. Identified strategies should be chosen by the youth and family, should be culturally relevant, and should maximize the use of natural supports wherever possible.

5. Implementation

5.1 Implement the Plan of Care. The HFW team carries out the initial Plan of Care, monitoring completion of action items and strategies and their success in

meeting needs and achieving outcomes in a manner consistent with the HFW principles. Teams celebrate successes as they occur.

5.2 **Review and Update the Plan of Care.** The facilitator engages the team to continually review the Plan; assess the progress and the effectiveness of strategies; and update the Plan as needed, including changing goals and strategies if the needs of the youth and family change. The facilitator documents and communicates, via meeting minutes and other forms of communication, completion of tasks and new assignments, team attendance, use of formal and natural supports, use of flex funds, and updates to the Plan. The Plan of Care is updated in an HFW team meeting and distributed to all team members at least every 90 days, and more frequently, as needed.

5.3 **Build Supports while Maintaining Team Cohesiveness and Trust.** The facilitator continually assesses and addresses team cohesion, trust, and commitment to ensure effective collaboration. When appropriate, teams seek and develop potential natural supports and add them to the team. Teams orient and engage new team members as they are added.

6. Transition from Fourth Phase of HFW

6.1 **Develop a Transition Plan.** When the family has reached pre-determined benchmarks indicating sufficient progress towards completing the team mission and goals, and the youth, family, and team agree the family is ready for transition, the HFW team will begin developing a formal individualized transition plan. Led by the facilitator, the HFW team will outline a purposeful transition process which identifies needs, services, and supports that will persist past formal HFW and includes strategies to transition any remaining support being provided by HFW staff to those ongoing supports. For adoptive families utilizing Adoption Assistance Program (AAP) funding, families are educated on post adoptive services that can assist with transition.

6.2 **Develop a Post-transition Safety Plan.** The facilitator leads the team in developing a crisis and safety plan (or adjusting the current crisis and safety plan) that identifies potential crisis situations that may occur after transitioning from formal HFW. The crisis and safety plan includes individualized, proactive, and reactive strategies for the youth, family, and other supports who will remain after HFW concludes. The youth and family play a pivotal role in identifying these strategies, which should be culturally relevant, and maximize the use of natural and community supports.

6.3 Create a Commencement and Celebrate Success. The team ensures that the conclusion of formal HFW is celebrated in a manner that reflects a positive transition, is culturally relevant, and is meaningful to the youth and family.

III. FACILITATIVE ORGANIZATIONAL SUPPORTS/SYSTEMS STANDARDS

OVERVIEW:
The Facilitative Organizational Supports/Systems Standards section of the CA Wraparound Standards pertains to the organizational and systems leadership functions supporting the HFW implementation. This includes the HFW organization's internal priorities and their relationship to the community and Children's System of Care. The emphasis is on the creation of effective operational environments for the development and delivery of quality supports and services. Included in this section are Standards relating to HFW Program and Community Leadership, Fiscal, Workforce Development and Human Resource Management, and Utility-Focused Data and Outcomes Processes.

These requirements will evolve over time. Future guidance will provide updates as to the continued application of the Standards in Medi-Cal, BHSA, or the Immediate Needs program.

7. HFW Program and Community Leadership

7.1 Youth and Family as Key Decision-Makers. Youth and family feedback is utilized to inform all levels of the HFW Program, including service planning and implementation, policy and procedure development, workforce development, and quality improvement of the CA High Fidelity Wraparound model.

7.2 Community Leadership Team. The county establishes a Community Leadership Team, which works collaboratively and engages in shared decision-making to ensure the CA Wraparound Standards are met at the organizational and systems level. Counties ensure formal communication structures are established between Community Leadership Teams and Interagency Leadership Teams (ILTs). Tribes within the region must be included in the Community Leadership Team. In addition, the Community Leadership Team works to:

(1) Ensure all other child serving entities are provided opportunities to participate in the Community Leadership Team.

(2) Actively identify and remove interagency and system barriers that interfere with interagency collaboration and effective service delivery to families.

(3) Identify and support cross-agency training and community collaboration to promote family-centered and culturally relevant practices and support high fidelity to the CA HFW model.

(4) Ensure there is a process in place to review family plans on the community and systems level based on the values, principles, and activities of the HFW process.

(5) Ensure there is a process in place to regularly review the use of, access to, and procedures around flex funds to ensure individualized family needs are being met.

(6) Ensure there is a process in place to regularly review HFW data at the organizational, community, and systems levels, and to use data to inform Continuous Quality Improvement (CQI) efforts that reflect HFW values and HFW implementation Standards.

7.3 **Eligibility and Equal Access.** HFW eligibility and referral criteria and processes ensure adequate, appropriate, and equitable access to HFW services, and do not exclude families because of the severity or nature of their needs. HFW is adequately publicized, available, and accessible so that youth and families who would benefit are able to participate. There is adequate program planning to ensure that once enrolled, families have access to an adequate array of services and 24/7 support to meet complex needs.

8. Fiscal

8.1 **Funding Supports the CA High Fidelity Wraparound Model.** The HFW Program has fiscal practices that are aligned with the values and principles of Wraparound and ensure the CA Wraparound Standards are met. Budgets and contracts at all levels, regardless of county or provider-based service provision allocate funding for essential Wraparound operations which include required staffing, workforce development data collection, and data management systems and the costs of services.

8.2 **Equitable Funding Across System Partners.** The HFW Program must ensure that federal, state, local, or private resources available across the Children's System of Care are leveraged to the maximum extent to meet the needs of youth and families served by HFW so that the service is funded adequately. Collaboration and equitable contribution across systems partners are principles of HFW services. Medi-Cal may be leveraged for youth who are eligible.

8.3 **Cost Savings are Reinvested.** Savings achieved by HFW (i.e., total annual revenues in excess of total expenditures) are reinvested to expand or enhance

services and resources for youth and families. There is a process to track the use of these reinvested funds that includes program description(s), budget(s), and reporting of outcomes achieved.

8.4 Availability, Access, and Approval of Flex Funds. The HFW Program has a process to ensure families have timely access to flexible funds to meet their urgent and individualized needs when these needs are not readily met by other resources. There is a defined approval process that ensures requests for flexible funds are evaluated based on approval/recommendation of the HFW team and whether the use of funds:

(1) adds value to the team mission and supports the individualized care plan,

(2) builds on family strengths,

(3) meets identified youth and family needs,

(4) are culturally relevant,

(5) builds on natural support and/or community capacity,

(6) represents a good deal for the investment and

(7) includes a plan for sustainability.

The defined approval process varies based on local county and provider policies. In the case of an Indian child, flex funds may be used to pay the Tribe for activities that address youth and family needs.

8.5 Collaborative Oversight of Flex Funds. There is collaboration and shared oversight amongst funders and providers regarding the use and availability of flexible funds. A process is in place to ensure flexible funds are pooled and held to meet the needs of all families served. Tracking and accounting for flexible funds whether approved or denied includes the amount, purpose, and HFW team recommendation of the request.

8.6 Funding Sources and Program Requirements do not Limit Flex Funds. 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.

9. Workforce Development and Human Resource Management

9.1 Culturally Responsive Workforce. HFW Programs attempt to hire staff that can appropriately meet the cultural, racial and linguistic needs of youth and

families. Staffing reflects the cultural, racial and linguistic diversity of the youth, families and communities served.

9.2 Tribally Responsive Workforce. In the cases of Indian children, the HFW Program shall prioritize respect for tribal sovereignty, traditions, and values and ensure respectful communication, collaboration, and advocacy. The team has the goal of promoting positive outcomes through culturally rooted support systems and services, and the team is responsible for building partnerships with tribal representatives, encouraging participation in tribal traditions and ceremonies and understanding the value of services and supports that the Tribe can offer.

9.3 Flexible and Creative Work Environment. There is a high degree of collective responsibility for program quality and improvement, cohesion among staff members, open communication, and a clear sense of mission and compliance with HFW. Programs and its leaders create structures that promote staff creativity and flexibility.

9.4 Hiring, Performance Evaluation, and Job Descriptions. Programs have rigorous hiring practices and use meaningful performance assessments. Job descriptions for all positions reflect best practices regarding Wraparound skills and expertise and have clear expectations for performance. The following are roles or functions on a HFW team, not necessarily individual people or positions.

(1) Youth Partner

(2) Parent Partner

(3) HFW Facilitator

(4) Family Specialist

(5) Fidelity Coach

(6) Clinical Supervisor (licensed)

(7) HFW Supervisor/Manager (license not required)

Forthcoming Medi-Cal guidance will provide additional requirements related to roles and staffing.

9.5 Workforce Stability. Programs implement strategies to maintain a stable workforce and reduce turnover, including matching wages according to the community the program is in, maintaining manageable workloads for staff, implementing promotion/advancement structures, and providing wage

increases or leadership opportunities that do not require a position change to achieve.

9.6 High Fidelity Training Plan. Programs have a high fidelity training plan that incorporates initial, annual, booster trainings, and ongoing trainings. The training plan includes both general HFW training and role-specific training for all roles, including specific training for all Clinical Supervisors and Wraparound Supervisors/Managers. The training plan should also include ICWA and Tribal sovereignty training, as well as training that supports populations with specific and unique needs.

In the future, a Medi-Cal HFW Center of Excellence may prescribe more specific requirements for this training plan.

9.7 Community-Based Training Program. Administer the training plan in collaboration with community members and families with HFW experience as part of the training team. Ensure efforts are inclusive of and promoted to system and community partners to ensure comprehensive support within the Children's System of Care and that team members from other systems have a context for HFW participation.

In the future, a Medi-Cal HFW Center of Excellence may prescribe more specific requirements for this training program.

9.8 Coaching and Supervision. Programs provide team members with initial apprenticeship and ongoing coaching that emphasizes Wraparound values, principles, phases and activities, as well as the effective use of flex funds to meet family needs. Leaders will ensure that staff have access to coaching and supervision 24/7, reflective of the flexible scheduling and crisis response needs of families and the community.

In the future, a Medi-Cal HFW Center of Excellence may prescribe more specific requirements for this training program.

10. Utility-Focused Data and Outcomes Processes

10.1 Continuous Quality Improvement. Programs implement a local CQI evaluation plan for both the system and the program to routinely and reliably monitor the overall quality of the HFW initiative. The evaluation plan includes a systematic evaluation process that informs and improves practice locally, assures accountability for achievement of desired outcomes, and contributes to state-wide data collection efforts as they become available. Collected data is current and accurate and minimally includes the ongoing collection, analysis, and reporting of data on:

(1) Demographic information regarding the youth and family population(s) served
(2) Wraparound Fidelity as detailed in Section 1: Fidelity Indicators
(3) Outcomes as detailed in Section 2: Expected Outcomes

In the future, a Medi-Cal HFW Center of Excellence may prescribe more specific requirements for quality improvement.

10.2 Informed Program Practice. Collected data is utilized for program evaluation and improvement at all levels including improving practice with youth and families, improving overall program effectiveness, and improving system supports which impacts the HFW implementation.

In the future, a Medi-Cal Center of Excellence may prescribe more specific requirements for metrics and reporting.

APPENDIX B

HFW Training Requirements and Curriculum

Initial and ongoing training is an integral component of all HFW programs. A robust training plan is essential for staff working in HFW to ensure consistent, high fidelity, and youth and family-driven services. Comprehensive training supports model fidelity, enhances staff confidence and skills, and promotes better outcomes for individuals and families.

As needed, future guidance will address training in the context of Medi-Cal, BHSA, and the Immediate Needs program.

Foundational Wraparound Training

Counties and providers shall comply with one of the following three options regarding Foundational Wraparound Training for all HFW team roles/functions:

1) HFW staff are trained externally by attending the Statewide Standardized Foundational HFW training through the UC Davis RCFFP;

2) HFW staff are trained internally by utilizing the Statewide Standardized Foundational Wraparound curriculum. Prior to counties and providers utilizing the curriculum internally, their internal training staff shall: (1) attend the Foundational Wraparound training available through the UC Davis RCFFP, (2) attend the Foundational Wraparound Training for Trainers available through UC Davis RCFFP, and (3) download the Foundational Wraparound curriculum; or

3) HFW staff are trained internally by utilizing internal curriculum that aligns with the Statewide Standardized Foundational Wraparound curriculum. Counties and providers who choose to utilize their own curriculum are required to submit their internal curriculum for approval through the Portal as a component of their Certification materials. A checklist to guide providers and counties with compliance of their curriculum with Statewide Standardized Foundational Wraparound curriculum is available on the Portal and in the CA Wraparound Standards Toolkit upon the release of this ACL/BHIN.

Child and Family Team Facilitation Training

Per ACL 21-116/BHIN 21-061, the HFW facilitator must be well-trained and skilled in a variety of competencies to support multi-layered responsibilities, care coordination, and dynamics of HFW teams. As such, the Statewide Standardized CFT Facilitation Training is required for all HFW Facilitators. The CFT Facilitation

Training can be accessed through the Cal-Academies, formerly Regional Training Academies, the UC Davis RCFFP, or the Statewide Standardized CFT model curriculum in the California Child Welfare Training (CACWT). The training through the UC Davis RCFFP is specifically tailored for HFW facilitators.

The Integrated Practice Child and Adolescent Needs and Strengths Training and Certification

As outlined in ACL 25-10, the IP-CANS, is required for all youth with an open child welfare case (whether voluntary or with Dependency Court involvement such as Family Maintenance, Family Reunification, and Other Planned Permanent Living Arrangement). The IP-CANS is also required for all youth with an open juvenile probation foster care case.

Although HFW staff are not required to be certified in IP-CANS, all HFW staff should be aware and knowledgeable of the IP-CANS and its role in HFW. Further, counties and providers must ensure roles and processes are clear regarding who completes the IP-CANS and how it is integrated into the HFW team meetings and Plan of Care development.

Individuals completing the IP-CANS on behalf of county placing agencies must complete CDSS-approved training through the Cal-Academies, formally Regional Training Academies, and maintain annual certification via the Praed Foundation. Updated curricula for CFT and IP-CANS courses are detailed in ACIN I-35-24, which also lists available courses. Training is accessible Cal-Academies, formally Regional Training Academies, via the CACWT website. Instructions for creating a CACWT account vary by region; Juvenile Probation and county Behavioral Health staff can refer to the CACWT Partner Organization Resource page. To identify your county's Cal-Academy, visit the CACWT RTA Map Resource Page. For additional information regarding the use of IP-CANS, including certification and training, please see ACL I-35-24.

Initial and Ongoing Trainings

The CA Wraparound Standards require initial and ongoing HFW role-specific training and coaching pertaining to the roles identified in Standard 9.4. These trainings may be provided internally or externally, such as through the UC Davis RCFFP, as available.

APPENDIX C

Continuous Quality Improvement and Evaluation

As needed, future guidance will address Continuous Quality Improvement and Evaluation in the context of Medi-Cal, BHSA, and the Immediate Needs program. Fidelity indicators and expected outcomes measures have been identified by Wraparound leaders across California and are included in the CA Wraparound Standards. Counties and providers must develop local CQI plans and processes pursuant to the CA Wraparound Standards. Technical Assistance for developing CQI plans and processes are available through UC Davis RCFFP. CDSS continues to develop a State-level CQI plan and procedures in partnership with the Wraparound Evaluation and Research Team (WERT).

The California Automated Response and Engagement System (CWS-CARES) is in development and is planned to "go-live" in October 2026. Future versions of CWS-CARES will be used for statewide data collection and reporting and further guidance will be issued at a later date. HFW fidelity indicators will be included in forthcoming versions of CARES and further guidance will be released. However, the data entered into CWS/CMS via the aforementioned SPC informs Wraparound reports currently available in Safe Measures, which is available to support CDSS' and counties' oversight and monitoring responsibilities of HFW programs, including aftercare requirements. The information gathered through the Portal will provide qualitative information to CDSS and DHCS. The following steps will take place to implement a Statewide Wraparound data analysis and collection system in future version of CWS-CARES:

- A draft Statewide CQI plan has been developed and is being piloted, including State-wide fidelity indicators and expected outcomes measures and CQI requirements with counties and providers.
- State-wide fidelity indicators and expected outcomes measures and CQI requirements will be implemented based on feedback and findings from the pilot.
- Technical assistance is available regarding CQI plans and processes, fidelity indicators and expected outcomes measure development, and the Wraparound Fidelity Assessment System (WFAS) tools, to all counties and providers who request support.
- Further guidance will be issued as Statewide CQI policies and processes are refined and updated.

APPENDIX D

California Wraparound Standards Toolkit

The CA Wraparound Standards Toolkit is a collection of HFW best practices and CA HFW model requirements. The Toolkit was developed to assist counties and providers in meeting the CA HFW model requirements. The CDSS and the DHCS, in partnership with the California Wraparound Steering Committee and statewide workgroups, developed this Toolkit to serve as a clearinghouse of information to assist counties and providers in the implementation of HFW. Dedicated community members with lived experience, peer partners, youth partners, and human services professionals all contributed significantly to the Toolkit.

The Toolkit contains valuable information for counties and providers who are in the initial stages of implementing HFW and those who have been long-time implementers and are wanting to keep up to date with new resources and updated policies. The Toolkit will be continually updated as new information and resources become available.

APPENDIX E

Instructions for the High Fidelity Wraparound County Plan Approval and Provider Certification Portal

The Portal is an online system for the CDSS's and DHCS's oversight of HFW. It will remain open indefinitely for the purposes of continued provider certification for new providers, county updates to their plan, providers that currently do not have county contracts, and for the purpose of provider recertification, which will occur every three years from the providers' original certification date.

The Portal instructions for counties:

- Verify compliance with each specific requirement for the CA HFW Model using the CA Wraparound Standards.
- Upload supporting documentation (for example, contracts with providers, policies, procedures, manuals, desk guides, training plans, etc.) that pertain to each of the requirements in the Portal and note next to each Standard the document(s) and the page number(s) where the Standard requirement is demonstrated.
- Utilizing the "Description of Practice" field, describe how the Standard requirements are operationalized within the HFW program.

Counties must complete all fields in the Portal, including uploading supporting documentation. Counties shall describe how the county holds contracted providers accountable for meeting each Standard requirement. Counties shall identify where in the supporting documentation the provider is tasked with meeting the Standard and how the county oversees the provider. The uploaded documents should be county documents, not provider documents. All 58 counties submit a unified plan with the approval of the MHP, child welfare and probation departments. Each county submits one plan, including counties who are contracting with a provider.

The Portal instructions for providers:

The Portal is the ongoing platform for initial certification and recertification for the CDSS's oversight of the CA HFW Model. In future guidance, DHCS will provide any additional information required and included in the Portal. Initially, providers shall complete the following using the Portal:

- Verify compliance with each specific requirement for the CA HFW Model using the CA Wraparound Standards.
- Upload supporting documentation. For example, contracts with counties, policies, procedures, manuals, desk guides, training plans, etc. that pertain to each of the

requirements in the Portal and note next to each Standard requirement the document(s) and the page number(s) where the Standard is demonstrated.
- Utilizing the "Description of Practice" field, describe how the Standards are operationalized within the providers' HFW program.
- Submit recertification information and supporting documentation every three years.

Providers shall have one submission with supporting documentation, even if they contract with multiple counties. Providers shall describe any specifics that vary by county in the "Description of Practice" field. The Portal will not accept multiple submissions for certification from the same provider.

REFERENCE 5

CDSS Social Services

Wraparound Services

Background History

In 1997, Wraparound was established in California under Senate Bill (SB) 163 (Chapter 795, Statutes of 1997) which allows California counties to develop a Wraparound Services program using State and county Aid to Families with Dependent Children -Foster Care (AFDC-FC) dollars.This legislation permits counties to use the funding for planning and service delivery instead of for placing children/youth in high-level group homes. The intent of the legislation was to return children and youth in group home care to their homes and communities or help children at imminent risk of placement in high-end group homes to remain in their homes. Wraparound may also be used for children who are eligible for Adoption Assistance Program benefits.

The SB 163 Legislation requires Wraparound services to:

- Be family centered, individualized, culturally relevant, and strength based;
- Be team and community based;
- Identify and rely on a family's natural & community supports,
- Develop a child and family team plan to identify service needs;
- Place child in the least restrictive environment;
- Track and evaluate outcomes;
- Reinvest cost saving into child welfare programs.

In 2010, Assembly Bill (AB) 1758 (Chaptered 561, Statutes of 2010) updated statue to established that Wraparound was no longer a pilot project, but an optional statewide program. AB 1758 also made clear that being in Wraparound does not, by itself, change the child's eligibility for Medi-Cal.

In 2017, Assembly Bill (AB) 404 (Chaptered 732, Statutes of 2017) updated statute to reflect the rate for Wraparound services to be equal to the rate for short-term residential therapeutic programs, less the cost of any concurrent out-of-home placement. AB 404 also revised the definition of an eligible child to mean (1) A child or nonminor dependent who has been adjudicated as either a dependent, transition dependent, or ward of the juvenile court pursuant to Section 300, 450, 601, or 602, (2) A child who is the subject of a petition filed pursuant to Section 602 and who is participating in a program described in Section 654.2, 725, or 790, and is at risk of placement in out-of-home care, (3) A child or nonminor dependent who is currently,

CDSS Social Services

To review the current Wraparound statue, please visit California Welfare and Institutions Code sections 18250 – 18258.

As amended by the Family First Prevention Services Act (FFPSA), Section 672(k)(4)(F) of Title 42 of the United States Code, requires six months of aftercare services to be provided to youth exiting Qualified Residential Treatment Programs (QRTPs). California operationalized FFPSA's mandate in Welfare Institutions (WIC) Code 4096.6, which states that by October 1, 2021, each county child welfare agency, probation department, and mental health plan will jointly provide, arrange for, or ensure the provision of the six months of aftercare services for youth and nonminor dependents transitioning from a Short-Term Residential Therapeutic Program (STRTP) to a family-based setting. Aftercare support in California will, by October 1, 2022, utilize California's High-Fidelity Wraparound model. By leveraging Wraparound to provide these services, aftercare services must be informed by the ten Wraparound Principles and the Wraparound Standards, published and outlined in ACIN I-52-15, supporting each child's permanency plan.

COVID-19 Resources

A Playbook and Webinars for Supporting Child and Youth Permanency through a Wraparound-Informed Approach during COVID-19

This Playbook is a practical guide for child welfare agencies and service providers to understand and implement Wraparound-informed strategies, recognize the flexible funding available on a short-term basis described in ACL 20-44, and to better understand behavioral health service delivery for child welfare and probation involved youth and families. Please note the flexible foster care rates authorization expired on September 30, 2020 and have not been reauthorized. However, most of the remaining information in the Playbook and webinars remains relevant and helpful.

CDSS General COVID-19 Resources, including COVID-19 related county letters

National Wraparound Implementation Center and National Wraparound Initiative COVID Resources

The purpose of this document is to review key elements of the Wraparound process practice model and potential modifications that may be necessary to effectively support young people and families participating in Wraparound during COVID-19, while also adhering to public health and safety standards.

Wraparound Resources

former foster youth in identifying key recommendations for the ALL-IN Foster Adoption Challenge and state and federal efforts toward achieving permanency for all waiting children and youth. The ACF Youth Engagement team provided specific recommendations on how agencies and courts could improve permanency outcomes by supporting connections with kin, securing relational permanency for youth, and achieving successful adoptions for older youth.

Wraparound Video

Hear from state child-welfare leadership, probation chiefs, and youth and families on why Wraparound services are a smart and effective intervention to keep families together and prevent system involvement for our children and youth.

National Wraparound Implementation Center (NWIC)

NWIC supports states, communities, and organizations to implement Wraparound as part of broader health reform strategies. NWIC uses innovative approaches grounded in implementation science and spanning the policy, financing, evaluation, and workforce development areas to comprehensively support implementation and build sustainable local capacity to provide high-quality Wraparound, thereby increasing positive outcomes for children, youth, and their families.

National Wraparound Initiative (NWI)

National Wraparound Initiative works to promote understanding about the components and benefits of care coordination using the Wraparound practice model, and to provide the field with resources and guidance that facilitate high quality and consistent Wraparound implementation.

The National Center for Innovation and Excellence

The National Center for Innovation & Excellence (NCFIE) is a dynamic community of thought leaders and experts dedicated to developing youth, strengthening families, and building strong communities by developing resources, delivering services, providing technical assistance, consultation and training. They specialize in family-centered, youth-driven system reform initiatives, scaling innovations to excellence, privatization and high-fidelity wraparound.

Vroon VDB

Vroon VDB LLC (VVDB) was the leading wraparound training, coaching, and consulting company dedicated to supporting improved access to high fidelity wraparound for individuals and families across North America.

Wraparound Evaluation and Research Team (WERT)

The Wraparound Evaluation and Research Team seeks to improve the lives of children and their families through research on the implementation and outcomes of the Wraparound

CDSS Social Services

Contact Us

California Department of Social Services
Children and Family Services Division
System of Care Branch
Family-Centered Practice Unit

744 P Street, MS 8-3-570
Sacramento, CA 95814
Email: WraparoundQuestions@dss.ca.gov

- County Wraparound Coordinators
- CDSS Program Consultants

Wraparound Links

- FFPSA Guidance and Resources
- UC Davis Resource Center for Family Focused Practice (RCFFP)
- Partnerships for Well-Being
- Wraparound Training
- Wraparound Consultation
- Wraparound Resources
- History of Wraparound in California

Wraparound Related Links

- Adoption Assistance Program (AAP)
- Family First Prevention Services Act (FFPSA)
- Child and Family Teams
- COVID-19 Resources
- Family Finding
- Integrated Core Practice Model
- Peer Partners
- Safety Organized Practice (SOP) Toolkit
- Early Childhood and Child Welfare

Letters and Notices

- ACL 21-116 (September 30, 2021) FFPSA Part IV Aftercare Requirements

CDSS Social Services

- CFT and CANS State Policy Letters
- ACIN I-73-21 (September 8, 2021) - Family First Prevention Services Act Implementation In California
- ACIN I-52-15 (July 29, 2015) – Updated Standards for California Wraparound
- ACIN I-15-18 (March 23, 2018) - California Wraparound Training Guidelines
- CFL 20-21-94 (April 30, 2021) – Updated Comprehensive Claiming Instructions For the Wraparound Program
- Related Wraparound Letters and Notices

Webinars

- FFPSA Recorded Trainings
- County Fiscal Letter (CFL) 20/21-94 - Wraparound Program Comprehensive Claiming Instructions
- Wraparound Evaluation and Research using Wraparound Fidelity Assessment System (WFAS)

REFERENCE 6

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

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	» Stable and Least Restrictive Living Environment
» Improved School Functioning	» Reduced Justice Involvement
» Improved Functioning in the Community	» Reduction in Inpatient, Emergency Department Admission for Behavioral Health Visits
» Improved Interpersonal Functioning	» Reduction in Crisis Visits
» Increased Caregiver Confidence	» 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.