MEMORANDUM

To:	Mainstream Medicaid Managed Care Plans (MMCPs) and HIV Special Needs Plans (HIV SNPs)
From:	New York State Office of Mental Health (OMH) and the Department of Health (DOH)
Date:	September 29, 2025
Subject:	Health Home Serving Children and High-Fidelity Wraparound

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Purpose of this Memo

The purpose of this memo is to provide Mainstream Medicaid Managed Care Plans (MMCPs) and HIV Special Needs Plans (HIV SNPs) (collectively referred to as Managed Care Organizations "MCOs" herein) with an overview of the High-Fidelity Wraparound (HFW) model and the eligibility criteria necessary for enrollment. Additional guidance may be issued as the Office of Mental Health (OMH) and the Department of Health (DOH) continue to expand HFW statewide.[1]

Overview

HFW is an evidence-based approach for intensive care coordination within the New York State (NYS) Health Home Serving Children (HHSC) program. HFW is designed to provide coordinated, comprehensive, and youth-and-family-driven care for children and youth with significant mental health needs or a determination of Serious Emotional Disturbance (SED) and complex cross system needs.

Guided by ten core principles, HFW supports youth with multiple system involvement who are experiencing serious mental health or behavioral challenges, including those at imminent risk of long-term hospitalization or out-of-home care and treatment. The process brings together a collaborative team that focuses on the strengths of the youth and family, with the goal of helping them achieve lasting success at home, in school, and within their community.

Core Principles

- Family voice and choice
- Team-based
- Natural Supports
- Collaboration
- Community-based
- Culturally competent
- Individualized
- Strengths-based
- Unconditional
- Outcome-based

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[1] **HFW is an expanding program and is not available in all counties. A list of Care Management Agencies offering HFW and the county they serve can be found here*

What Makes HFW Different

HFW stands apart from traditional care management approaches as an evidence-based practice that follows defined and measurable fidelity guidelines. Activities within each phase: engagement, planning, implementation, and transition are delivered according to specific standards to promote consistency, effectiveness, and quality. These standards include:

Individualized & Strength-Based Approach

- Fidelity guidelines ensure each Plan of Care is rooted in the youth and family's unique strengths, needs, and culture.

Team Based Planning Process

- HFW requires the creation of a Child & Family Team (CFT), made up of the family, professionals, and natural supports who co-create a plan focused on underlying needs, not just symptoms or service gaps. The use of Youth and Family Peer Support is encouraged, as evidence shows it improves engagement and outcomes.

Family Voice & Choice

- Fidelity standards prioritize family leadership. Families shape decisions based on their values, preferences, and lived experience.

Natural Supports Play a Central Role

- HFW requires natural supports such as family, friends, or community members to be invited and actively involved in the process.

Timely, Regular, Supportive Interaction

- Care Managers maintain weekly contact with families and facilitate monthly team meetings. Frequent engagement ensures that the Plan of Care evolves with the family's changing needs.

Flexible, To Meet the Needs of Youth and Family

- HFW typically lasts 10–18 months, but fidelity guidelines state that enrollment should continue until the youth and family complete the four phases of the model and graduate. A youth and family can choose to no longer participate in this voluntary program prior to graduation.

Lower Caseloads

- Each HFW Care Manager supports a caseload of ten youth. A lower caseload allows for frequent contact, deeper understanding, and flexible, responsive support which is key to maintaining fidelity and achieving individualized outcomes.

Eligibility Criteria

To enroll in HFW, the child/youth must meet each of the following criteria:

1. HHSC enrolled/eligible through either SED determination OR two (2) mental health (MH) diagnoses

   AND

2. Must be 6 – 21 years old upon HFW enrollment

   AND

3. The child/youth's acuity is determined to be Complex (High) based upon the Child Adolescent Needs and Strengths (CANS-NY) assessment.

   AND

4. Within the last year, the child/youth (A) has been involved with and transitioned from at least one (1) of the below programs, services, or facilities **and/or** (B) is currently receiving or enrolled in at least one (1) of the following services or programs and is expected to transition back to their community within the next 30 days:

   - Out-of-home care and treatment (e.g., State psychiatric center, psychiatric inpatient hospital, Residential Treatment Facility, Children's Community Residence, Residential Substance Used Disorder (SUD) Treatment, Juvenile Justice Residential Placement, Residential Treatment Center, etc.)
   - Intensive care/treatment for SED (e.g., Partial Hospitalization, Children's Day Treatment, Youth Assertive Community Treatment (ACT), Home and Community Based Services (HCBS) Waiver with K3 code (enrolled under SED)
   - Two (2) or more crisis responses due to mental health challenges (e.g., emergency room visit, mobile crisis response, Children's Crisis Residence, Home Based Crisis Intervention (HBCI), Mobile Integration Team (MIT)
   - Foster Care placement (QRTP, VFCA, etc.)

   OR

   The child/youth is currently going through the application process or on the waitlist for Youth ACT or out-of-home care and treatment.

   AND

5. The child/youth is involved with two (2) or more systems: Child Welfare, Juvenile Justice, Complex Health, Mental Health, Substance Use, School-Based Support, Intellectual/Learning Disabilities Services.

Referral and Enrollment

Referrals for HFW can originate from any source: however, youth must be enrolled in HHSC to receive HFW. Additionally, HFW can only be implemented by NYS HFW-Certified Care Managers employed by a HHSC Care Management Agency (CMA) that has been approved and designated by OMH. For this reason, the lead HHSCs are responsible for managing referrals, confirming eligibility, and coordinating with designated CMAs to determine capacity and assignment.

C-SPOAs play an active role in identifying and supporting eligible children/youth and families to access HFW. C-SPOAs review the specific needs of a referred child/youth/family to determine if the child/youth is eligible for HFW and would benefit from this approach to intensive care coordination. Additionally, C-SPOAs work closely with eligible children/youth and families to assess interest in participation and consult with the lead HHSCs to determine availability. If enrollment proceeds, C-SPOAs remain involved to support a smooth transition.

MCOs Role in HFW

MCOs are vital in identifying youth that may be eligible for HFW and should collaborate with the Lead HHSCs to ensure timely and appropriate access to HFW services. MCO's can contact the C-SPOA to assist with enrollment if the child/youth is not already enrolled with Health Home. MCOs and Health Homes should collaborate on information sharing and care coordination for HFW eligible youth. Collaboration should include but is not limited to educating/coaching youth and family members, developing Plans of Care, monitoring outcomes, information sharing, and coordination on the discharge plan.

Additional Resources

- Health Home High-Fidelity Wraparound for Children/Youth with Serious Emotional Disturbance- Eligibility and Care Management Requirements
- High-Fidelity Wraparound Referrals and Enrollment Process for Children/Youth with Serious Emotional Disturbance
- Health Homes Serving Children (HHSC) – there are subsections of the website specific for HFW and C-SPOA
- HFW FAQs
- New York State System of Care

Any questions should be submitted to OMH.HFW@OMH.NY.GOV