BH-CONNECT ACCESS, REFORM AND OUTCOMES INCENTIVE PROGRAM

TECHNICAL SPECIFICATIONS MANUAL

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DHCS
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BACKGROUND

About BH-CONNECT

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a five-year Medicaid Section 1115 demonstration and State Plan Amendments to expand coverage of evidence-based practices (EBPs) available under Medi-Cal, as well as complementary policies to strengthen behavioral health services statewide. In December 2024, the Centers for Medicare & Medicaid Services (CMS) approved the BH-CONNECT Section 1115 demonstration, which includes the BH-CONNECT Access, Reform and Outcomes Incentive Program (BH-CONNECT Incentive Program).

BH-CONNECT Access, Reform and Outcomes Incentive Program

The BH-CONNECT Incentive Program provides performance-based incentive payments to participating behavioral health plans (BHPs) for demonstrating improvements in access to behavioral health services and outcomes among Medi-Cal members living with significant behavioral health needs.

Areas of Focus

The BH-CONNECT Incentive Program includes measures in three areas of focus:[1]

- **Improved Access to Behavioral Health Services:** Participating BHPs may earn incentive payments related to improved access to behavioral health services, including by improving penetration and retention in behavioral health services; demonstrating timely access to specialty mental health services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services; and increasing utilization of specified behavioral health services.
- **Improved Health Outcomes and Quality of Life:** Participating BHPs may earn incentive payments related to improved health outcomes among Medi-Cal members living with significant behavioral health needs, including improved performance on select Department of Health Care Services (DHCS) Behavioral

[1]See BH-CONNECT Incentive Program Protocol (p. 117)

Health Accountability Set (BHAS) measures, improved member-reported quality of life, and improved health and wellbeing among members receiving key EBPs.

- **Targeted Behavioral Health Delivery System Reforms:** Participating BHPs may earn incentive payments for reducing BHP-specific gaps in quality improvement capabilities and making other targeted behavioral health delivery system reforms including enhancing data sharing capabilities and improved outreach and engagement to members that meet access criteria for SMHS and DMC-ODS services.

More information about the BH-CONNECT Incentive Program is available in the approved BH-CONNECT Section 1115 demonstration Special Terms and Conditions and on the DHCS BH-CONNECT website.

Purpose of Manual

The BH-CONNECT Incentive Program Technical Specifications Manual details how DHCS will calculate performance on BH-CONNECT Incentive Program measures. This manual includes technical specifications for most measures in the first two areas of focus described above. It does not include specifications for:

- Measures for which specifications are already published elsewhere (e.g., National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and measures related to DHCS network adequacy timely access standards).
- Measures in the "Targeted Behavioral Health Delivery System Reforms" area of focus. Instructions for these measures will be shared in separate DHCS guidance.

See the BH-CONNECT Incentive Program Scoring Methodology and Benchmarks Manual for information on how DHCS will score performance on BH-CONNECT Incentive Program measures and allocate incentive payments.

Updates to Technical Specifications

DHCS may update this manual annually or more frequently as needed to establish and/or update technical specifications for BH-CONNECT Incentive Program measures.[2]

[2] The first version of this manual focuses on technical specifications for BH-CONNECT Incentive Program measures that are pay-for-performance in measurement year 2025. DHCS will establish technical specifications for BH-CONNECT Incentive Program measures that become pay-for-performance in 2026 through 2029 prior to or during the respective measurement years.

Technical specifications will be determined prior to the start of or during the first pay-for-performance year for each measure. Technical specifications apply to the full applicable measurement year. Technical specifications will not be reissued annually for every measure.

If the technical specification for a specified measure changes between measurement years, DHCS will issue a second version of that specification and update this manual to reflect the most recent version.[3]

DHCS will notify participating BHPs and other stakeholders of any updates to the BH-CONNECT Incentive Program Technical Specifications Manual.

Updates to this manual will be limited to measures that are newly pay-for-performance or when refinements are necessary after initial performance data is available.

[3]See BH-CONNECT Incentive Program Protocol (p. 134-135)

BH-CONNECT INCENTIVE PROGRAM MEASURES

The BH-CONNECT Incentive Program includes 53 measures in 15 measure areas, which are categorized into the three areas of focus described above.[4] All BH-CONNECT Incentive Program measures were developed by DHCS, except for five measures from the Healthcare Effectiveness Data and Information Set (HEDIS) that are stewarded by the National Committee for Quality Assurance (NCQA).

Table 1 includes information about each measure in the BH-CONNECT Incentive Program, including:

- Area of Focus
- Measure Area
- Measure Name
- Measure Acronym
- Measurement Years
- Data Source

Measures will be calculated on the timelines described in the "Measurement and Payment Timelines" section below.

Table 1. BH-CONNECT Incentive Program Measures

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
Area of Focus: Improved Access to Specialty Behavioral Health (BH) Services				
1. Improve Penetration and Engagement in Specialty Behavioral Health Services	Penetration in Specialty Mental Health Services (SMHS) for Adults	PEN-SMHS-AD	2025-2029	Claims
	Penetration in SMHS for Children/Youth	PEN-SMHS-CH	2025-2029	Claims

[4] See BH-CONNECT Incentive Program Protocol (p. 121-131)

[5] "Measurement years" indicates years in which the measure is pay-for-performance. Where applicable, the baseline year of data for each measure will be the year of data prior to the first measurement year. Baseline years for each measure are specified in the BH-CONNECT Incentive Program Protocol Table 2 (p. 121-131)

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
	Engagement in SMHS for Adults	ENG-SMHS-AD	2025-2029	Claims
	Engagement in SMHS for Children/Youth	ENG-SMHS-CH	2025-2029	Claims
	Initiation of Substance Use Disorder (SUD) Treatment (IET) *NCQA HEDIS measure*	IET-I	2025-2029	Claims
	Engagement in SUD Treatment (IET) *NCQA HEDIS measure*	IET-E	2025-2029	Claims
2. Improve Performance on Timely Access Standards for Specialty Behavioral Health Services[6]	Timely Access to SMHS for Adults	TMLY-SMHS-AD	2025-2029	Timely Access Data Tool (TADT)
	Timely Access to SMHS for Children/Youth	TMLY-SMHS-CH	2025-2029	TADT
	Timely Access to Drug Medi-Cal Organized Delivery System (DMC-ODS) Services for Adults	TMLY-DMCODS-AD	2025-2029	TADT

[6] More information about DHCS' Timely Access Standards is in BHIN 25-013 or subsequent guidance.

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
	Timely Access to DMC-ODS Services for Children/Youth	TMLY-DMCODS-CH	2025-2029	TADT
3. Increase Utilization of Evidence-Based Practices (EBPs) for Adults	Utilization of Assertive Community Treatment (ACT)	ACT	2026-2027: Count[7] 2028-2029: Rate	Claims
	Utilization of Forensic Assertive Community Treatment (FACT)	FACT	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)	CSC	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Individual Placement and Support (IPS) Supported Employment	IPS	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Enhanced Community Health Worker (CHW) Services	ECHW	2026-2027: Count 2028-2029: Rate	Claims

[7] Measures in the measure areas "Increase Utilization of EBPs for Adults" and "Increase Utilization of EBPs for Children, Youth and Adolescents" are measured as a count for the first two measurement years and measured as a rate for the remaining measurement years.

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
	Utilization of Peer Support Services	PEER	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Clubhouse Services	CLUB	2026-2027: Count 2028-2029: Rate	Claims
4. Increase Utilization of EBPs for Children, Youth, and Adolescents	Utilization of Multisystemic Therapy (MST)	MST	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Functional Family Therapy (FFT)	FFT	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of Parent-Child Interaction Therapy (PCIT)	PCIT	2026-2027: Count 2028-2029: Rate	Claims
	Utilization of High-Fidelity Wraparound (HFW)	HFW	2028-2029: Rate	Claims
5. Increase Utilization of Enhanced Care Management (ECM)	Utilization of ECM for Adults	ECM-AD	2025-2029	QIMR[8] (2025); Claims (2026-2029)

[8]More information about the ECM and Community Supports Quarterly Implementation Monitoring Report (QIMR).

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
	Utilization of ECM for Children/Youth	ECM-CH	2025-2029	QIMR (2025); Claims (2026-2029)
Area of Focus: Improved Health Outcomes and Quality of Life				
6. Pharmacotherapy for Opioid Use Disorder (POD)	POD *NCQA HEDIS measure*	POD	2025-2029	Claims
7. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	SAA *NCQA HEDIS measure*	SAA	2025-2029	Claims
8. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	APP *NCQA HEDIS measure*	APP	2025-2029	Claims
9. Improve Patient-Reported Quality of Life (QOL)	Patient-Reported QOL	QOL	2028-2029	Survey data
10a. Improve Health Outcomes and QOL Among Members Receiving ACT	Emergency Department (ED) Visits Among Members Receiving ACT	ACT-EDV	2027-2029	Claims
	Hospital Admissions Among Members Receiving ACT	ACT-HOSP	2027-2029	Claims

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
	Homelessness Among Members Receiving ACT	ACT-PEH	2027-2029	Survey data[9]
	Justice Involvement Among Members Receiving ACT	ACT-JUST	2027-2029	Survey data
	QOL Among Members Receiving ACT	ACT-QOL	2027-2029	Survey data
10b. Improve Health Outcomes and QOL Among Members Receiving FACT	ED Visits Among Members Receiving FACT	FACT-EDV	2027-2029	Claims
	Hospital Admissions Among Members Receiving FACT	FACT-HOSP	2027-2029	Claims
	Homelessness Among Members Receiving FACT	FACT-PEH	2027-2029	Survey data
	Justice Involvement Among Members Receiving FACT	FACT-JUST	2027-2029	Survey data
	QOL Among Members Receiving FACT	FACT-QOL	2027-2029	Survey data
10c. Improve Health Outcomes and QOL Among	ED Visits Among Members Receiving CSC	CSC-EDV	2027-2029	Claims

[9] In future years of the BH-CONNECT Incentive Program, DHCS may also utilize CA Homelessness Integration System (HDIS) and/or correctional data for measures calculated using survey data.

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
Members Receiving CSC	Hospital Admissions Among Members Receiving CSC	CSC-HOSP	2027-2029	Claims
	Homelessness Among Members Receiving CSC	CSC-PEH	2027-2029	Survey data
	School/Work Involvement Among Members Receiving CSC	CSC-EMPL	2027-2029	Survey data
	QOL Among Members Receiving CSC	CSC-QOL	2027-2029	Survey data
10d. Improve Health Outcomes and QOL Among Members Receiving IPS	ED Visits Among Members Receiving IPS	IPS-EDV	2027-2029	Claims
	Hospital Admissions Among Members Receiving IPS	IPS-HOSP	2027-2029	Claims
	Homelessness Among Members Receiving IPS	IPS-PEH	2027-2029	Survey data
	School/Work Involvement Among Members Receiving IPS	IPS-EMPL	2027-2029	Survey data
	QOL Among Members Receiving IPS	IPS-QOL	2027-2029	Survey data
Area of Focus: Targeted Behavioral Health Delivery System Reforms				

Measure Area	Measure Name	Measure Acronym	Measurement Years[5]	Data Source
11. Plan to Address County-Specific Behavioral Health Delivery System Gaps			2025	County submission
12. Reduce County-Specific Gaps Identified in NCQA Behavioral Healthcare Accreditation (BHA)[10] Assessment			2025-2029	NCQA BHA assessment data
13. Demonstrate Improved Data Sharing for the Behavioral Health Population			2025-2029	County submission
14. Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services			2025-2029	County submission
15. Increase Capacity to Deliver Crisis Services			2025-2029	County submission

Measurement and Payment Timelines

Almost all BH-CONNECT Incentive Program measures are calculated using the calendar year as the applicable measurement period (e.g., the 2025 measurement year is for performance from January 1, 2025 to December 31, 2025).[11] For timely access measures (TMLY-SMHS-AD, TMLY-SMHS-CH, TMLY-DMCODS-AD, TMLY-DMCODS-CH), the measurement period is July 1 to March 31 (e.g., the 2025 measurement year is for performance from July 1, 2025 through March 31, 2026), consistent with BHIN 25-013 or subsequent guidance.

[10] Previously "Managed Behavioral Healthcare Organization" (MBHO)

[11]Assessment. See BH-CONNECT Incentive Program Protocol (p. 142-143).

Table 2. Measurement and Payment Timeline for Claims-Based Measures

Measurement Year	Measurement Period	Measure Calculated	Payment Issued
2025	January 1, 2025 - December 31, 2025	June 30, 2026	November 30, 2026
2026	January 1, 2026 - December 31, 2026	June 30, 2027	November 30, 2027
2027	January 1, 2027 - December 31, 2027	June 30, 2028	November 30, 2028
2028	January 1, 2028 - December 31, 2028	June 30, 2029	November 30, 2029
2029	January 1, 2029 - December 31, 2029	June 30, 2030	November 30, 2030

Table 3. Measurement and Payment Timeline for Measures Using Other Data Sources

Measure Area	Data Source	Submission	Measurement Years	Due Date(s)	Payment Issued
Improve Performance on Timely Access Standards for Specialty Behavioral Health Services	TADT	BHPs submit data as described in BHIN 25-013 or subsequent guidance	2025 – 2029[12]	• July 1, 2026 • July 1, 2027 • July 1, 2028 • July 1, 2029 • July 1, 2030	• November 30, 2026 • November 30, 2027 • November 30, 2028 • November 30, 2029 • November 30, 2030

[12] The measurement period for all Timely Access to Specialty Behavioral Health Services measures is July 1 – March 31 of each year. The measurement period for all other measures is the calendar year.

Measure Area	Data Source	Submission	Measurement Years	Due Date(s)	Payment Issued
Increase Utilization of ECM	QIMR	MCPs submit data as described in the ECM and Community Supports QIMR Requirements	2025[13]	• May 2025 • August 2025 • November 2025 • February 2026	• November 30, 2026
Homelessness, Justice Involvement, Work/School Involvement, and QOL Among Members Receiving ACT, FACT, CSC and IPS	Survey Data[14]	Centers of Excellence (COEs) transmit data directly to DHCS	2027-2029	n/a	• November 30, 2028 • November 30, 2029 • November 30, 2030
Plan to Address County-Specific Behavioral Health Delivery System Gaps	Report and data	BHPs submit report using template provided by DHCS	2025	• June 30, 2025	• November 30, 2025

[13] QIMR data will be used for measurement year 2025 only. DHCS will use claims data to calculate performance for measurement years 2026-2029.

[14] In future years of the BH-CONNECT Incentive Program, DHCS may also utilize CA Homelessness Integration System (HDIS) and/or correctional data for measures calculated using survey data.

Measure Area	Data Source	Submission	Measurement Years	Due Date(s)	Payment Issued
Reduce County-Specific Gaps Identified in NCQA BHA Assessment	NCQA BHA Assessment Data	NCQA transmits data directly to DHCS	2025-2029	n/a	• November 30, 2026 • November 30, 2027 • November 30, 2028 • November 30, 2029 • November 30, 2030
Demonstrate Improved Data Sharing for the Behavioral Health Population	Reports and data	BHPs submit report using template provided by DHCS and/or DHCS pulls reports on structured data (when available)	2025-2029	• June 30, 2026 • June 30, 2027 • June 30, 2028 • June 30, 2029 • June 30, 2030	• November 30, 2026 • November 30, 2027 • November 30, 2028 • November 30, 2029 • November 30, 2030
Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services					
Increase Capacity to Deliver Crisis Services					

OVERVIEW OF TECHNICAL SPECIFICATIONS

BH-CONNECT Incentive Program measures will be calculated by DHCS on an annual basis using the specifications in this manual. Participating BHPs are not responsible for calculating their own performance on any measures.

This manual includes technical specifications for all measures that are calculated using claims data, QIMR data, or survey data as indicated in Table 1 above except for NCQA HEDIS measures. For NCQA HEDIS measures (IET-I, IET-E, POD, APP and SAA), the NCQA specifications for the relevant measurement year apply. Guidance on calculating NCQA HEDIS measures is in Appendix A. DHCS is not developing any new specifications for these measures.

DHCS is leveraging claims and eligibility data available through Medi-Cal Connect to calculate BHP performance on measures that utilize claims data. Medi-Cal Connect is a DHCS-run population health management tool which aggregates data from multiple sources to measure performance on a variety of measures for BHPs and Medi-Cal Managed Care Plans (MCPs).

Terminology

This manual uses the following definitions for all relevant measures:

- **Child/youth.** Medi-Cal members under age 21 years as of the last day of the measurement year.
- **Adult.** Medi-Cal members aged 21 years and older (21+) as of the last day of the measurement year.
- **SMHS.** Specialty Mental Health Services. Refer to the SMHS Billing Manual for information on specific services and billing procedures.
- **DMC-ODS.** Drug Medi-Cal Organized Delivery System. Refer to the DMC-ODS Billing Manual for information on specific services and billing procedures.
- **SD/MC claims.** Claims for covered SMHS and DMC-ODS services processed through the Short-Doyle/Medi-Cal (SD/MC) claims processing system.
- **FFS psychiatric inpatient claims.** Claims for covered SMHS provided in licensed acute psychiatric facilities or psychiatric units of general hospitals processed through the California Medicaid Management Information System (CA-MMIS) claims processing system.

Claim Types

All BH-CONNECT Incentive Program measures that are calculated using claims data include a relevant claim type. The claim type is identified by a specified program code, source code, and where relevant, revenue code, as shown in Table 4.

Table 4. Claim Types

Claim Type	Codes Used to Identify Claim Type
SD/MC claims for SMHS	Program code = '08' (Short Doyle) AND Source code = '21' (SMHS)
SD/MC claims for DMC/DMC-ODS services	Program code = '08' (Short Doyle) AND Source code = '37' (DMC/DMC-ODS)
FFS psychiatric inpatient claims	Program code = '09' (FFS Psychiatric Inpatient Claims), AND Source code = '18' (Mental Health Inpatient), AND Psychiatric Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169'

Paid Claims

BH-CONNECT Incentive Program measures are calculated using paid claims only.[15] Paid claims are the final, paid version of claims that have been processed and adjudicated by the SD/MC claiming system and/or the CA MMIS (for FFS psychiatric inpatient claims). Denied claims are not included in the measure calculation.

Member Age

Some BH-CONNECT Incentive Program measures only include members of a specified age (for example, members under age 21). Member age is determined as of the last day of the applicable measurement year.

Service Dates

All BH-CONNECT Incentive Program measures are calculated using the date of service on a claim, not the date of claim submission.

Procedure Codes

Behavioral health services included in BH-CONNECT Incentive Program measures are identified by specified procedure codes.

[15] As described in NCQA guidance, some HEDIS measures include paid, suspended, pending, and denied claims. DHCS-developed measures use paid claims only.

For EBPs available under Medi-Cal as bundled services, only the procedure codes for the bundled service are included in the measure calculation. For example, only ACT services claimed using procedure code H0040 are included for the measure "Utilization of ACT." Unbundled service components claimed separately are not included in the calculation.[16]

More information about procedure codes used to calculate BH-CONNECT Incentive Program measures is available in the SMHS Billing Manual, DMC-ODS Billing Manual, and relevant DHCS BH-CONNECT guidance.

Eligible Population

All technical specifications include an eligible population of members that are captured in the measure calculation. The eligible population measure element includes the following:

- **Product line.** The coverage type required to be included in the eligible population. For BH-CONNECT Incentive Program measures, the product line is "Medi-Cal," meaning that the eligible population includes members with Medi-Cal coverage during the relevant measurement year.
- **Continuous enrollment.** The minimum amount of time a member must be enrolled in Medi-Cal before becoming eligible for inclusion in a measure calculation, before accounting for any allowable gap. For the BH-CONNECT Incentive Program, this is 12 months of Medi-Cal enrollment during the measurement year.
- **Allowable gap.** The maximum amount of time during the continuous enrollment period when the member is not covered by Medi-Cal while remaining eligible for inclusion in a measure calculation. For BH-CONNECT Incentive Program measures, the allowable gap is one month of enrollment during the measurement year, which can occur any time during the continuous enrollment period.
- **Benefit.** The Medi-Cal services for which the member qualifies. The BH-CONNECT Incentive Program only includes Medi-Cal members with full-scope benefits.
- **Delivery system.** Description of how healthcare services are provided and paid for, including specific benefit packages, plans, or programs that may be offered

[16] As described in BHIN 25-006, participating BHPs cannot earn incentive dollars for measures related to an optional EBP until the BHP covers and implements that EBP under Medi-Cal, consistent with BHIN 25-009 or subsequent guidance.

to members based on their eligibility and coverage determination. In Medi-Cal, services may be delivered through the Medi-Cal Managed Care (MCMC), Fee-for-Service (FFS), SMHS, and/or DMC/DMC-ODS delivery systems. The BH-CONNECT Incentive Program is focused on members who receive services through the specialty behavioral health delivery systems (SMHS and/or DMC/DMC-ODS).

Behavioral Health Plan Attribution

County-specific performance is calculated for each BHP participating in the BH-CONNECT Incentive Program. Members are attributed to each participating BHP based on their county of responsibility as of the last day of the relevant measurement year. The county of responsibility indicates the county that is responsible for maintaining the current county case record for Medi-Cal eligibility for an individual or family. The county of responsibility may be different from the county of residence.[17]

[17] The county of residence indicates the county the individual physically resides in.

BH-CONNECT INCENTIVE PROGRAM TECHNICAL SPECIFICATIONS

Measure Elements

The BH-CONNECT Incentive Program technical specifications in the subsequent sections of this manual include the measure elements in Table 5. Not all specifications include every measure element; elements that may vary by measure are indicated with a *.

Table 5. Technical Specifications Measure Elements

Measure Element	Description
Measure type	Classification of measure type. Measures can be classified as Process, Outcome, Intermediate Outcome, Structure, Efficiency, Patient Engagement/Experience, or Patient-Reported Outcome Based.
Description	Brief description of the measure.
Definitions	Includes any definitions needed to understand the measure description, eligible population, denominator, or numerator, including acronyms and key terminology.
Eligible population	Description of the population eligible for inclusion in the measure. Includes the standard non-clinical eligible population elements (product line, continuous enrollment, allowable gap, benefit, delivery system).
Counted variable*	Describes the steps required to identify members or events included in the measure. *This field only occurs if the metric is a count rather than a rate. For several measures, a count of enrollees using a service will be reported for early reporting years; in later years a rate will be reported. For count metrics, the Numerator, Denominator, and Metric Calculation fields are excluded from the specification.*
Numerator*	Describes the steps required to identify the members or events included in the numerator of a rate measure. *This field only occurs if the metric is a rate rather than a count.*

Measure Element	Description
Numerator exclusions*	An exclusion that will remove a member from the numerator based on information captured in claims, encounter, pharmacy, and/or enrollment data. Most measures do not have numerator exclusions. *This field only occurs if the metric is a rate rather than a count.*
Denominator*	Describe the steps required to identify the members or events included in the denominator of a rate measure. *This field only occurs if the metric is a rate rather than a count.*
Denominator exclusions*	An exclusion that will remove a member from the denominator based on information captured in claims, encounter, pharmacy, and/or enrollment data. *This field only occurs if the metric is a rate rather than a count.*
Metric calculation*	Describes the steps required to calculate the measure rate using preliminary totals derived from the numerator and denominator steps. *This field only occurs if the metric is a rate rather than a count.*
Stratifications	Describes the criteria required to calculate the measure for different groups, such as by age, demographic, or delivery system. Most measures use standard DHCS stratifications [include link].
Additional instructions	Includes any additional information relevant to calculating the measure (such as links to relevant policy documents).
Measurement period	The time period during which services or events occurred for performance evaluation in a given measure.
Data source	Describes the data source(s) used to report the measure. For claims-based measures, this section will include the type of claim that should be used to identify eligible members or encounters (e.g. include only paid claims).
Measurement years	The years the measure is being calculated for incentive payments (i.e., pay-for-performance) in the BH-CONNECT Incentive Program.
Measure version	The version of the measure described in the current specifications (e.g., v1, v2). Measures may be updated over time.

Measure Element	Description
Measure release date	The date the current version of the measure became available for use.
Summary of changes	Description of any changes to the measure specification that have occurred relative to previous versions.

Technical Specifications for Measurement Year 2025

Improve Penetration and Engagement in Specialty Behavioral Health Services

Penetration in Specialty Mental Health Services (SMHS) (Adult) (PEN-SMHS-AD)	
Measure element	**Description**
Measure type	Process
Description	Percent of members aged 21 years and older who had one or more claims for SMHS during the measurement year.
Definitions	Adult: Medi-Cal members aged 21 years and older (21+) as of the last day of the measurement year. BHP: Behavioral Health Plan. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual.
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: All Medi-Cal delivery systems

Penetration in Specialty Mental Health Services (SMHS) (Adult) (PEN-SMHS-AD)	
Measure element	**Description**
Denominator	The number of adult Medi-Cal members aged 21+ in the eligible population in the county. This is a cumulative count over the entire measurement year. Each member should only be counted once. Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of adult members aged 21+ who had at least one claim for SMHS services within the measurement year. Step 1: Among members in the denominator, identify those with any claims for SMHS services during the measurement year using the following criteria: a. Member has any Short Doyle claims during the measurement year: i. Program code = '08' (Short Doyle), AND ii. Source code = '21' (SMHS) OR b. Member has any FFS inpatient psychiatric claims during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 2: Determine the total number of unique members (de-duplicated) with one or more SMHS claims during the measurement year. Members should only be counted once per measurement year, regardless of whether that member had one or more claims for SMHS during the measurement year.

Penetration in Specialty Mental Health Services (SMHS) (Adult) (PEN-SMHS-AD)	
Measure element	**Description**
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage.
Stratifications	Standard DHCS stratifications
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. Refer to the SMHS Medi-Cal Billing Manual for specific codes.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, and enrollment data. Paid claims only.
Measurement years	2025-2029 (2024 baseline)
Measure version	v1
Measure release date	12/22/2025
Summary of changes	n/a

Penetration in Specialty Mental Health Services (SMHS) (Children/Youth) (PEN-SMHS-CH)	
Measure element	**Description**
Measure type	Process
Description	Percent of members under age 21 years who had one or more claims for SMHS during the measurement year.
Definitions	Child/Youth: Medi-Cal members under age 21 years as of the last day of the measurement year. BHP: Behavioral Health Plan. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual.
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: All Medi-Cal delivery systems
Denominator	The number of child/youth Medi-Cal members under age 21 years in the eligible population in the county. This is a cumulative count over the entire measurement year. Each member should only be counted once.

Penetration in Specialty Mental Health Services (SMHS) (Children/Youth) (PEN-SMHS-CH)	
Measure element	**Description**
	Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of members under age 21 years who had at least one claim for SMHS services within the measurement year. Step 1: Among members in the denominator, identify those with any claims for SMHS services during the measurement year using the following criteria: a. Member has any Short Doyle claims during the measurement year: i. Program code = '08' (Short Doyle), AND ii. Source code = '21' (SMHS) OR b. Member has any FFS inpatient psychiatric claims during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 2: Determine the total number of unique members (de-duplicated) with one or more SMHS claims during the measurement year. Members should only be counted once per measurement year, regardless of whether that member had one or more claims for SMHS during the measurement year.
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage.
Stratifications	Standard DHCS stratifications

Penetration in Specialty Mental Health Services (SMHS) (Children/Youth) (PEN-SMHS-CH)	
Measure element	**Description**
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. Refer to the SMHS Medi-Cal Billing Manual for specific codes.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, and enrollment data. Paid claims only.
Measurement years	2025–2029 (2024 baseline)
Measure version	v1
Measure release date	12/22/2025
Summary of changes	n/a

Engagement in Specialty Mental Health Services (SMHS) (Adult) (ENG-SMHS-AD)	
Measure element	**Description**
Measure type	Process
Description	Percent of members aged 21 years and older who received SMHS on five or more days during the measurement year.
Definitions	Adult: Medi-Cal members aged 21 years and older (21+) as of the last day of the measurement year. BHP: Behavioral Health Plan. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual.
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: All Medi-Cal delivery systems
Denominator	The number of adult Medi-Cal members aged 21+ in the eligible population in the county. This is a cumulative count over the entire measurement year. Each member should only be counted once.

Engagement in Specialty Mental Health Services (SMHS) (Adult) (ENG-SMHS-AD)	
Measure element	**Description**
	Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of adult members aged 21+ who received SMHS services on at least five separate calendar days within the measurement year. Step 1: Among members in the denominator, identify those with any claims for SMHS services during the measurement year using the following criteria: a. Member has any Short Doyle claims during the measurement year: i. Program code = '08' (Short Doyle), AND ii. Source code = '21' (SMHS) OR b. Member has any FFS inpatient psychiatric claims during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 2: Determine the total number of unique members (de-duplicated) with claims for SMHS services on five distinct service dates during the measurement year, overall. Members should only be counted once per measurement year and should only be counted in the numerator if their total number of distinct service dates is five or more.
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage.

Engagement in Specialty Mental Health Services (SMHS) (Adult) (ENG-SMHS-AD)	
Measure element	**Description**
Stratifications	Standard DHCS stratifications
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. Refer to the SMHS Medi-Cal Billing Manual for specific codes.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, and enrollment data. Paid claims only.
Measurement years	2025–2029 (2024 baseline)
Measure version	v1
Measure release date	12/22/2025
Summary of changes	n/a

Engagement in Specialty Mental Health Services (SMHS) (Children/Youth) (ENG-SMHS-CH)	
Measure element	**Description**
Measure type	Process
Description	Percent of members under age 21 years who received SMHS on five or more days during the measurement year.
Definitions	Child/Youth: Medi-Cal members under age 21 years as of the last day of the measurement year. BHP: Behavioral Health Plan. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual.
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: All Medi-Cal delivery systems
Denominator	The number of child/youth Medi-Cal members under age 21 years in the eligible population in the county. This is a cumulative count over the entire measurement year. Each member should only be counted once.

Engagement in Specialty Mental Health Services (SMHS) (Children/Youth) (ENG-SMHS-CH)	
Measure element	**Description**
	Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of members under age 21 years who received SMHS services on at least five separate calendar days within the measurement year. Step 1: Among members in the denominator, identify those with any claims for SMHS services during the measurement year using the following criteria: a. Member has any Short Doyle claims during the measurement year: i. Program code = '08' (Short Doyle), AND ii. Source code = '21' (SMHS) OR b. Member has any FFS inpatient psychiatric claims during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 2: Determine the total number of unique members (de-duplicated) with claims for SMHS services on at least five distinct service dates, during the measurement year, overall. Members should only be counted once per measurement year and should only be counted in the numerator if their total number of distinct service dates is five or more.
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage.
Stratifications	Standard DHCS stratifications

Engagement in Specialty Mental Health Services (SMHS) (Children/Youth) (ENG-SMHS-CH)	
Measure element	**Description**
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. Refer to the SMHS Medi-Cal Billing Manual for specific codes.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, and enrollment data. Paid claims only.
Measurement years	2025–2029 (2024 baseline)
Measure version	v1
Measure release date	12/22/2025
Summary of changes	n/a

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Adult) *(ECM-AD)*	
Measure element	**Description**
Measure type	Process
Description	Percent of members aged 21 years and older who received one or more Enhanced Care Management (ECM) Services among those who had at least one claim for SMHS and/or DMC/DMC-ODS services during the measurement year (including ECM Services).
Definitions	Adult: Medi-Cal members aged 21 years and older (21+) as of the last day of the measurement year. BHP: Behavioral Health Plan. DMC/DMC-ODS: Drug Medi-Cal State Plan and Drug Medi-Cal Organized Delivery System. Services listed in the DMC and DMC-ODS Billing Manual. ECM Services: Enhanced Care Management, a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM services include in-person and telephonic/electronic care coordination and outreach attempts provided by clinical staff, non-clinical staff, or multidisciplinary teams. Only non-outreach services are counted in this measure (care coordination, multidisciplinary team conference). See ECM Policy Guide Manual and ECM Claims & Encounter Guidance for details. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MCP: Managed Care Plan. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Adult) *(ECM-AD)*	
Measure element	**Description**
	federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. Quarterly Implementation Monitoring Report (QIMR): A standardized reporting tool used by Medi-Cal Managed Care Plans (MCPs) to document the implementation status of Enhanced Care Management (ECM) and Community Supports. Reporting requirements listed in the ECM and Community Supports QIMR Report Requirements. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual.
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: SMHS or DMC/DMC-ODS
Denominator	The number of adult members aged 21+ who had at least one claim for SMHS and/or DMC/DMC-ODS services during the measurement year. This is a cumulative count over the entire measurement year. Each member should only be counted once. Step 1: Identify all members in the eligible population who are aged 21+ as of the last day of the measurement year. Step 2: Among the members identified in Step 1, identify those with at least one claim with a service date during the measurement year for SMHS and/or DMC/DMC-ODS services using the following criteria: a. Member has any Short Doyle claims during the measurement year: i. Program code = '08' (Short Doyle), AND ii. Source code = '21' (SMHS) or '37' (DMC/DMC-ODS)

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Adult) *(ECM-AD)*	
Measure element	**Description**
	OR b. Member has any FFS inpatient psychiatric claims during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 3: Determine the total number of unique members (de-duplicated) with at least one SMHS and/or DMC/DMC-ODS claim during the measurement year. Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of adult members aged 21+ who received at least one non-outreach ECM service during the measurement year. Step 1. Determine the total number of unique members who received at least one non-outreach ECM service during the measurement year. Members should only be counted once per measurement year, regardless of whether that member received one or more non-outreach ECM services during the measurement year.
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage. To stratify by SMHS and DMC/DMC-ODS delivery system, count claims identified in the denominator step with Source code = '21' as SMHS and claims with Source code = '37' as DMC/DMC-ODS. Members should only be counted once within each delivery system per measurement year, regardless of whether that member had one or more ECM service claims during the measurement year.

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Adult) *(ECM-AD)*	
Measure element	**Description**
	Members may be counted once in each stratification if that member received services in both delivery systems.
Stratifications	SMHS and DMC/DMC-ODS Standard DHCS stratifications
Additional instructions	When calculating this measure, only include members receiving non-outreach ECM services in the numerator.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, enrollment, and QIMR data. Paid claims only.
Measurement years	2025 (2024 baseline)
Measure version	v1
Measure release date	12/22/2025
Summary of changes	n/a

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Children/Youth) *(ECM-CH)*	
Measure element	**Description**
Measure type	Process
Description	Percent of members under age 21 years who received one or more Enhanced Case Management (ECM) services during the measurement year, among those who had at least one claim for SMHS and/or DMC/DMC-ODS services during the measurement year (including ECM services).
Definitions	BHP: Behavioral Health Plan Child/youth: Medi-Cal members under age 21 years as of the last day of the measurement year. DMC/DMC-ODS: Drug Medi-Cal State Plan and Drug Medi-Cal Organized Delivery System. Services listed in the DMC and DMC-ODS Billing Manual. ECM Services: Enhanced Care Management, a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM services include in-person and telephonic/electronic care coordination and outreach attempts provided by clinical staff, non-clinical staff, or multidisciplinary teams. Only non-outreach services are counted in this measure (care coordination, multidisciplinary team conference). See ECM Policy Guide Manual and ECM Claims & Encounter Guidance for details. Fee-for-Service (FFS) inpatient psychiatric claims: Claims for medically necessary mental health treatment provided in licensed acute psychiatric facilities or psychiatric units of general hospitals, reimbursed under FFS Medi-Cal through a bundled rate for routine and ancillary services. With the exception of Short Doyle Medi-Cal hospitals, inpatient services are not billed through the MIS/DSS Short Doyle claims system. MCP: Managed Care Plan. MIS/DSS Short Doyle claims: Management Information System/Decision Support System Short Doyle Medi-Cal (SD/MC) claims are requests from a County Behavioral Health Plan for

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Children/Youth) *(ECM-CH)*	
Measure element	**Description**
	federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. Quarterly Implementation Monitoring Report (QIMR): A standardized reporting tool used by Medi-Cal Managed Care Plans (MCPs) to document the implementation status of Enhanced Care Management (ECM) and Community Supports. Reporting requirements listed in the ECM and Community Supports QIMR Report Requirements. SMHS: Specialty Mental Health Services. Services listed in the SMHS Medi-Cal Billing Manual
Eligible population	Product line: Medi-Cal Continuous enrollment: 12 months of Medi-Cal enrollment in the measurement year Allowable gap: No more than one gap in enrollment of up to one month during the measurement year Benefit: Members with full-scope Medi-Cal benefits Delivery system: SMHS or DMC/DMC-ODS
Denominator	The number of child/youth members under age 21 years in the eligible population who had at least one claim for SMHS and/or DMC/DMC-ODS services during the measurement year. This is a cumulative count over the entire measurement year. Each member should only be counted once. Step 1: Identify all members in the eligible population who are under age 21 years as of the last day of the measurement year. Step 2: Among the members identified in Step 1, identify those with at least one claim with a service date during the measurement year for SMHS and/or DMC/DMC-ODS services using the following criteria: a. Member has any Short Doyle claims (final, paid claims) during the measurement year: i. Program code = '08' (Short Doyle), AND

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Children/Youth) *(ECM-CH)*	
Measure element	**Description**
	ii. Source code = '21' (SMHS) or '37' (DMC/DMC-ODS) OR b. Member has any FFS inpatient psychiatric claims (final, paid claims) during the measurement year: i. Program code = '09' (FFS Psychiatric Inpatient Claims), AND ii. Source code = '18' (Mental Health Inpatient), AND iii. Revenue Code = '0114', '0124', '0134', '0154', '0204', or '0169' (Psychiatric Revenue Codes) Step 3: Determine the total number of unique members (de-duplicated) with at least one SMHS and/or DMC/DMC-ODS claim during the measurement year. Members are attributed to a county/BHP based on the last month of enrollment in the measurement year.
Denominator exclusions	None
Numerator	The number of members under age 21 years who received at least one non-outreach ECM service during the measurement year. Step 1. Determine the total number of unique members who received at least one non-outreach ECM service during the measurement year. Members should only be counted once per measurement year, regardless of whether that member received one or more non-outreach ECM services during the measurement year.
Metric calculation	Divide the number of members in the numerator by the number of members in the denominator to calculate the measure rate. This measure is reported as a percentage. To stratify by SMHS and DMC/DMC-ODS delivery system, count claims in the denominator with Source code = '21' as SMHS and claims with Source code = '37' as DMC/DMC-ODS. Members should only be counted once within each delivery system per measurement year, regardless of whether that member had one

Utilization of Enhanced Care Management (ECM) Among Members Receiving Specialty Behavioral Health Services (Children/Youth) *(ECM-CH)*	
Measure element	**Description**
	or more claims during the measurement year. Members may be counted once in each stratification if that member received services in both delivery systems.
Stratifications	SMHS and DMC/DMC-ODS Standard DHCS stratifications
Additional instructions	When calculating this measure, only include members receiving non-outreach ECM services in the numerator.
Measurement period	Calendar year
Data source	MIS/DSS Short Doyle Claims, FFS inpatient psychiatric claims, enrollment data, and QIMR data.
Measurement years	2025 (2024 baseline)
Measure version	v1
Measure release date	12/22/25
Summary of changes	n/a

APPENDIX 1. ACRONYMS

ACT	Assertive Community Treatment
BHA	Behavioral Health Accreditation
BHAS	Behavioral Health Accountability Set
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHP	Behavioral health plan
CA MMIS	California Medicaid Management Information System
CHW	Community health worker
CMS	Centers for Medicare & Medicaid Services
CSC	Coordinated Specialty Care
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based practice
ECM	Enhanced Care Management
ED	Emergency department
FACT	Forensic Assertive Community Treatment
FEP	First episode psychosis
FFS	Fee for service
FFT	Functional Family Therapy
HEDIS	Healthcare Effectiveness Data and Information Set
HFW	High-Fidelity Wraparound
IPS	Individual Placement and Support
MST	Multisystemic Therapy
NCQA	National Committee for Quality Assurance
PCIT	Parent-Child Interaction Therapy
QIMR	ECM and Community Supports Quarterly Implementation Monitoring Report

QOL	Quality of life
SD/MC	Short Doyle/Medi-Cal
SMHS	Specialty mental health services
SUD	Substance use disorder

APPENDIX 2. ESTABLISHED MEASURES IN BH-CONNECT INCENTIVE PROGRAM

The BH-CONNECT Incentive Program leverages existing specifications for the NCQA HEDIS measures shown in Table A.1 below.

Table A.1. NCQA HEDIS Measures

Measure	Measure Acronym	Measure Set	Measure Version	Accessing Measure Resources
Initiation and Engagement of Substance Use Disorder Treatment (IET)	IET-I IET-E	HEDIS Technical Specifications Volume H: Access / Availability of Care	Measurement Year 2025	Specifications and Value Set downloads available at the NCQA store
Pharmacotherapy for Opioid Use Disorder (POD)	POD	HEDIS Technical Specifications Volume D: Effectiveness of Care – Behavioral Health	Measurement Year 2025	Specifications and Value Set downloads available at the NCQA store
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	SAA	HEDIS Technical Specifications Volume D: Effectiveness of Care – Behavioral Health	Measurement Year 2025	Specifications and Value Set downloads available at the NCQA store
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	APP	HEDIS Technical Specifications Volume H: Access / Availability of Care	Measurement Year 2025	Specifications and Value Set downloads available at the NCQA store