BEHAVIORAL HEALTH TRANSFORMATION

TECHNICAL SPECIFICATIONS MANUAL

JULY 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

DOCUMENT REVISION HISTORY

Version	Review/Approval Date
1.0	July 2026

TABLE OF CONTENTS

ACRONYMS

AAP	Adults' Access to Preventive/Ambulatory Health Services
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
AS	Ambulatory surgery
AUD	Alcohol use disorder
BH	Behavioral Health
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHP	Behavioral Health Plan
BHSA	Behavioral Health Services Act
BHT	Behavioral Health Transformation
BH-ISL	Behavioral Health Individual and Service Level
BHIN	Behavioral Health Information Notice
CFT	Child and Family Team
CMS	Centers for Medicare & Medicaid Services
CSC	Coordinated Specialty Care
CPS	Consumer Perception Survey
CDE	California Department of Education
CDSS	California Department of Social Services
CDPH	California Department of Public Health
CDC	Centers for Disease Control and Prevention
CM	Contingency Management
CoC	Continuum of care
CLS	Current living situation

DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSH	California Department of State Hospitals
DHCS	Department of Health Care Services
DSF-E	Depression Screening and Follow-up for Adolescents and Adults
EBP	Evidence-based practice
ECM	Enhanced Care Management
ED	Emergency department
EDIM	Enterprise Data and Information Management Division
FDA	Food and Drug Administration
FSP	Full Service Partnership
FY	Fiscal Year
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder
FUH	Follow-Up After Hospitalization for Mental Illness
FUA	Follow-Up After Emergency Department Visit for Substance Use
FUM	Follow-Up After Emergency Department Visit for Mental Illness
FACT	Forensic Assertive Community Treatment
FEP	First episode psychosis
FFS	Fee-for-service
FFT	Functional Family Therapy
HCAI	California Department of Health Care Access and Information
HPD	Health Care Payments Data
HCPCS	Healthcare Common Procedure Coding System
HDIS	Homeless Data Integration System
HEDIS	Healthcare Effectiveness Data and Information Set
HFW	High Fidelity Wraparound

IET	Initiation and Engagement of Substance Use Disorder Treatment
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IMD	Institution for Mental Disease
IPS	Individual Placement and Support
JI	Justice-Involved
JSON	JavaScript Object Notation
MST	Multisystemic Therapy
MCP	Medi-Cal Managed Care Plans
MAT	Medications for Addiction Treatment
MH	Mental Health
MHRC	Mental Health Rehabilitation Center
MHSIP	Mental Health Statistics Improvement Project
NSMHS	Non-specialty mental health services
NCQA	National Committee for Quality Assurance
OHSU	Oregon Health and Sciences University
OID	Object identifier
OUD	Opioid use disorder
PHF	Psychiatric Health Facility
PRTF	Psychiatric Residential Treatment Facility
PCIT	Parent-Child Interaction Therapy
POS	Place of Service code
POD	Pharmacotherapy for Opioid Use Disorder
PDD	HCAI Patient Discharge Data
QIMR	Enhanced Care Management and Community Supports Quarterly Implementation Monitoring Report

SMI	Serious mental illness
SNF-STP	Skilled Nursing Facility-Special Treatment Programs
SMHS	Specialty mental health services
SUD	Substance use disorder
TPS	Treatment Perceptions Survey
SAMHSA	Substance Abuse and Mental Health Services Administration
WCV	Child and Adolescent Well-Care Visits

LICENSING AGREEMENTS AND ACKNOWLEDGEMENTS

The Behavioral Health Transformation (BHT) measure set includes select measures developed and stewarded by entities other than DHCS.

The Agency for Healthcare Research and Quality (AHRQ), within the US Department of Health and Human Services (DHHS), develops and maintains Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, including the survey item used for BHT measure #BH-11. CAHPS is a registered trademark of DHHS.

The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, including the survey item used for BHT measure #BH-9, was developed through a collaborative effort of consumers, the MHSIP community, and the Center for Mental Health Services. It is administered by UCLA ISAP.

The Oregon Pediatric Improvement Partnership (OPIP) at Oregon Health & Sciences University (OHSU) developed and owns the DEV-CH measure (BHT measure #SL-4).

The University of Los Angeles (UCLA) Integrated Substance Use and Addiction Programs (ISAP) developed the Treatment Perceptions Survey (TPS), including the survey item used for BHT measure #BH-10.

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The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO).

HCPCS Level II codes and descriptors are maintained by the Centers for Medicare & Medicaid Services (CMS).

The Value Set Authority Center (VSAC) is a repository and authoring tool for public value sets created by external programs. The VSAC is provided by the National Library of Medicine (NLM), in collaboration with the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS).

CHAPTER I. BEHAVIORAL HEALTH TRANSFORMATION: OVERVIEW

A. Background

About Behavioral Health Transformation (BHT)

In March 2024, California voters approved Proposition 1 to reform the Mental Health Services Act and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT), and a key goal is to improve accountability and transparency across the behavioral health delivery system.

As articulated in the Behavioral Health Services Act (BHSA) County Policy Manual (Section 2.C), California is committed to bold action to provide Californians with high-quality, culturally responsive behavioral health services when, how, and where they need them. BHT presents a historic opportunity to transform service delivery by:

- Taking a population health approach to align expectations across California's behavioral health delivery system;
- Establishing a vision for quality and equity and setting statewide goals to drive progress across the behavioral health delivery system; and
- Using data to support continuous quality improvement.

To advance this approach, the Department of Health Care Services (DHCS) identified 14 statewide behavioral health goals focused on improving well-being and decreasing adverse outcomes.

Goals for Improvement	Goals for Reduction
• Access to Care • Care Experience • Engagement in School • Engagement in Work	• Homelessness • Institutionalization • Justice Involvement • Overdoses • Removal of Children from Home

Goals for Improvement	Goals for Reduction
• Prevention and Treatment of Co-Occurring Physical Health Conditions • Social Connection • Quality of Life	• Suicides • Untreated Behavioral Health Conditions

Throughout 2025 and 2026, DHCS identified measures to track Medi-Cal and BHSA interventions and assess overall performance on the statewide behavioral health goals for County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs). DHCS identified BHT performance measures through a robust stakeholder engagement process, in consultation with the Quality and Equity Advisory Committee and in partnership with key California state agencies. Measures were identified in two key phases:

- **Phase 1 – Population-Level Measures:** In June 2025, DHCS published a set of one-time, population-level behavioral health measures, which are defined as measures of community health and well-being associated with the statewide behavioral health goals. These population-level measures (sometimes referred to as Phase 1 Measures) were limited to publicly available measures with data available from 2022–2024 (depending on the measure). More information about Phase 1 Measures is available in the Phase 1 County Performance Workbook.
- **Phase 2 – Performance Measures:** In 2026, DHCS finalized a list of performance measures that will be used for transparency, planning, population, and policy enforcement purposes and focus on the performance of county BHPs and Medi-Cal MCPs. These will be used on an ongoing basis for both county behavioral health and Medi-Cal MCPs. They will be calculated by DHCS using administrative data. These measures will replace Phase 1 population-level measures.

County BHPs will use performance measures to inform their BHSA Integrated Plans; Annual Updates; and Behavioral Health Outcomes, Accountability, and Transparency Reports. Medi-Cal MCPs will use performance measures to inform their annual Population Health Management Strategy Deliverables.

More information about BHT is available on the DHCS website.

Purpose of Manual

The BHT Technical Specifications Manual provides the full list of BHT performance measures and details on how each measure is calculated. This manual only includes specifications for measures that DHCS developed, validated, and calculated by June 2026 as part of the BHT performance measure set (also referred to as Phase 2 Measures). It does not include specifications for measures that were not developed or are not stewarded by DHCS.

BHT Measurement Years

This manual (Version 1.0) includes technical specifications for DHCS measures calculated in 2026 for the first BHT performance year. Most measures report performance corresponding to the state fiscal year (FY), which runs from July 1 to June 30. Most measures reported in 2026 reflect the measurement period of state FY 2024-2025. Technical specifications apply to the full applicable measurement period.

Updates to Technical Specifications Manual

DHCS will update this manual to add or revise technical specifications for DHCS measures before the start of the measurement periods as needed. DHCS will notify MCPs, BHPs, and other stakeholders of any updates to the BHT Technical Specifications Manual.

DHCS will not reissue technical specifications annually for every measure. Any updates made to these specifications between these planned versions will be denoted using the "Version 1.X" format. If the technical specification for a measure changes between performance years, DHCS will update this manual to reflect the most recent version and denote the latest version number of the measure.

Over time, planned updates will expand the eligible populations for many measures to include people who receive county behavioral health services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the BHSA, 1991 and 2011 Realignment, and the Substance Abuse and Mental Health Service Administration (SAMHSA) Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants.

DHCS will add specifications for measures targeted for a later release date. This includes specifying additional measures as new data become available; for example, data on BHSA services will not be available until after the first year of BHSA implementation.

B. Behavioral Health Transformation Performance Measures

Table 1 includes 51 BHT measures corresponding to 14 statewide behavioral health goals. Specifications for measures marked as N/A in the Measure Version column are not yet available and will be introduced in future versions of the manual. Measures with available specifications were calculated in 2026. Rates for certain measures may not be published in 2026 if they do not have a sufficient denominator size or the rate is not yet stable.

Appendix A includes instructions for accessing measure resources maintained by external measure stewards referenced in Table 1:

- Agency for Healthcare Research and Quality (AHRQ)
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)
- Oregon Health and Sciences University (OHSU)
- University of Los Angeles (UCLA) Integrated Substance Use and Addiction Programs (ISAP)

Table 1. BHT Performance Measures

Measure Number	Measure Name (Measure Acronym)	Measure Version
Goal 1	**Improving Access to Care**	
BH-1	One or More Behavioral Health Services for People with Mental Health Needs (BHSRV1-WMH)	v1.0
BH-2	One or More Behavioral Health Services for People with Significant Mental Health Needs (BHSRV1-WSMH)	v1.0
BH-3	Initiation of Substance Use Disorder Treatment (IET-I)	External (NCQA)
BH-4	One or More Behavioral Health Services for People with Significant Mental Health Needs and Co-Occurring Substance Use Disorders (BHSRV1-WSMH-SUD)	N/A

Measure Number	Measure Name (Measure Acronym)	Measure Version
Goal 2	**Reducing Untreated Behavioral Health Conditions**	
BH-5	Three or More Behavioral Health Services for People with Mental Health Needs (BHSRV3-WMH)	v1.0
BH-6	Three or More Behavioral Health Services for People with Significant Mental Health Needs (BHSRV3-WSMH)	v1.0
BH-7	Engagement in Substance Use Disorder Treatment (IET-E)	External (NCQA)
BH-8	Three or More Behavioral Health Services for People with Significant Mental Health Needs and Co-Occurring Substance Use Disorder (BHSRV3-WSMH-SUD)	N/A
BH-12	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	External (NCQA)
BH-13	Evidence-Based Practices for People with Significant Mental Health Needs (EBP-WSMH)	N/A
BH-14	Follow-Up After Emergency Department Visit for Substance Use – 7 Days (FUA-7d)	External (NCQA)
BH-15	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (FUM-7d)	External (NCQA)
Goal 3	**Improving Care Experience**	
BH-9	Perception of Care with Respect to One's Cultural Background: Specialty Mental Health Services (SMHS) (PC-SMHS)	External (UCLA ISAP)
BH-10	Perception of Care with Respect to One's Cultural Background: DMC-ODS (PC-DMCODS)	External (UCLA ISAP)
BH-11	Perception of Care with Respect to One's Cultural Background: Non-Specialty Mental Health Services (NSMHS) (PC-NSMHS)	External (AHRQ)

Measure Number	Measure Name (Measure Acronym)	Measure Version
Goal 4	**Improving Prevention and Treatment of Co-Occurring Physical Health Conditions**	
PH-1	Adults' Access to Preventive/Ambulatory Health Services: Significant Behavioral Health Needs (AAP-WSBH)	v1.0
PH-2	Child and Adolescent Well-Care Visits: Significant Behavioral Health Needs (WCV-WSBH)	v1.0
PH-3	Dental Visits for People with Significant Behavioral Health Needs (ADV-WSBH)	v1.0
Goal 5	**Reducing Homelessness**	
HO-1	Homelessness Among People with Significant Behavioral Health Needs (PEH-WSBH)	v1.0
HO-2	Housing Services for People with Significant Behavioral Health Needs at Risk of or Experiencing Homelessness (HOUSSRV-WSBH)	v1.0
HO-3	Full Service Partnership and Housing Services for People with Significant Behavioral Health Needs at Risk of or Experiencing Homelessness (FSP-PEH-WSBH)	N/A
Goal 6	**Reducing Institutionalization**	
IN-1	Institutional Stays for People with Behavioral Health Needs (IN-WBH)	N/A
IN-2	Coordinated Specialty Care for First Episode Psychosis (CSCFEP)	N/A
IN-3	Support for Transitions from Institutional Behavioral Health Care (INTRSN)	N/A
IN-4	Follow-Up After Hospitalization for Mental Illness – 7 Days (FUH-7d)	External (NCQA)
IN-5	Follow-Up After Other Institutional Stays for Behavioral Health (INFU)	N/A

Measure Number	Measure Name (Measure Acronym)	Measure Version
Goal 7	**Reducing Justice Involvement**	
JI-1	Incarceration Among People with Significant Behavioral Health Needs (JI-WSBH)	N/A
JI-2	Repeat Incarceration Among People with Significant Behavioral Health Needs (JIRPT-WSBH)	N/A
JI-3	Post-Release Behavioral Health Services for Justice-Involved Reentry Enrollees with Significant Behavioral Health Needs (JISRV-WSBH)	v1.0
JI-4	Continuation of Medications for Addiction Treatment (MAT) for Justice-Involved Reentry Enrollees (JIMAT)	v1.0
Goal 8	**Reducing Overdoses**	
OD-1	Deaths by Drug Overdose (ODDEATH)	v1.0
OD-2	Repeat ED Visit or Hospitalization for Drug Overdose (ODRPT)	v1.0
OD-3	Recovery Incentives - Contingency Management (CM)	v1.0
OD-4	Pharmacotherapy for Opioid Use Disorder (POD)	External (NCQA)
OD-5	Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (FUI-7d)	External (NCQA)
Goal 9	**Reducing Removal of Children from Home**	
RC-1	Children and Youth in Foster Care (FC)	v1.0
RC-2	Specialty Behavioral Health Services for Children and Youth in Foster Care (FCSRV)	v1.0
RC-3	Behavioral Health Services for Parents, Guardians, and Pregnant People with Significant Behavioral Health Needs (PARSRV-WSBH)	v1.0
RC-4	High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care (FCHFW)	N/A

Measure Number	Measure Name (Measure Acronym)	Measure Version
Goal 10	**Reducing Suicides**	
SU-1	Deaths By Suicide (SUIDEATH)	v1.0
SU-2	Repeat ED Visit or Hospitalization for Self-Harm (SUIRPT)	v1.0
Goal 11	**Improving Engagement in School**	
SL-1	Graduation Rate for Students with Behavioral Health Needs (GR-WBH)	N/A
SL-2	Chronic Absenteeism for Students with Behavioral Health Needs (CA-WBH)	N/A
SL-3	Care Coordination and Management Services for Children and Youth with Behavioral Health Needs (CCM-WBH)	N/A
SL-4	Developmental Screening in the First Three Years of Life (DEV-CH)	External (OHSU)
Goal 12	**Improving Engagement in Work**	
WK-1	Individual Placement and Support (IPS) Supported Employment for People with Significant Behavioral Health Needs (IPS-WSBH)	N/A
Goal 13	**Improving Social Connection**	
SC-1	Services That Strengthen Interpersonal Relationships for People with Significant Behavioral Health Needs (REL-WSBH)	N/A
	Equity Measures	
EQ-1	Disparities in Behavioral Health Services for People with Mental Health Needs (EQ-BHSRV1-WMH)	N/A
EQ-2	Disparities in Behavioral Health Services for People with Significant Mental Health Needs (EQ-BHSRV3-WSMH)	N/A
EQ-3	Disparities in Pharmacotherapy for Opioid Use Disorder (EQ-POD)	N/A

Measure Number	Measure Name (Measure Acronym)	Measure Version
	Cross-Goal BHSA Priority Population Measure	
CG-1	Multi-System Involvement for People with Behavioral Health Needs (MSI)	N/A

Goal 14: Improving Quality of Life

DHCS is committed to making progress on the Improving Quality of Life statewide behavioral health goal. DHCS does not currently have data to adequately measure quality of life. DHCS is exploring opportunities, in alignment with the DHCS Comprehensive Quality Strategy, to improve data collection on quality of life, which may include improving member surveys across delivery systems and exploring validated tools and strategies to collect data on quality of life. DHCS is also exploring approaches for assessing quality of life through the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Access, Reform, and Outcomes Incentive Program. These efforts will inform future BHT performance measures under the Improving Quality of Life goal.

Measure Validation Process

During measure development, DHCS implemented a measure validation process that incorporates best practices from national frameworks and emphasizes quality and alignment with measure goals. DHCS calculated measure rates as defined in the measure specifications and stratified by county, health plan, age group, sex, and race/ethnicity (if applicable). Additional analytics specific to each measure were conducted for validation as needed. Measure output was then reviewed by DHCS Medicaid policy and program staff, subject matter experts, Enterprise Data and Information Management (EDIM) Division staff, state agencies as applicable, and methodology experts.

Reviewers focused on multiple dimensions when evaluating preliminary BHT measure output, including:

- Usability of performance results for accountability and program improvement in alignment with state policy initiatives and behavioral health goals;

- Internal consistency with other BHT measures using the same measure concepts, such as measure components, populations, or services;
- Reliability, validity, and accuracy relative to technical specifications, data dictionaries, and national, state, or Medi-Cal benchmarks, if available;
- Quality, specificity, and complexity of available data sources; and
- Alignment of measure logic across specifications, programming code, and preliminary output data.

Reviewers systematically documented programming queries used to generate output, expected versus actual values, and notes explaining any discrepancies and decisions to inform updates to measures based on validation findings. This documentation creates a clear audit trail and shared understanding across interested parties. When issues were identified, programming teams implemented adjustments and produced updated output for reviewers to examine and use to revalidate the measures.

For measures from other measure sets, such as HEDIS measures, output validation was conducted jointly with the EDIM Data Science Branch to ensure the accuracy and reliability of BHT measure output by checking results against existing DHCS dashboards and/or Medi-Cal Connect datasets. This process compared backend results with data presented in dashboards and verifies numerators, denominators, filters, date ranges, populations, and year-over-year benchmarks to confirm the results are consistent and correct.

C. Overview of Technical Specifications

DHCS calculates BHT performance measures using the specifications in this manual. DHCS does not expect county BHPs or Medi-Cal MCPs to calculate and submit measures to DHCS.

DHCS will publicly report measure results with sufficient denominators annually, stratified by county BHP and Medi-Cal MCP and by age and other demographic characteristics. DHCS will also update the measure results and associated underlying data via Medi-Cal Connect, a DHCS-run population health management tool that aggregates data from multiple sources to assess performance on a variety of measures for county BHPs and Medi-Cal MCPs. DHCS will update the measure results as frequently as monthly, depending on the data source(s) used in a particular measure.

The specifications reference value sets, which are lists of codes for services and conditions, maintained by external measure stewards. DHCS will use the most recent version of value sets each year when calculating the measures. In the specifications, value set references are capitalized and underlined (e.g., Mental Illness Value Set). Appendix A includes information about organizations that maintain value sets referenced in this manual:

- American Institutes for Research (AIR)
- Health Level Seven International (HL7) Patient Care Working Group (WG)
- NCQA HEDIS

BHT Performance Measure Components

Many BHT performance measures refer to the same measure components—i.e., specific populations, diagnoses, or services—that are defined using common logic across measures to ensure consistency in BHT reporting. Descriptions and technical specifications for each measure component are in Chapter II and include the following.

Behavioral health needs

- Behavioral health needs, which includes:
    - Mental health needs

- Significant behavioral health needs, which includes:
  - Substance use disorder (SUD) needs
  - Significant mental health needs

Priority populations

- At risk of or experiencing homelessness
- Experiencing homelessness
- Incarceration

Services

- Core clinical services to address behavioral health
- Institutional stays

Data Sources

DHCS will calculate the BHT measures using the data sources described below. All data sources below were matched to a single Medi-Cal member record number in order to calculate the measures. DHCS expects additional data sources to become available in the future and will update this manual to reflect any changes in data sources.

California Department of Public Health (CDPH) Vital Records. Information collected from official death certificates that document deaths occurring within a population. Records include standardized information on the decedent's demographics (e.g., age, sex, race/ethnicity), date and location of death, and the underlying and contributing causes of death as coded using the International Classification of Diseases (ICD).

California Department of State Hospitals (DSH) data. Data used to identify state hospital civil commitments, which are behavioral health services provided through the DSH to individuals deemed by the court to be a danger to themselves or others, or unable to provide for their own basic needs because of a mental illness.

Enhanced Care Management (ECM) and Community Supports (CS) Quarterly Implementation Monitoring Report (QIMR) and .JSON data files. The QIMR is a standardized reporting tool that MCPs use to document the implementation status of ECM and CS. For reporting requirements, see the QIMR Reporting Guidance. Beginning in January 2024, DHCS is transitioning ECM and CS from QIMR to monthly JavaScript

Object Notation (.JSON) file submissions. The data file transition will take place in phases through 2026.

Homeless Data Integration System (HDIS). Statewide system that aggregates client-level data from Homeless Management Information Systems across California's continuums of care.

Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal). Statewide system used to validate Medi-Cal eligibility and determine, apply, and manage JI 90-day pre-release services eligibility time frames for individuals incarcerated in state prisons, county jails, and youth correctional facilities. The portal supports activation, termination, pausing, resetting, or restarting of the 90-day pre-release services period. The JI Screening Portal stores screening and eligibility data for reporting to the Centers for Medicare & Medicaid Services (CMS) and supports coordinated reentry planning.

Medi-Cal enrollment data. Medi-Cal enrollment data reported to the statewide Medi-Cal Eligibility Data System.

Medi-Cal Fee-For-Service (FFS) claims. Claims for services submitted for reimbursement through the FFS health care delivery system.

Managed care encounters. Encounter data submitted by MCPs to DHCS documenting institutional, professional, and pharmacy services provided to enrolled members.

Short Doyle/Medi-Cal claims. Requests from a county BHP for federal Medicaid payments for specialty behavioral health services provided to Medi-Cal members. Processed through the Management Information System/Decision Support System.

DHCS may incorporate the following data sources in future measure versions:

Behavioral Health Individual and Service Level (BH-ISL) encounters. Beginning in 2027, all counties will be required to submit BH-ISL encounters for individual and service-level behavioral health services and expenditures not funded by Medi-Cal. This will include, but is not limited to, services funded by the BHSA. More information is available in the Behavioral Health Informational Notice (BHIN) 26-016.

California Department of Education (CDE) data. CDE collects educational data, statistics, and information about California's students and schools. More information is available on the CDE Data & Statistics website.

Claims and encounter data

Unless otherwise specified, BHT measures use all paid claims and/or encounters.[1] Paid claims are the final, paid version of claims that have been processed and adjudicated by the appropriate claiming system. All BHT measures are calculated using the date of service on a claim, not the date of claim submission. Measures are calculated using the claims and encounters that are in the reporting system as of four months after the end of the measurement period.

Some BHT measures specify claim types used to identify relevant claims and services. The claim type is identified by a specified program code, source code, and, where relevant, a revenue code. For example, claims for covered services processed through the Short Doyle/Medi-Cal claims processing system are identified using program code = 08 (Short Doyle).

Many measures specify procedure codes, modifiers, and/or diagnosis codes that must be used in combination to identify eligible services. Modifiers are two-digit extensions added to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes to provide additional information about a service or procedure.

Definitions

Unless otherwise indicated, measure specifications use the following definitions to identify populations that are included in the measure:

- **Foster care.** A person enrolled in Medi-Cal under specified aid codes associated with foster care during the measurement period. Consistent with federal regulation, foster care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the state has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and proadaptive homes. See CFR 1355.20 for the full definition of foster care.
- **Mental health provider.** Includes both mental health and SUD providers. This aligns with how DHCS defines mental health provider under three HEDIS measures: FUA (Follow-Up After Emergency Department for Substance Use),

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

FUM (Follow-Up After Emergency Department Visit for Mental Illness), and FUH (Follow-Up After Hospitalization for Mental Illness).

- **Parent or guardian.** A person enrolled in Medi-Cal via a Medi-Cal aid code specific to parents or caretaker relatives. This definition does not include all Medi-Cal members who are parents and guardians. In future versions of this manual, DHCS will explore expanding this definition to include parents and guardians who are not enrolled in Medi-Cal but are receiving other county behavioral health services, such as BHSA services.
- **Pregnant or postpartum person.** A person enrolled in Medi-Cal via a Medi-Cal aid code specific to pregnant or postpartum individuals. In future versions of this manual, DHCS will explore expanding this definition to include pregnant or postpartum individuals who are not enrolled in Medi-Cal but are receiving other county behavioral health services, such as BHSA services.

Service and support definitions

Definitions and guidance for services included in measure specifications are available at the following locations:

- The BHSA County Policy Manual, with information on key policy manual definitions in Appendix D; Early Intervention Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices in Appendix E; and descriptions of services and supports in Chapter 7
- Full Service Partnerships (FSPs) (BHSA Policy Manual Chapter 7 Section B)
- ECM (CalAIM ECM Policy Guide and Coding Guidance; guidance on policy alignment included in BHSA Chapter 7 Section B.3.2)
- Contingency Management (CM) for stimulant use disorder treatment (BHIN-24-031 and BHSA Policy Manual Appendix E.3)
- Medications for addiction treatment (MAT) services for SUD recovery (BHIN-23-054 and BHSA Section B.7)
- Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent-Child Interaction Therapy (PCIT) (BHSA Appendix E.1 and DHCS website for Children and Youth EBPs)

- Intensive Care Coordination (ICC) (BHIN-21-058)
- Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), High Fidelity Wraparound (HFW), Individual Placement and Support (IPS) Model of Supported Employment, and Clubhouse services (BH-CONNECT EBP Policy Guide and BHIN-25-009)
    - Guidance on EBP policy alignment is available in BHSA Policy Manual Sections A.7.5 (CSC), B.4.3 (HFW), B.4.1 (ACT/FACT), B.5 (IPS)
- BHSA Housing Interventions (Section C), including Medi-Cal housing community supports (Section C.7) and Permanent Supportive Housing (Section C.9.3.1)
- 90-day pre-release services as part of the CalAIM Justice-Involved (JI) Reentry Initiative (BHIN-23-059)

Inpatient, residential, and institutional facility definitions

Definitions and additional guidance about the types of facilities and stays identified in BHT measure specifications are available on the following sites:

- Correctional facilities (CalAIM JI Policy and Operations Guide)
- Medi-Cal stays in Institutions for Mental Disease (IMDs) (BHIN-25-011)[2]
- Other psychiatric treatment facilities, including MHRCs and PHFs (DHCS website on Licensed Facilities), psychiatric hospitals (CDPH website on Facility/Provider Types), PRTFs (BHIN-25-024), and state hospital civil commitments (DSH website on Civil Commitments)
- Safety net clinics (SNCs) (DHCS SNCs FAQs)[3]
- SNF-STPs (DHCS SNF Long-Term Care Carve-In FAQs)

[2] In California, IMD stays for Medicaid members are covered by Behavioral Health Plans (BHPs) using non-Medicaid state funding, and certain stays are Medi-Cal billable under the BH-CONNECT demonstration. For additional information on IMD exclusions, see CRS IF 10222.

[3] Includes Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Services/Memorandum of Agreement 683 Clinics (community health centers).

Eligible Population

Each measure specification describes an eligible population to assess for inclusion in the measure denominator. The specification for the eligible population includes the following:

- **Product line.** The coverage type required to be included in the eligible population.
  - For all measures, the product line is Medi-Cal, meaning that the eligible population includes members with Medi-Cal coverage during the relevant measurement period.
  - Some measures with allowable adjustment of NCQA HEDIS specifications include modifications that exclude members with dual Medicare/Medicaid enrollment (dual eligible) from the eligible population.
- **Continuous enrollment.** The minimum amount of time an individual must be enrolled in Medi-Cal or other coverage before becoming eligible for inclusion in a measure denominator, before accounting for any allowable gap.
  - Continuous enrollment may include a range of time when the individual is required to have been enrolled in Medicaid with full benefits during the measurement period (for example, at least 30 consecutive calendar days, 90 days, or 12 months).
  - For some event-based measures, Medi-Cal or other coverage enrollment may only be required on the date an individual received a service.
- **Allowable gap.** The maximum amount of time during the continuous enrollment period when the individual is not covered by the specified product line while remaining eligible for inclusion in a measure denominator.
  - For most BHT measures with an allowable gap, the allowable gap is no more than one month during the measurement period.
- **Anchor date.** A required date on which an individual must be enrolled in order to be included in a measure denominator. Any gaps in coverage—including an allowable gap—must not include the anchor date.

- Most BHT measures do not have an anchor date. For some measures, the anchor date is the last day of the measurement period.

» **Benefit.** Measure specifications include benefits required during the continuous enrollment period, which are the services the individual qualifies for (e.g., medical, pharmacy, mental health, chemical dependency, or full scope).

- In the current manual version, most BHT measures include Medi-Cal members with full-scope benefits.

Denominator Exclusions

Some measures include required exclusions, which are criteria that must be applied when identifying individuals or events to include in the denominator. Measures may exclude individuals who died or received certain services or benefits (such as hospice or palliative care) because the services being captured in the measure may not be of benefit for this population or may not be in line with patients' goals of care. Some measures exclude visits that result in an inpatient stay or observation stay. A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

Health Plan Attribution

DHCS will calculate measure performance for each BHP and MCP. Individuals are attributed to a BHP based on their County of Responsibility and the date used for attribution. The County of Responsibility is the county that is responsible for maintaining the current county case record for Medi-Cal eligibility for an individual or family, and may be different from the county of residence, which is the county the individual physically resides in. Individuals are attributed to the MCP in which they were enrolled on the date used for attribution.

D. Technical Specifications Measure Elements

The technical specifications in the subsequent sections of this manual include the measure elements in Table 4. Measure elements are listed in Table 4 in the same order in which they appear in measure specifications.

Table 2. Technical Specifications Measure Elements

Measure Element	Description
Background	The policy or clinical reasoning behind the measure and how the measure was constructed.
Measure type	Classification of measure type. Each measure is assigned a measure type based on its conceptual focus and role in evaluating quality, helping to clarify its purpose and organize the overall measure set. Measures are classified as: access, component used in BHT measures, outcome, patient experience, population health, process, or utilization.
Description	Brief description of the measure.
Measure versions to account for data availability	Description of future versions of the specifications that DHCS expects will be necessary to account for data availability and transitions.
Eligible population	Description of the population eligible for inclusion in the measure. Includes the standard nonclinical eligible population elements (product line, continuous enrollment, allowable gap, anchor date, benefit).
Denominator	Description of the steps required to identify the individuals or events included in the denominator of a rate measure.
Denominator exclusions	Exclusions that will remove an individual or event from the denominator based on information captured in claims, encounter, pharmacy, and/or enrollment data.
Numerator	Description of the steps required to identify the individuals or events included in the numerator of a measure.
Metric calculation	Description of the steps required to calculate the measure rate using the numerator and denominator. For components, this row is labeled Component calculation.

Measure Element	Description
Date used for attribution	The date used to attribute individuals to their County of Responsibility for Behavioral Health Plans or to the Managed Care Plan they were enrolled in.
Stratifications	Description of the criteria used to calculate the measure for different groups, such as age, demographics, or delivery system.
Additional instructions	Any additional information relevant to calculating the measure.
Measurement period	The time period during which services, events, or outcomes had to occur to be considered for inclusion in a given measure. Most measures are calculated using two separate measurement periods for (1) public reporting and (2) Medi-Cal Connect reporting.
Data sources	Data source(s) used to report the measure, including data used in linked components.
First BHT measurement period	The first measurement period for which the measure will be calculated. Most measures are calculated using the state fiscal year, which runs from July 1 to June 30.
Measure version	Version number of the measure described in the current specifications (e.g., v1, v2). Measures may be updated over time.
Measure release date	The date on which the current version of the measure was published.
Summary of changes	Description of any changes to the measure specification that have been made since previous versions. This row is not relevant to Version 1 of the measure specifications.

CHAPTER II. BHT TECHNICAL SPECIFICATIONS

Goal 1. Improving Access to Care

The specification for measure BH-3 is available from external measure stewards described in Appendix A. The specification for measure BH-4 is not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

BHT Performance Measure #BH-1: One or More Behavioral Health Services for People with Mental Health Needs (BHSRV1-WMH)

Measure Element	Description
Background	This measure calculates the utilization of one or more core clinical services to address behavioral health (BH) during a 12-month period among people enrolled in Medi-Cal or receiving other county BH services[4] living with an identified mental health (MH) need. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as one of the Goal Measures for the Improving Access to Care statewide behavioral health goal, this measure includes all Medi-Cal members with an identified MH need. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, it assesses whether members received core clinical services to address BH regardless of whether they should be served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system.

[4] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the measure only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into this measure at a future date.

Background (continued)	For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they meet denominator criteria for identified MH needs. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria for identified MH needs. People with MH needs include people with an identified need for MH services across the full continuum of care, including mild, moderate, and significant MH needs. DHCS identifies people with MH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with MH needs for which there is no available administrative data indicating that need. This measure uses the standard definition of core clinical services utilized by all BHT measures, which is inclusive of services for both MH and Substance Use Disorder (SUD) needs. Core clinical services are intended to capture services in which a person's BH needs (including MH and SUD needs) are met. They focus on outpatient services delivered in community or clinic settings (excluding Emergency Department [ED], crisis, and acute inpatient visits) and include services in both the county BH and Medi-Cal managed care delivery systems. Improving performance on this measure therefore requires coordination between counties and MCPs. This measure differs from DHCS's existing Specialty Mental Health Services Penetration Rates and Non-Specialty Mental Health Services Penetration Rates, which look at whether a Medi-Cal member received one or more services—not limited to core clinical services—in the respective delivery system, regardless of whether they had a MH need. The rate for this measure is expected to be higher than the penetration rates because it is limited to people living with an identified MH need, rather than all Medi-Cal members. Note that this measure does not assess if people with unidentified MH needs are accessing or utilizing services; DHCS cannot identify someone living with MH needs who has not previously used the health care system for their need.
Measure type	Utilization

Measure Element	Description
Description	Percent of people enrolled in Medi-Cal or receiving other county BH services and living with MH needs who receive one or more core clinical services to address BH in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits

Measure Element	Description
Denominator	The number of individuals in the eligible population living with MH needs during the measurement period. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those living with MH needs as of the last day of the measurement period using the following logic: MH Needs Component Specification
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received one or more core clinical services to address BH during the measurement period. **Step 1**: Among individuals identified in Step 1 of the denominator, identify claims and encounters for core clinical services to address BH during the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to the enrollment criteria specified above.

Measure Element	Description
Measurement period	• Publication (semiannual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect *(*monthly update*)*: 12-month rolling
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #BH-2: One or More Behavioral Health Services for People with Significant Mental Health Needs (BHSRV1-WSMH)

Measure Element	Description
Background	This measure calculates the utilization of one or more core clinical services to address behavioral health (BH) during a 12-month period among people enrolled in Medi-Cal or receiving other county BH services[5] living with an identified significant mental health (MH) need. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as one of the Goal Measures for the Improving Access to Care statewide BH goal, this measure includes all Medi-Cal members with an identified Significant MH need. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, it assesses whether members received core clinical services to address BH regardless of whether they should be served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system. For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they meet denominator criteria for identified MH needs. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria for identified significant MH needs.

[5] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	People with significant MH needs are people with MH needs that are more likely to be associated with functional impairment, including those that likely require close collaboration between MCPs and county BHPs to determine the best system of BH care and where specialty MH support may be needed, depending on the individual's clinical needs. DHCS identifies people with significant MH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with significant MH needs for which there is no available administrative data indicating that need. This measure uses the standard definition of core clinical services utilized by all BHT measures, which is inclusive of services for both MH and Substance Use Disorder (SUD) needs. Core clinical services are intended to capture services in which a person's BH needs (including MH and SUD needs) are met. They focus on outpatient services delivered in community or clinic settings (excluding Emergency Department [ED], crisis, and acute inpatient visits) and include services in both the county BH and Medi-Cal managed care delivery systems. Improving performance on this measure therefore requires coordination between counties and MCPs. This measure differs from DHCS's existing SMHS Penetration Rates, which look at whether a Medi-Cal member received one or more SMHS services—not limited to core clinical services—regardless of whether they had a significant MH need. The rate for this measure is expected to be higher than the penetration rates because it is limited to people living with an identified significant MH need, rather than all Medi-Cal members. Note that this measure does not assess if people with unidentified significant MH needs are accessing or utilizing services; using only administrative data, DHCS cannot identify someone living with significant MH needs who has not previously used the health care system for their need.
Measure type	Utilization

Measure Element	Description
Description	Percent of people enrolled in Medi-Cal or receiving other county BH services and living with significant MH needs who receive one or more core clinical services to address BH in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits
Denominator	The number of individuals in the eligible population living with significant MH needs. This is a cumulative count over the entire measurement period. Each individual should only be counted once.

Measure Element	Description
Denominator (continued)	**Step 1**: Among individuals in the eligible population, identify those living with significant MH needs as of the last day of the measurement period. Logic for identifying individuals living with significant MH needs are within the Significant BH Needs component specification. Significant BH Needs Component Specification
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received one or more core clinical services to address BH during the measurement period. **Step 1**: Among individuals living with significant MH needs identified in Step 1 of the denominator, identify claims and encounters for core clinical services to address BH during the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to enrollment criteria specified above.
Measurement period	• Publication (semiannual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling

Measure Element	Description
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 2. Reducing Untreated Behavioral Health Conditions

Specifications for measures BH-7, 12, 14, and 15 are available from external measure stewards described in Appendix A. Specifications for measures BH-8 and BH-13 are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

BHT Performance Measure #BH-5: Three or More Behavioral Health Services for People with Mental Health Needs (BHSRV3-WMH)

Measure Element	Description
Background	This measure calculates the utilization of three or more core clinical services to address behavioral health (BH) during a 12-month period among people enrolled in Medi-Cal or receiving other county BH services[6] living with an identified mental health (MH) need. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as one of the Goal Measures for the Reducing Untreated BH Conditions statewide behavioral health goals, this measure includes all Medi-Cal members with an identified MH need. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, it assesses whether members received at least 3 core clinical services to address BH regardless of whether they should be served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system. For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they

[6] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	meet denominator criteria for identified MH needs. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria for identified MH needs. People with MH needs include people with an identified need for MH services across the full continuum of care, including mild, moderate, and significant MH needs. DHCS identifies people with MH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with MH needs for which there is no available administrative data indicating that need. This measure uses the standard definition of core clinical services utilized by all BHT measures, which is inclusive of services for both MH and Substance Use Disorder (SUD) needs. Core clinical services are intended to capture services in which a person's BH needs (including MH and SUD needs) are met. They focus on outpatient services delivered in community or clinic settings (excluding Emergency Department [ED], crisis, and acute inpatient visits) and include services in both the county BH and Medi-Cal managed care delivery systems. Improving performance on this measure therefore requires coordination between counties and MCPs. This measure differs from DHCS's existing Specialty Mental Health Services Penetration Rates and Non-Specialty Mental Health Services Penetration Rates, which look at whether a Medi-Cal member received five or more services in the respective delivery system—not limited to core clinical services—regardless of whether they had a mental health need. The rate for this measure is expected to be higher than the engagement rates because it is limited to people living with an identified MH need, rather than all Medi-Cal members. Note that this measure does not assess if people with unidentified MH needs are accessing or utilizing services; DHCS cannot identify someone living with MH needs who has not previously used the health care system for their need.

Measure Element	Description
Measure type	Utilization
Description	Percent of people enrolled in Medi-Cal or receiving other county BH services and living with MH needs who receive three or more core clinical services to address BH in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters. a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits

Measure Element	Description
Denominator	The number of individuals in the eligible population living with MH needs during the measurement period. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those living with MH needs as of the last day of the measurement period using the following logic: MH Needs Component Specification
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received three or more core clinical services to address BH during the measurement period. **Step 1**: Among individuals identified in Step 1 of the denominator, identify claims and encounters for core clinical services to address BH during the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to the enrollment criteria specified above.

Measure Element	Description
Measurement period	• Publication (semiannual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect *(*monthly update*)*: 12-month rolling
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #BH-6: Three or More Behavioral Health Services for People with Significant Mental Health Needs (BHSRV3-WSMH)

Measure Element	Description
Background	This measure calculates the utilization of three or more core clinical services to address behavioral health (BH) during a 12-month period among people enrolled in Medi-Cal or receiving other county BH services[7] living with an identified significant mental health (MH) need. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as one of the Goal Measures for the Reducing Untreated BH Conditions statewide behavioral health goal, this measure includes all Medi-Cal members with an identified Significant MH need. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, it assesses whether members received at least 3 core clinical services to address BH regardless of whether they should be served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system. For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they meet denominator criteria for identified significant MH needs. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in

[7] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	their rate if they meet denominator criteria for identified significant MH needs. People with significant MH needs are people with MH needs that are more likely to be associated with functional impairment, including those that likely require close collaboration between MCPs and county BHPs to determine the best system of BH care and where specialty MH support may be needed, depending on the individual's clinical needs. DHCS identifies people with significant MH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with significant MH needs for which there is no available administrative data indicating that need. This measure uses the standard definition of core clinical services utilized by all BHT measures, which is inclusive of services for both MH and Substance Use Disorder (SUD) needs. Core clinical services are intended to capture services in which a person's BH needs (including MH and SUD needs) are met. They focus on outpatient services delivered in community or clinic settings (excluding Emergency Department [ED], crisis, and acute inpatient visits) and include services in both the county BH and Medi-Cal managed care delivery systems. Improving performance on this measure therefore requires coordination between counties and MCPs. This measure differs from DHCS's existing Specialty Mental Health Services Engagement Rate, which looks at whether a Medi-Cal member received five or more SMHS services—not limited to core clinical services—regardless of whether they had a significant MH need. The rate for this measure is expected to be higher than the engagement rate because it is limited to people living with an identified significant MH need, rather than all Medi-Cal members. Note that this measure does not assess if people with unidentified significant MH needs are accessing or utilizing services; using only administrative data, DHCS cannot identify someone living with significant MH needs who has not previously used the health care system for their need.
Measure type	Utilization

Measure Element	Description
Description	Percent of people enrolled in Medi-Cal or receiving other county BH services and living with significant MH needs who receive three or more core clinical services to address BH in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits

Measure Element	Description
Denominator	The number of individuals in the eligible population living with significant MH needs. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those living with significant MH needs as of the last day of the measurement period. Logic for identifying individuals living with significant MH needs is within the Significant BH Needs component specification. Significant BH Needs Component Specification
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received three or more core clinical services to address BH during the measurement period. **Step 1**: Among individuals identified in Step 1 of the denominator, identify claims and encounters for core clinical services to address BH during the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.

Measure Element	Description
Additional instructions	Use enrollment data to identify the eligible population according to the enrollment criteria specified above.
Measurement period	• Publication (semiannual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 3. Improving Care Experience

Specifications for measures BH-9, BH-10, and BH-11 are available from external measure stewards described in Appendix A.

Goal 4. Improving Prevention & Treatment of Co-Occurring Physical Health Conditions

BHT Performance Measure #PH-1: Adults' Access to Preventive/Ambulatory Health Services: Significant BH Needs (AAP-WSBH)

Measure Element	Description
Background	This measure assesses whether adults with significant behavioral health (BH) needs receive annual preventive or ambulatory care visits. This measure is an allowable adjustment of the National Committee for Quality Assurance (NCQA) Adults' Access to Preventive/Ambulatory Health Services (AAP) measure, with modifications to limit the measure to Medi-Cal members with significant BH needs.[8] Identified as an Intervention Measure for the Improving Prevention and Treatment of Co-Occurring Physical Health conditions statewide BH goal, this measure focuses on primary care for adult Medi-Cal members with an identified significant BH need. Research shows that people with significant BH needs have poorer physical health outcomes, and timely access to primary care and preventive services has been shown to improve physical health outcomes. Medi-Cal Managed Care Plans (MCPs) are required to administer physical care benefits for adult Medi-Cal members, and County Behavioral Health Plans (BHPs) are required to help coordinate those visits. For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.

[8] For additional information regarding the HEDIS AAP measure, see: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adults-access-to-preventive-ambulatory-health-services-aap/.

Measure Element	Description
Background (continued)	Because this measure focuses on individuals with a significant BH need identified via Medi-Cal claims or encounters, these individuals are already engaged in the health care system and may have a higher rate of primary care visits compared to the general population, which includes individuals who have no claims or encounters.
Measure type	Utilization
Description	Percent of adults 20 years of age and older enrolled in Medi-Cal and living with significant BH needs who have one or more ambulatory or preventive care visits in a 12-month period
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounters data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal. Do not include individuals with dual Medicaid/Medicare enrollment ("dual eligible"). **Continuous enrollment:** All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap:** No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: Last day of the measurement period **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals 20 years of age and older in the eligible population living with significant BH needs during the measurement period. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those who were 20 years of age and older as of the last day of the measurement period. **Step 2**: Among individuals identified in Step 1, identify those living with significant BH needs using the following logic: Significant BH Needs Component Specification

Measure Element	Description
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period. Individuals who died any point during the measurement period.
Numerator	The number of individuals in the denominator who had one or more ambulatory or preventive care claims or encounters during the measurement period. **Step 1**: Among individuals in the denominator, identify those who had one or more ambulatory or preventive care claims or encounters in the measurement period using the numerator logic from the HEDIS AAP measure.
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. The numerator should use the most current version of the HEDIS AAP specifications.
Measurement period	• Publication (Annual Update): Fiscal Year (July 1- June 30) • In Medi-Cal-Connect *(*Monthly Update*)*: 12-month rolling

Measure Element	Description
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #PH-2: Child and Adolescent Well-Care Visits: Significant Behavioral Health Needs (WCV-WSBH)

Measure Element	Description
Background	This measure assesses whether children and youth with significant behavioral health (BH) needs receive annual well-care visits. This measure is an allowable adjustment of the National Committee for Quality Assurance (NCQA) Child and Adolescent Well-Care Visits (WCV) measure, with modifications to limit the measure to Medi-Cal members with significant BH needs.[9] Identified as an Intervention Measure for the Improving Prevention and Treatment of Co-Occurring Physical Health conditions statewide BH goal, this measure focuses on primary care for Medi-Cal children and youth with an identified significant BH need. Research shows that people with significant BH needs have poorer physical health outcomes, and timely access to primary care and preventive services has been shown to improve physical health outcomes. Medi-Cal Managed Care Plans (MCPs) are required to administer annual well-care visits for children and youth, and County Behavioral Health Plans (BHPs) are required to help coordinate those visits. For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. Because this measure focuses on individuals with a significant BH need identified via Medi-Cal claims or encounters, these individuals are already engaged in the health care system and may have a higher rate of primary care visits compared to the general population, which includes individuals who have no claims or encounters.

[9] For more information regarding the NCQA HEDIS WCV measure, see https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/.

Measure Element	Description
Measure type	Utilization
Description	Percent of children and youth 3 to 21 years of age enrolled in Medi-Cal and living with significant BH needs who have at least one comprehensive well-care visit in a 12-month period
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounters data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal. Do not include individuals with dual Medicaid/Medicare enrollment ("dual eligible"). **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date**: Last day of the measurement period **Benefit**: Members with full-scope Medi-Cal benefits
Denominator	The number of individuals 3 to 21 years of age in the eligible population living with significant BH needs. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those who were 3 to 21 years of age as of the last day of the measurement period. **Step 2**: Among individuals identified in Step 1, identify those living with significant BH needs using the following logic: Significant BH Needs Component Specification
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period. Individuals who died any point during the measurement period.

Measure Element	Description
Numerator	The number of individuals in the denominator who had at least one comprehensive well-care visit during the measurement period. **Step 1**: Among individuals in the denominator, identify those who had one or more comprehensive well-care visits during the measurement period using the numerator logic from the HEDIS WCV measure.
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above. The numerator should use the most current version of the HEDIS WCV specifications.
Measurement period	• Publication (annual update): Fiscal Year (July 1- June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data source	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.

Measure Element	Description
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #PH-3: Dental Visits for People with Significant Behavioral Health Needs (ADV-WSBH)

Measure Element	Description
Background	This measure is adapted from the DHCS Annual Dental Visit measure, with modifications to limit the measure to Medi-Cal members living with significant behavioral health (BH) needs.[10] Identified as an Intervention Measure for the Improving Prevention and Treatment of Co-Occurring Physical Health Conditions statewide BH goal, this measure is intended to measure access to dental care among members with significant BH needs enrolled in Medi-Cal dental benefits. Although Medi-Cal dental benefits are administered by dental Managed Care Plans (MCPs) or via fee-for-service, Medi-Cal MCPs and County Behavioral Health Plans (BHPs) are required to help coordinate those services for eligible members. For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.
Measure type	Access
Description	Percent of members enrolled in Medi-Cal dental benefits and living with significant BH needs who receive at least one dental visit in a 12-month period
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounters data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.

[10] For additional information see the DHCS Dental Fee-for-Service (FFS) and Dental Managed Care (DMC) Performance Fact Sheet, available at https://www.dhcs.ca.gov/services/Documents/MDSD/FFS-DMC-Fact-Sheet-August-2025.pdf.

Measure Element	Description
Eligible population	**Product line**: Medi-Cal **Continuous enrollment:** All members with 90 calendar days continuous Medi-Cal enrollment for the measurement period **Allowable gap**: None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits and the Medi-Cal dental benefit
Denominator	The number of individuals in the eligible population living with significant BH needs. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those living with significant BH needs using the following logic: Significant BH Needs Component Specification
Denominator exclusions	None
Numerator	The number of individuals in the denominator who received any dental service in a 12-month period. **Step 1:** Among individuals in the denominator, identify those who received any dental service in the measurement period, indicated by at least one claim or encounter with either of the following procedure codes, including dental claims and encounters at safety net clinics (SNCs): 1. Current Dental Terminology (CDT): D0100-D9999 2. Current Procedural Terminology (CPT): 99188
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.

Measure Element	Description
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to enrollment criteria specified above. The measure numerator is intended to align with the numerator specifications for the DHCS Annual Dental Visit measure. Any updates to the DHCS Annual Dental Visit measure should be incorporated.
Measurement period	• Publication (annual update): Fiscal Year (July 1- June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data sources	• Dental fee-for-service (FFS) claims and Dental Managed Care encounters. Paid claims only. • Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal FFS claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 5. Reducing Homelessness

The specification for measure HO-3 is not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

BHT Performance Measure #HO-1: Homelessness Among People with Significant Behavioral Health Needs (PEH-WSBH)

Measure Element	Description
Background	This measure compares the prevalence of homelessness over a 12-month period among two groups of people enrolled in Medi-Cal or receiving other county behavioral health (BH) services:[11] People with significant BH needs and the overall population. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as a Goal Measure for the Reducing Homelessness statewide BH goal, this is a cross-sector measure because performance on this measure will be impacted by the actions of County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) as well as stakeholders beyond Medi-Cal and behavioral health. For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria for metric one and two. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria for metric one and two.

[11] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	This measure uses a novel approach for identifying people experiencing homelessness using a combination of Homelessness Data Integration System (HDIS) data from California's housing Continuums of Care and available Medi-Cal and county BH data, including addresses, Z codes documenting housing status as part of medical encounters, and the place of service for medical encounters. It provides a more-complete-than-ever understanding of people experiencing homelessness within the Medi-Cal population. This measure was developed in collaboration with the California Interagency Council on Homelessness (Cal ICH). The approach for identifying people experiencing homelessness using HDIS is consistent with the approach used for the performance measures in the Cal ICH Action Plan for Preventing and Ending Homelessness in California, and builds on that approach to also include indicators of homelessness observed in Medi-Cal and county BH data.
Measure type	Population health
Description	Rate (per 10,000) of people enrolled in Medi-Cal or receiving other county BH services and living with significant BH needs who are identified as experiencing homelessness in a 12-month period based on available data, compared with the rate (per 10,000) of all people enrolled in Medi-Cal or receiving other county BH services who are identified as experiencing homelessness in a 12-month period based on available data
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data for Medi-Cal members is available to calculate this measure. As such, this specification includes only Medi-Cal members in the eligible population (as defined below).

Measure Element	Description
Measure versions to account for data availability (continued)	2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment**: All members with full benefits enrolled in Medicaid for at least one month (30 consecutive calendar days) during the measurement period **Allowable gap**: None **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits
Metric one: Homelessness among eligible population with significant BH needs	The rate of individuals in the eligible population with significant BH needs who experienced homelessness during the measurement period (per 10,000). Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those living with significant BH needs using the following logic: Significant BH Needs Component Specification **Step 2**: Among individuals identified in Step 1, identify those experiencing homelessness using the following logic: Experiencing Homelessness Component Specification **Step 3**: Divide the number of unique individuals identified in Step 2 by the number of unique individuals identified in Step 1. Multiply by 10,000 to get a rate per 10,000.

Measure Element	Description
Metric two: Homelessness among the eligible population	The rate of individuals in the eligible population who experienced homelessness during the measurement period (per 10,000). Each individual should only be counted once. **Step 1**: Among individuals in the eligible population, identify those experiencing homelessness using the following logic: Experiencing Homelessness Component Specification **Step 2**: Divide the number of unique individuals identified in Step 1 by the number of unique individuals identified in the eligible population. Multiply by 10,000 to get a rate per 10,000.
Metric calculation	Metric one and metric two are distinct rates that should be presented next to each other for comparison. Both metrics are calculated as the rate per 10,000 individuals.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (quarterly update): 12-month rolling
Data sources	• HDIS • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.

Measure Element	Description
First BHT measurement period	FY2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #HO-2: Housing Services for People with Significant Behavioral Health Needs Who Are At Risk of or Experiencing Homelessness (HOUSSRV-WSBH)

Measure Element	Description
Background	This measure captures the receipt of DHCS-funded housing services to support people enrolled in Medi-Cal or receiving other county behavioral health (BH) services[12] living with significant BH needs who are at risk of or experiencing homelessness. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as an Intervention measure for the Reducing Homelessness statewide BH goal, this measure includes all Medi-Cal members with an identified significant BH need, understanding that people with significant BH needs can be served by either the Specialty Mental Health Services or Non-Specialty Mental Health Services system depending on their functional status. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, this measure will assess whether a member received a housing service to address their housing needs, regardless of whether the service was delivered by an Managed Care Plan (MCP) or by a County Behavioral Health Plan (BHP); however, only data on MCP housing services is available for inclusion in this measure at this time.

[12] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria for identified significant BH needs. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria for identified significant BH needs. It will measure utilization of two types of housing services – Medi-Cal housing Community Supports, inclusive of Transitional Rent, and County BH Housing Interventions – among people with significant BH needs who are at risk of or experiencing homelessness. However, the current version of this measure includes only Medi-Cal housing Community Supports because data on county BH Housing Interventions is not yet available. This measure uses a novel approach for identifying people at risk of or experiencing homelessness using a combination of Homeless Data Integration System (HDIS) data from California's housing Continuums of Care and available Medi-Cal and county BH data, including addresses; Z codes documenting housing status as part of medical encounters; the place of service for medical encounters; and authorization or receipt of housing services and enrollment in Enhanced Care Management (ECM). It provides a more-complete-than-ever understanding of people at risk of or experiencing homelessness within the Medi-Cal population. This measure was developed in collaboration with the California Interagency Council on Homelessness (Cal ICH). The approach for identifying people experiencing homelessness using HDIS is consistent with the approach used for the performance measures in the Cal ICH Action Plan for Preventing and Ending Homelessness in California, and builds on that approach to also include indicators of homelessness observed in Medi-Cal and county BH data.
Measure type	Process

Measure Element	Description
Description	Percent of people enrolled in Medi-Cal or receiving other county BH services, living with significant BH needs, and are identified as at risk of or experiencing homelessness in a 12-month period based on available data, who receive at least one Medi-Cal housing Community Support or county BH Housing Intervention in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include the Enhanced Care Management (ECM) and Community Supports .JSON (JavaScript Object Notation) file a. DHCS will incorporate data from the ECM and Community Supports .JSON file once DHCS transitions to reporting this data from the Quarterly Implementation Monitoring Report (QIMR) to the monthly .JSON file. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.

Measure Element	Description
Eligible population	**Product line:** Medi-Cal **Continuous enrollment**: All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap**: No more than one gap in enrollment of up to one month during the measurement period **Anchor date:** None **Benefit**: Members with full-scope Medi-Cal managed care benefits (excludes fee-for-service Medi-Cal members)
Denominator	The number of individuals in the eligible population with significant BH needs who were at risk of or experiencing homelessness during the measurement period. Each member should only be counted once. **Step 1:** Among the individuals in the eligible population, identify those living with significant BH needs, using the following logic: Significant BH Needs Component Specification **Step 2:** Among the individuals identified in Step 1, identify those who were at risk of or experiencing homelessness during the measurement period using the following logic: At Risk of or Experiencing Homelessness Component Specification
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received at least one Medi-Cal housing Community Support during the measurement period. **Step 1:** Among individuals in the denominator, identify those who received at least one Medi-Cal Housing Community Support service during the measurement period, as documented in either the QIMR or in Medi-Cal claims and encounter data, by meeting at least one of the following criteria:

Measure Element	Description
Numerator (continued)	1. Received any of the following Housing Community Supports as indicated in the QIMR: Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits, Recuperative Care (Medical Respite), Short-Term Post-Hospitalization Housing, or Day Habilitation. 2. Received Transitional Rent, as indicated by at least one claim or encounter during the measurement period with Healthcare Common Procedure Coding System (HCPCS) code H0044 with modifier U6, or HCPCS code H0043 with modifier U2.[13]
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date Used for Attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to the enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (quarterly update): 12-month rolling

[13] For additional details, please see DHCS Community Supports Policy Guide: Volume 2, available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf.

Measure Element	Description
Data sources	• ECM and Community Supports QIMR data • HDIS • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal FFS claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 6. Reducing Institutionalization

Specifications for measures IN-1, IN-2, IN-3, IN-5 are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual. The specification for measure IN-4 is available from external measure stewards described in Appendix A.

Goal 7. Reducing Justice Involvement

Specifications for measures JI-1 and JI-2 are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

BHT Performance Measure #JI-3: Post-Release Behavioral Health Services for Justice-Involved Reentry Enrollees with Significant Behavioral Health Needs (JISRV-WSBH)

Measure Element	Description
Background	This measure focuses on utilization of core clinical services to address behavioral health (BH) among Medi-Cal members living with significant BH needs in the 14 days following their release from a correctional facility. Identified as an Intervention Measure for the Reducing Justice Involvement statewide BH goal, this measure examines whether people are connected to the BH care they need following incarceration, an intervention that has been shown to reduce recidivism. It includes Medi-Cal members who have their 90-day pre-release services activated as part of the California Advancing and Innovating Medi-Cal (CalAIM) Justice Involved (JI) Reentry Initiative and were identified with a significant BH need during their pre-release services. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, it assesses whether members received core clinical services to address BH in the post-release period regardless of whether they were served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system. Under the CalAIM JI Reentry Initiative, Medi-Cal Managed Care Plans (MCPs) and County Behavioral Health Plans (BHPs) are required to provide a timely BH appointment after Medi-Cal members with significant BH needs are released from a carceral setting.[14] DHCS defined timely access for this measure as 14

[14] For additional information about the CalAIM JI Initiative, please see the Policy and Operational Guide: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf.

Measure Element	Description
Background (continued)	calendar days to align with the DHCS timely access standards for outpatient BH.[15] For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. The rate reported for this measure captures release from incarceration as an individual event. If a member is released from incarceration multiple times in the same measurement year, then this measure captures all instances of releases. Additionally, this rate is limited to members 12 years of age and older as the California justice system is unlikely to see children incarcerated under this age.[16] Given that the CalAIM JI Reentry Initiative is still being implemented on a rolling basis through October 2026, many counties will have few or no individuals included in the initial BHT measurement period.
Measure type	Process
Description	Percent of releases from a correctional facility in a 12-month period among Medi-Cal members 12 years of age and older with a significant BH need enrolled in 90-day pre-release services in the CalAIM JI Reentry Initiative for which members received at least one core clinical service to address BH within 14 calendar days of release

[15] As of February 2026, the timely access standard for outpatient non-urgent non-psychiatric specialty mental health services was 10 business days, as outlined in BHIN 24-020: https://www.dhcs.ca.gov/Documents/BHIN-24-020-2024-Network-Certification-Requirements-for-County-MHP-and-DMC-ODS-Plans.pdf.

[16] More information available from the Center on Juvenile and Criminal Justice at https://www.cjcj.org/news/blog/sb-439-becomes-law-ending-the-prosecution-of-children-under-12 and in *Progress in Community Health Partnerships at* https://pmc.ncbi.nlm.nih.gov/articles/PMC10832849/

Measure Element	Description
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounters data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line**: Medi-Cal **Continuous enrollment:** Members must be Medi-Cal enrolled from the date of pre-release services activation to 14 calendar days post-release **Allowable gap**: None **Anchor date**: None **Benefit**: Members with full-scope Medi-Cal benefits and eligible for 90-day pre-release services as part of the CalAIM JI Reentry Initiative
Denominator	The number of releases of individuals in the eligible population 12 years of age and older with Medi-Cal coverage with a significant BH need identified upon enrollment to or while having 90-day pre-release services activated as part of the CalAIM JI Reentry Initiative. The denominator only includes releases for individuals whose significant BH needs were identified or known to Medi-Cal during their participation in the CalAIM JI Reentry Initiative. Individuals may have more than one release during the measurement period. The denominator for this measure is based on releases, not on individuals. **Step 1:** Among individuals in the eligible population, identify those with enrollment in or having 90-day pre-release services activated using the following criteria: 1. Identify individuals who were enrolled in pre-release services as part of the CalAIM JI Reentry Initiative, using JI Screening Portal data. a. Identify those whose enrollment in pre-release services was active at any point from the 3 months prior to the measurement period to the first 351 calendar days of the measurement period, using the

Measure Element	Description
Denominator (continued)	following JI Reentry Initiative aid codes: I2, I3, I4, I5, and I6. 2. For individuals identified in Step 1.1, identify releases in the first 351 calendar days of the measurement period, using the JI Screening Portal data. a. Individuals who were released are signified in the JI Screening Portal data by TRANS_ACTION_CD = T (Terminated). i. If reason code (JI_ELIG_DENIAL_REASON_CD) is J2 (Terminated because they no longer meet the JI screening criteria), use their JI eligibility end date (JI_ELIG_END_DT) as their date of release. ii. If reason code (JI_ELIG_DENIAL_REASON_CD) is Z1 (Terminated due to early release from incarceration) or other codes, use their release date (RELEASE_DT) as their date of release. b. If the individual had more than one release in the specified time period, identify all releases and release dates by using logic above. **Step 2:** Among the releases identified in Step 1, identify those where the individual was 12 years of age and older on the release date. Limit to releases for individuals meeting the age requirement. **Step 3:** Among releases identified in Step 2, identify those for individuals with a significant BH need identified upon enrollment to or while having 90-day pre-release services activated. Individuals can be identified as having a significant BH need if they meet either of the criteria below: 1. The individual was identified as having substance use disorder (SUD) or serious mental illness (SMI) upon screening for pre-release services, indicated in the JI Screening Portal by qualifying criteria identified as SUD: S (SUD) or SMI: M (Mental Illness) in any QUALIFY_CRITERIA_CD (1 through 8)

Measure Element	Description
Denominator (continued)	2. The individual had a Medi-Cal claim or encounter with any of the following, while the JI Reentry Initiative aid code is active: a. A claim or encounter with a diagnosis code(s) in any position from any of the following HEDIS or HL7 Patient Care Work Group Steward value sets:[17] i. For both adults and youth, the following HEDIS value sets: • AOD Abuse and Dependence Value Set • Unintentional Drug Overdose Value Set • Substance Induced Disorders Value Set • Schizophrenia Value Set • Psychosis Value Set • Bipolar Disorder Value Set ii. For youth 12-20 years of age only, the following value sets: • HEDIS Mental Illness Value Set • HEDIS Intentional Self Harm Value Set • HL7 Post Traumatic Stress Disorder PTSD ICD10 Value Set[18] b. Any claims or encounters with the following:[19]

[17] These diagnoses align with Pathway A of the Significant BH Needs component logic in this manual.

[18] Measure stewarded by Health Level Seven International (HL7) Patient Care Working Group (WG). OID: 2.16.840.1.113762.1.4.1222.104. Available from the Value Set Authority Center at https://vsac.nlm.nih.gov/.

[19] This logic aligns with select utilization from Pathway B of the Significant BH Needs component logic in this manual. DHCS will update logic to include the evidence-based practices Full Service Partnership Intensive Case Management (ICM) and High Fidelity Wraparound (HFW) once these services are available.

Measure Element	Description
Denominator (continued)	i. Source code = 37 (the Drug Medi-Cal [DMC]/Drug Medi-Cal Organized Delivery System [DMC-ODS] system) ii. Screening, Brief Intervention, and Referral to Treatment (SBIRT) (excluding SBIRT procedure codes for screening only without intervention and referral to treatment) • Has one or more claims with a procedure code = H0050 iii. Used medication assisted treatment, as indicated by any claim or encounter with a procedure code in any of the following HEDIS value sets: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medications List • Buprenorphine Implant Value Set • Buprenorphine Implant Medications List • Buprenorphine Injection Value Set • Buprenorphine Injection Medications List • Buprenorphine Naloxone Value Set • Buprenorphine Naloxone Medications List • Buprenorphine Oral Value Set • Buprenorphine Oral Medications List • Buprenorphine Oral Weekly Value Set • Methadone Oral Value Set • Methadone Oral Weekly Value Set • Naltrexone Injection Value Set • Naltrexone Injection Medications List • Naltrexone Oral Medications List

Measure Element	Description
Denominator (continued)	• Opioid Use Disorder Treatment Medications List • OUD Monthly Office Based Treatment Value Set • OUD Weekly Drug Treatment Service Value Set • OUD Weekly Non Drug Service Value Set iv. Any code from the HEDIS Long-Acting Injections Value Set v. Any code from the HEDIS Electroconvulsive Therapy Value Set vi. Transcranial Magnetic Stimulation (TMS): Procedure code = 90867, 90868, or 90869 vii. Intensive specialized mental health programs for high-risk populations, including Intensive Home-Based Services (IHBS), Intensive Care Coordination (ICC), and Child and Family Teams (CFT): program code = 08 (Short Doyle) and modifier = HK (any procedure code) viii. Mental Health Day Treatment Intensive and Day Rehabilitation: Procedure code = H2012 ix. Therapeutic behavioral health services (TBS): Procedure code = H2019 x. Partial hospitalization: Place of Service (POS) code = 52 xi. Assertive Community Treatment (ACT): Procedure code = H0040 xii. Forensic Assertive Community Treatment (FACT): Procedure code = H0039 xiii. Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP): Procedure code = H2040

Measure Element	Description
Denominator (continued)	xiv. Clubhouse Services: Procedure code = H2031 xv. Multisystemic Therapy (MST): Procedure code = H2033 xvi. Functional Family Therapy (FFT): Procedure code = H0036 xvii. Parent-Child Interaction Therapy (PCIT): Procedure code = 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847 or T2021 with modifier 22 xviii. Crisis stabilization: Procedure code = S9484 with modifiers HE and TG xix. Crisis intervention services: Procedure code = 90839 or 90840 or H2011 c. Any claims or encounters with the following:[20] i. For adults: • At least one claim or encounter for an ED visit (HEDIS ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with a diagnosis of intentional self-harm (HEDIS Intentional Self Harm Value Set) in any position on the claim • At least three claims or encounters for ED visits (HEDIS ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with a diagnosis code from any of the following value sets in any position on the claim: o HEDIS Mental Illness Value Set

[20] This logic aligns with the diagnosis and utilization logic pertaining to ED visits from Pathway C, Steps 1 and 3, of the Significant BH Needs component logic.

Measure Element	Description
Denominator (continued)	○ HEDIS Depression or Other Behavioral Health Condition Value Set ○ AIR Eating Disorders Value Set[21] Each claim or encounter does not need to include the same diagnosis code to qualify. ii. For youth 12 to 20 years of age: • At least three claims or encounters for ED visits (HEDIS ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with a diagnosis code from any of the following HEDIS value sets in any position on the claim: ○ Intentional Self-Harm Value Set ○ Depression or Other Behavioral Health Condition Value Set ○ Mental, Behavioral, and Neurodevelopmental Disorders Value Set ○ Mental Health Diagnosis Value Set ○ Mental Illness Value Set Each claim or encounter does not need to include the same diagnosis code to qualify. **Step 4:** Determine the total number of unique releases for individuals with a significant BH need identified upon enrollment or while having 90-day pre-release services activated as part of the CalAIM JI Reentry Initiative. Individuals may have more than one release during the measurement period. Only releases for which significant BH need was identified upon enrollment to or

[21] Measure stewarded by American Institutes for Research (AIR). OID: 2.16.840.1.113883.3.464.1003.1036. Available from the Value Set Authority Center.

Measure Element	Description
	while having 90-day pre-release services activated linked to the specific release should be included.
Denominator exclusions	Individuals who died at any point during the 14 calendar days after release.
Numerator	The number of releases in the denominator where a core clinical service to address BH was completed within 14 calendar days of release. **Step 1:** Among releases in the denominator, identify those for which the individual had a core clinical service to address BH needs within 14 calendar days of the release date, based on the following logic: Core Clinical Services Component Specification 1. Exclude core clinical services claims and encounters that occur on the date of release (Day 0) within the correctional facility (POS= 09 [Prison/Correctional Facility]). Core clinical services on the date of release with any other place of service code or a missing place of service code should be included. Note: Individuals may have more than one release during the measurement period. The measure is based on releases, not on individuals. Only releases with a completed core clinical service to address BH linked to the specific release should be included in the numerator.
Metric calculation	Divide the number of releases in the numerator by the number of releases in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the date of their release. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the date of their release.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.

Measure Element	Description
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (Annual Update): Fiscal Year (July 1 – June 30) • In Medi-Cal Connect (Monthly Update): 12-month rolling
Data sources	• JI Screening Portal • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement year	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #JI-4: Continuation of Medications for Addiction Treatment (MAT) for Justice-Involved Reentry Enrollees (JIMAT)

Measure Element	Description
Background	This measure calculates the rate of continued use of Medications for Addiction Treatment (MAT) for Medi-Cal members with opioid use disorder (OUD) or alcohol use disorder (AUD) in a 12-month period. Identified as an Intervention Measure for the Reducing Justice Involvement statewide BH goal, this measure intends to capture utilization of an evidence-backed intervention that reduces the risk of drug-related overdoses, which disproportionately impacts justice-involved (JI) individuals. It includes Medi-Cal members who have their 90-day pre-release services activated as part of the California Advancing and Innovating Medi-Cal (CalAIM) JI Reentry Initiative and receive MAT during their pre-release services. Consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy, this measure will assess whether members received MAT in the post-release period regardless of whether they were served by the Specialty Mental Health Services or Non-Specialty Mental Health Services system. For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. The rate reported for this measure captures release from incarceration as an individual event. If a member is released from incarceration multiple times in the same measurement year, then this measure captures all instances of releases. This rate is limited to individuals 16 years of age and older due to adolescents' limited access to MAT: buprenorphine is Food and Drug Administration (FDA) approved for patients 16 years of age and older, and most methadone programs are prohibited from

Measure Element	Description
Background (continued)	treating patients under 18 years old.[22] This rate intends to capture continued access to MAT after release from incarceration and is specific to Medi-Cal members who have received MAT during their 90-day pre-release services as part of the CalAIM JI Reentry Initiative.[23] Given that the CalAIM JI Reentry Initiative is still being implemented on a rolling basis through October 2026, many counties will have few or no individuals in the initial BHT measurement period.
Measure type	Process
Description	Percent of releases from a correctional facility in a 12-month period among Medi-Cal members 16 years of age and older that received MAT for OUD or AUD as part of their 90-day CalAIM JI Reentry Initiative pre-release services for which members continued MAT within 30 calendar days of release
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounters data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** Members must be Medi-Cal enrolled from the date of pre-release services activation to 30 calendar days post-release **Allowable gap**: None **Anchor date:** None

[22] For more information on MAT of Adolescents with Opioid Use Disorders, see https://publications.aap.org/pediatrics/article/138/3/e20161893/52715/Medication-Assisted-Treatment-of-Adolescents-With.

[23] More information on the CalAIM JI Reentry Initiative is available at https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx.

Measure Element	Description
Eligible population (continued)	**Benefit:** Members with full-scope Medi-Cal benefits and eligible for 90-day pre-release services as part of the CalAIM JI Reentry Initiative
Denominator	The number of releases for individuals 16 years of age and older in the eligible population who received MAT for OUD and/or AUD while having 90-day pre-release services activated as part of the CalAIM JI Reentry Initiative. The denominator for this measure is based on releases, not on individuals. Individuals may have more than one release during the measurement period. **Step 1**: Among individuals in the eligible population, identify those with enrollment in or having 90-day pre-release services activated using the following criteria: 1. Identify individuals who were enrolled in pre-release services as part of the CalAIM JI Reentry Initiative using the JI Reentry Initiative Screening Services Portal (JI Screening Portal) data. a. Identify those whose enrollment in JI pre-release services was active from during the 3 months prior to the measurement period or the first 11 months of the measurement period, using the following JI Reentry Initiative aid codes: I2, I3, I4, I5, and I6. 2. For individuals identified in Step 1.1, identify releases occurring in the first 11 months of the measurement period (e.g., January 1 to December 1 for a calendar year measurement period), using JI Screening Portal data. a. Individuals who were released are signified in the JI Screening Portal data by TRANS_ACTION_CD = T (Terminated). i. If Reason Code (JI_ELIG_DENIAL_REASON_CD) is J2 (Terminated because they no longer meet the JI screening criteria), use their JI eligibility end date (JI_ELIG_END_DT) as their date of release.

Measure Element	Description
Denominator (continued)	ii. If Reason Code (JI_ELIG_DENIAL_REASON_CD) is Z1 (Terminated due to early release from incarceration) or other codes, use their release date (RELEASE_DT) as their date of release. b. If they had more than one release in the specified time period, identify all releases and release dates by using logic above. **Step 2**: Among the releases identified in Step 1, identify those where the individual was 16 years of age and older on the release date. Limit to releases for individuals meeting the age requirement. **Step 3**: Among releases identified in Step 2, identify those that were for individuals who received MAT for OUD and/or AUD upon enrollment or while having pre-release services activated using the following criteria: 1. Individual had a claim or encounter indicating MAT for OUD and/or AUD, identified by a code from any of the following HEDIS medication lists or value sets: a. Opioid Use Disorder Treatment Medications List b. Buprenorphine Oral Medications List c. Buprenorphine Injection Medications List d. Buprenorphine Implant Medications List e. Buprenorphine Naloxone Medications List f. OUD Weekly Non Drug Service Value Set g. OUD Monthly Office Based Treatment Value Set h. OUD Weekly Drug Treatment Service Value Set i. Buprenorphine Oral Value Set j. Buprenorphine Oral Weekly Value Set k. Buprenorphine Injection Value Set l. Buprenorphine Implant Value Set m. Buprenorphine Naloxone Value Set n. Methadone Oral Value Set

Measure Element	Description
Denominator (continued)	o. Methadone Oral Weekly Value Set p. Alcohol Use Disorder Treatment Medications List q. AOD Medication Treatment Value Set r. Naltrexone Oral Medications List s. Naltrexone Injection Medications List t. Naltrexone Injection Value Set Note: For individuals with more than one release during the measurement period, only releases for which MAT for OUD and/or AUD were identified upon enrollment or while enrolled in pre-release services linked to the specific release should be included. **Step 4**. Determine the total number of unique releases for individuals who received MAT for OUD and/or AUD upon enrollment or during pre-release services.
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit within 30 calendar days after release. Individuals who died within 30 calendar days after release.
Numerator	The number of releases in the denominator where the individual had continued use of MAT for 30 calendar days following release, as determined by receipt of MAT within 30 calendar days of release or by the receipt of a MAT implant during pre-release services. **Step 1**: Among releases for individuals in the denominator, identify those with receipt of MAT for OUD and/or AUD within 30 calendar days post-release (excluding the day of the release) or who received a MAT implant during pre-release services. To do so: 1. Identify claims or encounters with a service date during the measurement period, after the date of release, and within the 30 calendar days after the individual's release date(s) that have a code indicating MAT for OUD and/or AUD from the medication lists and value sets in the denominator Step 3.

Measure Element	Description
Numerator (continued)	2. Identify claims or encounters for a MAT implant upon enrollment or during pre-release services (defined as services between JI_ELIG_BEGIN_DT and RELEASE_DT or between JI_ELIG_BEGIN_DT and JI_ELIG_END_DT, depending on the reason code for their release) with a code from either of the following HEDIS medication list or value sets: Buprenorphine Implant Medications List or Buprenorphine Implant Value Set. **Step 2**: Determine the total number of unique releases for individuals with at least one claim or encounter identified in Step 1 during the measurement period and following their release date(s). Note: Individuals may have more than one release during the measurement period. The measure is based on releases, not individuals. Only releases with continued receipt of MAT for OUD and/or AUD linked to the specific release should be included in the numerator.
Metric calculation	Divide the number of releases in the numerator by the number of releases in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the date of their release. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the date of their release.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal Year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling

Measure Element	Description
Data sources	• JI Screening Portal • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement year	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 8. Reducing Overdoses

Specifications for measures OD-4 and OD-5 are available from external measure stewards described in Appendix A.

BHT Performance Measure #OD-1: Deaths by Drug Overdose (ODDEATH)

Measure Element	Description
Background	This measure calculates the rate of fatal, unintentional drug overdoses among people enrolled in Medi-Cal or receiving other county behavioral health (BH) services[24] in a 12-month period. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as the Goal Measure for the Reducing Overdoses statewide BH goal, this measure is intended to assess progress on the overall goal. This measure includes all Medi-Cal members regardless of whether they have identified BH needs or receive BH services. It is a cross-sector measure because performance on this measure will be impacted by the actions of County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) as well as stakeholders beyond Medi-Cal and behavioral health. For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.

[24] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	This measure is based on Vital Records data and was developed in collaboration with the California Department of Public Health (CDPH). Intentional drug overdose deaths are excluded from this measure; instead, those deaths are included in the Deaths by Suicide measure (SUIDEATH). This measure is limited to people 10 years of age and older to align with CDPH reporting and minimize the inclusion of accidental drug ingestion on this measure. The rate reported for this measure is an age-adjusted rate, meaning most rates reported for this measure have been normalized to a standard age distribution to reduce the impact of variations in age distribution on this measure. The exception is the statewide rate's age group stratifications - given that these stratified rates are reported in standard age bands, they are presented as crude rates. In 2026, DHCS is reporting the FY2023-24 rate for this measure because Vital Records data for 2025 is not yet available for DHCS to calculate the FY2024-25 rate.
Measure type	Population Health
Description	Age-adjusted rate (per 100,000) of people 10 years of age and older enrolled in Medi-Cal or receiving other county BH services who die from an unintentional drug overdose during a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version**: Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include record axis codes from the CDPH Vital Records mortality data a. DHCS is working with CDPH to obtain these data elements. These data elements are not yet available to DHCS as of the publication of this specification.

Measure Element	Description
Measure versions to account for data availability (continued)	b. Once available, this data will provide additional insight on the mechanism of death and can be used to narrow the measure to unintentional overdoses by drugs of intoxication. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with full benefits enrolled in Medicaid for at least one month (30 consecutive calendar days) during the measurement period **Allowable gap:** None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals 10 years of age and older in the eligible population who were eligible for Medi-Cal for any length of time during the measurement period. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1:** Among individuals in the eligible population identify those who were (or would have been) 10 years of age and older on the last day of the measurement period. Use the date of birth and last day of the measurement period to determine age, regardless of whether the individual was alive on the last day of the measurement period.
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period.

Measure Element	Description
Numerator	The number of individuals in the denominator who died from an unintentional drug overdose during the measurement period. **Step 1**: Among individuals in the denominator, identify those who died from an overdose of any drug during the measurement period, as indicated in the CDPH Vital Records mortality data Field 144 - Final Cause of Death: 1. An underlying cause of death code indicating an overdose: Final Cause of Death = X40-X44, Y10-Y14 2. Determine the total number of unique individuals who died from any drug overdose at any point during the measurement period.
Age-adjusted metric calculation	Age-adjusted rates are calculated via direct standardization to the 2000 U.S. Standard Population, the same methodology applied in the CDPH California Overdose Surveillance Dashboard. This method adjusts for differences in age distribution by multiplying age-specific rates in the population of interest by age-specific weights (adjustment factors) from the age distribution of the 2000 U.S. Standard Population.[25] **Step 1**: Calculate the age-specific overdose mortality rate within each age stratum. 1. Divide the number of individuals in the numerator by the number of individuals in the denominator, limiting both to individuals in the given age stratum. **Step 2**: Identify the weights (adjustment factor) for each age stratum. Age stratum-specific weights are in Appendix B. **Step 3**: Calculate the overall age-adjusted rate. 1. For each age stratum, multiply the stratum-specific rate (Step 1) by the stratum-specific weight (Step 2). 2. Sum the resulting values across all age strata.

[25] Single age 2000 U.S. Standard Population values are available at https://seer.cancer.gov/stdpopulations/stdpop.singleages.html. For more detailed information on the CDPH methodology for age adjustment, which was used for this measure, please see: https://skylab.cdph.ca.gov/ODdash/_w_00b028e01f4747a39bbbafae2b408a10/Rate%20Algorithms.pdf.

Measure Element	Description
Age-adjusted metric calculation (continued)	3. Multiply the resulting value by 100,000. This will give the age-adjusted rate per 100,000 for the standard population. This measure is reported as a rate per 100,000.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Statewide race/ethnicity, sex and language stratifications.[26]
Additional instructions	Use Medi-Cal enrollment data to identify the eligible population according to age and Medi-Cal enrollment criteria specified above. Use CDPH Vital Records mortality data to identify drug overdose deaths according to the criteria specified above.
Measurement period	• Publication (annual update): Fiscal Year (July 1 – June 30) • In Medi-Cal-Connect (annual update): Fiscal Year (July 1 – June 30)
Data sources	• CDPH Vital Records • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2023-24
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

[26] Because this is an age-adjusted rate, the ability to stratify this measure is limited. DHCS expects to only report statewide demographic stratifications for this measure and does not expect to report county-specific stratifications.

BHT Performance Measure #OD-2: Repeat ED Visit or Hospitalization for Drug Overdose (ODRPT)

Measure Element	Description
Background	This measure calculates the rate of repeat emergency department (ED) visits and hospitalizations for drug-related overdoses among people enrolled in Medi-Cal or receiving other county behavioral health (BH) services[27] in a 12-month period. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as a Sub-Goal Measure for the Reducing Overdose statewide BH goal, this measure is intended to assess whether County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) are preventing re-occurrence of overdose for people who have previously experienced a non-fatal overdose that resulted in treatment in an ED or hospital. This measure includes all Medi-Cal members regardless of whether they have identified BH needs or receive BH services. It is a cross-sector measure because performance on this measure will be impacted by the actions of county BHPs and MCPs as well as stakeholders beyond Medi-Cal and behavioral health. For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.

[27] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	This measure was developed in collaboration with the California Department of Public Health (CDPH). Visits for intentional drug overdose are excluded from this measure; instead, those visits are included in the Repeat ED Visit or Hospitalization for Self-Harm measure (SUIRPT). The rate is limited to people 10 years of age and older to align with CDPH reporting and minimize the inclusion of accidental drug ingestion in this measure.
Measure type	Outcome
Description	Rate (per 100,000) of people 10 years of age and older enrolled in Medi-Cal or receiving other county BH services who had two or more unintentional drug-related overdoses resulting in treatment in an ED or hospital in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.

Measure Element	Description
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with full benefits enrolled in Medicaid for at least one month (30 consecutive calendar days) during the measurement period **Allowable gap:** None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals who were 10 years of age and older in the eligible population. This is a cumulative count. Each individual should only be counted once. **Step 1:** Among individuals in the eligible population, identify those who were 10 years of age and older as of the last day of the measurement period.
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period.
Numerator	The number of individuals in the denominator with two or more ED or inpatient claims or encounters with an unintentional drug-related diagnosis in the measurement period. **Step 1:** Among individuals in the denominator, identify those with claims and encounters for an unintentional drug-related overdose resulting in treatment in an ED or hospital during the measurement period, using the following criteria: 1. Claims and encounters for treatment in an ED (HEDIS ED Value Set or HEDIS ED Procedure Code Value Set with an ED Place of Service code = 23) or acute inpatient setting (HEDIS Inpatient Stay Value Set) for an overdose with:

Measure Element	Description
Numerator (continued)	a. Diagnosis code in any position on the claim or encounter = T40 (narcotics and psychodysleptics [hallucinogens]), T42.3 (barbiturates), T42.4 (benzodiazepines), T43.62 (amphetamines), T43.63 (methylphenidate) T43.64 (ecstasy), T43.65 (methamphetamines), T43.69 (other psychostimulants), T43.8 (other psychotropic drugs) with i. a sixth character of 1 (accidental (unintentional)) or 4 (undetermined), and ii. a seventh character of A (initial) or missing Note: Identify these claims and encounters from ED and acute inpatient settings only. Do not include ED visits that resulted in an inpatient stay (HEDIS Inpatient Stay Value Set). **Step 2:** Among individuals with claims and encounters identified in Step 1, determine the number of unique individuals with two or more episodes of unintentional drug-related overdose (with different dates of service and a gap of greater than one calendar day between dates of service) during the measurement period. 1. For inpatient settings, treat a continuous episode (with direct transfers or nested stays) as one episode, and start a new episode only when there was a gap greater than one calendar day. 2. For ED settings, consolidate claims and encounters under a single claim control number, and start a new episode only when there was a gap of greater than one calendar day. Do not count as separate episodes for claims that occurred on the same day or on consecutive calendar days.
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. Multiply by 100,000 to report the rate per 100,000 individuals. This measure is reported as a rate per 100,000.

Measure Element	Description
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #OD-3: Recovery Incentives - Contingency Management (CM)

Measure Element	Description
Background	This measure calculates the usage of Contingency Management (CM) services in the Recovery Incentives Program among members enrolled in Medi-Cal living with moderate or severe stimulant use disorder during a 12-month period. Identified as an Intervention Measure for the Reducing Overdose statewide behavioral health goal, this measure is intended to capture utilization of an intervention that evidence has shown to reduce the risk of drug-related overdoses. This rate is limited to individuals 12 years of age and older. While there are no age criteria for CM, CM services are not targeted for young children, and many adolescent treatment standards define adolescence as ages 12-17 for reporting and service design.[28] Currently, CM is an optional Medi-Cal benefit available only in the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. In these counties, a rate will be reported regardless of whether the county opted in; for counties that did not opt in, the rate will generally be zero (with rare exceptions involving someone who moved from a county that did offer CM to one that did not during the measurement period). Given that CM is not currently available in Drug Medi-Cal (DMC) only counties, this measure will be reported as "N/A". This approach will be updated if the Centers for Medicare & Medicaid Services (CMS) approve DHCS's request for waiver authority to offer CM in DMC counties as early as January 1, 2027.[29]
Measure type	Process

[28] More information is available in the DHCS Adolescent Substance Use Disorder Best Practices Guide, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/10/AdolBestPracGuideOCTOBER2020.pdf.

[29] DHCS seeks waiver authority to offer CM in DMC counties. The Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration is available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Section-1115-Application.pdf.

Measure Element	Description
Description	Percent of Medi-Cal members 12 years of age and older living with a moderate or severe stimulant use disorder who receive CM in the Recovery Incentives Program in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal data a. At this time, only Medi-Cal data is available to calculate this measure. 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to identify Medi-Cal members who meet the denominator criteria for this measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** 12 months Medi-Cal enrollment for the measurement period **Allowable gap:** No more than one gap in Medi-Cal enrollment of up to one month during the measurement period **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals 12 years of age and older in the eligible population living with a moderate or severe stimulant use disorder during the measurement period. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1:** Among individuals in the eligible population, identify those who were 12 years of age and older on the last day of the measurement period. **Step 2:** Among individuals identified in Step 1, identify those with a qualifying stimulant use condition using the following criteria:

Measure Element	Description
Denominator (continued)	1. At least one claim or encounter with one or more of the following diagnosis codes in any position on the claim: a. ICD-10-CM diagnosis codes = F14.20 - F14.29 (Cocaine dependence) or F15.20 – F15.29 (Other stimulant dependence) **Step 3:** Determine the total number of unique individuals living with a qualifying stimulant use condition during the measurement period.
Denominator exclusions	Laboratory claims (Place of service = 81) and pharmacy claims (Claim type ID = 3). Individuals attributed to counties that do not participate in DMC-ODS.[30] Individuals who died any point during the measurement period.
Numerator	The number of individuals in the denominator who received CM during the measurement period. **Step 1:** Among individuals in the denominator, identify individuals with claims for CM with a service date during the measurement period using the following criteria: 1. Individual had any Short Doyle claims for CM during the measurement period: a. Source code = 37 (Drug Medi-Cal (DMC)/DMC-ODS), and b. HCPCS Level II code = H0050 with modifier HF (CM Services) **Step 2:** Among the individuals identified in Step 1, determine the total number of unique individuals with at least one claim for CM during the measurement period. Individuals should only be counted once per measurement period, regardless of whether they had one or more CM claims during the measurement period.
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.

[30] List of counties implementing DMC-ODS is available at https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

Measure Element	Description
Date used for attribution	• For Behavioral Health Plans, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For Managed Care Plans (MCPs), attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Numerator-qualifying claims will be in the Short Doyle claims system because services are provided through DMC-ODS. Denominator-qualifying claims do not need to be in the Short Doyle claims system. For counties that do not participate in DMC-ODS, the numerator, denominator, and performance rate on this measure should be reported as "Not Applicable."
Measurement period	• Publication (annual update): Fiscal Year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 9. Reducing Removal of Children from Home

The specification for measure RC-4 is not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

BHT Performance Measure #RC-1: Children and Youth in Foster Care (FC)

Measure Element	Description
Background	This measure calculates the rate of children and youth enrolled in Medi-Cal and in foster care during a 12-month period. Identified as the Goal Measure for the Reducing Removal of Children from Home statewide behavioral health (BH) goal, this measure is intended to assess progress on the overall goal. This measure includes all Medi-Cal children and youth regardless of whether they have identified BH needs or receive BH services. It is a cross-sector measure because performance on this measure will be impacted by the actions of County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) as well as stakeholders beyond Medi-Cal and BH. For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. This measure is limited to children and youth ages 0 to 20 to align with eligibility criteria for foster care and extended foster care in California.[31]
Measure type	Population health
Description	Rate (per 10,000) of children and youth 0 to 20 years of age enrolled in Medi-Cal who are in foster care during a 12-month period

[31] For additional details on foster care criteria, see the California Department of Social Services (CDSS) website: https://www.cdss.ca.gov/inforesources/foster-care/extended-foster-care-ab-12.

Measure Element	Description
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with full-scope benefits enrolled in Medicaid for at least one month (30 calendar days) during the measurement period **Allowable gap:** None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of children and youth 0 to 20 years of age in the eligible population. **Step 1:** Among individuals in the eligible population, identify those who were 0 to 20 years of age as of the last day of the measurement period, based on their dates of birth. This includes any child or youth with 1 or more months of Medi-Cal enrollment during the measurement period.
Denominator exclusions	None
Numerator	The number of children and youth in the denominator who were in foster care at any point during the measurement period. **Step 1:** Among the individuals in the denominator, identify those in foster care for one or more months during the measurement period using the following logic: 1. Had any of the following Medi-Cal aid codes at any point during the measurement period: 2P, 2R, 2S, 2T, 2U, 4H, 4K, 4L, 4N, 40, 42, 43, 45, 46, 49, 5K, or 5L.[32]

[32] For additional information and descriptions of Medi-Cal aid codes, see the 2026 Master Aid Code Chart, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/12/2026-Master-Aid-Code-Chart.pdf.

Measure Element	Description
Numerator (continued)	**Step 2:** Among individuals identified in Step 1, determine the total number of unique individuals. Children and youth should only be counted once per measurement period, regardless of whether they were in foster care multiple months during the measurement period.
Metric calculation	Divide the number of children and youth in the numerator by the number of children and youth in the denominator to calculate the measure rate. Multiply by 10,000 to report the rate per 10,000 children and youth. This measure is reported as a rate per 10,000.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	The measure includes children and youth in foster care at any point during the measurement period. The numerator does not require the child or youth to be in foster care in the last month of the measurement period.
Measurement period	• Publication (Annual Update): Fiscal year (July 1 – June 30) • In Medi-Cal Connect (Monthly Update): 12-month rolling
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement year	FY 2024-25
Measure version	v1.0
Measure release date	2026

Measure Element	Description
Summary of changes	n/a

BHT Performance Measure #RC-2: Specialty Behavioral Health Services for Children and Youth in Foster Care (FCSRV)

Measure Element	Description
Background	This measure captures whether children and youth enrolled in Medi-Cal and in foster care receive at least three core clinical services in the Specialty Mental Health Services (SMHS) program during a 12-month period to address behavioral health (BH) needs. Identified as an Intervention measure for the Reducing Removal of Children from Home statewide behavioral health goal, this measure is intended to assess whether Medi-Cal children and youth in foster care are engaged in specialty mental health care to address BH needs for this population.[33] County Behavioral Health Plans (BHPs) deliver SMHS and Medi-Cal Managed Care Plans (MCPs) are required to help coordinate those visits for Medi-Cal members. For the MCP rates, all members assigned to an MCP are included in the rates if they meet denominator criteria. For the BHP rates, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.
Measure type	Process
Description	Percent of children and youth in foster care 0 to 20 years of age and enrolled in Medi-Cal who receive at least three core clinical services to address BH needs delivered by the SMHS within a 12-month period
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounter data. Since all data to report this measure are currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.

[33] For additional details on foster care criteria, see the California Department of Social Services (CDSS) website, at https://www.cdss.ca.gov/inforesources/foster-care/extended-foster-care-ab-12.

Measure Element	Description
Eligible population	**Product line**: Medi-Cal **Continuous enrollment:** All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap:** No more than one gap in enrollment of up to one month during the measurement period **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals in the eligible population 0 to 20 years of age who were enrolled in Medi-Cal and were in foster care during the measurement period. **Step 1:** Among individuals in the eligible population, identify children and youth who were 0 to 20 years of age as of the last day of the measurement period. **Step 2:** Among individuals identified in Step 1, determine the number in foster care for one or more months during the measurement period using the following logic: 1. Had any of the following Medi-Cal aid codes at any point during the measurement period: 2P, 2R, 2S, 2T, 2U, 4H, 4K, 4L, 4N, 40, 42, 43, 45, 46, 49, 5K, or 5L.[34]
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received at least three core clinical services to address BH needs in the SMHS during the measurement period. **Step 1:** Among individuals in the denominator, identify those who received at least three core clinical services in the SMHS system. 1. Limit to SMHS claims (source code = 21)

[34] For additional information and descriptions of the Medi-Cal aid codes, see the 2026 DHCS Master Aid Code Chart, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/12/2026-Master-Aid-Code-Chart.pdf.

Measure Element	Description
Numerator (continued)	2. Among SMHS claims, identify core clinical services within the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. This measure is reported as a percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement year	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

BHT Performance Measure #RC-3: Behavioral Health Services for Parents, Guardians, and Pregnant People with Significant Behavioral Health Needs (PARSRV-WSBH)

Measure Element	Description
Background	This measure captures whether pregnant and postpartum people and parents or guardians enrolled in Medi-Cal and living with significant behavioral health (BH) needs receive at least one core clinical service addressing BH in a 12-month period. Identified as an Intervention Measure for the Reducing Removal of Children from Home statewide BH goal, this measure includes all Medi-Cal parents and pregnant people with an identified significant BH need, understanding that people with significant BH needs can be served by either the Specialty Mental Health Services or Non-Specialty Mental Health Services system depending on their functional status. This methodology is consistent with a person-centered quality measurement approach and DHCS's No Wrong Door Policy. By targeting improvement in the rates of treatment for parents and pregnant people with untreated significant BH needs, inclusive of significant mental health and substance use disorder needs, this measure is intended to function as an upstream strategy to help prevent the removal of children from home. For the Medi-Cal Managed Care Plan (MCP) rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the County Behavioral Health Plan (BHP) rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria.
Measure type	Process
Description	Percent of pregnant and postpartum people and parents or guardians 12 to 64 years of age who are enrolled in Medi-Cal and are living with significant BH needs who receive at least one core clinical service for BH in a 12-month period

Measure Element	Description
Measure versions to account for data availability	DHCS anticipates that this measure will only be reported for Medi-Cal members using Medi-Cal enrollment, claims, and encounter data. Since all data to report this measure is currently available to DHCS, no additional versions are planned at this time. Any updates made to this specification will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with 12 months Medi-Cal enrollment for the measurement period **Allowable gap:** No more than one gap in enrollment of up to one month during the measurement period **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals in the eligible population who were pregnant or postpartum, parents, or guardians 12 to 64 years of age during the measurement period who are living with significant BH needs. **Step 1:** Among individuals in the eligible population, identify those living with significant BH needs as of the last day of the measurement period using the following logic: Significant BH Needs Component Specification **Step 2:** Among individuals identified in Step 1, identify the number who were pregnant or postpartum, parents, or guardians 12 to 64 years of age using the following logic: 1. Individual was 12 to 64 years of age during the last month of the measurement period and had any of the following Medi-Cal aid codes for parents or caretakers at any time during the measurement period: M3, M4, or P2.[35]

[35] For additional information and descriptions of Medi-Cal aid codes, see the 2026 Master Aid Code Chart, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/12/2026-Master-Aid-Code-Chart.pdf.

Measure Element	Description
Denominator (continued)	2. Individual was 12 to 64 years of age during the last month of the measurement period and had any of the following Medi-Cal aid codes for pregnant or postpartum individuals at any time during the measurement period: M0, M7, M8, M9, 86, 87, 0E, 0G, 7G, D8, D9, P4, or 7N.
Denominator exclusions	Individuals who died at any point during the measurement period.
Numerator	The number of individuals in the denominator who received at least one core clinical service for BH during the measurement period. **Step 1:** Among individuals in the denominator, identify those who received at least one core clinical service for BH during the measurement period using the following logic: Core Clinical Services Component Specification
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the percentage.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign individuals to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal Connect (monthly update): 12-month rolling

Measure Element	Description
Data sources	• Homeless Data Integration System (HDIS) • Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement year	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 10. Reducing Suicides

BHT Performance Measure #SU-1: Deaths by Suicide (SUIDEATH)

Measure Element	Description
Background	This measure calculates the rate of fatal suicides among people enrolled in Medi-Cal or receiving other county behavioral health (BH) services[36] in a 12-month period. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as the Goal Measure for the Reducing Suicides statewide BH goal, this measure is intended to assess progress on the overall goal. This measure includes all Medi-Cal members regardless of whether they have identified BH needs or receive BH services. It is a cross-sector measure because performance on this measure will be impacted by the actions of County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) as well as stakeholders beyond Medi-Cal and BH. For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. This measure is based on Vital Records data and was developed in collaboration with the California Department of Public Health (CDPH). This measure is limited to people 10 years of age and older to align with CDPH reporting.

[36] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This version of the specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Background (continued)	The rate reported for this measure is an age-adjusted rate, meaning most rates reported for this measure have been normalized to a standard age distribution to reduce the impact of variations in age distribution on this measure. The exception is the statewide rate's age group stratifications - given that these stratified rates are reported in standard age bands, they are presented as crude rates. In 2026, DHCS is reporting the FY 2023-24 rate for this measure because Vital Records data for 2025 is not yet available for DHCS to calculate the FY 2024-25 rate.
Measure type	Population Health
Description	Age-adjusted rate (per 100,000) of people 10 years of age and older enrolled in Medi-Cal or receiving other county BH services who died by suicide at any point in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.

Measure Element	Description
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with full benefits enrolled in Medicaid for at least one month (30 consecutive calendar days) during the measurement period **Allowable gap:** None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits
Denominator	The number of individuals 10 years of age and older in the eligible population. This is a cumulative count over the entire measurement period. Each individual should only be counted once. **Step 1:** Among individuals in the eligible population identify those who were (or would have been) 10 years of age and older on the last day of the measurement period. Use the date of birth and last day of the measurement period to determine age, regardless of whether the individual was alive on the last day of the measurement period.
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period.
Numerator	The number of individuals in the denominator who died by suicide during the measurement period. **Step 1:** Among individuals in the denominator, identify those who died by suicide during the measurement period, as indicated in the CDPH Vital Records mortality data by any of the following: 1. Manner of death = S (suicide), or 2. An underlying cause of death code indicating a suicide: U03, X60-X84, Y87.0 **Step 2:** Among individuals identified in Step 1, determine the total number of unique individuals who died by suicide at any point during the measurement period.

Measure Element	Description
Age-adjusted metric calculation	Age-adjusted rates are calculated via direct standardization to the 2000 U.S. Standard Population, the same methodology applied in the CDPH California Overdose Surveillance Dashboard. This method adjusts for differences in age distribution by multiplying age-specific rates in the population of interest by age-specific weights (adjustment factors) from the age distribution of the 2000 U.S. Standard Population.[37] **Step 1:** Calculate the age-specific suicide mortality rate within each age stratum. 1. Divide the number of individuals in the numerator by the number of individuals in the denominator, limiting both to individuals in the given age stratum. **Step 2:** Identify the weights (adjustment factor) for each age stratum. Age stratum-specific weights are in Appendix B. **Step 3:** Calculate the overall age-adjusted rate. 1. For each age stratum, multiply the stratum-specific rate (Step 1) by the stratum-specific weight (Step 2). 2. Sum the resulting values across all age strata. 3. Multiply the resulting value by 100,000. This will give the age-adjusted rate per 100,000 for the standard population. This measure is reported as a rate per 100,000.
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.

[37] Single age 2000 U.S. Standard Population values are available at https://seer.cancer.gov/stdpopulations/stdpop.singleages.html. For more detailed information on the CDPH methodology for age adjustment, which was used for this measure, please see: https://skylab.cdph.ca.gov/ODdash/_w_00b028e01f4747a39bbbafae2b408a10/Rate%20Algorithms.pdf.

Measure Element	Description
Stratifications	Statewide race/ethnicity, sex and language stratifications.[38]
Additional instructions	Use Medi-Cal enrollment data to identify the eligible population according to age and Medi-Cal enrollment criteria specified above. Use CDPH Vital Records mortality data to identify suicide deaths according to the criteria specified above.
Measurement period	• Publication (Annual Update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (Annual Update): Fiscal Year (July 1 – June 30)
Data source	• CDPH Vital Records • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2023-24
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

[38] Because this is an age-adjusted rate, the ability to stratify this measure is limited. DHCS expects to only report statewide demographic stratifications for this measure and does not expect to report county-specific stratifications.

BHT Performance Measure #SU-2: Repeat ED Visit or Hospitalization for Self-Harm (SUIRPT)

Measure Element	Description
Background	This measure calculates the rate of repeat emergency department (ED) visits and hospitalizations for suicide attempts or self-harm among people enrolled in Medi-Cal or receiving other county behavioral health (BH) services[39] in a 12-month period. This measure currently includes only Medi-Cal members, but DHCS is exploring including non-Medi-Cal members who receive county BH services in this measure at a future date. Identified as a Sub-Goal Measure for the Reducing Suicides statewide BH goal, this measure is intended to assess whether County Behavioral Health Plans (BHPs) and Medi-Cal Managed Care Plans (MCPs) are preventing re-occurrence of self-harm for people with a previous episode of self-harm that resulted in treatment in an ED or hospital. This measure includes all Medi-Cal members regardless of whether they have identified BH needs or receive BH services. It is a cross-sector measure because performance on this measure will be impacted by the actions of BHPs and MCPs as well as stakeholders beyond Medi-Cal and BH. For the MCP rate, all members assigned to an MCP are included in their rate if they meet denominator criteria. For the BHP rate, because BHPs do not have assigned members, all Medi-Cal members in that county (defined by County of Responsibility assignments) are included in their rate if they meet denominator criteria. This measure was developed in collaboration with the California Department of Public Health (CDPH). The rate is limited to people 10 years of age and older to align with CDPH reporting.

[39] In addition to Medi-Cal members, DHCS will explore over time including people who receive county BH services but are not enrolled in Medi-Cal. This includes but is not limited to services funded by the Behavioral Health Services Act, 1991 and 2011 Realignment, and SAMHSA's Projects for Assistance in Transition from Homelessness, Mental Health Block Grants, and Substance Use Prevention, Treatment, and Recovery Services Block Grants. This specification only includes Medi-Cal members. DHCS will explore whether non-Medi-Cal recipients of county BH services could be incorporated into the eligible population of this measure at a future date.

Measure Element	Description
Measure type	Outcome
Description	Rate (per 100,000) of people 10 years of age and older enrolled in Medi-Cal or receiving other county BH services who had two or more self-harm or suicide attempts resulting in treatment in an ED or hospital in a 12-month period
Measure versions to account for data availability	For this measure, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure limited to Medi-Cal members a. At this time, only data on Medi-Cal members is available to calculate this measure. As such, this measure specification includes only Medi-Cal members in the eligible population (as defined below). 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure to include non-Medi-Cal recipients of county behavioral health services in the eligible population and to identify qualifying non-Medi-Cal services that could be included in the measure. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	**Product line:** Medi-Cal **Continuous enrollment:** All members with full benefits enrolled in Medicaid for at least one month (30 consecutive calendar days) during the measurement period **Allowable gap:** None **Anchor date:** None **Benefit:** Members with full-scope Medi-Cal benefits

Measure Element	Description
Denominator	The number of individuals 10 years of age and older in the eligible population. This is a cumulative count. Each individual should only be counted once. **Step 1:** Among individuals in the eligible population, identify those who were 10 years of age and older as of the last day of the measurement period.
Denominator exclusions	Individuals who used hospice services (HEDIS Hospice Encounter Value Set; HEDIS Hospice Intervention Value Set) or elected to use a hospice benefit any time during the measurement period.
Numerator	The number of individuals in the denominator with two or more self-harm or suicide attempts resulting in treatment in an ED or hospital during the measurement period. **Step 1:** Among individuals in the denominator, identify those with ED and acute inpatient claims with diagnoses indicating self-harm or a suicide attempt during the measurement period, using the following criteria: 1. Claims for treatment in an ED or acute inpatient setting for self-harm or suicide attempt, with any of the following ICD-10-CM diagnosis codes:[40] a. X71–X83 b. T36–T50 with sixth character = 2 Note: Include T36.9, T37.9, T39.9, T41.4, T42.7, T43.9, T45.9, T47.9, and T49.9 with fifth character = 2 c. T51–T65 with sixth character = 2 Note: Include T51.9, T52.9, T53.9, T54.9, T56.9, T57.9, T58.0, T58.1, T58.9, T59.9, T60.9, T61.0, T61.1, T61.9, T62.9, T63.9, T64, and T65.9 with a fifth character = 2

[40] The ICD-10-CM diagnosis codes can be found from the Centers for Disease Control and Prevention (CDC)'s State Injury Indicators: Instructions for Preparing 2022 Data (https://www.cdc.gov/injury-core-sipp/media/pdfs/2024/06/CORRECTED-2022-Injury-Indicator-Instructions.pdf) on pgs. 54 and 56. This report is also cited by the CDPH on pg. 9 of 21-22 Suicide and Self-Harm Data Brief (21-22 Suicide and Self-Harm Data Brief).

Measure Element	Description
Numerator (continued)	d. T71 with sixth character = 2 e. T14.91 f. R45.88 Note: Only include claims if the seventh character of the code is A or missing (reflects initial encounter, active treatment). 2. Identify these claims from ED and acute inpatient settings only. Identify ED claims using either of the following: a. An ED visit (HEDIS ED Value Set), or b. A procedure code (HEDIS ED Procedure Code Value Set) with an ED Place of Service code (POS = 23) Note: Do not include ED visits that resulted in an inpatient stay (HEDIS Inpatient Stay Value Set). **Step 2**. Among individuals identified in Step 1, determine the number of unique individuals with two or more episodes of self-harm or suicide attempts, with different dates of service and a gap of greater than one calendar day between dates of service, during the measurement period. 1. For inpatient settings, treat a continuous episode (with direct transfers or nested stays) as one claim, and start a new episode only when there was a gap greater than one calendar day. a. For ED settings, consolidate claims under a single claim control number, and start a new episode only when there was a gap of greater than one calendar day. Do not count as separate episodes claims that occurred on the same calendar day or on consecutive calendar days.
Metric calculation	Divide the number of individuals in the numerator by the number of individuals in the denominator to calculate the measure rate. Multiply by 100,000 to report the rate per 100,000 individuals. This measure is reported as a rate per 100,000.

Measure Element	Description
Date used for attribution	• For BHPs, attribute individuals to their County of Responsibility as of the last day they were enrolled during the measurement period. • For MCPs, attribute individuals to the MCP in which they were enrolled as of the last day they were enrolled during the measurement period.
Stratifications	Standard DHCS demographic stratifications (age, race/ethnicity, sex, language) and standard BHT stratifications. Assign members to subgroups based on their reported characteristics as of the date used for attribution.
Additional instructions	Use enrollment data to identify the eligible population according to age and enrollment criteria specified above.
Measurement period	• Publication (annual update): Fiscal year (July 1 – June 30) • In Medi-Cal-Connect (monthly update): 12-month rolling
Data source	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Goal 11. Improving Engagement in School

The specifications for improving engagement in school measures are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

Goal 12. Improving Engagement in Work

The specifications for improving engagement in work measures are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

Goal 13. Improving Social Connection

The specifications for improving social connection measures are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

Equity Measures

The specifications for equity measures are not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

Cross-Goal BHSA Priority Population Measure

The specification for this measure is not yet available and will be introduced in a future version of the BHT Technical Specifications Manual.

Performance Measure Components

At Risk of or Experiencing Homelessness

Measure Element	Description
Background	This measure component identifies people who are enrolled in Medi-Cal or receiving other county behavioral health (BH) services who are at risk of or experiencing homelessness, in alignment with the federal[41] and Behavioral Health Services Act (BHSA) definitions[42] of experiencing homelessness and based on available data. This measure component is used in Behavioral Health Transformation (BHT) to identify people who are likely at risk of or experiencing homelessness. DHCS developed a novel approach for identifying people at risk of or experiencing homelessness using a combination of Homeless Data Integration System (HDIS) data from California's housing Continuums of Care and available Medi-Cal and county BH data, including addresses; Z codes documenting housing status as part of medical encounters; the place of service for medical encounters; authorization or receipt of housing services; and enrollment in Enhanced Care Management (ECM). It provides a more-complete-than-ever understanding of people at risk of or experiencing homelessness within the Medi-Cal population. This component was developed in collaboration with the California Interagency Council on Homelessness (Cal ICH). The approach for identifying people experiencing homelessness using Homeless Data Integration System data is consistent with the approach used for the performance measures in the Cal ICH Action Plan for Preventing and Ending Homelessness in California, building on that approach to also include indicators of homelessness observed in Medi-Cal and BHSA data.

[41] For additional details, see the Federal definition of experiencing homelessness, available at https://www.ecfr.gov/current/title-24/subtitle-A/part-91/subpart-A/section-91.5.

[42] For additional details, see the BHSA Policy Manual, available at https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/7-bhsa-components-and-requirements.

Measure Element	Description
Measure type	Measure component used in BHT measures
Description	People who are enrolled in Medi-Cal or receiving other county BH services and are known to be at risk of or experiencing homelessness in a 12-month period based on available data
Component versions to account for data availability	For this measure component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Identifies homelessness using HDIS and Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims, and ECM and Community Supports Quarterly Implementation Monitoring Report (QIMR). 2. Update to include the Enhanced Care Management (ECM) and Community Supports .JSON file a. DHCS will incorporate data from the ECM and Community Supports .JSON file once DHCS transitions reporting this data from the Quarterly Implementation Monitoring Report (QIMR) to the monthly .JSON file. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service-level (BH-ISL) encounters a. DHCS will explore incorporating BH-ISL encounter data and other sources of non-Medi-Cal data in this measure component to more robustly identify people experiencing homelessness. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	Count an individual if they meet one or more of the following criteria based on (1) HDIS, (2) Medi-Cal claims, encounters or enrollment data, (3) authorization for or receipt of Housing Community Supports or County BH Housing Interventions, or (4) enrollment in ECM with a Population of Focus indicating homelessness.

Measure Element	Description
Component calculation (continued)	**Step 1. HDIS:** Among individuals in the eligible population, count an individual as experiencing homelessness while accessing services at any point in the measurement period using HDIS. 1. Filter HDIS to relevant records: Select records from the HDIS dataset where Project Type is emergency shelter, safe haven, transitional housing, permanent housing (including rapid rehousing, permanent supportive housing, and other permanent housing), street outreach, services only, day shelter, coordinated entry or other. 2. Identify homeless start date. For each record, set homeless start date to project start date if Project Type is any of the following: a. Emergency shelter, safe haven, transitional housing, or permanent housing. b. Street outreach and current living situation (CLS) are homeless, institutional, or transitional. c. Services only, day shelter, coordinated entry or other, and CLS are "place not meant for habitation." 3. Identify homeless end date: a. Set homeless end date to project exit date if Project Type is any of the following: i. Emergency shelter, safe haven, or transitional housing. ii. Permanent housing and housing move-in date are null. iii. Street outreach and CLS are one of the following: homeless, institutional, or transitional. iv. Services only, day shelter, coordinated entry or other, and CLS are "place not meant for habitation." b. Set homeless end date to housing move-in date if Project Type is permanent housing and housing move-in date is not null.

Measure Element	Description
Component calculation (continued)	4. Determine if an individual is experiencing homelessness. a. For individuals for whom homeless start and end dates are determined, an individual is experiencing homelessness if both of the following are met: i. Homeless start date is on or before the measurement period end date, and ii. Homeless end date is on or after the measurement period start date. b. For individuals without HDIS homeless start/end dates during the measurement period, determine if the individual had a prior living situation during the measurement period indicating a homeless situation, including any of the following: i. Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter ii. Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside iii. Safe haven c. For individuals without HDIS homeless start/end dates during the measurement period, determine if the individual had any CLS recording indicating a homeless situation during the measurement period, including any of the following: i. Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter ii. Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) iii. Safe haven

Measure Element	Description
Component calculation (continued)	**Step 2. Medi-Cal claims, encounters and enrollment data:** Among individuals in the eligible population, count an individual as at risk of or experiencing homelessness in the measurement period if they meet one or more of the following criteria: 1. Had an address in the eligibility file that changed during the measurement period to an address indicating homelessness or risk of homelessness. The string in the eligibility file address field must be an exact match to one of the ~1,400 terms identified by DHCS, Cal ICH, and the California Health and Human Services Agency Office of Technology and Solutions Integration as indicated homelessness or housing insecurity. 2. Had any claim or encounter during the measurement period with any of the following ICD-10-CM Z codes: a. Z59.0, Z59.00, Z59.01, or Z59.02 (homelessness) b. Z59.1, Z59.10, Z59.11, Z59.12, or Z59.19 (inadequate housing) c. Z59.81, Z59.811, Z59.812, or Z59.819 (housing instability) 3. Had any claim or encounter during the measurement period with a place of service code of 04 (Homeless shelter) or 27 (Outreach site / street). **Step 3. Authorized for or received county BH housing services:** Among individuals in the eligible population, count an individual as at risk of or experiencing homelessness in the measurement period if they meet one or more of the following criteria: 1. Was authorized for or received any of the following Housing Community Supports as indicated in the QIMR: Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits, Recuperative Care (Medical Respite), Short-Term Post-Hospitalization Housing.

Measure Element	Description
Component calculation (continued)	2. Received Transitional Rent, as indicated by at least one claim or encounter during the measurement period with HCPCS code H0044 with modifier U6, or HCPCS code H0043 with modifier U2.[43] **Step 4. Enrollment in ECM with a Population of Focus indicating homelessness:** Among individuals in the eligible population, count an individual as at risk of or experiencing homelessness if they were enrolled in ECM at any point in the measurement period with a Population of Focus indicating homelessness, as recorded in the QIMR. Values indicating homelessness or risk of homelessness include: 1. I. Adult – Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness 2. J. Adult – Individuals Experiencing Homelessness: Homeless Families 3. Q. Child/Youth – Individuals Experiencing Homelessness: Unaccompanied Children/Youth Experiencing Homelessness 4. R. Child/Youth – Individuals Experiencing Homelessness: Homeless Families
Data sources	• HDIS • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only. • ECM and Community Supports QIMR
First BHT measurement period	FY 2024-25
Measure version	v1.0

[43] For additional details, please see DHCS Community Supports Policy Guide: Volume 2, available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

Measure Element	Description
Measure release date	2026
Summary of changes	n/a

Behavioral Health Needs

Measure Element	Description
Background	This measure component establishes a broad definition of a person's need for any mental health (MH) and/or substance use disorder (SUD) services across the full continuum of care, from mild to significant behavioral health (BH) needs for people who are enrolled in Medi-Cal or receiving other county BH services. This measure component is used in Behavioral Health Transformation (BHT) to identify and measure interventions or outcomes related to people who likely have behavioral health (BH) needs. DHCS identifies people with BH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with BH needs for which there is no available administrative data indicating that need.
Measure type	Measure component used in BHT measures
Description	People who are enrolled in Medi-Cal or receiving other county BH services and are identified as having BH needs in a 12-month period
Component versions to account for data availability	For this measure component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure component limited to Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, Short Doyle claims, Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal) data, and Homelessness Data Information System (HDIS) data 2. Update to include California Department of Education (CDE) data

Measure Element	Description
Component versions to account for data availability (continued)	a. DHCS will work with the California Department of Education on an approach to sharing data on the truancy and expulsion status of students and on the Individualized Education Program (IEP). Once that approach has been implemented, DHCS may consider including additional criteria to identify people with BH needs related to these data. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure component to more robustly identify people with BH needs. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	Count an individual if they meet the criteria in Steps 1, 2, or 3. **Step 1**. Count an individual if they meet any of the following criteria for MH needs: 1. The individual had a medical claim or encounter in the measurement period where the diagnosis code (in any position on the claim or encounter) is in one of the following HEDIS value sets: a. Intentional Self-Harm b. Depression or Other Behavioral Health Condition c. Mental, Behavioral, and Neurodevelopmental Disorders d. Mental Health Diagnosis e. Mental Illness 2. The individual had a medical claim or encounter for a BH medication during the measurement period, either:

Measure Element	Description
Component calculation (continued)	a. A claim or encounter where any procedure code is in one of the following HEDIS value sets: i. Long Acting Injections 14 Days Supply ii. Long Acting Injections 28 Days Supply iii. Long Acting Injections 30 Days Supply b. A pharmacy claim or encounter with a medication listed in one of the following HEDIS value sets: i. Dexmethylphenidate Medications ii. Dextroamphetamine Medications iii. Lisdexamfetamine Medications iv. Methylphenidate Medications v. Methamphetamine Medications vi. Clonidine Medications vii. Guanfacine Medications viii. Atomoxetine Medications ix. Antidepressant Medications x. Antipsychotic Combination Medications xi. Antipsychotic Medications xii. Aripiprazole Oral Medications xiii. Asenapine Oral Medications xiv. Brexpiprazole Oral Medications xv. Cariprazine Oral Medications xvi. Clozapine Oral Medications xvii. Haloperidol Oral Medications xviii. Iloperidone Oral Medications xix. Loxapine Oral Medications xx. Lumateperone Oral Medications xxi. Lurasidone Oral Medications xxii. Molindone Oral Medications xxiii. Olanzapine Oral Medications xxiv. Paliperidone Oral Medications

Measure Element	Description
Component calculation (continued)	xxv. Quetiapine Oral Medications xxvi. Risperidone Oral Medications xxvii. Ziprasidone Oral Medications xxviii. Chlorpromazine Oral Medications xxix. Fluphenazine Oral Medications xxx. Perphenazine Oral Medications xxxi. Prochlorperazine Oral Medications xxxii. Thioridazine Oral Medications xxxiii. Trifluoperazine Oral Medications xxxiv. Amitriptyline Perphenazine Oral Medications xxxv. Thiothixene Oral Medications xxxvi. SSD Antipsychotic Medications xxxvii. APM Antipsychotic Medications xxxviii. Long Acting Injections 104 Days Supply Medications xxxix. Long Acting Injections 14 Days Supply Medications xl. Long Acting Injections 201 Days Supply Medications xli. Long Acting Injections 28 Days Supply Medications xlii. Long Acting Injections 30 Days Supply Medications xliii. Long Acting Injections 35 Days Supply Medications 3. The individual received care from a MH provider during the measurement period, either: a. A medical claim or encounter with a rendering provider National Provider Identifier (NPI) or a billing provider NPI that has a MH provider taxonomy code. To determine the rendering provider's taxonomy code, take the following approach:

Measure Element	Description
Component calculation (continued)	i. Merge medical claims and encounters with CMS National Plan and Provider Enumeration System (NPPES) data by both rendering provider NPI number and billing provider NPI number to obtain provider taxonomy numbers. ii. If a medical claim or encounter has a rendering provider NPI number with a taxonomy code that is in the Measure Components Code Sets file (available to DHCS in the BHT Code Directory) where Code System = NUCC Taxonomy and MH = Yes, then it qualifies as a medical claim or encounter from a MH provider. iii. If a medical claim or encounter has a billing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and MH = Yes, then it qualifies as a medical claim or encounter from a MH provider. b. A pharmacy claim or encounter with a prescribing provider NPI that has a MH provider taxonomy code. To determine the prescribing provider's taxonomy code, take the following approach: i. Merge pharmacy claims with NPPES data by NPI number to obtain provider taxonomy numbers. ii. If a pharmacy claim has a prescribing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and MH = Yes, then it qualifies as a pharmacy claim from a MH provider. Note: This list includes MH providers and may also contain providers who do not have the authority to prescribe medication.

Measure Element	Description
Component calculation (continued)	4. The individual had a SMHS claim or encounter during the measurement period: a. Individual had a SMHS claim or encounter during the measurement period: i. Source code = 21 (SMHS) ii. Individual had a FFS inpatient psychiatric claim during the measurement period: iii. Program code = 09 (FFS Psychiatric Inpatient Claims), and iv. Revenue code = 0114, 0124, 0134, 0154, 0204, or 0169 (Psychiatric Revenue Codes), and b. Source code = 18 (Medical FI Claims – Mental Health Inpatient) c. Individual had a Kaiser Sacramento or Solano Inpatient Psychiatric encounter during the measurement period[44] i. Program code = 02 (managed care), and ii. Plan code = 191 or 656 (Sacramento or Solano) and iii. Revenue code = 0114, 0124, 0134, 0154, 0204 (Psychiatric Revenue Codes) 5. The individual had a medical claim or encounter with a MH revenue code that is in the Measure Components Code Sets file where Code System = Revenue Code and MH = Yes during the measurement period.

[44] Step 1.4.c is applicable for dates of service prior to December 31, 2024. Beginning January 1, 2025, SMHS in Sacramento and Solano counties are no longer capitated to the Kaiser Permanente Health Plan (SMHS are adjudicated by Mental Health Plans (MHP) as in other counties), and all inpatient psychiatric encounters for individuals in these counties will be captured under the logic described in Step 1.4.b.

Measure Element	Description
Component calculation (continued)	6. The individual had a medical claim or encounter with a MH place of service (POS) code that is in the Measure Components Code Sets file where Code System = POS and MH = Yes during the measurement period. 7. The individual had a medical claim or encounter with a MH diagnosis related group (DRG) code that is in the Measure Components Code Sets file where Code System = DRG and MH = Yes during the measurement period. **Step 2**. Count an individual if they meet any of the following criteria for additional BH needs: 1. The individual had a medical claim or encounter in the measurement period where the diagnosis code (in any position on the claim) is in one of the following HEDIS value sets: a. AOD Abuse and Dependence b. Unintentional Drug Overdose c. Substance Induced Disorders 2. The individual received care from a SUD provider during the measurement period, either: a. A medical claim or encounter with a rendering provider NPI or a billing provider NPI that has a SUD provider taxonomy code. To determine the rendering provider's taxonomy code, take the following approach: i. Merge medical claims and encounters with NPPES data by both rendering provider NPI number and billing provider NPI number to obtain provider taxonomy numbers. ii. If a medical claim or encounter has a rendering provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim or encounter from a SUD provider.

Measure Element	Description
Component calculation (continued)	iii. If a medical claim or encounter has a billing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim from a SUD provider. b. A pharmacy claim or encounter with a prescribing provider NPI that has a SUD provider taxonomy code. To determine the prescribing provider's taxonomy code, take the following approach: i. Merge pharmacy claims with NPPES data by NPI number to obtain provider taxonomy numbers. ii. If a pharmacy claim has a prescribing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a pharmacy claim from a SUD provider. Note: This list includes SUD providers and may also contain providers who do not have the authority to prescribe medication. 3. The individual had a medical claim or encounter with a SUD revenue code that is in the Measure Components Code Sets file where Code System = Revenue Code and SUD = Yes during the measurement period. 4. The individual had a medical claim or encounter with a SUD place of service (POS) code that is in the Measure Components Code Sets file where Code System = POS and SUD = Yes during the measurement period. 5. The individual had a medical claim or encounter with a SUD diagnosis related group (DRG) code that is in the Measure Components Code Sets file where Code System = DRG and SUD = Yes during the measurement period. 6. The individual received a Drug Medi-Cal/Drug Medi-Cal Organized Delivery System service during the measurement period:

Measure Element	Description
Component calculation (continued)	a. Source code = 37 **Step 3**. Count an individual if they meet the criteria for significant BH needs using the following logic: Significant BH Needs Component Specification
Data sources	• Homeless Data Integration System (HDIS) • JI Screening Portal • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Core Clinical Services

Measure Element	Description
Background	This measure component captures a subset of behavioral health (BH) encounters that are provided in community or clinic settings, and which may include ongoing or longitudinal care for people who are enrolled in Medi-Cal or receiving other county BH services. This measure component is used in Behavioral Health Transformation (BHT) to capture individuals' receipt or access to appropriate care outside of an inpatient or institutional setting. These services focus on outpatient care delivered in community, residential, or clinic settings, including ongoing (longitudinal) treatment for individuals with BH needs. These encounters involve assessment and/or treatment for BH conditions across the full continuum of care, including mild, moderate, and significant levels of need. The services exclude acute inpatient and emergency department (ED) services, as well as encounters that do not represent direct patient care (such as outreach). The approach to identifying these services draws from the services included in the numerators of three HEDIS measures: FUA (Follow-Up After Emergency Department Visit for Substance Use), FUM (Follow-Up After Emergency Department Visit for Mental Illness), and FUH (Follow-Up After Hospitalization for Mental Illness).
Measure type	Measure component used in BHT measures
Description	People who are enrolled in Medi-Cal or receiving other county BH services and have a claim or encounter for core clinical services for BH in a 12-month period

Measure Element	Description
Component versions to account for data availability	For this component, DHCS anticipates that, at minimum, the following versions of the specifications will be needed to account for data availability and transitions. 1. **This version:** Measure component limited to Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure component to more robustly identify core clinical services. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	**Step 1: Exclusions:** Exclude claims and encounters for crisis services, for services provided in the ED or acute inpatient setting, or observation stays. Follow these instructions to identify claims and encounters to exclude from Core Clinical Services: 1. Crisis services a. Residential crisis services: i. Procedure code = H0018 and ii. Procedure modifier = HE b. Crisis stabilization i. Procedure code = S9484, and ii. Procedure modifiers = HE and TG b. Crisis intervention services i. Procedure code = 90839, 90840 or H2011 2. ED visits a. HEDIS ED Value Set b. HEDIS ED Procedure Code Value Set with an ED Place of Service (POS) code = 23

Measure Element	Description
Component calculation (continued)	3. Acute inpatient stays and settings: a. In HEDIS Inpatient Stay Value Set but not in HEDIS Nonacute Inpatient Stay Value Set b. Acute inpatient settings i. HEDIS Acute Inpatient Value Set; or ii. HEDIS Acute Inpatient POS Value Set 4. Observation stays a. HEDIS Observation Stay Value Set **Step 2:** Identify individuals in the eligible population who had a claim or encounter for a core clinical service for BH during the measurement period. Individuals had a core clinical service for BH if they had at least one claim or encounter meeting any one or more of the following conditions: 1. Outpatient visit a. An outpatient visit (HEDIS Visit Setting Unspecified Value Set) with (HEDIS Outpatient POS Value Set) with any of the following: i. A diagnosis of a mental health disorder (HEDIS Mental Health Diagnosis Value Set), or ii. A diagnosis of Substance Use Disorder (SUD) (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set), or drug overdose (HEDIS Unintentional Drug Overdose Value Set), or iii. A mental health provider. b. An outpatient visit (HEDIS BH Outpatient Value Set) with any of the following: i. A diagnosis of a mental health disorder (HEDIS Mental Health Diagnosis Value Set), or

Measure Element	Description
Component calculation (continued)	ii. A diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set), or drug overdose (HEDIS Unintentional Drug Overdose Value Set), or iii. A mental health provider. c. A community mental health center visit (HEDIS Visit Setting Unspecified Value Set; HEDIS BH Outpatient Value Set; HEDIS Transitional Care Management Services Value Set) with POS code = 53. 2. Intensive outpatient encounter or partial hospitalization a. HEDIS Visit Setting Unspecified Value Set with POS code = 52, or b. HEDIS Partial Hospitalization or Intensive Outpatient Value Set. 3. Electroconvulsive therapy a. Electroconvulsive therapy (HEDIS Electroconvulsive Therapy Value Set) with (HEDIS Outpatient POS Value Set or POS code = 24, 52, or 53). 4. Nonresidential substance abuse treatment facility visit a. A nonresidential substance abuse treatment facility visit (HEDIS Visit Setting Unspecified Value Set) with (HEDIS Nonresidential Substance Abuse Treatment Facility POS Value Set) with either: i. any diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set) or drug overdose (HEDIS Unintentional Drug Overdose Value Set), or ii. A mental health provider.

Measure Element	Description
Component calculation (continued)	5. Opioid treatment service that bills monthly or weekly a. An opioid treatment service that bills monthly or weekly (HEDIS OUD Weekly Non Drug Service Value Set; HEDIS OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set) or drug overdose (HEDIS Unintentional Drug Overdose Value Set). 6. SUD service, counseling, surveillance, or screening a. A substance use disorder service (HEDIS Substance Use Disorder Services Value Set). b. Substance use disorder counseling and surveillance (HEDIS Substance Abuse Counseling and Surveillance Value Set). Do not include laboratory claims or encounters (POS code = 81). c. A behavioral health screening or assessment for SUD or mental health disorders (HEDIS Behavioral Health Assessment Value Set). d. A substance use service (HEDIS Substance Use Services Value Set). 7. Pharmacotherapy dispensing event a. A pharmacotherapy dispensing event (HEDIS Alcohol Use Disorder Treatment Medications List; HEDIS Opioid Use Disorder Treatment Medications List) or medication treatment event (HEDIS AOD Medication Treatment Value Set; HEDIS OUD Weekly Drug Treatment Service Value Set). 8. Telehealth visit a. A telehealth visit (HEDIS Visit Setting Unspecified Value Set) with (HEDIS Telehealth POS Value Set) with any of the following: i. A diagnosis of a mental health disorder (HEDIS Mental Health Diagnosis Value Set), or

Measure Element	Description
Component calculation (continued)	ii. A diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set) or drug overdose (HEDIS Unintentional Drug Overdose Value Set), or iii. A mental health provider. 9. Telephone visit a. A telephone visit (HEDIS Telephone Visits Value Set) with any of the following: i. A diagnosis of a mental health disorder (HEDIS Mental Health Diagnosis Value Set), or ii. A diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set) or drug overdose (HEDIS Unintentional Drug Overdose Value Set), or iii. A mental health provider. 10. Psychiatric collaborative care management a. HEDIS Psychiatric Collaborative Care Management Value Set. 11. Transitional care management a. Transitional care management services (HEDIS Transitional Care Management Services Value Set) with either: i. A diagnosis of mental health disorder (HEDIS Mental Health Diagnosis Value Set), or ii. A mental health provider. 12. Peer support service a. A peer support service (HEDIS Peer Support Services Value Set) with either: i. A diagnosis of mental health disorder (HEDIS Mental Health Diagnosis Value Set), or

Measure Element	Description
Component calculation (continued)	ii. A diagnosis of SUD (HEDIS AOD Abuse and Dependence Value Set), substance use (HEDIS Substance Induced Disorders Value Set), or drug overdose (HEDIS Unintentional Drug Overdose Value Set). 13. Psychiatric residential treatment a. HEDIS Residential Behavioral Health Treatment Value Set, or b. HEDIS Visit Setting Unspecified Value Set with POS code = 56. 14. Visit in a behavioral health care setting a. HEDIS Behavioral Healthcare Setting Value Set. Note: Identify mental health providers throughout this step in alignment with DHCS's definition of mental health providers for purposes of calculating HEDIS FUM, FUH, and FUA measures.
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Experiencing Homelessness

Measure Element	Description
Background	This measure component identifies people who are enrolled in Medi-Cal or receiving other county behavioral health (BH) services who are experiencing homelessness, in alignment with the federal[45] and the Behavioral Health Services Act (BHSA) definition[46] of experiencing homelessness and based on available Homeless Data Integration (HDIS) data and Medi-Cal enrollment, claims and encounter records. This measure component is used in Behavioral Health Transformation (BHT) to identify people who are experiencing homelessness. It uses a novel approach for identifying people experiencing homelessness using a combination of HDIS data from California's housing Continuums of Care and available Medi-Cal and county BH data, including addresses, Z codes documenting housing status as part of medical encounters, and the place of service for medical encounters. It provides a more-complete-than-ever understanding of people experiencing homelessness within the Medi-Cal population. This component was developed in collaboration with the California Interagency Council on Homelessness (Cal ICH). The approach for identifying people experiencing homelessness using HDIS is consistent with the approach used for the performance measures in the Cal ICH Action Plan for Preventing and Ending Homelessness in California and builds on that approach to also include indicators of homelessness observed in Medi-Cal and BHSA data.
Measure type	Measure component used in BHT measures
Description	People who are enrolled in Medi-Cal or receiving other county BH services and are identified as experiencing homelessness in a 12-month period based on available data

[45] For additional details, see the Federal definition of experiencing homelessness, available at https://www.ecfr.gov/current/title-24/subtitle-A/part-91/subpart-A/section-91.5.

[46] For additional details, see the BHSA Policy Manual, available at https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/9-appendix.

Measure Element	Description
Component versions to account for data availability	For this measure component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Identifies homelessness using HDIS and Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. 2. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service-level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data to more robustly identify people experiencing homelessness. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	Count an individual if they meet either of the following criteria based on (1) HDIS or (2) Medi-Cal claims, encounters or enrollment data. **Step 1. HDIS:** Among individuals in the eligible population, count an individual as experiencing homelessness while accessing services at any point in the measurement period using HDIS. 1. Filter HDIS to relevant records. Select records from the HDIS dataset where Project Type is emergency shelter, safe haven, transitional housing, permanent housing (including rapid rehousing, permanent supportive housing, and other permanent housing), street outreach, services only, day shelter, coordinated entry or other. 2. Identify homeless start date. For each record, set homeless start date to project start date if Project Type is any of the following: a. Emergency shelter, safe haven, transitional housing, or permanent housing. b. Street outreach and current living situation (CLS) are homeless, institutional, or transitional.

Measure Element	Description
Component calculation (continued)	c. Services only, day shelter, coordinated entry or other, and CLS are "place not meant for habitation." 3. Identify homeless end date. a. Set homeless end date to project exit date if Project Type is any of the following: i. Emergency shelter, safe haven, or transitional housing. ii. Permanent housing and housing move-in date are null. iii. Street outreach and CLS are one of the following: homeless, institutional, or transitional. iv. Services only, day shelter, coordinated entry or other, and CLS are "place not meant for habitation." b. Set homeless end date to housing move-in date if Project Type is permanent housing and housing move-in date is not null. 4. Determine if an individual is experiencing homelessness. a. For individuals for which homeless start and end dates are determined, an individual is experiencing homelessness if both of the following criteria are met: i. Homeless start date is on or before the measurement period end date, and ii. Homeless end date is on or after the measurement period start date. b. For individuals without HDIS homeless start/end dates during the measurement period, determine if the individual had a prior living situation during the measurement period indicating a homeless situation, including any of the following:

Measure Element	Description
Component calculation (continued)	i. Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter ii. Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) iii. Safe haven c. For individuals without HDIS homeless start/end dates during the measurement period, determine if the individual had any CLS recording indicating a homeless situation during the measurement period, including any of the following: i. Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter ii. Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) iii. Safe haven **Step 2. Medi-Cal claims, encounters and enrollment data:** Among individuals in the eligible population, count an individual as experiencing homelessness in the measurement period if they meet one or more of the following criteria: **1.** Had an address in the eligibility file that changed during the measurement period to an address indicating the individual is homeless or transient. The string in the eligibility file address field must be an exact match with one of following: homeless, home less, transient, homelss, homeles, home to, homles, homnel, homelses, hiomeles, hoemles, honel, homelless, hmls, holess, homess, hmels, homels, homelee, homeleless, hmles, homelles, hombles, houseless, ho,eless, homesle, homein, no home, h0mles, homle, home on.

Measure Element	Description
Component calculation (continued)	2. Had a claim or encounter during the measurement period with an ICD 10-CM diagnosis code indicating homelessness: Z59.0, Z59.00, Z59.01, or Z59.02. 3. Had a claim or encounter during the measurement period with a place of service code of 04 (Homeless shelter) or 27 (Outreach site / street).
Data sources	• HDIS • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Institutional Stays

Measure Element	Description
Background	This measure component identifies people who are enrolled in Medi-Cal or receiving other county behavioral health (BH) services with a stay in one of the following institutional settings: Psychiatric Health Facilities (PHF), psychiatric hospitals, and Psychiatric Residential Treatment Facilities (PRTFs). Currently, the component is limited to stays that are funded by Medi-Cal (i.e., stays not subject to the Medicaid Institutions for Mental Disease (IMD) exclusion or stays meeting Medicaid waiver criteria for coverage). Future versions of this measure component may identify stays in Mental Health Rehabilitation Centers (MHRCs), Skilled Nursing Facility-Special Treatment Programs (SNF-STPs), and state hospitals (civil commitments only). Future versions of this measure component may also include stays that are subject to the IMD exclusion.
Measure type	Measure component used in BHT measures
Description	People who are enrolled in Medi-Cal or receiving other county BH services with an institutional stay in a 12-month period
Component versions to account for data availability	For this component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Component limited to DHCS data on PHFs, psychiatric hospitals, and PRTFs for Medi-Cal members 2. Update to include data on state hospital civil commitments from the California Department of State Hospitals (DSH) and data on MHRCs and SNF-STPs from DHCS a. DHCS is coordinating with DSH for access to data. Once data is available, the specification may be updated to include state hospital civil commitments. b. DHCS may add available DHCS data on MHRC and SNF-STP stays to this component.

Measure Element	Description
Component versions to account for data availability (continued)	c. DHCS will incorporate logic for identifying unique stays, admission and discharge dates, and whether a stay is ongoing for all facility types. 3. Update to include Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data in this measure to identify institutional stays that are not covered by Medi-Cal, including stays for all facility types subject to the IMD exclusion for Medi-Cal members and stays funded by county behavioral health for individuals not enrolled in Medi-Cal. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	**Step 1:** Among individuals in the eligible population, identify those with an institutional stay in PHFs, psychiatric hospitals, and PRTFs during the measurement period. 1. Identify individuals with PHF stays during the measurement period in DHCS claims using the following logic: a. Individual had a Medi-Cal Short Doyle claim for PHFs during the measurement period: i. Program Code = 08 ii. Service_ID = H2013 2. Identify individuals with psychiatric hospital stays during the measurement period in DHCS claims using the following logic: a. Individual had a Medi-Cal Short Doyle claim for psychiatric hospitals during the measurement period: i. Program code = 08 ii. Revenue code = 0100 or 0101 b. Individual had any FFS inpatient psychiatric hospitalizations claims (available via the Fiscal Intermediary data) during the measurement period:

Measure Element	Description
Component calculation (continued)	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) 3. Identify individuals with PRTF stays during the measurement period in DHCS claims using the following logic: a. Individual had a Medi-Cal Short Doyle claim for a PRTF during the measurement period: i. Program code = 08 ii. Revenue code = 1001
Data sources	• Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Component version	v1.0
Measure release date	2026
Summary of changes	n/a

Incarceration

Measure Element	Description
Background	This measure component identifies adults and youth who are enrolled in Medi-Cal or receiving other county behavioral health (BH) services and are experiencing incarceration. This measure component is used in Behavioral Health Transformation (BHT) measures to identify and measure outcomes related to people experiencing incarceration. This measure component is limited to adults and youth 12 years of age and older to align with the use case for BHT's Reducing Justice Involvement measures, in which most measures have a lower age limit of 12 years old. Due to data limitations, this measure component focuses only on incarceration (excluding community supervision or arrests) and does not include all episodes of incarceration. As of June 2026, this component includes incarceration data from Medi-Cal enrollment data and the Justice-Involved Reentry Initiative Screening Services Portal (JI Screening Portal). Additionally, it does not include episodes of incarceration lasting less than 28 calendar days unless the incarcerated persons are also enrolled in the 90-day pre-release services as part of the California Advancing and Innovating Medi-Cal (CalAIM) JI Reentry Initiative.[47]
Measure type	Measure component used in BHT measures
Description	Adults and youth 12 years of age and older who are enrolled in Medi-Cal or receiving other county BH services and are experiencing incarceration in a 12-month period
Component versions to account for data availability	For this measure component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Identifies incarceration using JI Screening Portal data and Medi-Cal enrollment data.

[47] More information on the CalAIM JI Reentry Initiative is available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx.

Measure Element	Description
Component versions to account for data availability (continued)	2. Update to include other sources of incarceration, arrest, and community supervision data if it becomes available to DHCS at a later date. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this measure component
Component calculation	Any individual 12 years of age and older who had an indication of incarceration in the Medi-Cal enrollment data or completed a screening in the JI Screening Portal during the measurement period is considered incarcerated. **Step 1**. Among individuals in the eligible population, identify those who were 12 years of age and older as of the last day of the measurement period. **Step 2**. Among individuals identified in Step 1, identify those with indication of incarceration based on whether they met any of the following criteria during the measurement period: 1. Had Inmate Program aid code: These codes indicate an individual's enrollment in the CalAIM JI Reentry Initiative or Medi-Cal Inmate Eligibility Program (MCIEP), which are Medi-Cal programs only used during incarceration:[48] a. JI Reentry Initiative aid codes: I2, I3, I4, I5 and I6 b. State MCIEP: F1, G1, G0, N5, K2, K3, and K4 c. County MCIEP: F3, G3, N7, G5, G7, J1, J2, J5, J7, K6, and K8.

[48] DHCS will update this specification to include the following State MCIEP aid codes: F2, G9, K5, and N6, and the following County MCIEP aid codes: F4, G4, G6, G8, J3, J4, J6, J8, K7, K9, and N8, in alignment with the updated State and County MCIEP Aid Code Chart, effective January 1, 2026, available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/State-and-County-MCIEP-Aide-Code-Chart.aspx.

Measure Element	Description
Component calculation (continued)	2. Had an incarceration suspension code: This captures individuals whose records reflect restricted access with suspended Medi-Cal benefits due to incarceration, typically applied after 28 calendar days of incarceration: a. Use of 8XX Medi-Cal Eligibility Data System (MEDS) restriction codes and b. Eligibility status code: 691 (full month of incarceration) or X5X (partial month of incarceration) 3. Completed a screening in the JI Screening Portal: These individuals have been screened by a correctional facility for the 90-day pre-release services as part of the CalAIM JI Reentry Initiative and are considered incarcerated.[49] a. Any individual registered in the JI Screening Portal.
Data sources	• JI Screening Portal • Medi-Cal enrollment data
First BHT measurement period	FY 2024-25
Component version	v1.0
Component release date	2026
Summary of changes	n/a

[49] DHCS intends to capture data on any incarcerated individuals regardless of their eligibility for the 90-day pre-release services as part of the CalAIM JI Reentry Initiative. DHCS will capture this data through the screening for 90-day pre-release services conducted by correctional facilities.

Mental Health Needs

Measure Element	Description
Background	This measure component identifies people enrolled in Medi-Cal or receiving other county behavioral health (BH) services who need any mental health (MH) services, inclusive of services delivered by the Non-Specialty Mental Health Services (NSMHS) and Specialty Mental Health Services (SMHS) across the full continuum of care, from mild to significant MH needs. This component is used in Behavioral Health Transformation (BHT) to identify and measure interventions or outcomes related to people who likely have MH needs. DHCS identifies people with MH needs using administrative data, leveraging diagnosis, utilization, and systems involvement data indicating a need; DHCS cannot identify people with MH needs for which there is no available administrative data indicating that need.
Measure type	Measure component used in BHT measures
Description	People enrolled in Medi-Cal or receiving other county BH services who need any MH services in a 12-month period
Component versions to account for data availability	For this measure component, DHCS anticipates that, at minimum, the following versions of the specification will be needed to account for data availability and transitions. 1. **This version:** Measure component limited to Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, Short Doyle claims, Justice-Involved (JI) Reentry Initiative Screening Services Portal (JI Screening Portal) data, and Homelessness Data Information System (HDIS) data

Measure Element	Description
Component versions to account for data availability (continued)	2. Update to include California Department of Education (CDE) data a. DHCS will work with the California Department of Education on an approach to sharing data on the truancy and expulsion status of students and on the Individualized Education Program (IEP). Once that approach has been implemented, DHCS may consider including additional criteria to identify people with MH needs related to these data. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure component to more robustly identify people with MH needs. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.
Eligible population	Population eligible for the measure using this component
Component calculation	Count an individual if they meet the criteria in Step 1 or 2. **Step 1**. Among individuals in the eligible population, count an individual if they meet any of the following MH needs criteria: 1. The individual had a medical claim or encounter in the measurement period where the diagnosis code (in any position) is in one of the following HEDIS value sets: a. Intentional Self-Harm b. Depression or Other Behavioral Health Condition c. Mental, Behavioral, and Neurodevelopmental Disorders d. Mental Health Diagnosis e. Mental Illness

Measure Element	Description
Component calculation (continued)	2. The individual had a claim or encounter for a BH medication during the measurement period, either: a. A medical claim or encounter where any procedure code is in one of the following HEDIS value sets: i. Long Acting Injections 14 Days Supply ii. Long Acting Injections 28 Days Supply iii. Long Acting Injections 30 Days Supply Medications b. Or, a pharmacy claim or encounter with a medication listed in one of the following HEDIS value sets: i. Dexmethylphenidate Medications ii. Dextroamphetamine Medications iii. Lisdexamfetamine Medications iv. Methylphenidate Medications v. Methamphetamine Medications vi. Clonidine Medications vii. Guanfacine Medications viii. Atomoxetine Medications ix. Antidepressant Medications x. Antipsychotic Combination Medications xi. Antipsychotic Medications xii. Aripiprazole Oral Medications xiii. Asenapine Oral Medications xiv. Brexpiprazole Oral Medications xv. Cariprazine Oral Medications xvi. Clozapine Oral Medications xvii. Haloperidol Oral Medications xviii. Iloperidone Oral Medications xix. Loxapine Oral Medications xx. Lumateperone Oral Medications xxi. Lurasidone Oral Medications xxii. Molindone Oral Medications

Measure Element	Description
Component calculation (continued)	xxiii. Olanzapine Oral Medications xxiv. Paliperidone Oral Medications xxv. Quetiapine Oral Medications xxvi. Risperidone Oral Medications xxvii. Ziprasidone Oral Medications xxviii. Chlorpromazine Oral Medications xxix. Fluphenazine Oral Medications xxx. Perphenazine Oral Medications xxxi. Prochlorperazine Oral Medications xxxii. Thioridazine Oral Medications xxxiii. Trifluoperazine Oral Medications xxxiv. Amitriptyline Perphenazine Oral Medications xxxv. Thiothixene Oral Medications xxxvi. SSD Antipsychotic Medications xxxvii. APM Antipsychotic Medications xxxviii. Long Acting Injections 104 Days Supply Medications xxxix. Long Acting Injections 14 Days Supply Medications xl. Long Acting Injections 201 Days Supply Medications xli. Long Acting Injections 28 Days Supply Medications xlii. Long Acting Injections 30 Days Supply Medications xliii. Long Acting Injections 35 Days Supply Medications

Measure Element	Description
Component calculation (continued)	3. The individual received care from a MH provider during the measurement period, either: a. A medical claim or encounter with a rendering provider National Provider Identifier (NPI) or a billing provider NPI that has a MH provider taxonomy code. To determine the rendering provider's taxonomy code, take the following approach: i. Merge medical claims or encounters with CMS National Plan and Provider Enumeration System (NPPES) data by both rendering provider NPI number and billing provider NPI number to obtain provider taxonomy numbers. ii. If a medical claim or encounter has a rendering provider NPI number with a taxonomy code that is in the Measure Components Code Sets file (available to DHCS in the BHT Code Directory) where Code System = NUCC Taxonomy, and MH = Yes, then it qualifies as a medical claim from a MH provider. iii. If a medical claim or encounter has a billing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy, and MH = Yes, then it qualifies as a medical claim from a MH provider. b. Or, a pharmacy claim or encounter with a prescribing provider NPI that has a MH provider taxonomy code. To determine the prescribing provider's taxonomy code, take the following approach:

Measure Element	Description
Component calculation (continued)	i. Merge prescription drug claims and encounters with NPPES data by NPI number to obtain provider taxonomy numbers. ii. If a prescription drug claim or encounter has a prescribing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and MH = Yes, then it qualifies as a prescription drug claim from a MH provider. Note: This list includes MH providers and may also contain providers who do not have the authority to prescribe medication. 4. The individual had any SMHS claims or encounters during the measurement period: a. Individual had any SMHS claims during the measurement period: i. Source code = 21 (SMHS) b. Individual had any FFS inpatient psychiatric claims during the measurement period: i. Program code = 09 (FFS Psychiatric Inpatient Claims), and ii. Revenue code = 0114, 0124, 0134, 0154, 0204, or 0169 (Psychiatric Revenue Codes), and iii. Source code = 18 (Medical FI Claims – Mental Health Inpatient)

Measure Element	Description
Component calculation (continued)	c. Individual had any Kaiser Sacramento or Solano Inpatient Psychiatric claims or encounters during the measurement period[50] i. Program code = 02 (Managed care), and ii. Plan code = 191 or 656 (Sacramento or Solano), and iii. Revenue code = 0114, 0124, 0134, 0154, 0204 (Psychiatric Revenue Codes) 5. The individual had any medical claims or encounters with a MH revenue code that is in the Measure Components Code Sets file where Code System = Revenue Code and MH = Yes during the measurement period. 6. The individual had any medical claims or encounters with a MH place of service (POS) code that is in the Measure Components Code Sets file where Code System = POS and MH = Yes during the measurement period. 7. The individual had any medical claims or encounters with a MH diagnosis related group (DRG) code that is in the Measure Components Code Sets file where Code System = DRG and MH = Yes during the measurement period. **Step 2**. Among individuals in the eligible population, count an individual if they meet the criteria for significant MH needs as defined within the Significant BH Needs logic. a. Significant BH Needs Component Specification
Data sources	• HDIS • JI Screening Portal • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.

[50] Step 1.4.c is applicable for dates of service prior to December 31, 2024. Beginning January 1, 2025, SMHS in Sacramento and Solano counties are no longer capitated to the Kaiser Permanente Health Plan (SMHS are adjudicated by Mental Health Plans (MHP) as in other counties), and all inpatient psychiatric encounters for individuals in these counties will be captured under the logic described in Step 1.4.b.

Measure Element	Description
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Significant Behavioral Health Needs

Measure Element	Description
Background	This measure component intends to capture a subset of people enrolled in Medi-Cal or receiving other county behavioral health (BH) services with BH needs, whose BH needs are more likely to be associated with functional impairment. This measure component is used in Behavioral Health Transformation (BHT) measures to identify and measure outcomes related to people whose acuity of need likely requires close collaboration between Managed Care Plans (MCPs) and Behavioral Health Plans (BHPs) to determine and effectuate the best system of BH care. A person is considered to have significant BH needs if they meet any one of the following: A. **Diagnosis:** Narrowly defined set of historically significant diagnoses that frequently (not always) have associated functional impairment B. **Utilization:** Narrowly defined historical utilization criteria that usually (not always) signifies a significant BH condition with impairment C. **Diagnosis + Utilization:** Requires the presence of both a BH diagnosis (more broadly defined diagnostic criteria) *and* a proxy of functional limitation including utilization criteria or demonstrated social need This specification includes three different measure components, which are used in measures depending on the population of interest for that specific measure: • Living with substance use disorder (SUD) needs • Living with significant MH needs • Living with significant BH needs (including significant MH and/or SUD needs) Given the distinct needs, policy, and criteria by age group, this specification is outlined in two distinct parts: first for adults 21 years of age and older, and second for children and youth up to 21 years of age.
Measure type	Measure component used in BHT measures

Measure Element	Description
Description	People who are enrolled in Medi-Cal or receiving other county BH services and are identified as having significant BH needs in a 12-month period
Component versions to account for data availability	For this measure component, DHCS anticipates that the following versions of the specification may be needed to account for data availability and transitions. 1. **This version:** Measure component limited to Medi-Cal enrollment data, fee-for-service (FFS) claims, managed care encounters, Short Doyle claims, Justice-Involved Reentry Initiative Screening Portal (JI Screening Portal) data, and Homelessness Data Information System (HDIS) data 2. Update to include California Department of Education (CDE) data a. DHCS will work with the California Department of Education on an approach to sharing data on the truancy and expulsion status of students and on the Individualized Education Program (IEP). Once that approach has been implemented, DHCS may consider including additional criteria for Significant BH Needs Pathway C related to these data. 3. Update to include additional data beyond Medi-Cal data, including Behavioral Health Individual and Service Level (BH-ISL) encounters a. DHCS will explore using BH-ISL encounter data and other sources of non-Medi-Cal data in this measure component to more robustly identify people with significant BH needs. Any updates made to this specification between these planned versions will be denoted using the "Version 1.X" format.

Significant Behavioral Health Needs – Adults

Measure Element	Description
Eligible population	Adults (21 years of age and older) eligible for the measure using this measure component
Component 1: Living with SUD needs	An adult is classified as living with SUD needs if they were 21 years of age and older on the last day of the measurement period and meet the criteria for either Pathway A or B. **Step 1: Pathway A: Diagnosis.** An individual is classified as living with SUD needs if, in the 2 years prior to the last day of the measurement period, any of the following criteria are met: 1. Individual was identified as having SUD upon screening for pre-release services in the California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Reentry Initiative. a. In the JI Screening Portal, individual had qualifying criteria identified as SUD: S (Substance Use Disorder) in any QUALIFY_CRITERIA_CD (1 through 8) 2. Individual had at least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set) or at least one outpatient claim or encounter or ED visit (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, or Outpatient and ED Value Set, or ED Procedure Code Value Set with an ED Place of Service code [POS = 23]) with diagnosis code(s) in any position on the claim or encounter from any of the following HEDIS value sets: a. AOD Abuse and Dependence Value Set b. Unintentional Drug Overdose Value Set c. Substance Induced Disorders Value Set

Measure Element	Description
Component 1: Living with SUD needs (continued)	**Step 2: Pathway B: Utilization**. An individual is classified as living with SUD needs if, in the two years prior to the last day of the measurement period, they had utilization of any of the following: 1. Any service in the Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS) system a. Had one or more claims or encounters with source code = 37 (DMC/DMC-ODS) 2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) (excluding SBIRT procedure codes for screening only without intervention and referral to treatment) a. Had one or more claims or encounters with procedure code = H0050 3. Used medication assisted treatment a. Had any claim or encounter with a procedure code in any of the following HEDIS value sets: i. AOD Medication Treatment Value Set ii. Alcohol Use Disorder Treatment Medications List iii. Buprenorphine Implant Value Set iv. Buprenorphine Implant Medications List v. Buprenorphine Injection Value Set vi. Buprenorphine Injection Medications List vii. Buprenorphine Naloxone Value Set viii. Buprenorphine Naloxone Medications List ix. Buprenorphine Oral Value Set x. Buprenorphine Oral Medications List xi. Buprenorphine Oral Weekly Value Set xii. Methadone Oral Value Set xiii. Methadone Oral Weekly Value Set xiv. Naltrexone Injection Value Set xv. Naltrexone Injection Medications List xvi. Naltrexone Oral Medications List

Measure Element	Description
Component 1: Living with SUD needs (continued)	xvii. Opioid Use Disorder Treatment Medications List xviii. OUD Monthly Office Based Treatment Value Set xix. OUD Weekly Drug Treatment Service Value Set xx. OUD Weekly Non Drug Service Value Set 4. Received care from a SUD provider during the measurement period, either: a. A medical claim with a rendering provider National Provider Identifier (NPI) or a billing provider NPI that has a SUD provider taxonomy code. To determine the rendering provider's taxonomy code, take the following approach: i. Merge medical claims and encounters with CMS National Plan and Provider Enumeration System (NPPES) data by both rendering provider NPI number and billing provider NPI number to obtain provider taxonomy numbers. ii. If a medical claim or encounter has a rendering provider NPI number with a taxonomy code that is in the Measure Components Code Sets file (available to DHCS in the BHT Code Directory) where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim or encounter from a SUD provider. iii. If a medical claim or encounter has a billing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim or encounter from a SUD provider.

Measure Element	Description
Component 1: Living with SUD needs (continued)	b. A pharmacy claim with a prescribing provider NPI that has a SUD provider taxonomy code. To determine the prescribing provider's taxonomy code, take the following approach: i. Merge pharmacy claims with NPPES data by NPI number to obtain provider taxonomy numbers. ii. If a pharmacy claim has a prescribing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a pharmacy claim from a SUD provider. Note: This list includes SUD providers and may also contain providers who do not have the authority to prescribe medication.
Component 2: Living with significant MH needs	An adult is classified as living with significant MH needs if they were 21 years of age and older on the last day of the measurement period and any of the conditions of Pathway A, B, or C are met. **Step 1: Pathway A: Diagnosis.** An individual is classified as living with significant MH needs if any of the following criteria are met: 1. In the two years prior to the last day of the measurement period, the individual was identified as having Serious Mental Illness (SMI) upon screening for pre-release services in the CalAIM Justice-Involved Reentry Initiative. a. In the JI Screening Portal, individual had qualifying criteria identified as SMI: M (Mental Illness) in any QUALIFY_CRITERIA_CD (1 through 8)

Measure Element	Description
Component 2: Living with significant MH needs (continued)	2. In the five years prior to the last day of the measurement period, the individual had at least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set), or at least one outpatient claim or encounter or ED visit (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, or Outpatient and ED Value Set, or ED Procedure Code Value Set with an ED Place of Service code [POS = 23]) with diagnosis code(s) in any position on the claim or encounter from any of the following HEDIS value sets: a. Schizophrenia Value Set b. Psychosis Value Set c. Bipolar Disorder Value Set **Step 2: Pathway B: Utilization.** An individual is classified as living with significant MH needs if, in the two years prior to the last day of the measurement period, they had utilization of any of the following: 1. At least one claim or encounter with any of the following: a. Any code from the HEDIS Long-Acting Injections Value Set b. Any code from the HEDIS Electroconvulsive Therapy Value Set c. Transcranial Magnetic Stimulation (TMS): Procedure code = 90867, 90868, or 90869 2. At least one institutional or residential stay defined by at least one of the following: a. An institutional stay in a Mental Health Rehabilitation Center (MHRC), Psychiatric Health Facility (PHF), psychiatric hospital, Psychiatric Residential Treatment Facility (PRTF), or Skilled Nursing Facility- Special Treatment Program (SNF-STF), or a state hospital civil commitment, using the following logic: Institutional Stays Component Specification

Measure Element	Description
Component 2: Living with significant MH needs (continued)	b. Adult residential treatment: Procedure code = H0019 with modifier HE c. Residential crisis services: Procedure code = H0018 with modifier HE 3. At least one claim or encounter for the following intensive outpatient or partial hospitalization services: a. Intensive specialized MH programs for high-risk populations, including Intensive Home- Based Services (IHBS), Intensive Care Coordination (ICC), and/or Child and Family Teams (CFT): program code = 08 (Short Doyle) with modifier = HK (any procedure code) b. Mental Health Day Treatment Intensive and Day Rehabilitation: Procedure code = H2012 c. Therapeutic behavioral health services (TBS): Procedure code = H2019 d. Partial hospitalization: POS = 52 4. At least one claim or encounter for the following evidence-based practices (EBPs):[51] a. Assertive Community Treatment (ACT): Procedure code = H0040 b. Forensic Assertive Community Treatment (FACT): Procedure code = H0039 c. Coordinated Specialty Care (CSC) for First Episode Psychosis: Procedure code = H2040 d. Clubhouse Services: Procedure code = H2031 e. Multisystemic Therapy (MST): Procedure code = H2033 f. Functional Family Therapy (FFT): Procedure code = H0036

[51] DHCS will update logic to include the evidence-based practices FSP Intensive Case Management (ICM) and High Fidelity Wraparound (HFW) once these services are available.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	g. Parent-Child Interaction Therapy (PCIT): Procedure code = 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, or T2021, with modifier = 22 5. Two or more claims or encounters for any of the following crisis services: a. Crisis stabilization: Procedure code = S9484 with modifiers HE and TG b. Crisis intervention services: Procedure code = 90839, 90840, or H2011 **Step 3: Pathway C: Diagnosis plus an indicator for functional impairment.** An individual is classified as living with significant MH needs if they had any presence or history of specific MH diagnoses coupled with defined utilization or service-based criteria consistent with significant MH needs. An individual must meet both the Pathway C diagnostic and utilization criteria to be classified as living with significant MH needs through Pathway C. For the following criteria, "MH diagnosis code(s)" refers to any diagnosis code from the following value sets: • HEDIS Mental Illness Value Set • HEDIS Intentional Self Harm Value Set • HEDIS Depression or Other Behavioral Health Condition Value Set • AIR Eating Disorders Value Set[52] An individual is classified as living with significant MH needs if, in the two years prior to the last day of the measurement period, any of the following criteria are met: 1. At least one claim or encounter for an ED visit (HEDIS ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with a diagnosis of intentional self-harm (HEDIS Intentional Self Harm Value Set) in any position on the claim

[52] Measure stewarded by American Institutes for Research (AIR). OID: 2.16.840.1.113883.3.464.1003.1036. Available from the Value Set Authority Center.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	2. At least one claim or encounter for inpatient discharge with a diagnosis of intentional self-harm (HEDIS Intentional Self Harm Value Set) in any position on the claim a. To identify inpatient discharges: Identify all acute and nonacute inpatient stays that have a discharge date within the measurement period using the following HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set. 3. At least three claims or encounters for ED visits (HEDIS ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with any MH diagnosis code(s) in any position on the claim or encounter (each claim or encounter does not need to include the same diagnosis code to qualify). 4. Ongoing use of the SMHS system as defined by ten or more claims or encounters with source code = 21 (SMHS) with any MH diagnosis code(s) in any position on the claim or encounter (each claim or encounter does not need to include the same diagnosis code to qualify). 5. At least one claim or encounter for inpatient discharge with a MH diagnosis code as the principal diagnosis on the claim or encounter a. To identify inpatient discharges: Identify all acute and nonacute inpatient stays that have a discharge date within the measurement period using the following HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	6. At least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set) or at least one outpatient or ED claim or encounter (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, Outpatient and ED Value Set, or ED Procedure Code Value Set with an ED POS = 23) with any MH diagnosis code(s) in any position on the claim or encounter (each claim or encounter does not need to include the same diagnosis code to qualify), and either: a. Is a former foster youth: Had Medi-Cal aid code = 4M or 4E during any month of the measurement period, or b. Had combined incarceration and homelessness: Individuals who meet the definitions of both incarceration and homelessness, using the following logic: i. Experiencing Homelessness Component Specification ii. Incarceration Component Specification Note that the linked logic identifies homelessness and incarceration in a 12-month measurement period. For Significant MH needs, adapt the logic to use data from the 2 years (24 months) prior to the last day of the measurement period.
Component 3: Living with significant BH needs	Include any individual who is identified as having SUD needs (Component 1) or significant MH needs (Component 2).
Data sources	• HDIS • JI Screening Portal • Medi-Cal enrollment data • Medi-Cal fee-for-service (FFS) claims, managed care encounters, and Short Doyle claims. Paid claims only.

Measure Element	Description
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

Significant Behavioral Health Needs – Children and Youth

Measure Element	Description
Eligible population	Child and youth (0 to 20 years of age) population eligible for the measure using this measure component
Component 1: Living with SUD needs	Children and youth (12 to 20 years of age) are classified as living with SUD needs if they were 12 to 20 years of age on the last day of the measurement period and meet criteria for either Pathway A or B. **Step 1: Pathway A: Diagnosis.** Children and youth (12 to 20 years of age) are classified as living with SUD needs if, in the 2 years prior to the last day of the measurement period, any of the following criteria are met: 1. Individual was identified as having SUD upon screening for pre-release services in the CalAIM Justice-Involved Reentry Initiative. a. In the JI Screening Portal, individual had qualifying criteria identified as SUD: S (Substance Use Disorder) in any QUALIFY_CRITERIA_CD (1 through 8) 2. Individual had at least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set) or at least one outpatient claim or encounter or ED visit (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, or Outpatient and ED Value Set, or ED Procedure Code Value Set with an ED POS = 23) with diagnosis code(s) in any position on the claim from any of the following HEDIS value sets: a. AOD Abuse and Dependence Value Set b. Unintentional Drug Overdose Value Set c. Substance Induced Disorders Value Set

Measure Element	Description
Component 1: Living with SUD needs (continued)	**Step 2: Pathway B: Utilization.** Children and youth (12 to 20 years of age) are classified as living with SUD needs if, in the two years prior to the last day of the measurement period, they had utilization of any of the following: 1. Any service in the DMC/DMC-ODS system a. Had one or more claims or encounters with source code = 37 (DMC/DMC-ODS) 2. SBIRT (excluding SBIRT procedure codes for screening only without intervention and referral to treatment) a. Medi-Cal: Had one or more claims or encounters with a procedure code = H0050 3. Used medication assisted treatment a. Had any claim or encounter with a procedure code in any of the following HEDIS value sets: i. AOD Medication Treatment Value Set ii. Alcohol Use Disorder Treatment Medications List iii. Buprenorphine Implant Value Set iv. Buprenorphine Implant Medications List v. Buprenorphine Injection Value Set vi. Buprenorphine Injection Medications List vii. Buprenorphine Naloxone Value Set viii. Buprenorphine Naloxone Medications List ix. Buprenorphine Oral Value Set x. Buprenorphine Oral Medications List xi. Buprenorphine Oral Weekly Value Set xii. Methadone Oral Value Set xiii. Methadone Oral Weekly Value Set xiv. Naltrexone Injection Value Set xv. Naltrexone Injection Medications List xvi. Naltrexone Oral Medications List

Measure Element	Description
Component 1: Living with SUD needs (continued)	xvii. Opioid Use Disorder Treatment Medications List xviii. OUD Monthly Office Based Treatment Value Set xix. OUD Weekly Drug Treatment Service Value Set xx. OUD Weekly Non Drug Service Value Set 4. Received care from a SUD provider during the measurement period, either: a. A medical claim or encounter with a rendering provider NPI or a billing provider NPI that has a SUD provider taxonomy code. To determine the rendering provider's taxonomy code, take the following approach: i. Merge medical claims and encounters with NPPES data by both rendering provider NPI number and billing provider NPI number to obtain provider taxonomy numbers. ii. If a medical claim or encounter has a rendering provider NPI number with a taxonomy code that is in the Measure Components Code Sets file (available to DHCS in the BHT Code Directory) where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim or encounter from a SUD provider. iii. If a medical claim or encounter has a billing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a medical claim or encounter from a SUD provider.

Measure Element	Description
Component 1: Living with SUD needs (continued)	b. A pharmacy claim with a prescribing provider NPI that has a SUD provider taxonomy code. To determine the prescribing provider's taxonomy code, take the following approach: i. Merge pharmacy claims with NPPES data by NPI number to obtain provider taxonomy numbers. ii. If a pharmacy claim has a prescribing provider NPI number with a taxonomy code that is in the Measure Components Code Sets file where Code System = NUCC Taxonomy and SUD = Yes, then it qualifies as a pharmacy claim from a SUD provider. Note: This list includes SUD providers and may also contain providers who do not have the authority to prescribe medication.
Component 2: Living with significant MH needs	Children and youth (0 to 20 years of age) are classified as living with significant MH needs if they were 0 to 20 years of age on the last day of the measurement period and meet any of the conditions of Pathway A, B, or C. **Step 1: Pathway A: Diagnosis.** Children and youth are classified as living with significant MH needs if any of the following criteria are met: 1. In the two years prior to the last day of the measurement period the individual had at least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set) or at least one outpatient claim or encounter or ED visit (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, or Outpatient and ED Value Set, or ED Procedure Code Value Set with an ED POS = 23) with diagnosis code(s) from the following HEDIS value sets: a. Mental Illness Value Set b. Intentional Self Harm Value Set

Measure Element	Description
Component 2: Living with significant MH needs (continued)	2. In the five years prior to the last day of the measurement period the individual had at least one inpatient claim or encounter (HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set) or at least one outpatient claim or encounter or ED visit (HEDIS value sets: BH Outpatient Value Set, Psychiatry Value Set, Psychosocial Care Value Set, or Outpatient and ED Value Set, or HEDIS ED Procedure Code Value Set with an ED POS = 23) with diagnosis code(s) from any of the following value sets: a. HEDIS Schizophrenia Value Set b. HEDIS Psychosis Value Set c. HEDIS Bipolar Disorder Value Set d. HL7 Post Traumatic Stress Disorder PTSD ICD10 Value Set[53] **Step 2: Pathway B: Utilization.** Children and youth are classified as living with significant MH needs if they utilized inpatient or intensive outpatient MH treatments, are former foster youth, or were involved in the juvenile incarceration or child welfare systems. Children and youth are classified as living with significant MH needs if, in the two years prior to the last day of the measurement period, they had utilization of any of the following: 1. At least one claim or encounter with any of the following: a. Any code from the HEDIS Long-Acting Injections Value Set b. Any code from the HEDIS Electroconvulsive Therapy Value Set

[53] Measure stewarded by Health Level Seven International (HL7) Patient Care Working Group (WG). OID: 2.16.840.1.113762.1.4.1222.104. Available from the Value Set Authority Center at https://vsac.nlm.nih.gov/.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	c. Transcranial Magnetic Stimulation (TMS): Procedure code = 90867, 90868, or 90869 2. At least one inpatient or residential stay defined by at least one of the following: a. An institutional stay in a MHRC, PHF, psychiatric hospital, PRTF, or SNF-STF, or a state hospital civil commitment, using the following logic: Institutional Stays Component Specification b. Adult residential treatment: Procedure code = H0019 with modifier HE c. Residential crisis services: Procedure code = H0018 with modifier HE 3. At least one claim or encounter for the following intensive outpatient or partial hospitalization services: a. Intensive specialized MH programs for high-risk populations, including IHBS, ICC, and/or CFT: program code = 08 (Short Doyle) and modifier = HK (any procedure code) b. TFC services: Procedure code = S5145 c. Mental Health Day Treatment Intensive: Procedure code = H2012 d. TBS: Procedure code = H2019 e. Partial hospitalization: POS = 52 4. At least one claim or encounter for the following EBPs:[54] a. ACT: Procedure code = H0040 b. FACT: Procedure code = H0039 c. CSC for FEP: Procedure code = H2040 d. Clubhouse Services: Procedure code = H2031 e. MST: Procedure code = H2033

[54] DHCS will update logic to include the evidence-based practices FSP Intensive Case Management (ICM) and High Fidelity Wraparound (HFW) once these services are available.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	f. FFT: Procedure code = H0036 g. PCIT: Procedure code = 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, or T2021, with modifier = 22 5. Two or more claims or encounters for any of the following crisis services: a. Crisis stabilization: Procedure code = S9484 with modifiers HE and TG b. Crisis intervention services: Procedure code = 90839, 90840, or H2011 6. Any of the following system involvement: a. Former foster youth: Children and youth with a Medi-Cal aid code = 4E or 4M b. Involvement in child welfare: Children and youth with any of the following Medi-Cal aid codes: 03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 4A, 4F, 4G, 4H, 4K, 4L, 4N, 4S, 4T, 4W, 40, 42, 43, 45, 46, 49, 5K or 5L. c. Incarceration, using the following logic: Incarceration Component Specification Note that the linked logic identifies incarceration in a 12-month measurement period. For significant MH needs, adapt the logic to use data from the 2 years (24 months) prior to the last day of the measurement period.

Measure Element	Description
Component 2: Living with significant MH needs (continued)	**Step 3: Pathway C: Diagnosis plus an indicator for functional impairment.** Children and youth are classified as living with significant MH needs if they had any presence or history of specific MH diagnoses coupled with defined utilization or service-based criteria consistent with significant MH needs. An individual must meet both the Pathway C diagnostic and utilization criteria to be classified as living with significant MH needs through Pathway C. For the following criteria, "MH diagnosis code(s)" refers to any diagnosis code in the following HEDIS value sets: • Intentional Self Harm Value Set • Depression or Other Behavioral Health Condition Value Set • Mental, Behavioral, and Neurodevelopmental Disorders Value Set • Mental Health Diagnosis Value Set • Mental Illness Value Set Children and youth are classified as living with significant MH needs if, in the two years prior to the last day of the measurement period, the following criteria are met: 1. At least three claims or encounters for ED visits (HEDIS ED Value Set, or ED Procedure Code Value Set with an ED POS = 23) with any MH diagnosis code(s) in any position on the claim or encounter (each claim or encounter does not need to include the same diagnosis code to qualify.) 2. At least one claim or encounter for inpatient discharge with a MH diagnosis code as the principal diagnosis on the claim or encounter a. To identify inpatient discharges: Identify all acute and nonacute inpatient stays that have a discharge date within the measurement period using the following HEDIS value sets: Inpatient Stay Value Set, Nonacute Inpatient Stay Value Set, BH Stand Alone Acute Inpatient Value Set, BH Stand Alone Nonacute Inpatient Value Set.

Measure Element	Description
Component 3: Living with significant BH needs	Include any individual who is identified as having SUD needs (Component 1) or significant MH needs (Component 2).
Data sources	• HDIS • JI Screening Portal • Medi-Cal enrollment data • Medi-Cal FFS claims, managed care encounters, and Short Doyle claims. Paid claims only.
First BHT measurement period	FY 2024-25
Measure version	v1.0
Measure release date	2026
Summary of changes	n/a

APPENDICES

Appendix A. Established Measures in BHT

The BHT leverages existing specifications for the NCQA HEDIS measures shown in Table A.1. Non-HEDIS value sets stewarded by external measure stewards shown in Table A.2. BHT measures that leverage existing specifications from measure stewards other than NCQA are shown in Table A.3.

Table A.1: NCQA HEDIS Measures

HEDIS MY 2025 Specifications, Value Sets, and Medication List Directory downloads available at the NCQA store.

BHT Measure Acronym	Measure Name	HEDIS Measure Set	BHT First Measurement Period
BH-3: IET-I BH-7: IET-E	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS Technical Specifications: Access / Availability of Care	State fiscal year (FY) 2024-25
BH-12: DSF-E	Depression Screening and Follow-up for Adolescents and Adults (DSF-E)	HEDIS Technical Specifications: Measures reported using Electronic Clinical Data Systems	Calendar year (CY) 2024
BH-14: FUA-7d	Follow-Up After Emergency Department Visit for Substance Use (FUA)	HEDIS Technical Specifications: Effectiveness of Care – Behavioral Health	FY 2024-25
BH-15: FUM-7d	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Technical Specifications: Effectiveness of Care – Behavioral Health	FY 2024-25

BHT Measure Acronym	Measure Name	HEDIS Measure Set	BHT First Measurement Period
IN-4: FUH-7d	Follow-Up After Hospitalization for Mental Illness (FUH)	HEDIS Technical Specifications: Effectiveness of Care – Behavioral Health	FY 2024-25
OD-4: POD	Pharmacotherapy for Opioid Use Disorder (POD)	HEDIS Technical Specifications: Effectiveness of Care – Behavioral Health	FY 2024-25
OD-5: FUI-7d	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	HEDIS Technical Specifications: Effectiveness of Care – Behavioral Health	FY 2024-25
PH-1: AAP-WSBH*	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS Technical Specifications: Access / Availability of Care	FY 2024-25
PH-2: WCV-WSBH*	Child and Adolescent Well-Care Visits (WCV)	HEDIS Technical Specifications: Utilization	FY 2024-25

* BHT applies allowable adjustments to the HEDIS measure, narrowing the population to people with significant BH needs.

Table A.2: Non-HEDIS Value Sets used in BHT Measures

Non-HEDIS value set downloads available at the Value Set Authority Center, which requires a free license and account to access. Request a UMLS License to search value sets and set up a free account to download code sets.

Value Set Name	Steward	Object Identifier (OID)	Associated BHT Measures and Components
Eating Disorders Value Set	American Institutes for Research (AIR)	2.16.840.1.113883.3.464.1003.1036	• JI-3: JISRV-WSBH • Significant BH Needs Measure Component

Value Set Name	Steward	Object Identifier (OID)	Associated BHT Measures and Components
Post Traumatic Stress Disorder PTSD ICD10 Value Set	Health Level Seven International (HL7) Patient Care Working Group (WG)	2.16.840.1.113762.1.4.1222.104	• JI-3: JISRV-WSBH • Significant BH Needs Measure Component

Table A.3: Other External Specification Sources for BHT Measures

BHT measures that leverage specifications from measure stewards other than NCQA are listed in Table A.3.

BHT Measure Acronym	BHT Measure Name	Measure Steward	Measure Description
BH-9: PC-SMHS	Perception of Care with Respect to One's Cultural Background: SMHS	UCLA ISAP	Percent of people who completed the Mental Health Statistics Improvement Project (MHSIP) Consumer Survey in a 12-month period who responded with "strongly agree" or "agree" to Q18 asking if "Staff were sensitive to my cultural background (race, religion, language, etc."
BH-10: PC-DMCODS	Perception of Care with Respect to One's Cultural Background: DMC-ODS	UCLA ISAP	Percent of people who completed the Treatment Perception Survey in a 12-month period who responded with "strongly agree" or "agree" to Q7 asking if "Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)"
BH-11: PC-NSMHS	Perception of Care with Respect to One's Cultural Background: NSMHS	AHRQ	Percent of people who completed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care and Health Outcomes (ECHO) Survey 3.0 for Managed Care Organizations (MCOs) (i.e., ECHO Survey) in a 12-month period who responded with

BHT Measure Acronym	BHT Measure Name	Measure Steward	Measure Description
			"Yes" to Q27 asking if "Care responsive to cultural needs"
SL-4: DEV-CH	Developmental Screening in the First Three Years of Life	OHSU	Percent of children 1 to 3 years of age enrolled in Medi-Cal or receiving other county BH services who are screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Appendix B. Age-Adjusted Weights

Two BHT performance measures are calculated as age-adjusted rates: People Who Died By Drug-Related Overdose (OD-1) and People Who Die By Suicide (SU-1). These age-adjusted rates are calculated via direct standardization to the 2000 U.S. Standard Population, the same methodology applied in CDPH's California Overdose Surveillance Dashboard. This method adjusts for differences in age distribution by multiplying age-specific rates in the population of interest by age-specific weights (adjustment factors) from the age distribution of the 2000 U.S. Standard Population.

For more detailed information, see the CDPH methodology for age adjustment.

The following table includes weights used to calculate age-adjusted rates for OD-1 and SU-1.

Table B.1: Age-Adjusted Weights (Adjustment Factors)

Age	2000 U.S. Standard Population	Adjustment weight
Age 10+ years	235,727,282	1.0000000000
10-11 years	8,258,281	0.0350331999
12 - 17 years	23,616,813	0.1001870161
18 - 20 years	12,038,802	0.0510708896
21 - 25 years	17,640,725	0.0748353133
26 - 34 years	33,812,338	0.1434383738
35 - 49 years	64,464,978	0.2734727073
50 - 64 years	41,185,865	0.1747182789
65 - 74 years	18,135,514	0.0769343024
75+ years	16,573,966	0.0703099186