CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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On May 1, 2020, the Centers for Medicare & Medicaid Services (CMS) published "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally Facilitated Exchanges, and Health Care Providers" (referred to as "CMS Interoperability and Patient Access Final Rule" and later in this document as the "Interoperability Final Rule") to further advance interoperability for Medicaid, Medicare, Exchange, and CHIP providers and improve beneficiaries' access to their data.

In California, one implication of the Interoperability Final Rule is that it **requires Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, hereafter referred to as Behavioral Health Plans (BHPs)**, to implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and be available through a public-facing digital endpoint on each BHP's website. Please reference Behavioral Health Information Notice (BHIN) 22-068 for more information regarding the requirements of the Patient Access and Provider Directory APIs.

Under Proposition 30, which was approved by voters in 2012, the state is obligated to share half of the increased non-federal share costs associated with implementing the federal mandates created by the Interoperability Final Rule. Federal and state general funds are available as of November 2022, and these FAQs provide additional information on how those dollars will be distributed and can be used by counties.

1. **Where is this funding coming from?**
   The funding was authorized in the governor's 2022-2023 budget, and the California Legislature appropriated funds to the California Department of Health Care Services (DHCS) to disburse to counties to support county compliance with the CMS Interoperability and Patient Access Final Rule.

2. **How much funding is available?**
   $67 million in total funds is available, composed of federal matching dollars ($29 million), state general funds ($19 million) and county share ($19 million).

3. **When will the funding be available?**
   The funding is available now through the routine process used by counties to secure quarterly or annual reimbursement for Medi-Cal direct and administrative expenditures.

4. **How can my county gain access to this funding?**
   MHPs and DMC-ODS counties can include on administrative claim forms expenditures attributable to the Interoperability Final Rule as they incur them. MHPs use Form 1982B, and DMC-ODS counties use form MC 5312 for administrative claiming. DHCS will reimburse counties for these expenses in the same manner as other plan costs per BHIN 22-049.

5. **Is the funding available on a first-come, first-served basis?**
   DHCS will reimburse counties the federal share of all costs incurred to implement the CMS Interoperability and Patient Access Final Rule. The $19 million in State General Funds appropriated to DHCS to reimburse counties half of the non-federal share of costs incurred to implement the CMS Interoperability and Patient Access Final Rule will be paid to counties on a first-come, first-served basis. Any counties that submit claims for reimbursement that are not reimbursed the state share of cost at the time the claim is processed will be reimbursed through the annual cost settlement process, which will include the state's half of the non-federal share costs associated with the expenditures.

6. **How much will each county be paid? Can any county draw down any amount?**
   Counties will receive dollars consistent with how much they have spent to implement the CMS Interoperability and Patient Access Final Rule; the state is obligated to reimburse the county 50% of the non-federal share of costs incurred.

7. **When will the county receive payments?**
   As with other expenses submitted on Form 1982B and form MC 5312, payment will take approximately 45-60 days after invoicing.

8. **What kinds of activities can be reimbursed?**
   Per BHIN 22-049, Proposition 30 requires the state to reimburse counties 50% of the non-federal share of increased costs to implement realigned programs that result from new requirements the federal government imposed after September 30, 2012. To that end, all direct and indirect costs the county incurs to come into compliance with this requirement may be submitted for reimbursement.

9. **I don't know where to start. Are there other resources available?**
   CMS has provided a Policies and Technology for Interoperability and Burden Reduction web page as well as an Interoperability Final Rule FAQ page with many resources for payers and providers. BHIN 22-068 provides information regarding interoperability requirements.

10. **When are counties supposed to be in compliance?**
    Counties should have been in compliance by January 1, 2022, per the Interoperability Final Rule. Managed care plans also have a requirement for compliance with this federal rule. Per BHIN 22-068, DHCS will begin verifying compliance after July 1, 2023.

11. **If this rule was finalized in 2020, why was so much time given for compliance?**
    CMS exercised enforcement discretion for the Patient Access API and Provider Directory API policies for Medicare Advantage, Medicaid, CHIP and QHP issuers on the Federally-facilitated Exchanges (FFEs) effective January 1 through July 1, 2021, and began enforcing these new requirements on July 1, 2021.

12. **Any other new rules or requirements I should know about?**
    In December 2022, CMS released the Interoperability and Prior Authorization Proposed Rule that would expand the requirements for electronic exchange of health information

between health plans, providers and patients through APIs. A proposed rule is merely that – a proposal, and CMS was accepting comments on it until March 13, 2023. It's helpful because it signals new data exchange requirements that may be forthcoming in final rulemaking. If finalized as written, the new rule would, among other things:

- Add requirements for payers to implement an API for use by in-network providers and an API for the exchange of data between payers, on top of existing requirements for a patient-facing API.
- Expand the specifications for currently required patient-facing APIs to include information on prior authorization.
- Adopt new response time requirements for prior authorization requests and a requirement to accept electronic prior authorization requests.

The proposed rule also contains a number of requests for information, including one on accelerating the adoption of standards related to social risk factor data and another on electronic exchange of behavioral health information.

13. With whom should we speak if we have additional questions?

Questions regarding claiming may be directed to BHFSOps@dhcs.ca.gov. Questions regarding implementing the DHCS interoperability policy consistent with BHIN 22-068 should be sent to CountySupport@dhcs.ca.gov.