DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: May 12, 2026

ALL PLAN LETTER 26-008

SUPERSEDES ALL PLAN LETTER 22-026

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: INTEROPERABILITY FINAL RULES, INCLUDING PRIOR AUTHORIZATION REQUIREMENTS

PURPOSE:

To provide information to all Medi-Cal managed care plans (MCPs)[1] regarding the Centers for Medicare and Medicaid Services' (CMS) interoperability requirements. This All Plan Letter (APL) supersedes APL 22-026.[2]

BACKGROUND:

In May 2020, CMS published the Interoperability and Patient Access Final Rule (CMS-9115-F).[3] The Department of Health Care Services (DHCS) issued APL 22-026 to MCPs on November 29, 2022, with guidance pertaining to this Final Rule, which required MCPs to implement and maintain standards-based Application Programming Interfaces (APIs) allowing Members or Members' Authorized Representatives (ARs) to request health information through an authorized third-party application (TPA) of their choice. CMS and the Assistant Secretary for Technology Policy[4] have established a series of technical standards and implementation specifications that govern such specific transactions.[5]

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[1] All MCPs, including Senior Care Action Network (SCAN).
[2] APLs can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[3] CMS Interoperability and Patient Access Final Rule (CMS-9115-F): https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.
[4] The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology oversees the Department of Health and Human Services' (HHS) strategies and policies on data, technology, interoperability, and artificial intelligence (AI).
[5] https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-and-standards/application-programming-interfaces-apis-and-relevant-standards-and-implementation-guides-igs.

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In January 2024, CMS released the Interoperability and Prior Authorization Final Rule (CMS-0057-F)[6], which sets the requirements for MCPs to improve the electronic exchange of health information and Prior Authorization processes for all items and services, excluding drugs, with implementation dates beginning as early as January 1, 2026.[7]

POLICY:

CMS-9115-F required that by January 1, 2021, MCPs implement and maintain a secure, standards-based Patient Access API in accordance with Title 42 Code of Federal Regulations (CFR) section 438.242(b)(5) and a publicly accessible standards-based Provider Directory API described at 42 CFR section 438.242(b)(6), including required policies, procedures, and publicly accessible documentation and resources. CMS-9115-F also requires impacted payers to comply with the public reporting and information blocking components of 45 CFR Part 171, where applicable.

CMS-0057-F requires that by January 1, 2026, MCPs must enhance Fast Healthcare Interoperability Resources (FHIR)® API infrastructure to align with newly adopted technology standards and specifications under 45 CFR section 170.213 and 45 CFR section 170.215; comply with mandatory Prior Authorization decision timeframes under 42 CFR section 438.210(d)[8]; communicate a reason for denial when denying a Prior Authorization request in accordance with 42 CFR section 431.80(a)[9]; and publicly report a list of all items and services that require Prior Authorization, as well as key metrics required under 42 CFR section 438.210(f). Additionally, CMS-0057-F requires impacted payers to report Patient Access API usage to CMS in accordance with 42 CFR section 438.242(b)(5)(iii).

CMS-0057-F requires that by January 1, 2027, MCPs must enhance the Patient Access API with information about Prior Authorizations for items and services in accordance with 42 CFR section 438.242(b)(9)(ii) and 42 CFR section 431.60(b)(5), excluding drugs; and must implement and maintain a secure, standard-based: Payer-to-Payer API, Provider Access API, and Prior Authorization API, under 42 CFR section 438.242(b)(7). Additionally, CMS-0057-F requires MCPs to publish Member and Provider education

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[6] CMS Advancing Interoperability and Improving Prior Authorization Processes (CMS-0057-F): https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[7] 89 Federal Register 8758-8988.

[8] MCPs are required to follow the authorization timeframes in APL 21-011, which meet or exceed the requirements set in 42 CFR section 438.210(d).

[9] As cross-referenced through 42 CFR section 438.242(b)(8).

resources as required at 42 CFR section 431.61(a)(4)(ii), 42 CFR section 431.61(a)(5), and 42 CFR section 431.61(b)(7).

In addition to these requirements, MCPs must also comply with 42 CFR section 438.242, 45 CFR section 170.215, the Provider Directory information specified in 42 CFR section 438.10, and the public reporting and information blocking components of the interoperability Final Rules to the extent these requirements are applicable to MCPs.[10]

I. Patient Access API

MCPs must implement and maintain a secure, standards-based Patient Access API as specified at 42 CFR section 438.242(b)(5). The Patient Access API must permit TPAs to retrieve, with the approval and at the direction of a Member[11] data specified in this APL using common technologies and without special effort from the Member.

MCPs must make the data that they maintain for dates of services on or after January 1, 2016, available to the Member, through the API, as follows:[12,13]

Type of Information	Time by Which Information Must be Accessible
Adjudicated claims data, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, Provider remittances, and Member cost-sharing pertaining to such claims.	Within one (1) business day after a claim is processed.
Encounter Data, including Encounter Data from any Network Providers compensated on capitation payments and adjudicated claims,	Within one (1) business day after receiving data from Providers.

[10] 42 CFR section 438.242(b)(7).
[11] When referencing the Member giving direction in this APL, it means the Member or their AR. An AR means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
[12] 42 CFR section 431.60(a-b) ;(h).
[13] 42 CFR section 438.242(b)(5)(ii). Noting that information about covered outpatient drugs is no longer required to be included as accessible content on the Patient Access API.

Type of Information	Time by Which Information Must be Accessible
and Encounter Data from any Subcontractors or Downstream Subcontractors.[14]	
All data classes and data elements as specified in 45 CFR section 170.213.[15] United States Core Data for Interoperability (USCDI) v1: This standard expires January 1, 2026; USCDI v3: Beginning January 1, 2026.	Within one (1) business day after receiving data from Providers.
Information about covered outpatient drugs and updates to such information, including formulary of prescription drugs, costs to the Member, and preferred drug list information, if applicable.	Within one (1) business day after the effective date of any such information or updates to such information.
Beginning January 1, 2027, the information about Prior Authorizations for items and services (excluding drugs)[16] as follows: • The Prior Authorization status. • The date the Prior Authorization was approved or denied. • The date or circumstance under which the Prior Authorization ends. • The items and services approved.	Be accessible no later than one (1) business day after the MCP receives a Prior Authorization request; Be updated no later than one (1) business day after any status change; and, Continue to be accessible for the duration that the authorization is active

[14] If the MCP does not reimburse Providers using risk-based capitation payments, then this requirement to include Encounter Data does not apply.

[15] 45 CFR section 170.213. USCDI is a standardized set of health data classes and component data elements for nationwide, interoperable health information exchange. Information about USCDI data is available at: https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.

[16] 42 CFR section 431.60(b)(6). Drugs are defined as any and all drugs covered by the state.

Type of Information	Time by Which Information Must be Accessible
• If denied, a specific reason why the request was denied. • Related structured administrative and clinical documentation submitted by a Provider related to Prior Authorizations.	and at least one (1) year after the Prior Authorization's last status change.

Reporting on Patient Access API Usage

Beginning in 2026, MCPs are required to report Patient Access API metrics on an annual basis, by no later than March 31st, for the previous calendar year. These metrics must be in the form of de-identified and aggregated data, which include:[17]

1. The total number of unique Members whose data are transferred via the Patient Access API to a health app designated by the Member, and
2. The total number of unique Members whose data are transferred more than once via the Patient Access API to a health app designated by the Member.

II. Provider Directory API

MCPs must implement and maintain a publicly accessible standards-based Provider Directory API as described in 42 CFR section 438.242(b)(6), and meet the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of Provider Directory information to particular persons or organizations. MCPs are required to update the online Provider Directory at least weekly after the MCP receives the Provider information or is notified of any information that affects the content or accuracy of the Provider Directory.[18]

[17] https://www.ecfr.gov/current/title-42/part-438/section-438.242#p-438.242(b)(5)(iii).
[18] See Health and Safety Code (H&S) 1367.27(e)(1), which also gives four examples of notice requiring a weekly update to the online Provider Directory which are also encompassed by "information that affects the content or accuracy of the Provider Directory." While 42 CFR sections 431.70 and 438.10(h)(3)(ii) also cover this topic, the weekly update requirement of the H&S governs MCPs in California.

The Provider Directory API must include the following information about the MCP's Provider types of Physicians, Specialists, Hospitals, Pharmacies, Mental Health and Substance Use Disorder Providers, Long Term Supports and Services Providers as appropriate, Enhanced Care Management (ECM) Providers, Community Supports Providers as appropriate, and any other Providers contracted for Covered Services:

- Name of Provider or site, and any group affiliation;[19]
- Name of medical group/foundation, independent physician/Provider association (IPA), if applicable;
- National Provider Identifier (NPI) number;
    - Practitioner (individual) NPI
    - Organization (Type 2) NPI, if applicable
- Street address(es);
- Telephone number(s), including the telephone number to call after business hours;
- Website URL for each service location or physician/Provider of affiliated group or IPA, as appropriate;
- Specialty, as appropriate;[20]
- Hours and days when each service location is open, including the availability of evening and/or weekend hours;
- Services and benefits available, including accessibility symbols approved by DHCS and whether the office/facility has accommodations for people with disabilities, including offices, exam room(s), and equipment;
- Cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered by the Provider or a skilled medical interpreter at the Provider's office, and if the Provider has completed cultural competency training;
- Whether the Provider is accepting new patients;

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[19] Provider group affiliation refers to the formal association or contractual relationship between an individual Provider (such as a physician, nurse practitioner, etc.) and a Provider group or medical group that contracts with an MCP.
[20] DHCS has created a site to house resources for MCPs, including the Taxonomy Crosswalk. To request access to the site, or request the current DHCS Taxonomy Crosswalk, email MCQMDNAU@dhcs.ca.gov.

- Whether the Provider is accepting new Children's Health Insurance Program (CHIP) patients;[21]
- Identification of Providers or sites that are not available to all or new Members;
- Link to the Medi-Cal Rx Pharmacy Locator, which can be found on the Medi-Cal Rx website described in APL 25-013;
- Whether the Provider offers Covered Services via Telehealth;[22,23] and
- Other relevant information, as required by the Secretary.

MCPs must update their Provider Directory API in accordance with 42 CFR section 438.10(h), H&S section 1367.27, the MCP Contract, and APL 25-014. MCPs must attest that they meet all Provider Directory API requirements as outlined in this APL during their next bi-annual submission or during their next monthly File and Use submission (whichever comes first). MCPs must continue to submit their bi-annual Provider Directory reviews to their Managed Care Operations Division (MCOD)-MCP Submission Portal[24]. Additionally, MCPs must continue to submit the monthly File and Use Provider Directories to their MCOD-MCP Submission Portal on months that fall outside of the month of their bi-annual review that are due to DHCS. MCPs must submit an attestation that they meet the Provider Directory API requirements from this APL during the aforementioned Provider Directory submissions.

DHCS' Provider Directory reviews will be reviewed biannually per the MCP Contract.[25] All requirements in the MCP Contract are subject to the annual medical audits. Any DHCS findings must be addressed by the MCP within the timeframe specified by DHCS.

III. Provider Access API

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[21] The following statement may be added to MCPs' Provider Directories in lieu of adding an indicator to each applicable Provider listed in the directory regarding Providers accepting new CHIP patients: "In California, the Children's Health Insurance Program (CHIP) is fully administered through the Medi-Cal program. All Providers who are contracted with a Medi-Cal Managed Care Plan (MCP) to serve pediatric Members also serve CHIP-funded children. There is no separate Network or distinction in service delivery between Medi-Cal and CHIP enrollees; both are covered under the same benefits, funding structure, and Provider access standards."
[22] 42 CFR section 438.10; MCP Contract, Exhibit A, Attachment III, Section 5.1 Member Services.
[23] These content requirements are consistent with the requirements of the MCP Contract and apply to an MCP's electronic Provider Directory and Provider Directory API.
[24] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.
[25] MCP Contract, Exhibit A, Attachment III, Section 7.0 Operations Deliverables and Requirements.

By January 1, 2027, MCPs must implement and maintain a secure, standards-based Provider Access API, in accordance with requirements specified at 42 CFR section 438.242(b)(7) and 42 CFR section 431.61(a).[26] The Provider Access API must permit Network Providers to request access to the data specified in this APL for Members that the MCP has attributed to a Provider.

Within one (1) business day of receiving a valid request from a Network Provider, MCPs must respond with the data that they maintain for dates of services on or after January 1, 2016, in accordance with 42 CFR section 431.61(a)(2).

The data required to be exchanged via the Provider Access API is as follows:

Type of Information	Time by Which Information Must be Accessible
Adjudicated claims data, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, excluding Provider remittances and Member cost-sharing information pertaining to such claims.	Within one (1) business day after a claim is processed.
Encounter Data, including Encounter Data from any Network Providers compensated on capitation payments and adjudicated claims, and Encounter Data from any Subcontractors and Downstream Subcontractors.	Within one (1) business day after receiving data from Providers.
All data classes and data elements as specified in 45 CFR section 170.213.[27]	Within one (1) business day after receiving data from Providers.

[26] Provider Access API Standards are specified at 45 CFR section 170.215(a)(1), (b)(1)(i), (c)(1), and (d)(1).
[27] 45 CFR section 170.213. USCDI is a standardized set of health data classes and component data elements for nationwide, interoperable health information exchange. Information about USCDI data is available at: https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.

Type of Information	**Time by Which Information Must be Accessible**
Information about covered outpatient drugs and updates to such information, including formulary of prescription drugs, costs to the Member, and preferred drug list information, if applicable.	Within one (1) business day after the effective date of any such information or updates to such information.
Information about Prior Authorizations for items and services (excluding drugs)[28] as follows: • The Prior Authorization status. • The date the Prior Authorization was approved or denied. • The date or circumstance under which the Prior Authorization ends. • The items and services approved. • If denied, a specific reason why the request was denied. • Related structured administrative and clinical documentation submitted by a Provider related to Prior Authorizations.	Be accessible no later than one (1) business day after the MCP receives a Prior Authorization request; Be updated no later than one (1) business day after any status change; and Continue to be accessible for the duration that the authorization is active and at least one (1) year after the Prior Authorization's last status change.

A valid request requires that all conditions at 42 CFR section 431.61(a)(2) are met, including:

[28] 42 CFR section 431.60(b)(6). Drugs are defined as any and all drugs covered by the MCP.

- The MCP authenticates the identity of the Provider that requests access and attributes the Member to the Provider under the MCP's established attribution process.
- The Member has not opted out of the Provider Access API exchange.
- Disclosure of the data is not prohibited by law.

Attribution

To comply with 42 CFR section 431.61(a)(2), MCPs must establish and maintain a process to attribute Members to Providers. Patient attribution is the method used to identify and verify a treatment relationship between a Member and a Provider through the use of existing clinical or administrative data. MCPs can use processes that they already have in place to attribute Members to their Providers. Processes may include, but are not limited to, utilizing claims data to establish a treatment relationship between a Member and a Provider; using existing Member rosters for individual Providers or organizations; or, for new Members, using an upcoming appointment to verify the Provider-Member treatment relationship.

Consent: Opt-Out Adherence

MCPs must also establish and maintain a process for Members to opt out of data exchange via the Provider Access API and to change their permission at any time. This process must be made available before the first date on which the MCP makes Member information available via the Provider Access API, and at any time while the Member is enrolled with the MCP.

Disclosure of Data

Rules of confidentiality for Member records associated with mental health or substance use disorder, such as 42 CFR Part 2[29], which may require Member consent to share with Providers, still apply.

IV. Payer-to-Payer API

[29] 89 Federal Register 8809: Confidentiality of Substance Use Disorder Patient Records 42 CFR Part 2.

By January 1, 2027, MCPs must implement and maintain a secure, standards-based Payer-to-Payer API in accordance with 42 CFR section 438.242(b)(7) and 42 CFR section 431.61(b)(1); (4-6); and (7)(ii-iii).[30]

Within one (1) business day of receiving a valid request as defined at 42 CFR section 431.61(b)(5), MCPs must respond with the data specified below[31] and at 42 CFR section 431.61(b)(4)(ii), that the MCP maintains with a date of service within five (5) years before the request.

Disclosure of Data

Rules of confidentiality for Member records associated with mental health or substance use disorder, such as 42 CFR Part 2, which may require Member consent to share with Providers, still apply.

Additionally, MCPs must request Member data from the Member's previous and concurrent payers[32] in accordance with 42 CFR section 431.61(b)(4) and (6), including the following data under 42 CFR section 431.61(b)(4)(ii), and MCPs must incorporate into their records about the Member any data made available by other payers in response to the request:

Type of Information	Time by Which Information Must be Accessible
Adjudicated claims data, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, excluding Provider remittances and Member cost-sharing information pertaining to such claims.	Within one (1) business day after a claim is processed.

[30] CMS requires DHCS to establish a process for obtaining opt-in permissions into the payer-to-payer data exchange. DHCS will collaborate with MCPs to develop and clarify the payer-to-payer opt-in process, including consents for 42 CFR Part 2 data to be exchanged and educational resources for Members. 89 Federal Register 8851.
[31] 42 CFR section 431.61(b)(5)(ii).
[32] The following are non-exhaustive examples of "previous" and "concurrent" payers: 1) When a Member moves to another plan, the MCP that was responsible for the Member's care would be a "previous payer"; 2) a Member's MCP would be the "concurrent payer" while receiving services from a MCP vice versa; and 3) Two non-integrated MCPs providing services to a Member at the same time would be considered "concurrent payers".

Type of Information	**Time by Which Information Must be Accessible**
Encounter Data, including Encounter Data from any Network Providers compensated on capitation payments and adjudicated claims, and Encounter Data from any Subcontractors and Downstream Subcontractors.	Within one (1) business day after receiving data from Providers.
All data classes and data elements as specified in 45 CFR section 170.213.[33]	Within one (1) business day after receiving data from Providers.
Information about covered outpatient drugs and updates to such information, including preferred drug list information, if applicable.	Within one (1) business day after the effective date of any such information or updates to such information.
Information about Prior Authorizations for items and services (excluding drugs)[34] as follows: • The Prior Authorization status. • The date the Prior Authorization was approved. • The date or circumstance under which the Prior Authorization ends. • The items and services approved.	Be accessible no later than one (1) business day after the MCP receives a Prior Authorization request; Be updated no later than one (1) business day after any status change; and Continue to be accessible for the duration that the authorization is active and at

[33] 45 CFR section 170.213. USCDI is a standardized set of health data classes and component data elements for nationwide, interoperable health information exchange. Information about USCDI data is available at: https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.

[34] 42 CFR section 431.60(b)(6). "Drugs" in this section are defined as any and all drugs covered by the MCP.

Type of Information	Time by Which Information Must be Accessible
• Related unstructured and structured administrative and clinical documentation submitted by a Provider pertaining to Prior Authorizations.	least one (1) year after the Prior Authorization's last status change.

To comply with 42 CFR section 431.61(b)(4) and 42 CFR section 431.61(b)(6), MCPs must have a process in place to verify that the Member has opted in to the Payer-to-Payer API exchange and that the disclosure of the data is not prohibited by law. When requesting Members' data from other payers, MCPs must include an attestation with the request affirming that the Member is enrolled with the MCP and has opted into the data exchange as required under 42 CFR section 431.61(b)(4)(iii).

The request for information must be completed in accordance with 42 CFR section 431.61(b)(4)(iv) and 42 CFR section 431.61(b)(6)(i), which stipulates that the request must be completed:

- No later than one (1) week after the payer has sufficient identifying information about previous payers and the Member has opted in;
- At a Member's request, within one (1) week of the request; and
- At least quarterly thereafter while the Member is enrolled with both payers.

V. Prior Authorization API

By January 1, 2027, MCPs must implement and maintain a secure, standards-based Prior Authorization API in accordance with 42 CFR section 438.242(b)(7) and 42 CFR section 431.80(b) that:

- Is populated with its list of covered items and services (excluding drugs, as defined in 42 CFR section 431.60(b)(6)) that require Prior Authorization;
- Identifies all documentation required by the MCP for approval of any items or services that require Prior Authorization;

- Supports a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Prior Authorization request and response, as described in 45 CFR Part 162[35,36]; and
- Communicates whether the MCP:
    - Approves the Prior Authorization request (and the date or circumstance under which the authorization ends);
    - Denies the Prior Authorization request (including a specific reason for the denial)[37]; or
    - Requests more information.

VI. Educational Resources

Member Educational Resources

In accordance with 42 CFR section 431.60(g), MCPs must provide, in an easily accessible location on their public websites and/or through other appropriate mechanisms through which they ordinarily communicate with current and former Members seeking to access their health information, educational resources in non-technical, simple, and easy-to-understand language explaining at a minimum:[38]

- General information on steps the Member may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application, including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and
- An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Health and Human Services Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to the OCR and FTC.

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[35] Plans must comply with all relevant privacy laws as they apply, including 42 CFR Part 2.
[36] https://www.cms.gov/files/document/discretion-x12-278-enforcement-guidance-letter-remediated-2024-02-28.pdf.
[37] 42 CFR section 431.80(b).
[38] For an overview of what is required to be included in an MCP's Member resource document, MCPs may refer to the Patient Privacy and Security Resources document developed by CMS. Use of this document is not required; it is to support MCPs as they produce Member resources tailored to their Member population. The document is available at: https://www.cms.gov/files/document/patient-privacy-and-security-resources.pdf.

- The benefits of Payer-to-Payer and Provider Access API data exchange, their opt-in and opt-out rights, their ability to change that permission, and instructions for doing so in accordance with 42 CFR section 431.61(a)(4) and 42 CFR section 431.61(b)(7).[39]

MCPs must tailor these Member educational resources to best meet the needs of their Member population, including literacy levels, languages spoken, conditions, etc., as required by APL 25-005. Per APL 25-009, MCPs must engage their Community Advisory Committees to review and provide input on the cultural, linguistic, and outreach appropriateness of these materials. MCPs may combine the educational resources about the Provider Access, Patient Access, and Payer-to-Payer APIs to give Members a holistic view of how interoperability policies work together to improve data exchange.

Provider Resources

In accordance with 42 CFR section 431.61(a)(5), MCPs must provide on their website and through other appropriate Provider communications, information in plain language explaining the process for Providers requesting Member data using the Provider Access API. The resources must include information about how to use the MCP’s attribution process to associate Members with their Providers.

VII. Improving Prior Authorization Processes

Contractual requirements pertaining to Utilization Management and Prior Authorization

MCPs are reminded that the MCP Contract contains provisions pertaining to Utilization Management and Prior Authorizations which should be considered when updating relevant systems and policies. For example, MCPs must develop, implement, update as needed (but at least annually), and improve their Utilization Management program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for their Members. In addition, MCPs are required to provide training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of contracting with a Network Provider. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, the MCP must ensure that

[39] 42 CFR section 431.61(b)(7)(ii) and 42 CFR section 431.61(b)(7)(iii).

Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization.[40]

Timeframes and Noticing Requirements

CMS-0057-F changed the timeframe for a standard Prior Authorization.[41] It also requires that decisions and the specific reason for denial are communicated within the decision timeframe.[42] For information on authorization timeframes and noticing requirements, see APL 21-011.[43]

Public Reporting of Prior Authorization Metrics

Beginning January 1, 2026, MCPs must make the following metrics publicly accessible by posting them on their website no later than March 31st of each year. These metrics must be reported at the plan level and include all items and services (excluding any and all drugs) from the previous calendar year:

1. A list of all items and services that require Prior Authorization;
2. The percentage of standard Prior Authorization requests that were approved, aggregated for all items and services;
3. The percentage of standard Prior Authorization requests that were denied, aggregated for all items and services;
4. The percentage of standard Prior Authorization requests that were approved after appeal, aggregated for all items and services;
5. The percentage of Prior Authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;
6. The percentage of expedited Prior Authorization requests that were approved, aggregated for all items and services;
7. The percentage of expedited Prior Authorization requests that were denied, aggregated for all items and services;
8. The average and median time that elapsed between the submission of a request and a determination for standard Prior Authorizations, aggregated for all items and services; and

[40] MCP Contract, Exhibit A, Attachment III. Section 2.3
[41] 42 CFR section 438.210(d).
[42] 42 CFR section 431.80(a) as cross-referenced at 42 CFR section 438.242(b)(8).
[43] APLs can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

9. The average and median time that elapsed between the submission of a request and a decision for expedited Prior Authorizations, aggregated for all items and services.[44]

VIII. Oversight and Monitoring

MCPs must review Prior Authorization metrics on at least a quarterly basis through their Quality Improvement Committee (QIC) or similar forum. MCPs are required to submit the aforementioned Prior Authorization metrics along with additional data to DHCS on a quarterly and annual basis, on a template provided by DHCS. This reporting fulfills the requirements of the Managed Care Program Annual Report (MCPAR) as required under 42 CFR section 438.66(e) and supports DHCS's oversight of MCP Utilization Management Systems. The annual report must include an analysis of Prior Authorization metrics and an assessment that identifies trends and systemic issues, as well as an explanation of how the MCP is addressing the trends and systemic issues identified, and actions taken as a result of the QIC reviews, such as implementing automated Prior Authorization approvals with high approval rates to streamline the process.

MCPs must ensure that data received from their Network Providers, Subcontractors, and Downstream Subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate. MCPs must make all collected data available to DHCS and CMS upon request.[45]

MCPs must ensure that the required content, for each mandated API, is maintained, kept up to date, and made accessible through the APIs in accordance with the timeframes stipulated in the federal regulations and this APL.

MCPs must ensure that mandated APIs remain conformant to adopted technical standards and specifications in accordance with 45 CFR section 170.215, where applicable, including the new versions of the implementation specifications required by January 1, 2026, which require the HL7® FHIR® US Core Implementation Guide STU 6.1.0 and the HL7® SMART App Launch Implementation Guide Release 2.0.0. MCPs may use an updated version of any standard or all standards under certain conditions specified at 42 CFR section 431.60(c)(4).

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[44] 42 CFR section 438.210(f).
[45] 42 CFR section 438.242(b)(3),(4).

MCPs must ensure APIs comply with the content and vocabulary standards requirements, as applicable to the data type or data element, unless alternate standards are required by other applicable law:

- Content and vocabulary standards at 45 CFR section 170.213, which requires United States Core Data for Interoperability Version 3 by January 1, 2026, where such standards are applicable to the data type or element, as appropriate; and
- Content and vocabulary standards at 45 CFR Part 162 and 42 CFR section 423.160, where required by law, or where such standards are applicable to the data type or element, as appropriate.[46]

MCPs must make publicly accessible, by posting directly on their website or via publicly accessible hyperlink(s), complete accompanying documentation for each implemented API that contains, at a minimum, the information listed below:

- API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;
- The software components and configurations an application must use in order to successfully interact with the API and process its response(s); and
- All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.[47]

MCPs must conduct routine testing and monitoring, and update their systems as appropriate, to ensure the APIs function properly, including conducting assessments to verify that the APIs are fully and successfully implementing privacy and security features such as those required to comply with the HIPAA Security Rule requirements in 45 CFR Parts 160 and 164, 42 CFR Parts 2 and 3, and other applicable laws protecting the privacy and security of individually identifiable data.[48]

MCPs must ensure that denial and/or discontinuation of any TPA's connection to an API occurs only when the organization reasonably determines, consistent with its security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective, verifiable criteria that are applied fairly and consistently across all applications and developers, through which parties seek

[46] 42 CFR section 431.60(c)(3).
[47] 42 CFR section 431.60(d)(1-3).
[48] 42 CFR section 431.60(c)(2).

to access electronic health information, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.[49]

The requirements in this APL necessitate a change in MCPs' contractually required policies and procedures (P&Ps). MCPs must submit their updated P&Ps to their MCOD Oversight SharePoint Submission Portal within 90 days of the release of this APL.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. This may include updated appropriate Network Agreements, Data Use Agreements, and Business Associates Agreements with Network Providers, Subcontractors, Downstream Subcontractors, and other third parties as appropriate. DHCS may impose enforcement actions, including Corrective Action Plans, as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider Agreements, Subcontractor Agreements, and/or Downstream Subcontractor Agreements as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007. Any failure to meet the requirements of this APL may result in enforcement actions.

MCPs must comply with the Patient Access API, Provider Directory API, Provider Access API, Payer-to-Payer API, Prior Authorization API, and Prior Authorization requirements outlined in this APL and must demonstrate their compliance by submitting deliverables as directed by DHCS.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Eric Lichtenberger

Eric Lichtenberger, Division Chief

Health Information Management Division

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[49] 42 CFR section 431.60(e).