CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: [Month] [Day], 2025

Behavioral Health Information Notice (BHIN) No:25-XXX
Supersedes BHIN No: 22-068

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Interoperability Requirements for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Plans.

PURPOSE: To notify all MHPs and DMC-ODS Plans about existing and updated Centers for Medicare and Medicaid Services (CMS) interoperability requirements.

REFERENCE: 85 Federal Register 25510-25640; 89 Federal Register 8758-8988.

BACKGROUND:
In May 2020, CMS finalized the Interoperability and Patient Access final rule (CMS-9115-F), which established members as the owners of their health information with the right to direct its transmission to third-party applications.[1] [2] CMS and the Assistant

[1] 85 Federal Register 25510-25640.
[2] Section 4003 of the Office of the National Coordinator for Health Information Technology 21st Century Cures Act defines "Interoperability" as health information technology that (1) enables the secure exchange and use of electronic health information without special effort on the part of the user; (2) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law; and (3) does not constitute information blocking as defined in section 3022(a) of the Public Health Service Act.

Secretary for Technology Policy have established a series of technical standards and implementation specifications that govern such specific transactions.[3]

In January 2024, CMS published the Interoperability and Prior Authorization final rule (CMS-0057-F), which advances interoperability and improves prior authorization processes by requiring impacted payers, including but not limited to Medicaid managed care plans, to implement and maintain certain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Application Programming Interfaces (APIs). The new API policies build on the technological foundation of CMS-9115-F and seek to improve the electronic exchange of interoperable healthcare data for members, providers, and payers; streamline prior authorization processes; and improve care coordination. CMS requires certain operational provisions and API enhancements to be implemented beginning January 1, 2026, and the implementation of Provider Access, Payer-to-Payer and Prior Authorization APIs and Patient Access API enhancement by January 1, 2027.[4] [5]

This information notice supersedes BHINs 22-068 and communicates the API requirements outlined in CMS-9115-F and the provisions of CMS-0057-F final rule.

POLICY:
CMS-9115-F required that by January 1, 2021 impacted payers, including MHPs and DMC-ODS Plans, collectively referred to hereafter as Behavioral Health Plans (BHPs), must 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, impacted payers, including BHPs, enhance 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)[6]; communicate a reason for denial when denying a prior authorization

[3] The data exchange standards for the . CMS mandated APIs: https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-and-standards/application-programming-interfaces-apis-and-relevant-standards-and-implementation-guides-igs.
[4] 89 Federal Register 8758-8988.
[5] Relevant Standards and Implementation Guides (IGs) for CMS required APIs are located here: APIs and Relevant Standards IGs.
[6] BHPs are required to follow the authorization timeframes in BHINs 22-016, 22-017 and 24-001 which meet or exceed the requirements set in 42 CFR § 438.210 (d). Please see the policy below.

request in accordance with 42 CFR 438.242(b)(8) and 42 CFR section 431.80(a); 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 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, impacted payers, including BHPs, enhance the Patient Access API with information about prior authorizations for items and services in accordance with 42 CFR section 431.60(b)(5), excluding drugs, and implement and maintain a secure, standard-based: Provider Access API, Payer-to-Payer API, and Prior Authorization API, under 42 CFR section 438.242(b)(7). Additionally, CMS-0057-F requires impacted payers to publish member and provider education resources as required at 42 CFR 438.242, 42 CFR section 431.61(a)(4)(ii), 42 CFR section 431.61(a)(5) and 42 CFR section 431.61(b)(7).

Patient Access API

BHPs must implement and maintain a secure, standards-based Patient Access API as specified at 42 CFR section 438.242(b)(5) and 42 CFR section 431.60. The Patient Access API must permit third-party applications to retrieve data specified in this BHIN, with the approval and at the direction of a member or the member's authorized representative, using common technologies and without requiring special effort from the member.

BHPs must make data that they maintain for dates of services on, or after, January 1, 2016, available to the member or their authorized representative, through the API, as follows:[7] [8]

Type of Information	**Time by Which Information Must be Accessible**
Adjudicated claims data, including claim data for payment decisions that may be appealed, were appealed, or 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.

[7] 42 CFR section 431.60(a-b) ;(h).

[8] Prior authorization information for covered outpatient drugs is not required to be made available on the Patient Access API.

Type of Information	Time by Which Information Must be Accessible
Encounter data from providers compensated on the basis of risk-based capitation payments, as defined in 42 CFR section 438.2[9]	Within one (1) business day after receiving data from providers.
All data classes and data elements as specified in 45 CFR section 170.213[10]: 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)[11] 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.	Be accessible no later than one (1) business day after the BHP 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.

[9] If the BHP does not reimburse providers using risk-based capitation payments, then this requirement to include encounter data does not apply.
[10] 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.
[11] 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
• Related structured administrative and clinical documentation submitted by a provider related to prior authorizations.	

Reporting on Patient Access API Usage

Beginning in 2026, a BHP must report to DHCS the following plan-level metrics, on an annual basis, for the previous calendar year. These metrics must be in the form of de-identified and aggregated data:

- The total number of unique members whose data is transferred via the Patient Access API to a health app designated by the member; and
- The total number of unique members whose data is transferred more than once via the Patient Access API to a health app designated by the member.[12] [13]

Provider Directory API

BHPs must implement and maintain a publicly accessible standards-based Provider Directory API as described under 42 CFR section 438.242(b)(6) and 42 CFR section 431.70 that meets the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization. BHPs are required to update the Provider Directory API by no later than 30 calendar days after the BHP receives the provider information or is notified of a change.[14] Refer to BHIN 25-026 for updated provider directory information requirements.

Provider Access API

By January 1, 2027, BHPs 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)[15]. The Provider Access API must permit in-network providers to request access to the data specified in this BHIN for members that the BHP has attributed to a provider.

Within one (1) business day of receiving a valid request from an in-network provider, BHPs must respond with the data that they maintain for dates of services on or after

[12] 42 CFR section 431.60(f)(2).
[13] DHCS will report these metrics to CMS via the MCPAR report.
[14] 42 CFR section 431.70 and 42 CFR section 438.10(h)(3)(ii).
[15] Provider Access API Standards are specified at 45 CFR section 170.215(a)(1), (b)(1)(i), (c)(1), and (d)(1).

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 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 from providers compensated on the basis of risk-based capitation payments, as defined in 42 CFR section 438.2.[16]	Within one (1) business day after receiving data from providers.
All data classes and data elements as specified in 45 CFR section 170.213:[17] 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.
Information about prior authorizations for items and services (excluding drugs)[18] as follows: • The prior authorization status.	Be accessible no later than one (1) business day after the BHP receives a prior authorization request;

[16]If the BHP does not reimburse providers using risk-based capitation payments, then this requirement to include encounter data does not apply.
[17] 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.
[18] 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
• 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 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:

- The BHP authenticates the identity of the provider that requests access and attributes the member to the provider under the BHPs' 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), BHPs 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. BHPs may utilize claims data to establish a treatment relationship between a member and a provider, existing member rosters for individual providers or organizations, or for new members, proof of an upcoming appointment to verify the provider-member treatment relationship. BHPs can use processes that they already have in place to attribute members to their providers.

Provider Resources
In accordance with 42 CFR section 431.61(a)(5) BHPs must provide on its 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 BHPs attribution process to associate members with their providers.

Consent: Opt-Out Adherence
BHPs must also establish and maintain a process for members or their personal representatives 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 BHP makes member information available via the Provider Access API, and at any time while the member is enrolled in Medi-Cal.

Disclosure of Data
Rules of confidentiality for member records associated with mental health or substance use disorder member, such as 42 CFR Part 2[19], which may require patient consent to share with providers, will still apply.

Payer-to-Payer API
By January 1, 2027, BHPs 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); (b)(7)(ii-iii)[20].

Within one (1) business day of receiving a valid request as defined at 42 CFR section 431.61(b)(5), BHPs must respond with the data specified below and at 42 CFR section 431.61(b)(4)(ii), that the BHP 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 member, such as 42 CFR Part 2, which may require patient consent to share with providers, will still apply.

Additionally, BHPs must request member data from the member's previous and concurrent payers[21] in accordance with 42 CFR section 431.61(b)(4);(6) including the following data under 42 CFR section 431.61(b)(4)(ii) and BHPs must incorporate into its records about the member, any data made available by other payers in response to the request:[22]

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[19] 89 Federal Register 8809: Confidentiality of Substance Use Disorder Patient Records 42 CFR Part 2
[20] CMS requires DHCS to establish a process for obtaining opt-in permissions into the payer-to-payer data exchange. DHCS will collaborate with BHPs 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.
[21] The following are non-exhaustive examples of "previous" and "concurrent" payers: 1) When a member moves to another county, the BHP that was responsible for the member's care in the previous county would be a "previous payer". 2) a member's MCP would be the "concurrent payer" while receiving services from a BHP and vice versa. 3) Two non-integrated BHPs providing services to a member at the same time would be considered "concurrent payers".
[22] 42 CFR section 431.61(b)(4)(v).

Type of Information	**Time by Which Information Must be Accessible**
Adjudicated claims data, including claim data for payment decisions that may be appealed, were appealed, or in the process of appeal, *excluding* provider remittances, and member cost-sharing pertaining to such claims.	Within one (1) business day after a claim is processed.
All data classes and data elements as specified in 45 CFR section 170.213: 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 preferred drug list information, if applicable.	Within one (1) business day after the effective date of any such information or updates to such information.
Encounter data from providers compensated on the basis of risk-based capitation payments, as defined in 42 CFR section 438.2.[23]	Within one (1) business day after receiving data from providers.
Beginning January 1, 2027, the information about prior authorizations for items and services (excluding drugs)[24] as follows: • The prior authorization status. • The date the prior authorization was approved. • The date or circumstance under which the prior authorization ends.	Be accessible no later than one (1) business day after the BHP 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

[23] If the BHP does not reimburse providers using risk-based capitation payments, then this requirement to include encounter data in the Patient Access API does not apply.
[24] 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
• The items and services approved. • 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), BHPs 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, BHPs must include an attestation with the request affirming that the member is enrolled with the BHP 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.
- At least quarterly thereafter while the member is enrolled with both payers.

Prior Authorization API

By January 1, 2027, BHPs 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 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.
- Can identify all documentation required by the BHP 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.[25]

[25] Plans must comply with all relevant privacy laws as they apply, including 42 CFR Part 2. Statement of Enforcement Discretion for Referral Certification and Authorization Transaction Standard at 45 CFR § 162.1302 for HIPAA Covered Entities Subject to the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) that Implement an AI.

- Communicates whether the BHP:
  - 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); or
  - Requests more information.[26]

Educational Resources

Member Resources
In accordance with 42 CFR section 431.60(g), BHPs 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:[27]

- 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.
- 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. Educational resources must be provided to members according to the information requirements of 42 CFR section 438.10.
- 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).[28]

BHPs 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.

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[26] 42 CFR section 431.80(b).
[27] CMS developed a resource to assist BHPs in meeting this requirement, the Patient Privacy and Security Resources-Supporting Payers Educating their Patients document. It includes an overview and sample content to meet these requirements. Use of this document is not required; it is to support BHPs 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.
[28] 42 CFR section 431.61(b)(7)(ii) and 42 CFR section 431.61(b)(7)(iii).

Prior Authorization: Communicating a Reason for Denial

Beginning January 1, 2026, if the BHP denies a prior authorization request (excluding a request for coverage of drugs)[29] the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.[30]

Prior Authorization: Decision Timeframes

BHPs are required to follow the decision timeframes for prior authorization in 22-016, 22-017 and 24-001, which either meet or exceed the standard decision timeframes that CMS-0057-F established at at42 CFR section 438.210(d), beginning January 1, 2026. BHPs shall continue to follow the timeframes in 22-016, 22-017 and 24-001.

Publicly Reporting of Prior Authorization Metrics

Beginning January 1, 2026, BHPs following each calendar year must make the following data from the previous calendar year publicly accessible by posting them on its website by March 31st:

- A list of all items and services that require prior authorization;
- Total standard prior authorization requests received;
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services;
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services;
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services;
- 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;
- Total expedited prior authorization requests received;
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;
- Total standard and expedited prior authorization requests received;
- The average and median time that elapsed between the submission of a request and a determination by the BHP for standard prior authorizations, aggregated for all items and services; and

[29] As defined in 42 CFR section 431.60(b)(6).
[30] 42 CFR section 431.80(a).

- The average and median time that elapsed between the submission of a request and a decision by the BHP for expedited prior authorizations, aggregated for all items and services.[31]

Oversight and Monitoring

BHPs must ensure that data received from their network providers and 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. BHPs must make all collected data available to DHCS and CMS, upon request.[32] BHPs 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.

BHPs 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. BHPs may use an updated version of any standard or all standards under certain conditions specified at 42 CFR section 431.60(c)(4).

BHPs 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.[33]

BHPs 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 where such standards are applicable to the data type or element, as appropriate; and
- (ii) 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.[34]

[31] 42 CFR section 438.210(f), 2025 MCPAR Template D1.XIII.1 - D1.XIII.15
[32] 42 CFR section 438.242(b)(3), 42 CFR section 438.242(b)(4).
[33] 42 CFR section 431.60(c)(2).
[34] 42 CFR section 431.60(c)(3).

API Documentation
BHPs must make complete accompanying documentation for each implemented API publicly accessible, either by posting it directly on their website or via a publicly accessible hyperlink, and ensure it includes , 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.[35]

Denial or Discontinuation of Access to the API
BHPs must ensure that denial and/or discontinuation of any third-party application'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 to access electronic health information, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.[36]

COMPLIANCE:
BHPs shall update policies and procedures to ensure compliance with this policy. DHCS may impose a corrective action plan, as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see BHIN 25-023, or any of its subsequent iterations, on this topic.

BHPs must comply with the Patient Access API, Provider Directory API, Provider Access API, Payer-to-Payer API, Prior Authorization API, and prior authorization requirements and must demonstrate compliance by submitting deliverables as directed by DHCS. DHCS will release guidance at a later time communicating the deliverables that will be required to demonstrate compliance with the requirements of this information notice.

[35] 42 CFR section 431.60(d)(1-3).
[36] 42 CFR section 431.60(e).

Claiming

DHCS will reimburse MHPs and DMC-ODS Plans for administrative expenses related to Interoperability. In addition to the federal reimbursement of administrative expenses, the state reimburses counties 50% of the non-federal share of increased costs to implement new federal requirements. Counties can claim these expenses on the "Prop 30 Federal" line on either the DHCS 5312 DMC Administrative Claim form or the DHCS 1982 (b) SMHS Administrative Claim form found on the MedCCC website.

If you have any questions regarding this BHIN, please contact your county support liaison or countysupport@dhcs.ca.gov.

Sincerely,

Original signed by

Michele Wong, Division Chief
Behavioral Health Oversight and Monitoring Division