CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: June 24, 2026

ALL PLAN LETTER 26-006
SUPERSEDES ALL PLAN LETTER (APL) 22-013

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: INTEROPERABILITY FINAL RULES REQUIREMENTS FOR DENTAL MANAGED CARE PLANS

PURPOSE:

The purpose of this All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide guidance to all Dental Managed Care Plans (Dental MCPs) about existing and updated Centers for Medicare and Medicaid Services (CMS) Interoperability requirements. This APL supersedes APL 22-013 Interoperability and Patient Access Final Rule.[1][2]

BACKGROUND:

In May 2020, CMS finalized the Interoperability and Patient Access Final Rule (CMS-9115-F). DHCS issued APL 22-013 to Dental MCPs on November 30, 2022, with guidance pertaining to the CMS-9115-F Final Rule[3], which required impacted payers, including but not limited to Medicaid managed care plans, to implement and maintain standards-based Application Program Interfaces (API) allowing Members or their 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]

[1] All Plan Letters (APLs) can be found here: https://www.dhcs.ca.gov/services/Pages/DentalAllPlanLetters.aspx

[2] Dental Managed Care Contract can be found here: https://www.dhcs.ca.gov/services/Documents/MDSD/DMC-Boilerplate-Contract-2025.pdf

[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).

have established a series of technical standards and implementation specifications that govern such specific transactions.[5]

In January 2024, CMS released the Interoperability and Prior Authorization Final Rule[6] (CMS-0057-F), which sets the requirements for Dental 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, Dental MCPs implement and maintain a secure, standards-based Patient Access API[8] and a publicly accessible standards-based Provider Directory API[9], including required policies, procedures, and publicly accessible documentation and resources. CMS-9115-F also required 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, Dental MCPs must enhance their Fast Healthcare Interoperability Resources (FHIR)® API infrastructure to align with newly adopted technology standards and specifications[10]; comply with mandatory Prior Authorization decision timeframes[11]; communicate a reason for denial when denying a Prior Authorization request[12]; and publicly report a list of all items and services that

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[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
[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]CFRs are searchable here: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438 Title 42 Code of Federal Regulations (CFR) section 438.242(b)(5).
[9] 42 CFR section 438.242(b)(6).
[10] 45 CFR section 170.213 and 45 CFR section 170.215.
[11] 42 CFR section 438.210(d).
[12] 42 CFR section 431.80(a).

require Prior Authorization as well as key metrics required[13]. Additionally, CMS-0057-F requires impacted payers to report Patient Access API usage to CMS.[14]

CMS-0057-F requires that by January 1, 2027, Dental MCPs must enhance the Patient Access API with information about Prior Authorizations[15] for items and services and must implement and maintain a secure, standard-based: Payer-to-Payer API, Provider Access API and Prior Authorization API[16]. Additionally, CMS-0057-F requires Dental MCPs to publish Member and Provider education resources.[17]

In addition to these requirements, Dental 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 Dental MCPs[18].

Dental MCPs must comply with all applicable CMS Interoperability requirements. Below is a summary of the Interoperability requirements:

A. Patient Access API

Dental MCPs must implement and maintain a secure, standards-based Patient Access API[19]. The Patient Access API must permit TPAs to retrieve, with the approval and at the direction of a Member[20], or Member's authorized representative, data specified in this APL through the use of common technologies and without special effort from the Member.

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[13] 42 CFR section 438.210(f).
[14] 42 CFR section 438.242(b)(5)(iii).
[15] 42 CFR section 431.60(b)(5).
[16] 42 CFR section 438.242(b)(7).
[17] 42 CFR section 431.61(a)(4)(ii) and 42 CFR section 431.61(a)(5).
[18] 42 CFR section 438.242(b)(7)
[19] 42 CFR section 438.242(b)(5).

[20] When referencing the Member giving direction in this APL, it means the Member or their authorized representative (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.

Dental MCPs 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 in Table 1:[21]

Table 1: Patient Access API

Type of Information	Time by Which Information Must be Accessible
Adjudicated claims, including claims 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.
All data classes and data elements included in a content standard in 45 CFR section 170.213[22]: 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 the data.
Encounter Data, including Encounter Data from any Network Providers compensated on capitation payments and adjudicated claims and encounter data	Within one (1) business day after receiving data from Providers.

[21] 42 CFR section 431.60(a-b) ;(h) and 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.

[22] 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
from any Subcontractors or Downstream Subcontractors.[23]	
Beginning January 1, 2027, the information about Prior Authorizations for items and services (excluding drugs) as follows[24]: • 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 Dental 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.

Reporting on Patient Access API Usage

Beginning in 2026, Dental MCPs are required to report Patient Access API metrics on an annual basis, by March 31 for the previous calendar year. The following metrics must be reported to DHCS in the form of aggregated, de-identified 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.

[23] If the Dental MCP does not reimburse providers using risk-based capitation payments, then this requirement to include encounter data does not apply.
[24] 42 CFR section 431.60(b)(6)

B. Provider Directory API

Dental MCPs must implement and maintain a publicly accessible standards-based Provider Directory API[25] that meets the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization that restrict the availability of Provider Directory information to particular persons or organizations. Dental MCPs are required to update the online Provider Directory at least weekly after the Dental MCP receives the Provider information or is notified of any information that affects the content or accuracy of the Provider Directory.[26] Please refer to the Dental MC Contract[27] and APL 25-010[28] or any superseding APL for Provider Directory requirements. If a Dental MCP Plan is currently maintaining an electronic Provider Directory on their website and is meeting the required Provider Directory data elements above, then the Dental MCP may copy the information to the Provider Directory API. If any of the required data elements are missing from the electronic Provider Directory, the Dental MCP must take the appropriate steps to ensure the Provider Directory API includes all required data elements.

Dental MCPs must update their Provider Directory API in accordance with 42 CFR section 438.10(h), Health and Safety Code section 1367.27, the Dental MCP Contract, APL 25-010 and any subsequent iterative APLs.

C. Provider Access API

[25] 42 CFR section 438.242(b)(6) and 42 CFR section 431.70

[26] Health and Safety Code section 1367.27(e)(1), requires weekly updates to the online Provider Directory when informed of certain changes in information that affect the content or accuracy of the Provider Directory. 42 CFR sections 431.70(b)(1) and 438.10(h)(3)(ii) state that the Provider Directory must be updated no later than 30 calendar days after receiving updated provider information. The federal regulations set a minimum timeframe for updates to the Provider Directory. Where the state and federal laws reference the required updates for the same materials, DHCS must follow the shorter weekly requirement found in Health and Safety Code section 1367.27(e)(1).

[27] The Dental MC Contract can be found here: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/DMC-Boilerplate-Contract-2025.pdf

[28] APL 25-010 Provider Directory can be found here: https://www.dhcs.ca.gov/wp-content/uploads/2025/12/APL-25-010-Provider-Directory.pdf

By January 1, 2027, Dental MCPs must implement and maintain a secure, standards-based Provider Access API[29] [30]. The Provider Access API must permit in-network Providers to request access to the data specified in this APL for Members that the Dental MCP has attributed to a Provider.

Within one (1) business day of receiving a valid request from an in-network Provider, Dental MCPs must respond with data that they maintain for dates of services on or after January 1, 2016.[31] The data required to be exchanged via the Provider Access API is as follows in Table 2:

Table 2: Provider Access API

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.
All data classes and data elements specified in 45 CFR section 170.213.[32]	Within one (1) business day after receiving data from Providers.
Encounter data, including Encounter Data from any Network Providers compensated on capitation payments[33] and adjudicated claims and Encounter Data from any Subcontractors.	Within one (1) business day after receiving data from Providers.

[29] 42 CFR section 438.242(b)(7) and 42 CFR section 431.61(a).
[30] Provider Access API Standards are specified at 45 CFR § 170.215(a)(1), (b)(1)(i), (c)(1), and (d)(1).
[31] 42 CFR section 431.61(a)(2).
[32] 45 CFR § 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.
[33] 42 CFR section 438.2.

Type of Information	Time by Which Information Must be Accessible
Information about Prior Authorizations for items and services (excluding drugs) 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 Dental 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 Prior Authorization is active and at least one (1) year after the Prior Authorization's last status change.

A valid request requires that all of the following conditions[34] are met, including:

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

Attribution

To comply with 42 CFR section 431.61(a)(2), Dental 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. Dental MCPs can use processes that they already have in place to attribute members to their Providers, processes may include but not be limited to utilizing claims data to establish a treatment relationship

[34] per 42 CFR 431.61(a)(2).

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
Dental MCPs 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 Dental MCP makes member information available via the Provider Access API, and at any time while the Member is enrolled in Medi-Cal with the Dental MCP.

Disclosure of Data
Rules of confidentiality for Member records associated with sensitive data, including mental health or substance use disorder, such as 42 CFR Part 2[35], which may require patient consent to share with providers, will still apply.

D. Payer-to-Payer API

By January 1, 2027, Dental MCPs must implement and maintain a secure, standards-based Payer-to-Payer API[36].

Within one (1) business day of receiving a valid request[37], Dental MCPs must respond with the data specified[38] as listed in Table 3, that the Dental 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[39], which may require patient consent to share with providers, will still apply.

[35] 89 Federal Register 8809: Confidentiality of Substance Use Disorder Patient Records 42 CFR Part 2.
[36] 42 CFR 431.61(b)(1), (4-6), (7)(ii);(iii) as cross-referenced in 42 CFR 438.242(b)(7).
[37] 42 CFR section 431.61(b)(5).
[38] 42 CFR section 431.61(b)(4)(ii).
[39] 89 Federal Register 8809: Confidentiality of Substance Use Disorder Patient Records 42 CFR Part 2

Additionally, Dental MCPs must request member data from the member's previous and concurrent payers[40] [41] including the following data under 42 CFR section 431.61(b)(4)(ii) and Dental MCPs must incorporate into their records about the Member, any data made available by other payers in response to the request as described in Table 3:

Table 3: Payer-to-Payer API

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[42]	Within one (1) business day after receiving data from Providers.
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.

[40] 42 CFR section 431.61(b)(4) and (6).

[41] The following are non-exhaustive examples of "previous" and "concurrent" payers: 1) When a Member moves to another plan, the Dental MCP that was responsible for the Member's care would be a "previous payer". 2) a Member's Dental MCP would be the "concurrent payer" while receiving services from a Dental MCP vice versa; and 3) Two non-integrated Dental MCP's providing services to a Member at the same time would be considered "concurrent payers".

[42] 45 CFR § 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 Prior Authorizations for items and services (excluding drugs)[43] 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. • Related unstructured and structured administrative and clinical documentation submitted by a Provider pertaining to Prior Authorizations.	Be accessible no later than one (1) business day after the Dental 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.

Dental 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.[44] When requesting members' data from other payers, Dental MCPs must include an attestation with the request affirming that the member is enrolled with the Dental MC[45] and has opted into the data exchange.

The request for information must be completed[46]:

- 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.

E. Prior Authorization API

[43] 42 CFR § 431.60(b)(6). Drugs are defined as any and all drugs covered by the Dental MCP.
[44] 42 CFR section 431.61(b)(4) and 42 CFR 431.61(b)(6)
[45] 42 CFR section 431.61(b)(4)(iii).
[46] 42 CFR section 431.61(b)(4)(iv) and 42 CFR section 431.61(b)(6)(i).

By January 1, 2027, Dental MCPs must implement and maintain a secure, standards-based Prior Authorization API[47] [48] that:

- Is populated with its list of covered items and services (excluding drugs[49]) that require Prior Authorization.
- Identifies all documentation required by the Dental MCP for approval of any items or services that require Prior Authorization[50].
- Supports a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Prior Authorization request and response.[51] [52]
- Communicates whether the Dental 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); or
  - Requests more information.

F. Educational Resources

Member Resources

In accordance with 42 CFR 431.60(g), Dental 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:[53]

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[47] CMS FAQs for Prior Authorization API can be found here: https://www.cms.gov/priorities/burden-reduction/overview/interoperability/frequently-asked-questions/prior-authorization-api

[48] 42 CFR section 438.242(b)(7) and 42 CFR section 431.80(b).

[49] 42 CFR section 431.60(b)(6)).

[50] CMS Prior Authorization and pre-Claim Review initiatives can be found here: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives

[51] 45 CFR Part 162. Plans must comply with all relevant privacy laws as they apply, including 42 CFR Part 2.

[52] https://www.cms.gov/files/document/discretion-x12-278-enforcement-guidance-letter-remediated-2024-02-28.pdf.

[53] For an overview of what is required to be included in a Dental MCP's Member resource document, Dental 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 Dental MCPs as they

- 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.
- 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[54].

Dental 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[55] and any subsequent iterative APLs on this topic. Dental MCPs must engage their Community Advisory Committees to review and provide input on the cultural, linguistic, and outreach appropriateness of these materials. Dental MCPs must combine the educational resources regarding 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

Dental MCPs 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[56]. The resources must include information about how to use the Dental MCPs' attribution process to associate Members with their Providers.

G. Improving Prior Authorization Processes

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.

[54] 42 CFR section 431.61(a)(4) and 42 CFR section 431.61(b)(7)

[55] APL 25-006 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats and its Attachments can be found here: https://www.dhcs.ca.gov/services/dental-managed-care-all-plan-letters/

[56] CFR section 431.61(a)(5).

As specified in the Contract, Dental MCPs are required to continue to develop, implement and update relevant systems and policies as they pertain to Utilization Management and Prior Authorizations. In addition to existing contractual requirements[57] the Dental MCP must implement the following updates:

Timeframes and Noticing Requirements

CMS-0057-F changed the timeframe for a standard Prior Authorization[58] [59] [60]. It also requires that decisions and the specific reason for denial are communicated within the decision timeframe. For information on authorization timeframes and noticing requirements, please see the Dental MCP Contract and APLs on this topic.

Public Reporting of Prior Authorization Metrics

Beginning January 1, 2026, Dental MCPs following each calendar year must make the following metrics for all items and services (excluding any and all drugs) from the previous calendar year publicly accessible by posting them on its website by March 31[61]:

- A list of all items and services that require Prior Authorization.
- 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.
- 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.

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[57] Dental MCP Contract Exhibit A7, Sections 1-5, Exhibit A5, Section 5, 6, 8, and 9; APL 18-002
[58] 42 CFR 438.210(d).
[59] 42 CFR 431.80(a) as cross-referenced at 42 CFR 438.242(b)(8).
[60] Dental MCP Contract Exhibit A7, section 3 – Timeframes for Dental Authorization and Exhibit A15, section 4 – Authorization Timeframes and Adverse benefit Determination
[61] Prior Authorization Metrics Reporting – CMS overview can be found here: https://www.cms.gov/files/document/prior-authorization-metrics-reporting-overview-template.pdf

- The average and median time that elapsed between the submission of a request and a determination by the Dental MCP for standard Prior Authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the Dental MCP for expedited Prior Authorizations, aggregated for all items and services.

H. Oversight and Monitoring

As specified in the contract, Dental MCPs are required to ensure all components required by federal law including CMS-9115-F and CMS-0057-F are implemented in accordance with the timeframes of the Final Rules.

Dental MCPs must review prior authorization metrics on at least a quarterly basis through their Quality Improvement Committee (QIC) or similar forum. Dental MCPs are required to submit prior authorization metrics along with additional data to DHCS on a cadence and template determined by DHCS. Dental MCPs submit an annual report including an analysis of Prior Authorization metrics and an assessment that identifies trends and systemic issues, as well as an explanation on how the Dental 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 on a date specified by DHCS.

Dental 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. Dental MCPs must make all collected data available to DHCS and CMS, upon request.[62]

Dental 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.

Dental MCPs must ensure that mandated APIs remain conformant to adopted technical standards and specifications[63], where applicable, including the new versions of the

[62] 42 CFR section 438.242(b)(3),(4).
[63] 45 CFR section 170.215.

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. Dental MCPs may use an updated version of any standard or all standards under certain conditions[64].

Dental 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[65] where such standards are applicable to the data type or element, as appropriate; and
- Content and vocabulary standards[66] where required by law, or where such standards are applicable to the data type or element, as appropriate.[67]

Dental MCPs must make publicly accessible, by posting directly on its 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.[68]

Dental 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 in 45 CFR parts 160 and

[64] 42 CFR section 431.60(c)(4).
[65] 45 CFR section 170.213.
[66] 45 CFR Part 162 and section 423.160 of this chapter.
[67] 42 CFR § 431.60(c)(3).
[68] 42 CFR § 431.60(d)(1-3).

164, 42 CFR parts 2 and 3, and other applicable laws protecting the privacy and security of individually identifiable data.[69]

Dental MCPs must ensure that denial and/or discontinuation of any TPAs in connection to an API occurs only when the organization reasonably determines, consistent with their 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, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.[70]

Dental MCPs shall 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.

REQUIREMENTS:
If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a Dental MCP's contractually required policies and procedures (P&Ps), the plan must submit its updated P&Ps with and without Track Changes to DHCS' Medi-Cal Dental Services Division (MDSD) at dmcdeliverables@dhcs.ca.gov within 90 days prior to implementation of each component in the CMS Interoperability Final Rule.

If a Dental MCP determines that no P&P changes are necessary, the Dental MCP must submit an email confirmation to dmcdeliverables@dhcs.ca.gov. Dental MCPs are responsible for ensuring that their Subcontractors, Network Providers, and Downstream Subcontractors 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 Dental MCP to all Subcontractors, Network Providers, and Downstream Subcontractors.

Any failure to meet the requirements of this APL may result in a Corrective Action Plan (CAP) and/or monetary sanctions. For information regarding administrative and

[69] 42 CFR section 431.60(c)(2).
[70] 42 CFR § 431.60(e).

monetary sanctions, see Dental MCP Contract, APL 22-009[71], and any subsequent iterative APLs on this topic.

If you have any questions regarding this APL, please contact the MDSD at dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by

Dana Durham
Chief, Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure: Interoperability Application Programming Interface (API) Templates

- Interoperability API Endpoint Directory Template_V.03
- Interoperability API Usage and Outcomes Report_V.03

[71] APLs can be found at: https://www.dhcs.ca.gov/services/Pages/DentalAllPlanLetters.aspx