SANTA CRUZ COUNTY
Behavioral Health Services

POLICIES AND PROCEDURE MANUAL

Subject: Patient Access & Availability Application Programming Interface (API) Requirements

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Responsible for Updating: Information Technology (IT) & BH Administration

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Date

BACKGROUND:

In May 2020, CMS finalized the Interoperability and Patient Access final rule (CMS Interoperability Rule), which seeks to establish beneficiaries as the owners of their health information with the right to direct its transmission to third-party applications.[1][2] CMS and the Office of the National Coordinator for Health Information Technology have established a series of data exchange standards that govern such specific transactions.[3]

Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021) implements various components of the CalAIM initiative, including those components in Welfare and Institutions Code (W&I) section 14184.100, et seq., and Health and Safety Code section 130290 to implement the California Health and Human Services Data Exchange Framework, including the CMS Interoperability Rule. The Department of Health Care Services is authorized to develop and implement Article 5.51 of the W&I Code and the requirements of the California Health and Human Services Data Exchange Framework.[4] This Santa Cruz County Behavioral Health policy supports this implementation.

SCOPE:

This policy applies to all IT staff, vendors, and partners involved in the development, maintenance, and management of the Patient Access and Provider Directory APIs at Santa Cruz County Behavioral Health.

[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.
[3] The data exchange standards for the Patient Access Application Programming Interface; CARIN Implementation Guide; Payer Data Exchange for US Drug Formulary; Provider Directory Application Programming Interface.
[4] W&I section 14184.102(d); HSC section 130290(j).

PURPOSE:

The purpose of this policy is to provide information regarding when a beneficiary can access health information through a third-party application. Various types of data may require several system exchanges before it is available in a personal application, such as healthcare claims.

DEFINITIONS:

1. **MyAvatar:** MyAvatar™ Netsmart Technologies is the electronic health record (EHR) system that supports Santa Cruz County Behavioral Health Services (BHS). Staff who provide services document the service information in MyAvatar, which was specifically designed for organizations that provide behavioral health and substance use treatment services.

POLICY / PROCEDURES:

1. **Data Updates in MyAvatar:**
   Healthcare claims and payment information is sent as an electronic submission from healthcare providers to health insurance companies (payors). These claims may be referred to as an "835 file." Santa Cruz County Mental Health Plan and Substance Use Disorder Treatment Plan (DMC-ODS) submit claims to Medi-Cal and other insurance plans for the services provided to beneficiaries through MyAvatar Cal-Practice Management (PM).

2. **Claims (or an "835" file) Information:**
   a. Information Included:
      i. What charges were paid/reduced/denied.
      ii. Deductible/co-insurance/co-pay amounts.
      iii. Bundling and splitting of claims, and how the payment was made.
   b. Only data electronically received and posted via a claim will be listed in the Explanation of Benefits (EOB) resource and available for electronic viewing.
      i. In MyAvatar Cal-PM, data will be available once the claim / 835 file has been posted in the "835 Health Claim Payment/Advice" form.
      ii. Once a medical claim is submitted for processing and payment, this data will be available.

3. **Data Availability for Access Through an Application**:

Patient records will be updated within the following timelines:	
Data Type	**Timeframe**
Adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, provider remittances and beneficiary cost-sharing pertaining to such claims.	Within one (1) business day after a claim is processed.

Encounter data.	No later than one (1) business day after receiving the data from providers, other than MCOs, PIHPs, and PAHPs, compensated on the basis of capitation payments.
Clinical data, including diagnoses and related codes, and laboratory test results.	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 beneficiary, 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.

PRIOR VERSIONS: None

REFERENCES: CMS Interoperability Rule & CMS Interoperability Specifications, Assembly Bill (AB) 133, Welfare and Institutions Code (W&I) section 14184.100, et seq., Health and Safety Code section 130290, Cures Act, CARIN Implementation Guide

FORMS/ATTACHMENTS: None