Scripps
Health Plan Services

Newsletter

FEBRUARY 2025 – 1ST QUARTER EDITION

SHPS MATRICES

SHPS Institutional Matrix 2025 SHPS Professional Matrix 2025

Please note: Prospect Health Plan has replaced Optum Care as the MSO for Mercy Physicians Medical Group.

SCRIPPS CARE LINK

Scripps Care Link is our online web portal where you can check Scripps Health Plan member eligibility, enter referral requests, check the status of your referral requests, and view claims. Contracted providers can send in-basket messages to SHPS departments and retrieve remittance advices. Please complete form and email to ProviderRelations@scrippshealth.org.

Care Link Access Request form

For password resets and unlocking your Scripps Care Link account please call the IS Service Desk, 858-678-7500.

Please keep us updated with staff who are no longer with your group/facility and were issued access to Scripps Care Link. For security purposes, we want to make sure only current active staff have access to our portal.

ELECTRONIC FUNDS TRANSFER (EFT)

Complete the EFT Enrollment form Electronic-funds-transfer.pdf and return your signed form to SHPS by fax (858)260-5851 or email to ProviderRelations@scrippshealth.org

A prerequisite is being able to retrieve your ERAs (835 files) via one of our Clearinghouses, Office Ally, or Change.

Once your Vendor EFT is activated, paper Remittance Advices (RAs) will no longer be provided by SHPS.

RAs should be available electronically via your clearinghouse or through Scripps Care Link. Confirm your EFT is active and contact Providers Relations to report any issues.

PROVIDERS/GROUPS TERMINATING THEIR CONTRACTS

Scripps Health Plan Services (SHPS) requests a minimum of ninety (90) days written notice when providers are seeking to terminate their contracts with SHPS. This allows time to coordinate and ensure members (patients) receive the sixty (60) day notice. In addition, to ensure continuity of care for our members (patients), we request the terminating provider indicate the desired provider for whom all open referrals should be reissued to.

REMINDER: Please email ProviderRelations@scrippshealth.org when someone has joined or left your practice.

SENATE BILL 137

Senate Bill 137 defines strict requirements for the accuracy of both online search tools and the provider directory for payors and practitioners in California. The law requires that medical groups and/or plans validate the provider information below once or twice a year based on your contracted Status.

Update your information by completing a Provider Demographic Update Form under Directory Updates on the SHPS Website.

MEDICAL BILLING TIPS/CPT MODIFERS

SHPS has received a few questions about **Multiple Procedures modifiers 51 and 59; and Bilateral Procedures modifier 50.**

It is important to remember some key points when you are coding submissions.

CMS may not require **modifiers 51, 59, or 50** since their hard-coded logic allows the claims payment reductions on multiple and/or bilateral procedures to adjust payment automatically, per guidelines.

The processing of **modifiers 51, 59, and 50** by any other carrier besides CMS is determined by the carrier. SHPS requires these modifiers to be present on the claim for it to be processed accurately which results in faster reimbursement.

PAYMENTS

Scripps Health Plan Services and Scripps Health Plan will pay claims at the lesser of its billed charges or at the negotiated rate and/or fee schedule whichever is less.

Scripps Health Plan Services and Scripps Health Plan will not be responsible for paying any amount that exceeds the billed charges.

SERVICE FEE

A $15 service fee will apply for copies of Canceled Checks or Remittance Advice effective 7/1/2023.

Once payment is received a copy will be issued.
Please consider signing up for Scripps Care Link and EFT to access copies and avoid the service fee.

LANGUAGE ASSISTANCE PROGRAM

State and federal law requires that health plans establish a **Language Assistance Program for limited English proficient members.** Providers are required to assist members in accessing language services made available by each health plan. Providers can access a qualified medical language interpreter for office appointments or other member encounters by contacting the member's health plan.

To request interpreter or translation services for SHP members, contact SHP's Customer Service by calling **(844) 337-3700** or TTY **(888) 515-4065**. Face-to-face interpreter service requests must be submitted at least five (5) days prior to an appointment. Should an interpreter not be available for face-to-face services, health plans can also arrange for telephone interpreting services. Scripps Clinic and Coastal providers also have access to interpreters through in-office **Blue Phones** or may contact their Operations Supervisor for assistance.

For SHPS Managed Care members, you can contact SHPS Managed Care Customer Service at **(888) 680-2273** for assistance.

TRAINING

Scripps Health Plan is committed to fostering multicultural diversity and promoting health equity. This allows everyone the opportunity to be as healthy as possible regardless of race, ethnicity, age, gender, location, socioeconomic status or other demographic factors. Below are resources to assist you in providing culturally and linguistic appropriate services.

Education - Think Cultural Health

PROVIDER OPERATIONS MANUALS

SHP Manual SHPS Manual

ELIGIBILITY AND CLAIMS STATUS AUTOMATED PHONE SYSTEM FOR PROVIDERS

Our **automated phone system** allows for a quick check of claims status and Scripps Health Plan HMO eligibility status for one or more patients 24 hours a day, 7 days a week. Using this system saves you valuable time on the phone and offers a convenient self-serve option at any time of day. If you are in need to speak to a live agent, they are available Monday-Friday 8 a.m. – 5 p.m. SHP (844) 337-3700, SHPS (888) 680-2273.

To check **Scripps Health Plan HMO member eligibility**, please have the following information ready:

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- Your Tax ID number
- Member ID number (example: SH012345601 – you will input numbers only 012345601)
- Member date of birth

The system will provide the following **eligibility information**:

- Medical Group and PCP
- Coverage Information
- Effective and Term dates
- List of copays
- Maximum out of pocket limit (met/not met)

To check **claims status** for any of our managed care members, please have the following information ready:

- NPI associated with the claim (vendor or rendering provider NPI)
- Member Date of Birth
- Date of Service associated with the claim
- Billed Amount associated with the claim
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The system will provide the following **claims information**:

- Claim Status
- If claim paid: claim number, paid amount, patient responsibility, check number, and check date
- If claim denied: claim number, received date, and denied date
- If claim is pending: claim number and received date

SPOTLIGHT ON SHPS UTILIZATION MANAGEMENT – REFERRAL REQUESTS

Prior Authorization Guide
The following services do not require authorization:

- Emergency room services
- Family planning services (abortion, FDA approved contraceptive devices)
- STD services and testing
- Vasectomy services
- Basic prenatal care
- Preventative care (immunizations, annual physicals)
- Routine labs, x-rays
- FDA approved biomarker testing for members with stage III/IV metastatic cancer

All other services may be subject to prior approval. In network and out of network services are evaluated based on medical criteria. Utilization patterns are reviewed to guide prior authorization rule sets to ensure administrative efficiency is maintained.

Services should be scheduled and rendered after an approved referral is received (excludes emergent services).

Effective February 2025, approximately 200 CPT codes will auto-approve (will no longer be reviewed) and approximately 200 codes will no longer auto-approve (will be reviewed by SHPS UM clinicians prior to making a decision). When services auto-approve, a decision is available immediately when the referral is submitted in Scripps Care Link.

Important reminders:

- **Referral requests should be made electronically through Epic or Scripps Care Link**. Do not fax referral requests unless absolutely necessary (e.g., system issues, waiting for Scripps Care Link access).
- **The Authorization Change Request form is no longer in use**
- **There are regulated timeframes for making referral decisions are below**:

CATEGORY	COMMERCIAL TIMEFRAMES	MEDICARE TIMEFRAMES
Routine	Within five (5) business days of receipt	Within fourteen (14) calendar days of receipt
Urgent	Within seventy-two (72) hours of receipt	Within seventy-two (72) hours of receipt
Routine Pharmacy	Within seventy-two (72) hours from the receipt of request	Within seventy-two (72) hours from the receipt of request
Urgent Pharmacy	Within twenty-four (24) hours from the receipt of request	Within twenty-four (24) hours from the receipt of request

- **Approved referrals cannot be modified** due to regulatory requirements. If you need to add a CPT code, please submit a new referral request.
- **Request a peer-to-peer meeting with a physician reviewer**. The physician reviewer name and direct telephone number is printed on all referral denial letters.

- **Physician reviewers are not financially incentivized**, motivated, or otherwise rewarded for issuing denials of requested health services and are not offered any financial incentives that would encourage underutilization of services.
- **Need help to coordinate language interpreter services?** Call our SHPS Customer Service department to assist at 888-680-2273 (MSO members) or 844-337-3700 (Scripps Health Plan members).
- **If you are unable to obtain a timely referral** to an appropriate provider for a member, you may contact the member's health plan for assistance (see the "Managed Care Grievance Process" section of this newsletter for plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and a TDD line (877-688-9891) for the hearing and speech impaired, as well as an internet website www.dmhc.ca.gov.

POST-STABILIZATION CARE

Notification is required within 24 hours of admission for all Scripps Health Plan Services Managed Care Members

For Emergent Medical Admissions or Transfers	**Call Scripps Centralized Transfer Center at (858) 678-6205**

If you do not obtain authorization to provide post-stabilization care to a member, neither Scripps Health Plan Services nor the member will be held financially responsible for any unauthorized care provided by the hospital.

Your facility cannot balance bill our members.

ACCESS TO CARE STANDARDS

Access Standards: As a contracted provider, you are required to comply with the regulatory standards regarding access to care and services for our members. The following standards are monitored on an ongoing basis:

SCRIPPS HEALTH EXPRESS (SHEX) SITES RECENTLY CLOSED:

- SHEX Vista
- SHEX Solana Beach
- SHEX Torrey Pines

COVID-19

For COVID-19 related information, including FAQs, testing, and vaccine information, visit Scripps Health's dedicated COVID-19 webpage.

NON-EMERGENT APPOINTMENT ACCESS STANDARDS-MEDICAL

Appointment Type	Time-Elapsed Standard
Non-urgent appointments for Primary Care Physician (PCP)	Must offer the appointment within ten (10) business days of request.
Non-urgent appointments with Specialist physicians (SPC)	Must offer the appointment within fifteen (15) business days of request.
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within forty-eight (48) hours of request. (Weekends and holidays included).
Urgent Care appointments that require prior authorization (such as an urgent appointment with a Specialist)	Must offer the appointment within ninety-six (96) hours of request.
Follow-up appointment with a non-physician mental health or substance use disorder (MHSUD) provider for those undergoing a course of treatment	Must offer the appointment within ten (10) business days following prior appointment.
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within fifteen (15) business days of request.

The timeframes for obtaining out-of-network specialty services if needed are consistent with the timeframes for obtaining in-network specialty services as outlined in the table above.

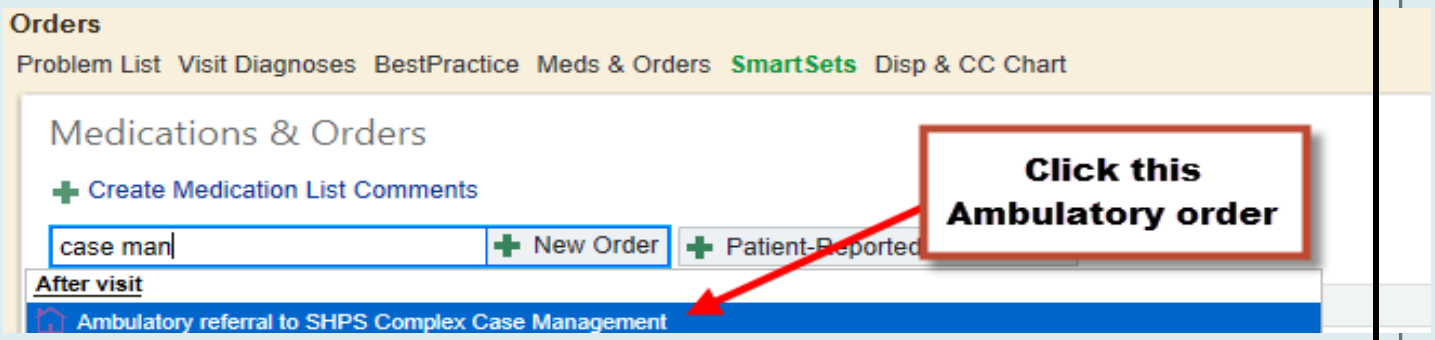
If you are unable to obtain a timely referral to an appropriate provider for a member, you may contact the member's health plan for assistance (see the "Managed Care Grievance Process" section of this newsletter for the plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and TDD line (877-688-9891) for the hearing and speech impaired, as well as an internal website www.dmhc.ca.gov.

SHPS COMPLEX CARE MANAGEMENT

Complex Care Management (CCM) is a team of highly trained registered nurses and social workers who are available to assist you and your patients to reach their health care goals. At no cost to your patient, we are here to provide that extra level of support to overcome health and social challenges. CCM partners with you and your patients to develop a customized care management plan of care, connection to available community resources, education on complex health conditions and help navigating through the health care system. CCM offers the extra level of support needed by developing a one-to-one relationship with your patient through telephonic and video outreach. In addition to complex cases with co-morbid conditions and high utilization, the CCM team offers specialty focus areas including:

- Three (3) or more admissions within a 12-month period
- Two (2) or more emergency room visits in a 6-month period
- Re-admission within 30 days with the same or similar diagnosis or condition
- Poly-pharmacy utilization consisting of more than 30 prescriptions
- Cancer diagnosis requiring multiple treatment modalities with complex care coordination across multiple disciplines
- Major organ transplant/ Major trauma
- High Risk OB/ High Risk Pediatric
- Minimum of one (1) complex condition with high risk for hospitalization or two (2) or more conditions expected to last at least 12-months.

Did you know that anyone can make a referral to our Care Management Program? Referrals can be made via: **Epic: Ambulatory Order #210 (Ambulatory referral to SHPS Complex Care Management)**



- Email: shcmreferrals@scrippshealth.org
- Voicemail: 888-399-5678
- Fax: 858-260-5834
- CM Referral Form

MATERNITY PROGRAM

The Maternity Program helps you:

- Coordinate your care to help you manage your pregnancy.
- Get specialized care if you have a high-risk pregnancy.
- Prepare for a new baby.
- Support and coordinate your postpartum care.
- Offer support if you are dealing with a pregnancy loss.
- Manage family planning decisions.
- Learn about breastfeeding and resources.
- Provide a recommendation for doula services.
- Get connected with a doula.

Scripps Health Plan offers doula services as part of our efforts to improve access to pregnancy care. Our goal is a healthy outcome for parent and baby.

One of the other key aspects of a doula is to ensure mother and baby are supported in the social conditions that may affect their overall health, or their social determinants of health.

Continuous doula support during the pregnancy journey may lead to improved health outcomes and offer additional social, emotional, and physical supports for the pregnant and birthing person. Studies have demonstrated that support from non-clinical providers, such as doulas, is associated with lower cesarean rates, fewer obstetric interventions, fewer complications, lower use of pain medication, shorter labor, higher rates of breastfeeding and higher scores on the Apgar test.

With a referral, our members are eligible for the following doula services:

- One (1) initial visit with your doula.
- Up to eight (8) additional visits; these can be a combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two (2) three-hour postpartum visits.
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Members can get doula services up to 12 months after the end of pregnancy.

PREVENTATIVE HEALTH & WELLNESS

Free benefits for our patients that make a difference

Our patient's health is our top priority. We encourage our practitioners to recommend our patient's take advantage of the many preventive care services that are available to them at no additional charge when scheduled with an in-network provider.

- Well-baby and well-child (up to age 18) physical exams, immunizations and related laboratory services
- Well-adult physical exams, immunizations and related laboratory services
- Routine gynecological exams, immunizations and related laboratory services
- Screenings for: breast cancer, cholesterol, cervical cancer, colorectal cancer, depression, diabetes, hypertension, obesity, prostate cancer, sexually transmitted infections, tobacco and alcohol use/misuse
- Adult Immunization Schedule by Age | Vaccines & Immunizations | CDC
- Child and Adolescent Immunization Schedule by Age | Vaccines & Immunizations | CDC
- National Guideline Clearinghouse
- Autism Spectrum Disorder in Your Children: Screening

Wellness tips and resources

- https://www.scripps.org/health-and-wellness

You also have access to the wellness solution library by clicking on the link below.

The wellness solution library includes decision making aids that provide information about treatment options and outcomes. We encourage you to use these decision-making aids during the treatment decision process, including during discussions with your patients.

- https://scrippshealthib.staywellsolutionsonline.com/Library/Encyclopedia/

NONPHARMACOLOGICAL PAIN MANAGEMENT TREATMENT

Information regarding the benefits and uses of nonpharmacological pain management treatment is available at https://www.scripps.org/services/integrative-medicine/integrative-pain-management.

POTENTIAL QUALITY ISSUES (PQI)

A PQI is any suspected provider quality of care or service issue that has the potential to impact the level of care being provided to the enrollee/patient. Providers may include independent physicians, medical groups, hospitals, nurses, ancillary providers, and their staff as well as health plan staff.

Please see PQI Referral forms and PQI frequently asked questions below.

Scripps Health Plan : SHP PQI Referral Form SHP PQI FAQ

Scripps Health Plan Services: SHPS PQI Referral Form SHPS PQI FAQ

MANAGED CARE GRIEVANCE PROCESS

Scripps Health Plan Services is not delegated for grievances by any of the major health plans except for Scripps Health Plan (HMO) when we are the Plan. **Refer the patient to contact their health plan directly.**

Patient may file a complaint by call customer service, submit via mail, or use online grievance form. They can find the Health Plan contact information on the insurance identification card. (See below).

Health Plan Name	Phone Number	Link to Appeals and Grievances Form
Anthem Blue Cross	1-800-331-1476	https://www.anthem.com/ca/forms/
Blue Shield	1-800-393-6130	https://www.blueshieldca.com/bsca/bsc/public/member/mp/login
Cigna	1-800-997-1654	https://www.cigna.com/individuals-families/member-resources/appeals-grievances
Health Net	1-800-675-6110	https://www.healthnet.com/content/healthnet/en_us/members.html
United Healthcare	1-866-414-1959	https://www.uhc.com/member-resources/forms
SCAN	1-800-559-3500	How to Complete a Grievance (scanhealthplan.com)
Scripps Health Plan (HMO)	1-844-337-3700	www.scrippshealthplan.com Grievance and Appeal Process - Scripps Health Plan

CREDENTIALING AND RECREDENTIALING PROCESS FOR CONTRACTED PROVIDERS

As a provider, you have the right to:

- Nondiscrimination during the credentialing process
- Confidentiality of all information submitted during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you
- Review information submitted to support your credentialing application, with the exception of references, recommendations and peer-review protected information
- Be informed of the status of your application upon request, you can email the Credentialing Department at SHPSCRED@scrippshealth.org
- Receive notification of the credentialing decision within 60 days of the SHP's decision
- Receive notification of your rights as a provider to appeal an adverse decision made by SHP
- Be informed of the above rights.

Credentialing and recredentialing is required for all contracted providers, practitioners and allied health care professionals (for example, physician assistants and nurse practitioners) and health delivery organizations providing services to SHPS members. The Quality Improvement staff, as part of the credentialing and recredentialing process, may perform site visits and medical record reviews. Providers will be contacted in advance if a site visit or audit is needed

Please review your Provider Manual or call your Provider Relations Specialist if you have any questions regarding the above.

Provider's Right to Notification and Corrections of Erroneous Information

SHP will notify you, the Provider, in writing, in the event that SHP receives conflicting information. Areas where variation from information provided may occur include, but are not limited to, actions on a license; malpractice claims history or board certification. SHP is not required to reveal the source of information that was not obtained to meet verification requirements. A notification to you will identify the information in question and the apparent conflict.

You have the right to correct erroneous information within thirty (30) calendar days of receiving notification from SHP by submitting a written response to:

Scripps Health Plan
Attention: Credentialing 4S-300
10790 Rancho Bernardo Road
San Diego, California 92127

You are required to explain any discrepancy and include any proof that may be available in order to support your request. Please be advised that any failure to honestly, fully and completely provide information can be used to recommend and adverse credentialing decision, even if you correct your response. If you do not respond within thirty (30) calendar days of notification, your application will be considered withdrawn, and processing will be discontinued. Upon receipt of any response from you, SHP may re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the credentials file. You will be notified in writing of any correction has been made to the credentials file. If the primary source information remains inconsistent, the Credentialing Department will notify you.

SHPS COMPLIANCE PLAN

Providers can view the SHPS Compliance Plan on the SHP website under SHP Forms, Credentialing & Dispute Resolution and the SHPS website under SHPS Provider Resources.

HOW TO REPORT COMPLIANCE CONCERNS

There are multiple ways to report compliance concerns, including potential fraud, waste, and abuse incidents:

- Notify your supervisor or manager.
- Notify SHPS Compliance Department: SHPSCompliance@scrippshealth.org.
- Notify SHPS Chief Compliance Officer: Pantovic.Linda@scrippshealth.org or **858-927-5360.**
- Report via the Scripps Health Compliance and Patient Safety Alertline (online or by phone **1-888-424-2387**). You can also choose to report anonymously.

MEDICAL RECORD DOCUMENTATION STANDARDS

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. There are specific elements that reflect a set of commonly accepted standards for medical record documentation. Providers will be required to meet minimum documentation standards to continue participation in the SHPS network. This includes electronic medical record (EMR) documentation. SHPS conducts periodic audits and ongoing oversight of documentation to ensure compliance with such standards. Medical record documentation audit activities are often directed to the PCP; however, audits of other practitioners and ancillary providers will be conducted as directed by the SHPS Compliance Department as a result of claims trends, suspected fraud, waste, or abuse, documentation issues, and/or as directed by any of our Scripps Health Plan Services Committees. Please refer to the "Medical Record Documentation Standards - Tip Sheet" available via the SHP and SHPS websites under SHP Forms, Credentialing & Dispute Resolution or SHPS Provider Resources.

OIG/GSA/STATE EXCLUSION CHECKS

SHPS is prohibited from hiring, contracting, or making payments to any person or business that is excluded or debarred from federal health care programs. All applicable individuals and entities, including providers, are checked against the Office of Inspector General ("OIG") and General Services Administration ("GSA") federal exclusion lists and the consolidated State of California Medi-Cal Suspension Lists prior to hire or contracting, and monthly thereafter.

NON-DISCRIMINATION IN HEALTH CARE

SHPS requires providers to deliver services to members without regard to race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Provider offices, facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act (ADA). The Health Industry Collaborative Effort (HICE) has prepared Better Communication, Better Care: Provider Tools to Care for Diverse Populations. Provider guidance on civil rights is also available on the U.S. Department of Health and Human Services (HHS) website.

Providers are expected to disclose complaints of discrimination to SHPS. If you or a member believe that SHPS has failed to provide language services or has discriminated against an individual in another way, a grievance may be submitted to the SHPS Appeals & Grievances Department by mail, phone, fax, email, or online:

Scripps Health Plan Services
Attn: Appeals & Grievances Department
10790 Rancho Bernardo Rd., 4S-300
San Diego, CA 92127
Phone: (844) 337-3700 TTY: (888) 515-4065
Fax: (858) 260-5879
www.scrippshealthplan.com
Email: SHPSAppealsAndGrievancesDG@scrippshealth.org

The U.S. Department of HHS, Office for Civil Rights (OCR) also accepts complaints of discrimination electronically through the OCR Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by phone at (800) 368-1019 TDD: (800) 537-7697, or by mail at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

LEGISLATIVE UPDATES

There are several state bills that are effective this year that may impact you. The information below is a summary of these legislative bills.

#	Bill	Bill Summary	Effective Date
1	**AB 1842 - Medication-assisted treatment**	•Plans must provide coverage for at least one medication approved by the US FDA in each of the following categories without prior authorization, step therapy, or utilization review: (1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist. (2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product. (3) A long-acting buprenorphine product. (4) A long-acting injectable naltrexone product.	1/1/2025
2	**AB 1936 - Maternal Mental Health Screenings**	•Plans' maternal mental health program must consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider.	1/1/2025
3	**AB 2105 - Coverage for PANDAS and PANS**	•Plans must provide coverage for prophylaxis, diagnosis, and treatment for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed/ordered by the treating physician/surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. •Plans must authorize PANDAS/PANS prophylaxis, diagnosis, or treatment to be provided in a timely manner appropriate for the severity of the enrollee's condition pursuant to Section 1367.03. •Plans must not deny/delay coverage for PANDAS/PANS therapies if the enrollee previously received treatment, including the same or similar treatment, for PANDAS or PANS, or if the enrollee was diagnosed with or received treatment for their condition under a different diagnostic name, including autoimmune encephalopathy. •Plans must not limit coverage of immunomodulating therapies for PANDAS/PANS that is inconsistent with the treatment recommendations pursuant to Section 1367.38(d) nor require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies.	1/1/2025

4	**AB 2129 - Immediate Postpartum Contraception**	•Plans must authorize providers who separately submits a bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center.	1/1/2025
5	**AB 2258 - Health Care Coverage: Cost Sharing**	•Plans are prohibited from imposing any cost-sharing requirements for items or services that are integral to the provision of an item/service that is set forth in Section 1367.002(a)(1)-(4), regardless of whether or not the integral item/service is billed separately from an item or service required by Section 1367.002. •Plans are prohibited from imposing cost-sharing for office visits associated with a preventive care service described in Section 1367.002 if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service. •Plans are required to cover items/services in accordance with applicable requirements, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.	1/1/2025
6	**AB 2556 - Behavioral Health and Wellness Screenings: Notice**	•Plans must provide an annual written or electronic notice to enrollees regarding the benefits of a behavioral health and wellness screening (i.e., depression and anxiety) for children and adolescents 8 to 18 years of age.	1/1/2025
7	**AB 3059 - Human Milk**	•Plans must cover the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) as a basic health care service.	1/1/2025
8	**AB 3221 - DMHC: Review of Records**	•Plans, management companies, solicitors, solicitor firms, and any providers or subcontractors providing health care/services to a plan, management company, solicitor, or solicitor firm must open their records, books, and papers at the request of a DMHC inspection, including through electronic means.	1/1/2025
9	**SB 729 - Health Care Coverage: Treatment for Infertility and Fertility Services**	•Plans must provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate. •Plans must cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.	7/1/2025
10	**SB 1180 - Health Care Coverage: Emergency Medical Services**	•Plans must establish a process to reimburse services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program. •Plans are prohibited from requiring enrollees who receive covered services from the aforementioned to pay more than the in-network cost-sharing amount for the same covered services received from a contracting community paramedicine program, triage to alternate destination program. •Plans are prohibited from adopting reimbursement rates that exceed the Plan's usual and customary charges for services rendered.	7/1/2025
11	**AB 2843 - Health Care Coverage: Rape and Sexual Assault**	•Plans must provide coverage for emergency room medical care and follow-up health care treatment for enrollees who are treated following a rape/sexual assault without imposing cost-sharing for the first nine months after the enrollee initiates treatment. The waiver of cost sharing only applies if the enrollee's treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape/sexual assault. •Plans are prohibited from requiring: (1) an enrollee to file a police report on the rape/sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape/sexual assault. •Enrollees are not authorized to receive follow-up health care treatment furnished by a nonparticipating provider, with the exception of the following: (1) Plans are required to arrange for the provision of follow-up health care treatment from providers outside the Plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03; and (2) Plans shall cover follow-up health care treatment that is for emergency services and care as defined in Section 1317.1. •This coverage is considered a sensitive service provided to a protected individual as defined in Civil Code Section 56.05 and pursuant to Civil Code Section 56.107.	7/1/2025