

## Health Plan Celebrates 30 Years of Partnership and Community Care

Health Plan is proud to celebrate 30 years of serving our communities.

Since 1996, we have grown from a local plan supporting approximately 40,000 members in San Joaquin County to nearly 400,000 members across Alpine, El Dorado, San Joaquin, and Stanislaus counties. Through every stage of that growth, one constant has remained: our commitment to improving access to care and supporting the health and well-being of the communities we serve.

This milestone would not be possible without the dedication and partnership of our provider network. Your commitment to delivering timely, high-quality, and culturally responsive care has been essential to our shared success. As we look ahead, we remain focused on strengthening member experience, supporting providers, and continuing to invest in community-based solutions that improve health outcomes.

**Thank you for being a valued partner in this work — over the past 30 years and in the years to come.**

# 30 Years





## Stay Connected with Health Plan Provider Alerts

At Health Plan, keeping you informed is a priority. Provider Alerts are sent directly to your office by fax to share timely updates, regulatory requirements, and resources that support quality care for your patients.

### MISSED ANY RECENT ALERTS?

Here are a few highlights from March:

- [Mandatory Annual Trainings](#)  
(complete by 6/30/2026)
- [Medical Benefit Update](#)  
(effective 6/1/2026)
- [DHCS MCAS MY 2026 Required Measures and Reporting Requirements](#)

### DON'T MISS AN UPDATE

Visit [www.hpsj.com/alerts](http://www.hpsj.com/alerts) to access current and past Provider Alerts.

Use the search feature to quickly find the information most relevant to your practice.

## PHARMACY

# Health Plan's Medical Benefit Resources

## Medi-Cal Rx Formulary

The pharmacy benefit for Medi-Cal beneficiaries is administered by Medi-Cal Rx. Medications that are prescribed and dispensed by a retail or specialty pharmacy fall within the pharmacy benefit and are subject to any restrictions (e.g. Code 1 restrictions, Prior Authorization required, age limit) from Medi-Cal Rx.

Health Plan has full coverage policies available as a reference for any coverage criteria created by Health Plan for physician administered drugs. Medications covered on the medical benefit are classified as physician administered drugs and are administered by Health Plan. The medications on the Health Plan medical benefit may have restrictions (e.g. Prior Authorization, quantity limitations) which are specified within [Health Plan's coverage policies](#) as well.



### Online Drug Lookup

[medi-calrx.dhcs.ca.gov/provider/drug-lookup](http://medi-calrx.dhcs.ca.gov/provider/drug-lookup)



### Covered Products List

[medi-calrx.dhcs.ca.gov/provider/forms](http://medi-calrx.dhcs.ca.gov/provider/forms)



### Health Plan Medical Benefits Updates

[hpsj.com/medical-drug-benefit](http://hpsj.com/medical-drug-benefit)



### Health Plan Provider Manual

[hpsj.com/provider-manual](http://hpsj.com/provider-manual)

# Supporting Better Outcomes Through Disease Management



Health Plan's Disease Management Program is designed to empower members with the knowledge, tools, and support they need to better manage chronic conditions and improve their overall health.

Through education and ongoing engagement, we help members understand their condition, medications, the importance of routine follow-up with providers and specialists, and the value of completing recommended screenings and testing. Our Case Management Department supports high-risk members living with conditions such as:

- Diabetes
- Congestive Heart Failure
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease (CKD)

**When members are equipped with the right information and support, they are more likely to stay engaged in their care and successfully manage their health.** Each enrolled member receives educational materials by mail, along with access to helpful community resources.

## ➤ How the Program Supports Your Patients

Health Plan's Disease Management approach includes:

- A comprehensive assessment conducted by a Registered Nurse
- Development of an individualized care plan tailored to the member's needs
- Regular outreach to review educational materials and address barriers
- Post-appointment follow-up to reinforce the provider's plan of care

Our Case Management team works to build trust with members, improve medication adherence, and strengthen communication between members and their providers — helping to close care gaps and support better health outcomes.



## ➤ Partner With Us

You play a key role in connecting patients to the support they need. Referring eligible members to Disease Management can enhance care coordination and improve outcomes for your patients.

To refer a patient, please contact Health Plan's Case Management Department at **1-209-942-6352**.

# Patient Care, On Time — Every Time

## Adhering to Access Standards

Timely access to care is a key component of quality, member satisfaction, and regulatory compliance. Health Plan encourages all provider partners to review and follow established access standards to ensure members receive care when they need it.

Access standards are set by the California Department of Health Care Services and the California Department of Managed Health Care and are routinely monitored by managed care plans, including Health Plan.

## Supporting Timely Access for Members

Health Plan members have the right to be scheduled for appointments within established timeframes. Adhering to these standards helps:

- Ensure timely diagnosis and treatment
- Improve the outcomes and continuity of care
- Enhance the member experience



Print and post access standards in scheduling areas as a quick reference for staff responsible for appointment coordination.



In-office wait times for scheduled appointments are monitored and should align with regulatory expectations.

## Appointment Access Standards for Medi-Cal

Members have the right to be scheduled for appointments within the following time frames:

Types of Services	Standard
Access to non-urgent appointments or primary care – regular and routine care (with a PCP)	Within 10 business days of request
Access to non-urgent appointments for mental health (non-physician)	Within 10 business days of request
Access to urgent care services that do not require prior authorization	Wait time not to exceed 48 hours of request
Access to urgent care (specialist and other) services that require prior authorization	Wait time not to exceed 96 hours of request
Access to non-urgent appointments with a specialist	Within 15 business days of request
Access to after-hours care (with a PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues
Access to preventive health services within 30 business days of request	Access to preventive health services within 30 business days of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury	Within 15 business days of request
In-office wait time for scheduled appointments (PCP)	Not to exceed 45 minutes
In-office wait time for scheduled appointments (Specialists)	Not to exceed 60 minutes

Per DMHC, non-physician mental health providers include counseling professionals, substance abuse professionals, and qualified autism service providers. Access the Timely Access to Care Fact Sheet by visiting [https://dmhc.ca.gov/Portals/0/Docs/DO/TAC\\_accessible.pdf](https://dmhc.ca.gov/Portals/0/Docs/DO/TAC_accessible.pdf).

## Clinical Flexibility When Appropriate

In certain cases, appointment timeframes may be adjusted:

- If the referring or treating provider determines that a longer wait time will not negatively impact the member's health, and documents this in the medical record
- For preventive care or ongoing treatment (e.g., chronic conditions, pregnancy care, behavioral health), appointments may be scheduled in advance based on clinical judgment and established standards of care

## Partnering to Meet Access Standards

Your team plays a critical role in ensuring members receive timely, appropriate care. By reinforcing access standards within your practice, you help support compliance, reduce care delays, and improve overall health outcomes.

For full access standards and guidance, please visit the Provider Resources section of our website. If you have questions, contact Health Plan's Provider Services Department at **1-209-942-6340**.

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**PARTNERSHIP**

# Provide Quality Care. Earn Meaningful Rewards.



At Health Plan, we know that high-quality care starts with strong provider partnerships. Together, we are building healthier communities by prioritizing prevention, early intervention, and whole-person care.

Our 2026 Provider Incentive Programs are designed to support the work you already do — while offering additional rewards for improving health outcomes for our members.

By scheduling timely screenings, well visits, and follow-up care, you not only support your patients' health, you also have the opportunity to earn incentives tied to quality performance.

## Partner With Us to Close Care Gaps

Your role is critical in ensuring members receive the right care at the right time.

Whether it's encouraging annual wellness visits, managing chronic conditions, or supporting maternal and child health, your efforts make a lasting difference.

Explore full program details, eligibility, and participation guidelines at [www.hpsj.com/provider-incentives](http://www.hpsj.com/provider-incentives).

## Health Plan Provides Tools and Resources to Help You



Identify when your Health Plan Medi-Cal patients are due for preventive services



Track performance on key quality measures



Close care gaps that improve patient outcomes and experience

Check to see if your Health Plan patient is up to date with wellness visits here:

**Care GAP Reports**



## 2026 Quality Incentives: Quality Improvement Measures – HEDIS®

- > **Chronic Health Measures**
  - Controlling High Blood Pressure (CBP)
  - Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD)
  
- > **Behavioral Health Measures**
  - Follow-Up After ED Visit for Substance Use: 30 days (FUA)
  - Follow-Up After ED Visit for Mental Illness: 30 days (FUM)
  
- > **Children’s Health Measures**
  - Child and Adolescent Well-Care Visits (WCV)
  - Childhood Immunization Status: Combination 10 (CIS-10-E)
  - Immunization for Adolescents: Combination 2 (IMA-2-E)
  - Well-Child Visits in the First 30 Months of Life: 0-15 Months (Six or More Well-Child Visits) (W30-6+)
  - Well-Child Visits in the First 30 Months of Life: 15-30 Months (Two or More Well-Child Visits) (W30-2+)
  - Developmental Screening in the First Three Years of Life (DEV-CH)
  - Topical Fluoride for Children (TFL-CH)
  
- > **Women’s Health Measures**
  - Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
  - Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)
  - Chlamydia Screening in Women (CHL)
  - Cervical Cancer Screening (CCS-E)
  - Breast Cancer Screening (BCS-E)

Thank you for your support in improving health and potentially reducing preventable diseases in our members. Learn more about Quality Improvement Measures at [www.hpsj.com/provider-incentive-program](http://www.hpsj.com/provider-incentive-program).

## HEALTH EQUITY

### No-Cost Interpretive Services Available for All Member Visits

Health equity means ensuring every patient has the support they need to understand and access care — not just providing the same services to everyone.

At Health Plan, over 36% of members have Limited English Proficiency (LEP), representing more than 75 languages. Clear, effective communication between providers and patients is essential to building trust, improving health outcomes, and ensuring equitable access to care.

We partner with our provider network to offer **no-cost, qualified interpreter services** for members. Using trained interpreters — and documenting use or refusal in the EMR — helps support quality care and protects both providers and patients.

Interpreter services are available **24/7/365** in multiple formats, including phone, video, and onsite support. To ensure accuracy and patient safety, providers should use qualified interpreters rather than relying on family or friends.

#### HOW YOU CAN SUPPORT YOUR PATIENTS



**Over-the-Phone Interpreting (OPI)** is available to all network providers. For details, contact your Provider Services Representative (PSR) or email [ProviderServices@hpsj.com](mailto:ProviderServices@hpsj.com).



**Video Remote Interpreting (VRI)** offers real-time video interpretation, combining visual cues with on-demand convenience. Available for practices with compatible devices.



**Onsite Interpreting** is also available. Submit a request at [www.hpsj.com/customer-service](http://www.hpsj.com/customer-service) under “Interpreter,” or call **1-888-936-PLAN (7526)**.

- Request at least **5 business days** in advance for spoken languages
- **10 business days** for ASL
- Include appointment details and a practice contact for coordination

Whether members need an interpreter or materials in another language or format, Health Plan’s Cultural & Linguistic Services team can help.

Visit the **Language Access Resources** page on [www.hpsj-mvhp.org](http://www.hpsj-mvhp.org) or contact Provider Services at [ProviderServices@hpsj.com](mailto:ProviderServices@hpsj.com) for more information.

# Improving Immunization Measures

Childhood and adolescent immunizations are among the most effective preventive services in medicine.

HEDIS measures track whether recommended vaccines are delivered on time — helping prevent serious illness, reduce community spread, and improve overall population health. Strong office workflows and proactive outreach can significantly improve performance on these measures.

## Communicating with Parents About Vaccines

Parents often have questions about vaccines, and clear, confident recommendations from providers play a critical role in improving acceptance. Helpful communication strategies include:



Present vaccines as the **standard of care**



Emphasize protection **from serious disease and reduction of outbreaks**



Address questions with **clear, confident guidance**



## HEDIS Immunization Measures

MEASURE	WHAT IT TRACKS	TIPS TO IMPROVE PERFORMANCE	COMMON CODES
<b>CIS-10</b>  Childhood Immunization Status (Combo 10)	% of children who receive recommended vaccines by age 2 (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, Hep A, Rotavirus, Flu)	<ul style="list-style-type: none"> <li>Review vaccine status at <b>every visit</b></li> <li>Check <b>state registry</b> for complete records</li> <li><b>Schedule next visit</b> before patient leaves</li> <li>Use <b>reminder/recall systems</b> (calls, texts, portal)</li> <li>Provide <b>early parent education</b></li> </ul>	<b>DTaP:</b> 90697, 90698, 90700, 90723 <b>IPV:</b> 90713 <b>MMR:</b> 90707, 90710 <b>HiB:</b> 90644–90648 <b>HepB:</b> 90740–90748 <b>PCV:</b> 90670–90677 <b>VZV:</b> 90710, 90716 <b>HepA:</b> 90633 <b>Flu:</b> 90655–90689 <b>RV:</b> 90681, 90680
<b>IMA-2</b>  Immunizations for Adolescents (Combo 2)	% of adolescents who receive Tdap, meningococcal, and complete HPV series by age 13	<ul style="list-style-type: none"> <li>Use <b>age 11–12 visit</b> as vaccination milestone</li> <li><b>Co-administer vaccines</b> when possible</li> <li>Strongly recommend <b>HPV as cancer prevention</b></li> <li>Track and follow up on HPV series completion</li> <li>Offer vaccines at <b>acute/sports visits</b></li> </ul>	<b>Tdap:</b> 90715 <b>Meningococcal:</b> 90619, 90623, 90733, 90734 <b>HPV:</b> 90649–90651



# A Streamlined Health Plan for Your Dual-Eligible Patients



Through the Medi-Cal program, California is streamlining care for dual-eligible individuals by allowing health plans like Health Plan of San Joaquin/Mountain Valley Health Plan to coordinate Medicare and Medi-Cal benefits in one integrated Dual Eligible Special Needs Plan (D-SNP), making it easier for providers to deliver comprehensive and connected care to their patients.

On January 1, 2026, Health Plan began offering Advantage D-SNP. This new plan is designed for individuals who qualify for both Medicare and Medi-Cal, providing a fully integrated experience with one plan, one ID card, and one care team.

## HOW THIS HELPS PROVIDERS

- Simplified processes: One plan handles both Medicare and Medi-Cal — less paperwork and better communication.
- Centralized support: One phone number for authorizations, referrals, claims, and coordination.
- Smarter care coordination: Shared data systems help close care gaps and improve follow-up.
- Your patients stay within your network — we are working with the same trusted provider partners.

## BENEFITS FOR YOUR PATIENTS

- All-in-one coverage for hospitals, primary care, mental health, dental, prescriptions, labs, transportation, and more.
- Extra benefits may include vision, hearing, and over-the-counter (OTC) allowances.
- One dedicated care team helps patients manage appointments, medication refills, transitions of care, and support services.



## Medicare + Medi-Cal = Medi-Medi (D-SNP)

Physicians  
Dental  
Mental Health  
Rx & Pharmacies  
Labs & X-rays  
Nursing Facilities  
Long-term Services & Supports  
Non-Emergency  
Medical Transport  
Durable Medical Equipment

*Health Plan's Advantage D-SNP program includes a comprehensive network of hospitals, providers, and pharmacies to provide integrated care for your dual-eligible patients.*

**Contact Provider Services at  
1-209-942-6340 to learn more.**

# Help Your Medi-Cal Patients Keep Their Coverage



**A quick check-in during a visit or call can help your Medi-Cal patients prevent unnecessary loss of Medi-Cal benefits.**

People enrolled in Medi-Cal are required to renew their Medi-Cal coverage every year. Starting January 2027, people who receive Medi-Cal may need to renew every 6 months.

- The renewal process starts when Medi-Cal checks the enrollee’s eligibility for the program using data collected from sources such as the Internal Revenue Service (IRS). If an enrollee successfully renews through this process, there is nothing they need to do. This process is called auto-renewal. A notice of action will be mailed to the enrollee letting them know that they have been renewed for the program.
- However, if the enrollee does not meet the eligibility criteria, they may receive a yellow envelope from their local Medi-Cal office telling them that more information is needed to renew. They will also receive an alert through their **BenefitsCal.com** account. If the enrollee does not respond in a timely manner or fails to provide the information requested, they may be terminated from the program.

Loss of coverage results in missed appointments, delayed care and impacts the health and wellbeing of the entire community.


## **Your Support is Key. Help Connect Patients to the Best Resources.**

Other ways to spread the word and educate our community about Medi-Cal renewal help:

- Download our **Social Media Toolkit** and leverage **pre-composed text messages** for your next texting campaign.
- Share printed materials like **flyers and handouts** when a patient has a question or issue related to Medi-Cal eligibility and renewals.

It is our responsibility to ensure that our community maintain access to important healthcare services — knowledge is power!

To learn more about partnering around this important initiative, visit [www.hpsj-mvhp.org/access](http://www.hpsj-mvhp.org/access).



**BenefitsCal**

Encourage your patients to create or log in to their **BenefitsCal.com** account to:

- **Find out their renewal date**
- **Update their contact information**
- **Check for messages about their renewal status**

## Unlawful D-SNP Patient Billing Practices

D-SNP enrollees should not pay for covered services received from any Health Plan Advantage D-SNP provider.

This means enrollees cannot be charged for co-pays, co-insurance, or deductibles. If the services provided are covered services in accordance with Health Plan Advantage D-SNP benefits, then Health Plan Advantage D-SNP's reimbursement to the provider constitutes full payment and the enrollee cannot be balance billed for these services.

### ▶ What Happens if an Enrollee Is Charged or Invoiced in Error?

If an enrollee was invoiced or charged in error, all billing efforts must stop as soon as the error is identified.

### ▶ What if an Enrollee Paid for Covered Services?

If the enrollee paid for covered services, the provider must refund the enrollee within 15 calendar days.

### ▶ What if the Enrollee Is Willing To Pay for Non-Covered Services?

If an enrollee is willing to compensate the provider for a non-covered service and the provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of D-SNP and outside of the supervision of Health Plan Advantage D-SNP. However, the service must clearly be identified as Not a Covered Benefit (NCB) in advance of providing the service.



**Balance billing Health Plan Advantage D-SNP enrollees is prohibited by federal and state laws.**

Read more about this topic in Section 12 of your [HPSJ/MVHP Provider Manual](#).

# PLANSKAN

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