Winter 2024/Spring 2025
PLANSCAN
Health Plan of San Joaquin
Mountain Valley Health Plan

Review and Verify Your Information

Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") is required to ensure we have the most current provider network information available to our members on a regular basis.

Network data validation helps to ensure the integrity of information related to provider locations, specialties, and services. By keeping your data up to date, you help us provide better support to our patients and ensure seamless access to the care they need.

It's that time again- Please validate your contact and practice information.

Provider data must be validated every six (6) months or as often as changes occur.

According to California Health & Safety Code 1367.27, failure to comply with validating data with the health plan could result in your data being temporarily removed from Health Plan's directory until it is resolved. This could also result in a delay of payment or reimbursement of claims. **Avoid payment delays or removal from the provider directory – take action today!**

1. **Review your network information:** Please verify that your practice details, including office addresses, contact numbers, specialties, and provider availability, are accurate and up to date.
2. **Confirm or update any changes:** If there are any changes, including new locations, changes in specialties, or staff updates, please submit the necessary adjustments.

The Roster Template is available on our website at **www.hpsj.com/forms-documents**
Once completed should be emailed to **providernetworks.verification@hpsj.com**

The Provider Services Department is available to assist you at 1-209-942-6340, Monday through Friday, 8AM – 5PM.

In this issue:

PHARMACY

Medi-Cal Rx Formulary Benefit Resources

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 determining if a medication is on the pharmacy benefit, medical benefit, or both. 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 (**www.hpsj.com/medication-coverage-policies**) as well.

Online Drug Lookup Tool

medi-calrx.dhcs.ca.gov/provider/drug-lookup

Covered Products List

medi-calrx.dhcs.ca.gov/provider/forms

Health Plan Medical Benefits Updates

www.hpsj.com/benefits-and-services

Health Plan Provider Manual

www.hpsj.com/provider-manual

Health Plan Member Rights & Responsibilities

Health Plan members have specific rights and responsibilities under Medi-Cal managed care plans as outlined under Title 22, California Code of Regulations Sections 72527.

As a Health Plan provider, you can make sure that your patients are aware of important information regarding:

- How Health Plan protects their privacy
- How to change health information
- Rights to timely access to care
- Rights to no-cost interpreter and language services
- Access to medical records

View the complete list online at www.hpsj.com/rights-responsibilities

Share this resource with your Health Plan patients

PATIENT CARE ON TIME, EVERY TIME

Adhering to Access Standards

Provider partners should review, print and post the following information in their office as a reminder for staff who schedule appointments for Health Plan members. Access standards are established by both the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). In-office wait times for scheduled appointments are set and monitored by managed care plans.

Health Plan 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

- Appointment wait times may be extended if the referring or treating Provider, or the clinician providing triage or screening, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.
- Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treatment Provider acting within the scope of their practice.

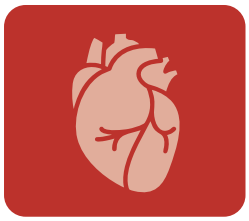
If you have questions, contact our Provider Services Department at 1-209-942-6340.

Empowering Patients through Disease Management

The goal of disease management is to educate our members on their disease, medications, the importance of regular follow up with providers and specialists and completion of routine testing.

Health Plan's Case Management Department provides high risk members with education and support for several chronic diseases such as:

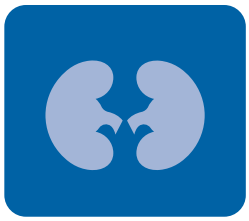
Diabetes



Congestive Heart Failure (CHF)

Asthma

Chronic Obstructive Pulmonary Disorder (COPD)



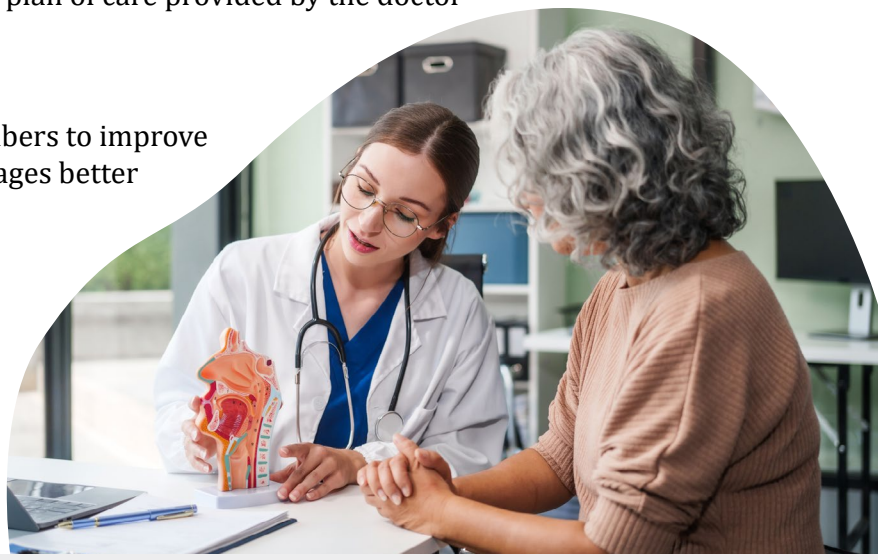
Chronic Kidney Disease (CKD)

When members are educated on their disease processes, they are more likely to effectively manage their health. Every member that is enrolled in the Disease Management program receives an educational booklet in the mail along with lists of resources available in the community.

Health Plan's Disease Management process:

- Members receive a comprehensive assessment by one of our Registered Nurses
- An individualized care plan is developed
- Members are called on a weekly or bi-weekly basis to work through the booklets and discuss their individual challenges and goals for optimal health
- Post-appointment follow-up to support the plan of care provided by the doctor

Our case management team builds trust with members to improve compliance with medication regimens and encourages better communication with their providers.



Refer your Health Plan patients for Disease Management by calling Health Plan's Case Management Department at ***1-209-942-6352****.*

Not subscribed to PlanScan?
Sign up to receive our quarterly issue at
www.hpsj.com/planscan

PLANSCAN

SUBSCRIBE

DIABETES

Diabetes Prevention Program Available to Your Health Plan Patients

Studies show this year-long program can **help patients lose 5-7% of their body weight** and **reduce risk of developing Type 2 diabetes by 58%.**

Do you have Health Plan members who are at risk for Type 2 diabetes? Refer your patients to our virtual National Diabetes Prevention Program. This service is possible through our partnership with Inspiring Communities- a community-based organization that is American Diabetes Association (ADA) approved to deliver evidence-based Diabetes Self-Management Education curriculum.

Health Plan members can connect with a health coach and access the program through a browser or can download an app to their phone for convenient access. Members will have access to weekly coaching programs, connect with the online community, messaging and calling their health coach, completing a daily health journal, and implementing regular physical activity.

To be eligible for the program, members must meet each component of the following criteria:

Meet ALL of these

18 YEARS OR OLDER

OVERWEIGHT

NOT DIAGNOSED WITH TYPE 1 OR TYPE 2 DIABETES

NOT CURRENTLY PREGNANT

And ONE of these

HIGH-RISK RESULT ON PREDIABETES RISK TEST

PREVIOUSLY DIAGNOSED WITH GESTATIONAL DIABETES

DIAGNOSED WITH PREDIABETES

DPP is NOT for those who have Type 1 or Type 2 diabetes or are pregnant at this time.

Refer your patients at www.inspiringcommunities.org by providing their patient information in the program sign-up section.

*For more information visit **www.hpsj.com/dpp** or contact Health Education at **1-209-942-6356** or email **healtheducation@hpsj.com.***

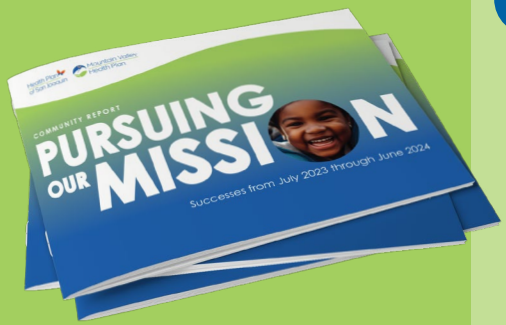
Investing in Prevention to Build Healthier Communities

Health Plan builds healthier communities by investing in prevention. This quarter, we are spotlighting two of our quality measures and providing resources that can help you improve patient care.

Check to see if your Health Plan patient is up to date with wellness visits and access our list of 2025 Quality Incentives at **www.hpsj.com/provider-incentive-program.**

This site has all the tools to help you identify when your HPSJ/MVHP Medi-Cal patients may be due for services. Schedule your patients for preventative screenings today!

Measure
Controlling High Blood Pressure (CBP): Patients aged 18-85 with a diagnosis of hypertension (HTN) whoseblood pressure (BP) was adequately controlled (<140/90 mm Hg) during the year.
Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): Patients aged 18-75 with diabetes (types 1 and 2) must have at least one HbA1c screening or glucose management Indicator (GMI) screening during the measurement year resulting in a level <9%.



Health Plan's annual community report is now available!

Visit our web page **www.hpsj.com/about-us** to read about our recent quality achievements, commitment to investing in the community, and aspirations for the future.

Thank you for being our partners in health and wellness. Your support and dedicated service to our members led to numerous successes for 2024. We are eager to work with you to continue to deliver the highest quality of care so our members stay healthy and happy.

Provider Tips	Common CPT-II Codes
• Document blood pressure at every visit. • Confirm CPT-II codes are mapped to fields where systolic and diastolic readings are recorded within EHR. This will help to ensure the codes are sent on the claim. • If a patient is meeting measure requirements on lists generated from EHR but not on the GIC list, confirm if CPT codes were sent to the health plan. • Retake blood pressures that are 140/90. • Make sure the patient has their feet flat on the ground, legs uncrossed, and arms supported and raised to be level with the heart when blood pressure is being taken to avoid inadvertently increasing blood pressure. • If the patient has access to a blood pressure monitor, use patient-reported readings via virtual visit. • Document medication adherence at every visit.	• Diastolic BP: 3078F, 3079F, 3080F • Systolic BP: 3074F, 3075F, 3077F
• CPT-II codes must be coded for GSD; confirm codes are properly mapped in EHR to be included on the claim. • Quarterly monitoring of HbA1c allows for greater visibility into medication/lifestyle habits. • Review Gap lists and prioritize outreach to patients who do not have any HbA1c results on file for the year. • If patient has HbA1c tests ordered by another provider, request a copy of results, and include the historical results on claim during next visit, along with the CPT-II codes that correspond with the results. • Members receiving hospice or palliative care are excluded from this measure. Notify health plan if this exclusion applies to any members on GIC list.	• 3044F (if HbA1c<7%), • 3046F (if HbA1c>9%) • 3051F (if HbA1c >=7.0% and <8.0%) • 3052F (if HbA1c level >=8.0% =<9.0%

Did You Get the Update?

Provider Alerts are sent via fax to provider partner offices to communicate important regulatory updates and other helpful information and resources.

Did you miss any of these important alerts from January?

- Non-Specialty Mental Health Outreach and Education Plan
- 2025 Provider Incentive Program
- Billing Guidelines for BHT/ABA Services
- Medical Benefit Update

Stay up-to-date with Health Plan and access past Provider Alerts at www.hpsj.com/alerts.

Utilize the search function to find exactly what you're looking for!

Improving Health Equity through Language Services

Health Plan serves a diverse population of members with limited English proficiency (LEP). It is essential that members can access qualified interpreting services. Offering qualified interpreting services protects both you and the member and ensures clear communication, which improves health outcomes. We continue to partner with you to provide free-of-charge interpreting services to our members.

Health Plan tracks the preferred languages of our members to ensure that interpreting needs are met. Review the tables below that breakdown our top Limited English Proficient languages based on our membership as well as the top languages by total fiscal year 2024 interpreting encounters, which represent each time phone, video, or onsite interpreting services were engaged.

FY 2024

Top Languages by Membership		Top Languages by Interpreting Encounters	
Spanish	122,403	Spanish	62,979
Punjabi	3,621	Punjabi	3,359
Khmer	3,096	Dari	2,688
Vietnamese	2,865	Arabic	2,152
Farsi	2,677	Chinese*	1,441
Arabic	1,720	Urdu	1,406
Hmong	1,244	Farsi	1,072
Chinese*	1,201	Vietnamese	907
Tagalog	1,072	Pashto	846
Lao	724	Khmer	818
Urdu	520	ASL	473
Hindi	342	Tagalog	359
Assyrian	245	Hindi	257
Russian	236	Russian	179

(*Chinese (spoken) is a sum of Mandarin, Cantonese, and Taishanese.)

Acquire Qualified Interpreting

Onsite Interpreting
Make a request online by visiting **www.hpsj.com/customer-service** and filling out the form under "Interpreter". In the "Name of Doctor or Practice" field, please also include the phone number and email of someone at your practice with whom to communicate regarding the request.

You may also call Customer Services at **1-888-936-PLAN (7526)**. Requests should be made at least 5 business days prior to the appointment date for spoken language interpreting, 10 days prior for ASL interpreting, and provide all relevant appointment and member details.

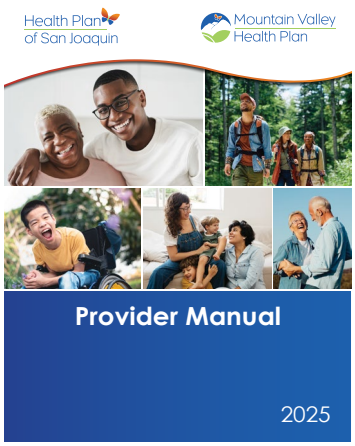
Over-the-Phone Interpreting
All Health Plan network providers have access to on-demand over-the-phone (OPI) interpreting services. For specific access information, contact your Provider Services Representative (PSR). If you are not sure who your PSR is, email Provider Services at **ProviderServices@hpsj.com**, or C&L Services at **CLServices@hpsj.com** to get your specific calling instructions for ongoing use.

Video Remote Interpreting (VRI) combines the visual benefits of onsite interpreting with the on-demand convenience of over-the-phone interpreting. Health Plan network providers can contact **CLServices@hpsj.com** to inquire about dedicated VRI services for their locations.

"I Speak" Language Identification Sheets

Health Plan has language identification materials, such as "I Speak" flyers, that can be printed and utilized in care settings to assist in identifying language needs. These flyers are available on Health Plan's website at **www.hpsj.com/forms-documents** under the Resources section.

2025 Provider Manual is Here!



Health Plan recently updated our Provider Manual to reflect the most current standards and guidelines approved by the Department of Managed Health Care (DMHC); California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS).

The Provider Manual will be updated as needed to reflect changes to important information regarding Health Plan policies, procedures, and programs previously communicated. The manual is intended to be a resource for providers/practitioners to use for operational guidance within Health Plan's Medi-Cal line of business.

*You can view or download the updated manual on our website. Contact our Provider Services Department at **1-209-642-6340** with questions or concerns.*

Provider Recruitment Grant Program Enhancements

Since launching our Provider Recruitment Grant Program in 2023, Health Plan has added 30 new providers from various specialties to our network!

Grant Funding is Still Available!

We are focused on supporting recruiting efforts for specialists in the fields of endocrinology, neurology, psychiatry, rheumatology, hematology/oncology, reconstructive surgery and in service areas where we have identified access issues.

Apply

ProviderRecruitmentGrant@hpsj.com

Goals:

- Expand our provider network
- Increase access to providers in specialized/ hard-to-recruit services
- Decrease avoidable emergency room visits and preventable acute care hospital admissions by increasing access

Qualifications:

- Provide services at a professional office or clinic within the Health Plan service area
- Facility/organization must be contracted with Health Plan and execute the provider recruitment program memorandum of understanding (MOU)

Early Successes of Our Recruitment Goals

Health Plan has eleven (11) organizations participating in our grant program and have recruited licensed providers from community health centers, FQHC's and medical groups. Recruits include physician assistants, family and internal medicine providers, pediatricians, primary care doctors, and marriage family therapists.

For more information on the grant program, email ProviderRecruitmentGrant@hpsj.com

Grant funding is not eligible for the following specialties or provider types: urgent care centers, ambulatory surgical centers, and hospital-based specialties; specialists that practice primarily out of area or out of county; and specialties where the health plan has not identified access issues in the county.

HIE Grant Funding Underway

To bolster data sharing initiatives, Health Plan committed $8.775 million in community investment funds for a Health Information Exchange program. To date, we have approved over $3 million in grants for Basic HIE, Admission, Discharge, and Transfer (ADT) Data, Healthcare Effectiveness Data and Information Set (HEDIS) Data Aggregator Validation (DAV) Certification and more! Health Plan is committed to supporting traditional and non-traditional providers through our HIE grant program.

Benefits of Connecting to an HIE

- ★ Access patient data created outside of your office/facility
- ★ Close gaps in care to improve quality measures
- ★ Share information between healthcare providers
- ★ Avoid duplicating services

www.hpsj.com/community-reinvestment

Ready to connect to the HIE? Grant funding is still available!

Apply today!

Advancing Health Equity

Thank you to our provider partners who participated in Health Plan's Network Cultural Responsiveness Survey in January 2025. Your feedback is helpful in ensuring that we are meeting the unique cultural needs of our members as we prepare for Health Equity Accreditation.

By collecting detailed member data, such as race/ethnicity, language, gender identity, and sexual orientation, we can identify areas of opportunity to increase access to health care and improve the quality of care for our members.

In the coming months, we will share updates on quality improvement projects that are aimed at addressing health disparities and eliminating barriers to care to improve health outcomes for all patients.

Our ongoing commitment to advancing health equity across every level of our healthcare system is only possible through the partnership of our valued providers – thank you!

Celebrating one year of

Community • Partnership • Wellness

In January, Mountain Valley Health Plan (MVHP) celebrated its one-year anniversary serving Health Plan members in Alpine and El Dorado Counties.

Thank you to our valued providers for your support this past year. Our achievements would not be possible without your collaboration. We are proud to serve nearly 10,000 people who qualify for Medi-Cal in Alpine and El Dorado counties, and work with you to improve the health of our community.

MVHP 2024 Highlights

- Expanded access to essential healthcare services for thousands of individuals and families.
- Engaged local organizations to promote health education, provide preventive care services, and support health equity initiatives.
- Fostered stronger ties with local stakeholders to become a trusted partner in improving the overall health and well-being of the community.

Mosquito Volunteer Fire Association's Fall Festival

Asociación Guadalupana's Community Resource and Health Fair

El Dorado Veterans Stand Down Health Fair

Georgetown Divide Ready By 21 Youth Expo

MVHP Placerville Office

If you have not stopped by our office at 4327 Golden Center Drive in Placerville, consider taking our virtual tour online at www.hpsj-mvhp.org/choose.

www.hpsj-mvhp.org
1-888-936-PLAN (7526) TTY 711