PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | FEBRUARY 8, 2018 | UPDATE 18-068 | 3 PAGES

Perinatal Notification Incentive Program Continues in 2018

Health Net Community Solutions, Inc. (Health Net) is continuing to offer the Perinatal Notification Incentive Program (PNIP) in 2018. The PNIP is a financial incentive program that recognizes and rewards participating Medi-Cal providers for ensuring timely access to care for pregnant and postpartum women.

The Department of Health Care Services (DHCS) requires timely prenatal and postpartum care. It is also part of the Healthcare Effectiveness Data and Information Set (HEDIS®) measures for Medi-Cal members.

Providers are encouraged to submit PNIP forms for all 2017 dates of service and corrections before February 14, 2018. PNIP forms for services performed in 2017 received after February 14, 2018, will not be accepted.

Health Net obstetricians and gynecologists (OB/GYNs), other prenatal care specialists and primary care physicians (PCPs) can earn two separate incentive payments of $50 each for documenting prenatal and postpartum care visits on the PNIP forms: the Timely Prenatal Visit and Pregnancy Notification Form and the Postpartum Care Notification Form. The PNIP forms are attached for reference.

On a quarterly basis, Health Net will pay $50 for each complete and accurate form faxed to Health Net prior to the close of the quarter. OB/GYNs and other prenatal care specialists must meet the minimum requirements of the PNIP to qualify for this supplemental compensation, which include:

- Currently contracting with Health Net or a Health Net participating physician group (PPG) under the Medi-Cal program.
- Providers who have no licensing or credentialing restrictions and are in good standing with Health Net and their PPGs.
- Accurately completing, in its entirety, and returning the Timely Prenatal Visit and Pregnancy Notification Form or the Postpartum Care Notification Form within the required time frames. Signatures must be included.
- For providers new to the program who have not yet submitted a W-9 form, completing and faxing a W-9 form to Health Net at 1-877-783-0287.

The PNIP is not considered part of the base provider compensation under the Health Net Medi-Cal *Provider Participation Agreement (PPA)* and is separate from contracting rates with Health Net's PPGs. The PNIP is supplemental compensation offered to providers. PCPs who submit PNIP forms for the incentive will be paid for the correctly completed PNIP forms, but will not be paid for the same measure under the PCP HEDIS Improvement Program, which would create a duplicate payment.

By accurately completing a form for timely prenatal or postpartum visits per HEDIS, the Health Net member will also receive a $25 gift card from Health Net.

For additional information about the PNIP, contact Juli Coulthurst by telephone at (661) 321-3916 or via email at juli.b.coulthurst@healthnet.com.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ● Riverside
  - ○ Sacramento
  - ● San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

Health Net
COMMUNITY SOLUTIONS

TIMELY PRENATAL VISIT and PREGNANCY NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to [Health Net/PPG name] within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, or certified nurse midwife.
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into Health Net Medi-Cal.
- This form must be kept in the patient's medical record.

Fax to [Health Net/PPG Name at 1-877-783-0287]

Date of prenatal visit: _____

Member Information

First name:	**Last name:**
Medi-Cal ID # (CIN #):	**Date of birth:**
9	**Telephone number:**
Address:	**City:** / **ZIP code:**
Medical group name (also known as IPA or PPG):	

Primary Language

☐English ☐Spanish ☐Vietnamese ☐ Mandarin ☐Farsi ☐Korean ☐Arabic ☐Other_____

Pregnancy Information - Required

Pregnancy diagnosis confirmed: ☐Yes

LMP:_____ **or EDD:**_____

Is this a high-risk pregnancy? ☐Yes ☐ No

Gravida:	Para:	Abortions:	OR	Gestational age: weeks	Gestational age: days	Fetal heart rate: (pos. or neg.)	Fundal height: cm

Provider Information

Practitioner name:		**Clinic name:**	
Practitioner NPI:	**Specialty (OB/GYN, PCP, NP, or CNM):**	**Clinic address:**	
Office contact name:		**City:**	**County:**
Office telephone number:		**ZIP code:**	

☐ **I confirm that this document is also filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

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Health Net®
COMMUNITY SOLUTIONS

POSTPARTUM CARE NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to [Health Net/PPG name] within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, or certified nurse midwife.
- The postpartum visit must be between three and eight weeks (21 to 56 days) after delivery.
- This form must be kept in the patient's medical record.

Fax to [Health Net/PPG Name at 1-877-783-0287]

Date of postpartum visit: _____

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Telephone number:**	
Address:	**City:**	**ZIP code:**
Medical group name (also known as IPA or PPG):		

Primary Language

☐English ☐Spanish ☐Vietnamese ☐ Mandarin ☐Farsi ☐Korean ☐Arabic ☐Other:_____

Postpartum Assessment

Date of delivery: _____ Hospital: _____

☐ **Confirmation of live birth** **BP: _____** **Weight: _____**

Abdomen	☐ Normal ☐ Abnormal	**Comments:**
Breasts	☐ Normal ☐ Abnormal ☐ Breastfeeding	**Comments:**

OR

Pelvic	**Uterus:_____** **Cervix: _____** **Other comments:**	**Pap test: (optional)** ☐ Normal ☐ Abnormal

Additional comments/visit notes:

Provider Information

Practitioner name:		**Clinic name:**	
Practitioner NPI:	**Specialty (OB/GYN, PCP, NP, or CNM):**	**Clinic address:**	
Office contact name:		**City:**	**County:**
Office telephone number:		**ZIP code:**	

☐ **I confirm that this document is filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

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