

## Perinatal Notification Incentive Program Continues in 2018

For CalViva Health members, 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. These requirements are 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.

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, on behalf of CalViva Health, 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 CalViva Health or Health Net under the Medi-Cal program.
- Providers who have no licensing or credentialing restrictions and are in good standing with CalViva Health and their participating physician groups (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 1-877-783-0287.

The PNIP is not considered part of the base provider compensation under the Medi-Cal *Provider Participation Agreement (PPA)* and is separate from contracting rates with 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 Postpartum Care Notification Form for timely postpartum visits per HEDIS, the member will also receive a \$25 gift card from Health Net, on behalf of CalViva Health.

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

THIS UPDATE APPLIES TO  
MEDI-CAL PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

1-888-893-1569

[provider.healthnet.com](http://provider.healthnet.com)



## TIMELY PRENATAL VISIT and PREGNANCY NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for CalViva Health members only and fax 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 CalViva Health.
- This form must be kept in the patient's medical record.

**Fax to 1-877-783-0287**

<b>Date of prenatal visit:</b> _____											
<b>Member Information</b>											
<b>First name:</b>					<b>Last name:</b>						
<b>Medi-Cal ID # (CIN #):</b>					<b>Date of birth:</b>						
<b>9</b>					<b>Telephone number:</b>						
<b>Address:</b>					<b>City:</b>			<b>ZIP code:</b>			
<b>Medical group name (also known as IPA or PPG):</b>											
<b>Primary Language</b>											
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin <input type="checkbox"/> Farsi <input type="checkbox"/> Korean <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____											
<b>Pregnancy Information – Required</b>											
<b>Pregnancy diagnosis confirmed:</b> <input type="checkbox"/> Yes					<b>Is this a high-risk pregnancy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>LMP:</b> _____ <b>or EDD:</b> _____											
<b>Gravida:</b>		<b>Para:</b>		<b>Abortions:</b>		<b>OR</b>		<b>Gestational age:</b>		<b>Fetal heart rate:</b> (pos. or neg.)	<b>Fundal height:</b>
								weeks	days		cm
<b>Provider Information</b>											
<b>Practitioner name:</b>					<b>Clinic name:</b>						
<b>Practitioner NPI:</b>			<b>Specialty (OB/GYN, PCP, NP, or CNM):</b>		<b>Clinic address:</b>						
<b>Office contact name:</b>					<b>City:</b>			<b>County:</b>			
<b>Office telephone number:</b>					<b>ZIP code:</b>						
<input type="checkbox"/> <b>I confirm that this document is also filed in the member's legal health/outpatient record.</b>											
<b>Practitioner signature:</b>					<b>Date signed:</b>						

## POSTPARTUM CARE NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for CalViva Health members only and fax 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 1-877-783-0287**

<b>Date of postpartum visit:</b> _____	
<b>Member Information</b>	
<b>First name:</b>	<b>Last name:</b>
<b>Medi-Cal ID # (CIN #):</b>	<b>Date of birth:</b>
<b>9</b>	<b>Telephone number:</b>
<b>Address:</b>	<b>City:</b> <b>ZIP code:</b>
<b>Medical group name (also known as IPA or PPG):</b>	
<b>Primary Language</b>	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin <input type="checkbox"/> Farsi <input type="checkbox"/> Korean <input type="checkbox"/> Arabic <input type="checkbox"/> Other: _____	
<b>Postpartum Assessment</b>	
<b>Date of delivery:</b> _____ <b>Hospital:</b> _____	
<input type="checkbox"/> Confirmation of live birth <b>BP:</b> _____ <b>Weight:</b> _____	
<b>Abdomen</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <b>Comments:</b>
<b>Breasts</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Breastfeeding <b>Comments:</b>
<b>OR</b>	
<b>Pelvic</b>	<b>Uterus:</b> _____ <b>Cervix:</b> _____ <b>Other comments:</b> _____
<b>Pap test: (optional)</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
<b>Additional comments/visit notes:</b>	
<b>Provider Information</b>	
<b>Practitioner name:</b>	<b>Clinic name:</b>
<b>Practitioner NPI:</b>	<b>Specialty (OB/GYN, PCP, NP, or CNM):</b>
<b>Office contact name:</b>	<b>Clinic address:</b>
<b>Office telephone number:</b>	<b>City:</b> <b>County:</b>
<b>ZIP code:</b>	
<input type="checkbox"/> I confirm that this document is filed in the member's legal health/outpatient record.	
<b>Practitioner signature:</b>	<b>Date signed:</b>