[date]

Health Net's Medicare Advantage and Dual Eligible Programs
Issue Write-Up Form - Instructions for Completion

This process is not related to and is separate from any provider appeals processes.

Consider the following when drafting the issue write-up.

- Use clear language that a layperson could understand. Anyone reading any section of the issue write up should be able to understand the system's issues, actions and timeline
- Identify systems involved, such as pharmacy or enrollment
- Use only widely accepted abbreviations after completely spelling out the term the first time. Explain all acronyms
- Do not lay blame when explaining issues. CMS considers Health Net to be ultimately responsible even if the issue involved an external source
- Do not use individual names. Use department names or Health Net

Consider the following when drafting the issue for Medicare Compliance department review:

Provider (also referred to as First Tier, Downstream or Related Entity (FDR)) may work with their Health Net business contact to determine the appropriate response.

Who:	Were members impacted? How many members were directly/indirectly impacted? Which HN contracts were affected?
What:	What occurred? What systems failed? What oversight protocols were in place and/or will be put in place?
When:	When did the issue occur? When was the issue identified? When will the issue be resolved? (Provide an estimate) What are the key dates for addressing issue/resolving problem and to ensure follow up occurs? Remember to keep the dates realistic.
Why:	Why did the issue occur? Why did the systems or processes fail? Why did existing oversight protocols fail?
How:	How were members impacted? How was the issue identified? How will the issue be resolved? How and when will members be contacted? (If access to benefits were denied members need to be contacted immediately).

IMPORTANT: If you do not provide a manageable due date for completing Action Steps or Follow-Up items, CMS may assign one for you.

[date]

Name of Issue

Contract Numbers Affected

Select all that apply or to be determined (TBD) if not currently known:

☐ H0351 (AZ HMO)	☐ H0562 (CA HMO)	☐ H5439 (CA PPO)	☐ H3237 (Dual Eligible)	☐ H5520 (OR PPO)	☐ H6815 (OR HMO)	☐ TBD

Executive Summary

[Provide a short clear description (500 characters or three to four sentences) of the issue in plain English understandable to a lay person. Summary must be sufficient in content to ensure a recipient can completely understand the issue without having to read the rest of the document. This section may need to be updated as the issue is further investigated and a solution is implemented.

Please note, the Executive Summary is specifically written for executives who need to have a basic understanding of the issue (e.g., brief statement of issue, members impacted, and when the issue was resolved) without having to read the entire issue write-up.]

Requirement

[Describe the regulatory or internal requirements that apply to the issue (e.g., Code of Federal Regulation (CFR), section of manual chapter, or policy and procedure number).]

Background

[Add section if applicable. This section summarizes relevant information needed to understand the issue. (e.g., describing a current process; explaining key elements).]

Date Issue Identified

[This is the date Health Net or a Health Net provider identified the non-compliant issue. For example: Health Net receives a member complaint on July 5th. Health Net initiates a review of the issue and on July 8th, determines it was caused by a plan set up error. The issue identification date is July 8th.]

Description of Incidence

[Specifically describe the Who, What, When, and How of the incident. (e.g., were members impacted (Who); what occurred (What); when did the issue occur (When); and how were members impacted (How).]

[date]

Description of Similar Incidents

[Include the name of the issue, a description of the issue, how the issues are similar, the solution implemented, and monitoring activities. For example, if the issue relates to a plan set up error, list other plan set up errors that were previously reported.

If there were no similar incidents– just note – "None known that are similar."]

Impact of Incidence

[Add section if applicable. Include the final count of members impacted by the issue.

If impact currently unknown, indicate "TBD by <date>." Note: date should not be more than 30 days from date issue reported to Medicare Compliance. Provide justification if the impact information will not be available within this timeframe.

As applicable, the final count should be broken down by:

- Low income subsidy (LIS) vs. non-LIS members;
- Contract number;
- Plan benefit package (PBP);
- State; and
- County.

Be prepared to provide a copy of the impact report if requested by Medicare Compliance.

If an impact report is required, it must be a separate document, not attached to the issue write up form, and sent separately to only the assigned Medicare Compliance contact.]

Root Cause Analysis

[Describe the primary reason or cause for issue and the steps taken to reach that conclusion. This section describes 'why' an issue occurred.]

Primary Root Cause Reason

The check box below will allow you to select one of the pre-defined root cause reasons.

Select only one:

☐ Benefit Configuration Error	Benefit input into a Health Net or provider database does not match the CMS approved bid or the employer group contract
☐ Contracting	Contract between Health Net and provider or between provider and provider's downstream provider entity is inaccurate, incomplete or not available.
☐ Deficient Monitoring/ Validation Process	Internal monitoring or validation process is inaccurate, incomplete or not available.
☐ Deficient Procedures	P&P, desktop, standard operating procedure or workflow is inaccurate, incomplete or not available.
☐ Deficient Training	Specialized operational training is inaccurate, incomplete or not available.
☐ Formulary Set Up Error	Formulary placement input into a Health Net or provider database that does not match the CMS approved formulary, bid or employer group contract.
☐ Human Error	Error that occurs when an individual's action causes an error. (e.g., procedure not followed, manual cut and paste error, or keying errors)
☐ Implementation Error or Deficiency	New or revised regulatory requirement or internal business process implemented incorrectly or incompletely.
☐ ITG Limitation	No manual workaround and no system enhancement available due to Health Net or provider Information Technology Group (ITG).
☐ Non-Communicated Changes	New or revised regulatory requirement or medications to internal business process not communicated to applicable staff, Health Net to provider or provider to Health Net.
☐ Other	An issue source not otherwise defined.
☐ System Error	System is set up correctly, but is not working properly.
☐ System Limitation	System limitation does not allow for a particular change or medication.
☐ System Programming	Computer system or application is not programmed correctly or available.
☐ Timing of Process	Issues concurrent to a new or revised regulatory requirement or internal business process is being implemented retroactively.

[date]

Corrective Action Plan:
(Provide a short summary of your plan to prevent recurrence of the deficiency.)

Corrective Action Plan Tasks					
Task #	**Task Description**	**Description of Validation/ Monitoring Activities**	**Planned Completion Date[1]**	**Status[2]**	**Date Completed[3]**

[1] Typical maximum timeframes for completing Corrective Action Plan tasks:

- Impact report: 5 calendar days from issue identification
- Benefit configuration: 14 calendar days from issue identification
- Revise/develop P&Ps, desktops or workflows approved and available to staff: 30 calendar days from issue identification
- Train on revised/new P&Ps, desktops or workflows: 45 calendar days from issue identification
- Revise/develop member materials: 14 calendar days from issue identification to submit materials via Alfresco, 30 calendar days to implement once materials are approved by Medicare Compliance or CMS
- Claim correction: 45 calendar days from issue identification
- IT system implementation: To be determined on a case-by-case basis
- Other: To be determined on a case-by-case basis

Discuss with the Medicare Compliance contact if a Corrective Action Plan task will take longer than the typical timeframe.

[2] Status options are limited to: Too Soon to Tell, On-Track, Delayed, and Closed. If delayed, an explanation must be provided including expected completion date. The Medicare Compliance contact will follow up on any tasks not closed as of the date of initial receipt.

[3] Escalation Policy: Failure to meet the timelines will be subject to Health Net's escalation process. Per Health Net's policies Issue Identification, Tracking, Escalation & Resolution, # MD321-154443, section 9.d and Issue Identification, Tracking, Escalation & Resolution – First Tier, Down Stream and Related Entities, # MD45-124554, section 7.d "The Medicare Compliance Officer will escalate to Executive Management and the Board of Directors any reported issue that affects member access to care or well-being (including financial well-being) when the corrective action plan due date falls past due beyond 30 days."