Medicare & Medicaid Programs Issue Write Up Instructions

Please note the Medicare and Medicaid Programs Issue Write Up form should only be used to report compliance issues identified by or reported to business units that are not related to potential privacy breaches, security incidents, employee misconduct, or fraud, waste, and abuse (FWA).

Links to instructions for reporting potential privacy breaches, security incidents, employee misconduct, or FWA are available via the Compliance page of Health Net Connect under Something to report? https://hnc.healthnet.com/departments/compliance

Prior to completing this form, refer to P&P MD321-154443 Issue Identification, Tracking, Escalation & Resolution, P&P MD45-124554 Issue Identification, Tracking, Escalation & Resolution – First Tier, Down Stream and Related Entities, or your department specific policies and procedures for information regarding identification and escalation of Medicare Programs compliance issues.

- Please read this document in its entirety.
- Use concise, clear, plain English.
- Recipients of the write-up may not know Health Net's systems, i.e., ABS, MC400; therefore, use clear language that a layperson could understand, i.e. Health Net's eligibility system. Anyone reading any section of the write up should be able to understand the systems issues, updates and dates actions have or will be taken.
- Identify systems involved such as "pharmacy", "enrollment," etc.
- Use only widely accepted abbreviations (i.e. LEP, SEP, BAE, etc.) **after completely spelling out the term the first time**. Explain all acronyms.
- Don't lay blame on external sources. Health Net is ultimately responsible even if the issue involved an external source (e.g., CMS, vendor, provider, etc.).
- Don't use individual names. Use department names or Health Net.
- Email the completed write-up form to:

  Medicare Write up Reviews/GRP/HNCA/HNT

  and Donovan Ayers, VP Compliance, **within 24 hours of issue** identification.

  CC your Department VP/Director.

  If the issue is related to the MMP/Cal-MediConnect, please CC: Jason Silva.

Medicare & Medicaid Programs Issue Write Up Instructions

Item	Description
Title of Issue	Enter a short descriptive title.
Contract Number(s) Affected	Select all that apply or To Be Determined (TBD) if not currently known
Executive Summary	Provide a short clear description of the issue in plain English understandable to a lay person. The Executive Summary should be limited to a total of 100 words or 2 – 3 sentences. The Executive Summary is specifically written for Health Net executives or regulatory representatives who need to have a basic understanding of the issue (e.g. brief statement of issue, members impacted, and when the issue was or will be resolved) without having to read the entire write-up. Use acronyms sparingly and only after first spelling out.
Requirement	Provide a description of the regulatory and/or internal requirement(s) that apply to the issue (e.g., CFR, section of manual chapter, P&P#, etc.)
Background	Provide information essential to understanding the issue. This may include a description of system or process changes that precipitated the issue or a description of the process that should have been followed but wasn't.
Date Issue Identified	Enter the date Health Net or First Tier, Downstream, or Related Entity (FDR) 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	Describe the Who, What, When, and How of the incident. Consider the following when completing this section: Who: Were members directly/indirectly impacted? Which type(s) of members were impacted (e.g., HMO, PPO, employer group, MA-PD, MA-only, etc.)? What: What occurred? What processes or data system(s) failed? What oversight protocols were in place at the time the issue occurred? What actions were taken once the issue was identified? When: When did the issue occur? When was the issue identified? If there was a delay in identifying or reporting the issue, what caused the delay?

Medicare & Medicaid Programs Issue Write Up Instructions

	How: How were members impacted? How was the issue identified?
Description of Similar Incidents	If one or more similar issues were previously reported, include the name(s) of the issue(s), a description of the issue(s), when the issues occurred and were reported, 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, indicate "N/A".
Impact of Incidence	Provide the number of members impacted by the issue and demographic information, as applicable: • LIS vs. non-LIS members; • Contract number; • Plan Benefit Package (PBP); • State; and/or • County. Be prepared to provide a copy of the impact report if requested by Medicare Compliance.

Impact of Incidence, cont'd	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 Compliance Contact. If impact is currently unknown, indicate "TBD by <date>." Note the date should not be more than 5 calendar days from date issue reported to Medicare Compliance. Provide justification if the impact information will not be available within this timeframe. If no members impacted, indicate "N/A".

Medicare & Medicaid Programs Issue Write Up Instructions

Root Cause Analysis: Describe the reason for the failure(s) that caused the issue to occur and the steps taken to reach that conclusion. Consider the following when completing this section:

- Why did the issue occur?
- Why did the system(s) or process(es) fail?
- Why did existing oversight protocols fail?

One method for conducting a root cause analysis is to identify the issue and ask the question why? 5 (or more) times.

Example Part 1

HN was enrolling new members from outside the service area. While conducting the Root Cause Analysis, the following "why?" questions could be asked:

- ***Why did the issue occur?*** *Crossover zip codes are not taken into consideration during the enrollment application data entry process.*
- ***Why?*** *The primary enrollment system does not identify when a zip code crosses into multiple counties.*
- ***Why?*** *The enrollment system is programmed to identify only one county per zip code.*
- ***Why?*** *There is a system limitation that does not allow more than one county to be linked to a zip code. As a result, the review for crossover zip codes must be completed manually.*
- ***Why?*** *A manual process step for checking crossover zip codes is not currently incorporated into associates' daily tasks.*

Medicare & Medicaid Programs Issue Write Up Instructions

Primary Root Cause Reason: Although the root cause analysis may identify multiple failures, you may only select the one primary root cause reason that ultimately resulted in the negative impact to the member.

> ***Example Part 2***
> *Although there were several contributing factors to the issue identified during the root cause analysis, the primary reason for the failure is lack of procedures for manually checking for crossover zip codes when the application is entered into the enrollment system. Therefore, the primary root cause is Deficient Procedures.*

Note: Human Error should only be listed as the primary root cause when everything else was correct (e.g., the system was programmed correctly, benefits were entered correctly into data systems, P&Ps and training accurately and appropriately detailed the requirement and the process, etc.) but an individual performed an action that caused the failure (e.g., clicked the wrong button, forgot to click the button, etc.) In other words, Human Error should only be used when the only corrective action available or necessary is to coach and/or retrain the individual who caused the failure.

If any other intervention is needed (reprogram the system, revise P&Ps, revise training, etc.), then the primary root cause should not be listed as Human Error. One way to confirm if Human Error is the appropriate primary root cause is to start with asking why the associate caused the error as the first question when using the 5 whys methodology, then following with questions designed to confirm if P&Ps, training, data systems, source documents, etc. were appropriate.

Medicare & Medicaid Programs Issue Write Up Instructions

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

Corrective Action Plan Tasks:

Task: Assign a number to each corrective action plan (CAP) task.

Task Description: Describe the high-level CAP tasks that will be accomplished in order to ensure the issue is resolved and compliance is achieved and maintained. The CAP tasks must correct each of the failures identified in the root cause analysis and rectify any direct impact to members.

Example Part 3
CAP tasks may include, but may not be limited to:

- *Developing policies, procedures, or desktop instructions regarding manual review for crossover zip codes;*
- *Training applicable staff on the new policies, procedures, or desktop instructions;*
- *Implementing monitoring protocols to review for proper identification of crossover zip codes at the time of data entry; and*
- *Implementing monitoring protocols to review for enrolled members who reside outside of the CMS approved service area for the plan benefit package (PBP) to which they are assigned.*

Description of Validation/Monitoring Activities*:* For each CAP task, describe what validation and/or monitoring activities will be used to ensure the CAP task was completed such that compliance is achieved and maintained, as applicable.

Planned Completion Date*:* Typical maximum timeframes for completing CAP tasks:

- Impact report: 5 calendar days from issue identification
- Benefit configuration: 14 calendar days from issue identification
- Revise/develop P&Ps, desktops and/or workflows approved and available to staff: 30 calendar days from issue identification
- Train on revised/new P&Ps, desktops and/or workflows: 45 calendar days from issue identification
- Revise/develop member materials: 14 calendar days from issue identification to submit material(s) via Alfresco, 30 calendar days to implement once material(s) approved by 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 Compliance Contact if a CAP task will take longer than the typical timeframe. If a manageable due date for completing a CAP task is not provided, one will be assigned.

Medicare & Medicaid Programs Issue Write Up Instructions

Status: Options are limited to: Too Soon to Tell, On-Track, Delayed and Closed. If delayed, must provide an explanation including expected completion date. The Compliance Contact will follow up on any tasks not closed as of the date of initial receipt.

Date Completed*:* List the date the CAP task was completed.

Failure to meet time designated time lines will be subject to Health Net's escalation process. Per Health Net Policy EJ44-83932 , Medicare Compliance – Prompt Response to Detected Offenses, "Any reported issues that affects member access to care or well-being (including financial well-being) are escalated to Executive Management should the corrective action plan due date falls past due beyond 30 days."