

[date (date write-up submitted to Compliance)]

Please reference the separate Issue Write-up Instructions document on important instructions on how to complete this form.

Name of Issue

Contract Number(s) Affected

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

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

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 issue entire write-up.]

Requirement

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

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 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.]

[date (date write-up submitted to Compliance)]

Description of Incident

[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).]

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 Incident

[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/or
- 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:

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

<p>Corrective Action Plan: <i>(Provide a short summary of your plan to prevent recurrence of the deficiency)</i></p>					
<p>Corrective Action Plan Tasks</p>					
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.”