Audit Review Period:	

Issue of non-compliance:	Coordination of 24-hour Care Delivery

Scope:	• The scope of this Impact Analysis is limited to 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection. • The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.

Definitions:	**Delayed**: Means a service was fully or partially provided at some point but not on the intended date. **Facility**: Nursing facilities (including long-term, rehabilitation, and respite stays), assisted living facilities, board and care facilities, and other sub-acute residential facilities. **IDT authorized services**: Any service that is determined necessary by the IDT or an IDT member, approved by the IDT, ordered by a PACE PCP, or care planned. **Not provided**: Means a service was never provided. **Partially provided**: Means a service was provided in-part but not as authorized by the IDT. Example: The care plan required home care twice daily (morning and evening), and the participant only received morning home care.

Instructions:	• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab. • Review the selected medical records (e.g., medical record documentation) to determine if all IDT authorized care and services (and only IDT authorized care and services) were provided to participants who resided in, or received care from, a nursing facility, assisted living facility, board and care facility, or other sub-acute residential facility where coordination of care was required to ensure the delivery of necessary services. This includes temporary placement in a facility (e.g., for respite care or rehabilitation). For the purposes of this impact analysis, do not identify services for participants who ONLY received services in the PACE center and the participant's home. • Consider all relevant documentation and/or evidence, including but not limited to, the medical record, facility records, invoices, outside specialist notes, etc., when determining if services were provided. • A 'service' means all Medicare-covered services, all Medicaid-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, including items and drugs. • Respond to the questions in the participant impact tab. If a participant was not in a nursing facility (including long-term, rehabilitation, and respite stays), assisted living facility, board and care facility, or other sub-acute residential facility during the audit review period, during the audit review period, the PO should enter No in column H and then NA in all additional blue fields. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.

Impact Analysis Due Date:	

Brief Description Of Issue (Completed By The CMS Audit Lead)	Detailed Description of the Issue (Explain what happened)

Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)	Brief Description Of Issue (Completed By The CMS Audit Lead)	Condition Language (Completed By The CMS Audit Lead)

Root Cause Analysis for the Issue
(Explain why it happened)

Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted	# of Individuals Impacted

Action Taken to Resolve System/ Operational Issues	Date System/ Operational Remediation Initiated (MM/DD/YY)	Date System/ Operational Remediation Completed (MM/DD/YY)	Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status	Date Individual Outreach and Remediation Initiated (MM/DD/YY)	Date Individual Outreach and Remediation Completed (MM/DD/YY)

Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY	Definitions: Delayed: Means a service that was fully or partially provided at some point but not on the intended date. Facility: Nursing facilities (including long-term, rehabilitation, and respite stays), assisted living facilities, board and care facilities, and other sub-acute residential facilities. IDT authorized services: Any service that is determined necessary by the IDT or an IDT member, approved by the IDT, ordered by a PACE PCP, or care planned. Not provided: Means a service was never provided. Partially provided: Means a service was provided in-part but not as authorized by the IDT.

During the audit review period, did the participant receive any services while in a facility?

Enter Yes if the participant received services while in a facility.

Enter No if all services were provided in the PACE center or participant's home.

(If No, enter NA in columns I through Y.)

During the audit review period, were any IDT authorized services that should have been provided by a facility NOT provided, partially provided, or delayed? (Examples include, but are not limited to, medications, wound care, therapy, DME, lab tests, diagnostics tests, etc.) If Yes: 1. Enter each IDT authorized service NOT provided, partially provided, or delayed. 2. Enter each service on a new line. 3. Enter the service as ordered, approved, care planned, etc. If No: 1. Enter No. 2. Enter NA in columns J-O. 3. Go to column P	Was the service not provided, partially provided, or delayed? (Enter not provided, partially provided, or delayed. Enter partially provided and delayed if both are applicable)	Enter the date the service was ordered or authorized by the IDT or PACE PCP. If the service was a recurring service, enter the date the services were first ordered or authorized. MM/DD/YYYY	Enter the date the order or authorization was communicated to the facility. MM/DD/YYYY	Enter the date the facility began providing the services to the participant. MM/DD/YYYY Enter NA if the service was not provided.	If the service was only partially provided, describe the service provided to the participant.	Describe why the service was not provided, partially provided, or delayed.

During the audit review period, were any services provided by a facility that were NOT authorized by the IDT or ordered PACE PCP (for example, medications, wound care, lab tests, diagnostic tests, etc.)? If Yes: 1. Enter each service provided and NOT authorized by the IDT. 2. Each service provided must be entered on a new line. If No: 1. Enter No. 2. Enter NA in columns Q-U. 3. Go to column V.	If the service was ordered by someone other than the PACE PCP, who ordered the service (include their credentials)? If there was no order for the services provided, enter No Order.	Date the service started. MM/DD/YYYY	Date the service ended. MM/DD/YYYY Enter NA is the service is still being provided.	Describe why the service was provided without IDT authorization.	Enter the date the PO became aware of this service being provided to the participant. MM/DD/YYYY

Identify the facility. Enter NA if the participant did not receive services from a facility or received all IDT authorized services and only IDT authorized services from a facility.	Did the participant experience negative outcomes, in some part, as a result of the failure to coordinate care with a contracted facility? (Enter Yes or No)	If yes, describe the negative outcomes. Enter NA if the participant did not experience negative outcomes.	Optional: Please note, you do not have to complete this column. If there are any mitigating factors that you would like CMS to consider related to a specific participant, please enter the information in this column.