

Audit Review Period:	
Issue of non-compliance:	Access to emergency services
Scope:	<ul style="list-style-type: none"> • The scope of this Impact Analysis is no more than 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.
Instructions:	<ul style="list-style-type: none"> • Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab. • Read each question carefully before responding. • Respond to the questions in the Participant Impact tab. • The review timeframe is the audit review period stated above. Errors noted prior to the audit review period should not be included. • 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:	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1327. This information collection will allow CMS to conduct comprehensive reviews of PACE organizations to ensure compliance with regulatory requirements. The time required to complete this information collection is estimated at 780 per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory per CMS's authority under Section 1894 and 1934 of the Social Security Act and implementing regulations at 42 CFR § 460.190 and 460.194, which state that CMS, in conjunction with the State Administering Agency (SAA), audit PACE organizations (POs) annually for the first 3 contract years (during the trial period), and then on an ongoing basis following the trial period. Additionally, per § 460.200(a) PACE organizations are required to collect data, maintain records, and submit reports as required by CMS and the State administering agency. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tracking ID Number	Brief Description Of Issue (Completed By The CMS Audit Lead)	Type of Issue Identified (Completed By The CMS Audit Lead) (Applies to condition <u>1P.02 Only</u> . For all other conditions enter N/A)	Detailed Description of the Issue (Explain what happened)
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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)
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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
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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)
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Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment	Date of Disenrollment	Reason for Disenrollment
				MM/DD/YYYY	MM/DD/YYYY	Enter NA if the participant is still enrolled.
					Enter NA if the participant is still enrolled.	

During the audit review period, did the participant utilize emergency services or request to utilize emergency services (this includes requests from caregivers)? (Yes/No) If NO, enter NA in all remaining columns.	Did staff or contractors from the PO: • Instruct the participant and/or caregiver that prior authorization was needed before going to the ER or calling 911; OR • Instruct the participant and/or caregiver that approval was needed before going to the ER or calling 911; OR • Instruct the participant and/or caregiver not to go to the ER or call 911; OR • Hold the participant or their caregivers responsible for any costs associated with an ER visit? (Yes/No) If NO, enter NA in all remaining columns.	Did the participant contact the PO before going to the ER? (Yes/No)	If the participant contacted the PO before going to the ER, please enter the date and time of the initial contact. MM/DD/YYYY, HH:MM AM/PM Enter NA if the participant did not contact the PO before utilizing emergency services.	Please briefly describe the concerns and/or symptoms reported by the participant and/or caregiver. Enter NA if the participant did not contact the PO before utilizing emergency services.	Did staff or contractors from the PO assess the participant in response to the participant/caregiver's initial contact? (Yes/No) Enter NA if the participant did not contact the PO before utilizing emergency services.	Who conducted the assessment of the participant (PCP, on-call nurse, etc.)? Enter NA if the participant did not contact the PO before utilizing emergency services.	Date of assessment. MM/DD/YYYY Enter NA if the participant did not contact the PO before utilizing emergency services.	Time of assessment. HH:MM AM/PM Enter NA if the participant did not contact the PO before utilizing emergency services.
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Was the assessment completed prior to the participant utilizing the ER?

(Yes/No)

Enter NA if the participant did not utilize the ER or if the participant/caregiver did not contact the PO before utilizing emergency services.

<p>Date/ Time the participant went to the ER.</p> <p>MM/DD/YYYY, HH:MM</p> <p>Enter NA if the participant did not utilize emergency services.</p>	<p>Did emergency room records indicate that the participant was experiencing an emergent situation?</p> <p>(Yes/No)</p> <p>Enter NA if the participant did not utilize emergency services.</p> <p>This question applies to all ER visits regardless of whether the participant/caregiver contacted the PO.</p>	<p>If emergency room records indicated that the participant experienced an emergent situation, please enter the chief complaint/primary diagnosis as indicated in the ER record.</p> <p>Enter NA if the participant did not utilize emergency services or if the records did not indicate the participant was experiencing an emergent situation.</p> <p>This question applies to all ER visits regardless of whether the participant/caregiver contacted the PO.</p>	<p>If the participant was evaluated/treated in an ER, what was the final ER diagnosis?</p> <p>This question applies to all ER visits regardless of whether the participant/caregiver contacted the PO.</p> <p>Enter NA if the participant did not utilize emergency services.</p>	<p>Was the participant admitted to the hospital or held for observation?</p> <p>(Yes/No)</p> <p>Enter NA if the participant did not utilize emergency services.</p> <p>This question applies to all ER visits regardless of whether the participant/caregiver contacted the PO.</p>	<p>If the participant was held responsible for any of the cost of the ER visit, how much did the participant pay?</p> <p>This question applies to all ER visits regardless of whether the participant/caregiver contacted the PO.</p> <p>Enter NA if the PO covered 100% of the cost of the ER visit or if the participant did not utilize emergency services.</p>	<p>Did the participant experience any negative outcomes after being instructed:</p> <ul style="list-style-type: none">• That prior authorization was needed before going to the ER or calling 911; or• That approval was needed before going to the ER or calling 911; or• Not to go to the ER or call 911? <p>(Yes/No)</p> <p>Enter NA if none of the above are applicable.</p>
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<p>If yes, describe the negative outcomes.</p> <p>Enter NA if the participant did not experience any negative outcomes.</p>	<p>Optional: Please note, you do not have to complete this column.</p> <p>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.</p>
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