

<b>Audit Review Period:</b>		
<b>Issue(s) of non-compliance:</b>	<b>Auditors:</b> <b>Select All that Apply</b>	<b>Issue:</b>
		Investigation and Resolution of participant grievances
		Grievance Resolution Notification
		QIO Cooperation
<b>Scope:</b>	<b>Investigation and Resolution of participant grievances:</b> <ul style="list-style-type: none"> <li>• All grievances during the audit review period.</li> </ul> <b>Grievance Resolution Notification:</b> <ul style="list-style-type: none"> <li>• All grievances during the audit review period.</li> </ul> <b>QIO Cooperation:</b> <ul style="list-style-type: none"> <li>• All grievances during the audit review period.</li> </ul>	
<b>Instructions:</b>	<b>General:</b> <ul style="list-style-type: none"> <li>• The review timeframe is the audit review period. Errors noted prior to the audit review period should not be included.</li> <li>• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.</li> </ul> <b>Investigation and Resolution of participant grievances:</b> <ul style="list-style-type: none"> <li>• Review each grievance and respond to the questions in the Participant Impact tab.</li> </ul> <b>Grievance Resolution Notification:</b> <ul style="list-style-type: none"> <li>• Review each grievance and respond to the questions in the Participant Impact tab.</li> </ul> <b>QIO Cooperation:</b> <ul style="list-style-type: none"> <li>• Review each grievance and respond to the questions in the Participant Impact tab.</li> </ul>	
<b>Impact Analysis Due Date:</b>		

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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<b>Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)</b>	<b>Brief Description Of Issue (Completed By The CMS Audit Lead)</b>	<b>Condition Language (Completed By The CMS Audit Lead)</b>
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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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Section 1. General Information. This information is to be completed for all Impact Analyses.						
Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Person who submitted the Grievance (participant, family member, designated representative, caregiver)	Date Grievance Received MM/DD/YYYY	Enter a brief description of each issue identified in the grievance.

Section 2. This information is to be completed if the Impact Analysis is being requested for Investigation and Resolution of participant grievances.					
Was an investigation completed for all distinct issues that required an investigation?	Which issues that required an investigation were not investigated? Enter a brief description.	Were ALL of the issues within the grievance resolved?	Which issues were unresolved? Enter a brief description.	Why were the issues not resolved?	Did the participant experience any negative outcomes as a result of the failure to investigate (if applicable) and resolve all issues within a grievance?
Enter NA if none of the issues required an investigation.  (Yes/No/NA)	Enter NA if none of the issues required an investigation.	Yes/No	Enter NA if all issues within the grievance were resolved.	Enter NA if all issues within the grievance were resolved.	(Yes/No)  Enter NA if all issues within the grievance were investigated (if applicable) and resolved.
If the auditor did not select Investigation and Resolution of participant grievances on the Instructions tab the PD may enter NA in all columns in Section 2.					

<b>Section 3 - This information is to be completed if the Impact Analysis is being requested per Grievance Resolution Notification</b>							
Did grievance resolution notification include all of the required content?  • Enter <u>NA</u> if the individual who submitted the grievance requested for the PO to withhold notification.  (Yes/No/NA)  If the auditor did not select Grievance Resolution Notification on the instructions tab the PO may enter NA in all columns in Section 3.  If the answer to this question is NA enter NA in all remaining columns in section 3.	Were any of the issues within the grievance related to quality of care concerns?  (Yes/No)  A quality of care concern means a concern that care provided did not meet a professionally recognized standard of health care.	Was an investigation of one or more issues within the grievance required?  (Yes/No)	Was corrective action required as a result of the grievance?  (Yes/No)	Date oral notification was provided.  MM/DD/YYYY  Enter "Not Provided" if the individual requested to receive oral notification and notification was not provided.  Enter <u>NA</u> if the individual who submitted the grievance requested to receive <u>written notification only</u> .	Date written notification was provided.  MM/DD/YYYY  Enter "Not Provided" if the individual requested to receive written notification or if any of the issues within the grievance were related to quality of care concerns and notification was not provided.  Enter <u>NA</u> if the individual who submitted the grievance requested to receive <u>oral notification only</u> .	Did oral or written grievance resolution notification include a summary of all distinct issues?  (Yes/No)	Did oral or written grievance resolution notification include a summary of the pertinent findings or conclusions (if an investigation was required)?  Enter <u>NA</u> if <u>NONE</u> of the issues within the grievance required an investigation.  (Yes/No/NA)

Did oral or written grievance resolution notification identify the corrective actions taken (or those that would be taken) as a result of the grievance (if corrective actions were required)?  Enter <u>NA</u> if <u>NONE</u> of the issues within the grievance required corrective actions. (Yes/No/NA)	Did written grievance resolution notification describe the right to file a written complaint with the QIO with regard to Medicare covered services (if the grievance was related to a quality of care concern)?  Enter <u>NA</u> if the grievance <u>WAS NOT</u> related to quality of care concerns. (Yes/No/NA)	Did the participant experience any negative outcomes as a result of a failure to provide all necessary information in oral and/or written grievance resolution notification?  Enter <u>NA</u> if grievance notification included all required content. (Yes/No/NA)
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Section 4 - This information is to be completed if the Impact Analysis is being requested for QIO Cooperation					Section 5 - General Information: This information is to be completed for all impact	
Was the grievance or any issue within the grievance referred to a QIO? (Yes/No)  If the auditor did not select QIO Cooperation on the Instructions tab the PO may enter NA in all columns in Section 4.  If the answer to this question is No enter NA in all remaining columns in section 4.	Did the QIO request any information or assistance from the PO to resolve the complaint? (Yes/No)  If the answer to this question is No enter NA in all remaining columns in section 4.	Did the PO cooperate with the QIO in resolving the complaint? (Yes/No)  If the answer to this question is Yes enter NA in all remaining columns in section 4.	If the PO did not cooperate with the QIO in resolving the complaint, please provide an explanation.	Did the participant experience any negative outcomes as a result of a failure cooperate with the QIO in resolving the complaint?  (Yes/No)	If the participant experienced any negative outcomes, please describe the 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 grievance, please enter the information in this column.