

Audit Review Period:		
Issue(s) of non-compliance:	Auditors: Select All that Apply	Issue:
		Incorporating recommendation from initial assessments into the initial plan of care
		Care plan timeliness
		Discussion with the participant and/or caregiver
		Content of Plan of Care
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:	<p>General:</p> <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. The review timeframe is the audit review period. Errors noted before or after 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. <p>Incorporating recommendation from initial assessments into the initial plan of care:</p> <ul style="list-style-type: none"> Review the selected medical records to determine if all IDT member recommendations in <u>initial</u> assessments were incorporated into the initial plan of care. Respond to the questions in the Participant Impact tab. <p>Care plan timeliness:</p> <ul style="list-style-type: none"> Review the plans of care for the selected medical records to determine when they were finalized. Respond to the questions in the Participant Impact tab. <p>Discussion with the participant and/or caregiver:</p> <ul style="list-style-type: none"> Review the plans of care for the selected medical records to determine if care plan was reviewed with the participant and/or caregiver. Respond to the questions in the Participant Impact tab. <p>Content of Plan of Care:</p> <ul style="list-style-type: none"> Review the plans of care for the selected medical records Respond to the questions in the Participant Impact 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)
-----------------------	-----------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------

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)
-----------------------------------------------------------	-----------------------------------------------------------	----------------------------------------------------------------------------------------------------	---------------------------------------------------------------	---------------------------------------------------------------

Section 1 - General Information: This information is to be completed for all Impact Analyses						To be completed by the PO for each participant
Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY Enter NA if the participant is still enrolled.	Was a care plan (any type) completed or due during the audit review period? (Yes/No) If No, enter NA in all remaining columns.

Section 2 - This information is to be completed if the Impact Analysis is being requested for: Incorporating recommendation from initial assessments into the initial plan of care			
Was the participant enrolled during the audit review period? (Yes/No) If <u>No</u> , enter NA in all remaining columns in Section 2. If the auditor did not select Incorporating recommendation from initial assessments into the initial plan of care on the instructions tab enter NA in all columns in Section 2.	Were all services recommended by the PCP, RN, MSW, PT, OT, recreational therapist/activities coordinator, dietitian, home care coordinator, in their initial assessments, incorporated as interventions in the initial care plan as recommended? For purposes of this impact analysis, 'as recommended' means the same or more services as those identified in the initial assessments. (Yes/No) If <u>Yes</u> , enter NA in all remaining columns in Section 2.	If any recommended services were not incorporated as interventions in the initial care plan as recommended, identify each service. Enter <u>each recommended service</u> that was <u>not</u> incorporated as an intervention in a <u>new row</u> . <u>Please note:</u> Impact analyses will be <u>returned</u> for correction if each service is not listed in a new row.	Did the IDT document their rationale for not including the recommended service as an intervention in the initial care plan? (Yes/No)

			Section 3 - This information is to be completed if the Impact Analysis is being requested for: Care plan timeliness			
Was the recommended service authorized (ordered, care planned, approved) by the IDT? (Yes/No)	Date the recommended service was provided? MM/DD/YYYY Enter 'Not Provided' if the service was ordered but not provided. Enter 'Pending' if the service was ordered and is currently pending. Enter NA if the service was not authorized by the IDT.	If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to incorporate recommended services from initial assessments into the initial care plan? (Yes/No)	Initial Plan of Care Timeliness Did the IDT complete an initial plan of care within 30 calendar days of the participant's date of enrollment? (Yes/No) Enter NA if the participant's date of enrollment is prior to the audit review period. If the auditor did not select Care plan timeliness on the instructions tab enter NA in all columns in Section 3.	Semiannual Plan of Care Timeliness Did the IDT complete a semiannual reevaluation of the plan of care within 180 calendar days from the date the latest plan of care was finalized? (Yes/No) Enter NA if the semiannual care plan evaluation was not due during the audit review period.	Unscheduled Plan of Care Timeliness Did the IDT complete an unscheduled reevaluation of the plan of care within 14 calendar days after the PACE organization determined, or should have determined, there was a change in the participant's health or psychosocial status, or within the 14 days from the date of discharge from a hospital (if the participant was hospitalized)? (Yes/No) Enter NA if the participant did not have a change in status during the audit review period.	If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to develop or evaluate the care plan within the required timeframes? (Yes/No)

Section 4 - This information is to be completed if the Impact Analysis is being requested for: Discussion with the participant and/or caregiver	
<p>Participant and Caregiver Involvement</p> <p>Did the IDT review and discuss <u>each</u> plan of care with the participant or the participant's caregiver or both before the plans of care were completed to ensure that there was agreement with the plans of care and that the participant's concerns were addressed?</p> <p>(Yes/No)</p> <p>Enter NA if no plans of care were due or completed during the audit review period.</p> <p>If the auditor did not select Discussion with the participant and/or caregiver on the instructions tab enter NA in all columns in Section 4.</p>	<p>If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to discuss the care plan with the participant and/or caregiver?</p> <p>(Yes/No)</p>

Section 5 - This information is to be completed if the Impact Analysis is being requested for: Content of Plan of Care

Participant Needs	Minimum Content Requirements	Interventions	Implementation of Interventions
Did <u>each</u> plan of care identify <u>all</u> of the participant's current medical, physical, emotional, and social needs, including all needs associated with chronic diseases, behavioral disorders, and psychiatric disorders that require treatment or routine monitoring? (Yes/No) Enter NA in all of the columns in Section 5 if no plans of care were due or completed during the audit review period. If the auditor did not select Content of Plan of Care on the instructions tab enter NA in all columns in Section 5.	At a minimum, did <u>each</u> care plan address: vision, hearing, dentition, skin integrity, mobility, physical functioning (including activities of daily living), pain management, nutrition (including access to meals that meet the participant's daily nutritional and special dietary needs), the participant's ability to live safely in the community (including the safety of their home environment), home care, center attendance, transportation, and communication (including any identified language barriers)? (Yes/No)	Did <u>each</u> plan of care identify <u>each</u> intervention (the care and services) needed to meet <u>each</u> medical, physical, emotional, and social need (except for medications)? (Yes/No)	Did <u>each</u> plan of care identify how <u>each</u> intervention would be implemented, including a timeframe for implementation? (Yes/No)

					Section 6 - General Information: This information is to be completed for all Impact Analyses	
Measurable Goals Did <u>each</u> plan of care identify measurable goals for <u>each</u> intervention? (Yes/No)	Evaluation of Measurable Goals Did <u>each</u> plan of care identify how the goal for <u>each</u> intervention will be evaluated to determine whether the intervention should be continued, discontinued, or modified? (Yes/No)	Participant Preferences Did <u>each</u> plan of care identify participant's preferences and goals of care? (Yes/No) Enter NA if no plans of care were due or completed during the audit review period.	Which types of care plans were impacted by noncompliance? (Initial, Semi-annual, Unscheduled)	If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to develop and/or reevaluate each plan of care, as required? (Yes/No)	If the participant experienced any negative outcomes, please describe the negative outcomes. Enter NA if there were no 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 appeal, please enter the information in this column.