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| <b>Audit Review Period:</b>        |  |   |
| <b>Issue(s) of non-compliance:</b> | <b>Auditors:</b><br><b>Select All that Apply</b>   | <b>Issue:</b>   |
|                                    |  | Documenting the reason(s) for not approving or providing recommended care or services |
|                                    |  | Review of hospital, ER, and urgent care recommendations within the required timeframe |
|                                    |  | Review of all other recommendations within the required timeframe                     |
| <b>Scope:</b>                      | <ul style="list-style-type: none"> <li>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.</li> <li>The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.</li> </ul>   |   |
| <b>Instructions:</b>               | <p><b>General:</b></p> <ul style="list-style-type: none"> <li>Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.</li> <li>The review timeframe is the audit review period. Errors noted before or after 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> <p><b>Documenting the reason(s) for not approving or providing recommended care or services:</b></p> <ul style="list-style-type: none"> <li>Review the selected medical records to determine if <u>any employees or contractors</u>, including specialists, ER providers, urgent care providers, or hospital providers recommended services for the participant.</li> <li>Respond to the questions in the Participant Impact tab.</li> </ul> <p><b>Review of Hospital, ER, and Urgent Care Recommendations:</b></p> <ul style="list-style-type: none"> <li>Review the selected medical records to determine if <u>ER providers, hospital providers, or urgent care providers</u> recommended services for the participant.</li> <li>Respond to the questions in the Participant Impact tab.</li> </ul> <p><b>Review of All Other Recommendations:</b></p> <ul style="list-style-type: none"> <li>Review the selected medical records to determine if <u>any other employees and contractors</u> (other than ER providers, hospital providers, and urgent care providers) recommended services for the participant.</li> <li>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<br>Number | Brief Description Of Issue<br>(Completed By The CMS Audit Lead) | Type of Issue Identified<br>(Completed By The CMS Audit Lead)<br><br>(Applies to condition <u>1P.02 Only</u> .<br>For all other conditions enter N/A) | Detailed Description of the Issue<br><br>(Explain what happened) |
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| <b>Date Identified<br/>(MM/DD/YY)<br/>(Completed By The<br/>CMS Audit Lead)</b> | <b>Brief Description Of Issue<br/>(Completed By The CMS Audit Lead)</b> | <b>Condition Language<br/>(Completed By The CMS Audit Lead)</b> |
|---|---|---|
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| Root Cause Analysis for the Issue<br>(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/<br>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 |                       |                                 |                |                                  |   | To be completed by the PO for each participant   |
|--|-----------------------|---------------------------------|----------------|----------------------------------|---|--|
| Participant First Name   | Participant Last Name | Medicare Beneficiary Identifier | Participant ID | Date of Enrollment<br>MM/DD/YYYY | Date of Disenrollment<br>MM/DD/YYYY<br><br>Enter NA if the participant is still enrolled. | Were recommendations made by any employees or contractors, including recommendations from specialists, emergency room providers, or hospital providers, during the audit review period?<br><br>(Yes/No)<br><br>If No, enter NA in all remaining columns. |
|  |                       |                                 |                |                                  |   |  |

| Section 2 - This information is to be completed if the Impact Analysis is being requested for: Documenting the reason(s) for not approving or providing recommended care or services  |   |   |   |
|---|---|---|---|
| <p>Were all recommended services approved and provided?<br/>(Yes/No)</p> <p>If <b>Yes</b>, enter NA in all remaining columns in Section 2.</p> <p>If the auditor did not select Documenting the reason(s) for not approving or providing recommended care or services on the instructions tab enter NA in all columns in Section 2.</p> | <p>Did the IDT document the reason(s) for not approving or providing all recommendations for care and services made by employees and contractors, including recommendations from specialists, emergency room providers, and hospital providers, during the audit review period?</p> <p>(Yes/No)</p> <p>If <b>Yes</b>, enter NA in all remaining columns in Section 2.</p> | <p>Recommended Services</p> <p>If the IDT <u>did not</u> document the reason(s) for not approving or providing all recommended care and services, enter <u>each recommended service</u> that was not approved or provided in a <u>new row</u>.</p> <p>Only include services that were not approved and provided. Only include services if the IDT did not document a reason for not approving or providing the services.</p> <p>Please note: Impact analyses will be <u>returned</u> for correction if each service is not listed in a new row.</p> | <p>Source of Recommendations</p> <p>Enter a description of the employee or contractor that made the recommendation. For example, PCP, RN, MSW, pulmonologist, oncologist, dentist, hospital, ER, etc.</p> |

| Date of Recommendations<br>MM/DD/YYYY | Documentation of Recommendations<br>Were the recommendations documented in the medical record before the Entrance Conference of the CMS audit?<br><br>(Yes/No) | Necessary Services<br>Were the recommended services necessary to meet the participants medical, physical, emotional, or social needs?<br><br>(Yes/No) | Rationale (if known)<br>What was the IDT's rationale for not approving or providing the recommended care or services (if known)? | If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to document why recommended services were not approved or provided by the IDT?<br><br>(Yes/No) |
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Section 3 - This information is to be completed if the Impact Analysis is being requested for: Review of Hospital, ER, and Urgent Care Recommendations

| Review of Hospital, ER, and Urgent Care Recommendations  | Recommended Services   | Source of Recommendations  | Date of Discharge | Time of Discharge  | Date Recommendation Reviewed by IDT   | Time of Recommendation Reviewed by IDT                                       | If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to review recommended services and/or determine if they were necessary to meet the participant's needs within 48 hours from the time of discharge? |
|--|--|--|-------------------|--------------------|---|--|---|
| <p>Did the appropriate member(s) of the IDT review all recommendations from hospitals, emergency departments, and urgent care providers and determine if the recommended services were necessary to meet the participant's medical, physical, social, or emotional needs as expeditiously as the participant's health condition requires, but no later than <b>48 hours from the time of the participant's discharge</b>?</p> <p>(Yes/No)</p> <p>If <u>Yes</u>, enter NA in all remaining columns in Section 3.</p> <p>If the auditor did not select Review of Hospital, ER, and Urgent Care Recommendations on the instructions tab enter NA in all columns in Section 3.</p> | <p>If the IDT <u>did not</u> review all recommendations from hospitals, emergency departments, and urgent care providers and determine if the services were necessary within 48 hours from the time of the participant's discharge, enter <u>each recommended service</u> in a <u>new row</u>.</p> <p>Only include recommended services that were <u>not</u> reviewed within 48 hours from the time of discharge.</p> <p>Please note: Impact analyses will be <u>returned</u> for correction if each service is not listed in a new row.</p> | <p>(Hospital Provider, ER Provider, or Urgent Care Provider)</p> | <p>MM/DD/YYYY</p> | <p>HH:MM AM/PM</p> | <p>MM/DD/YYYY</p> <p>Enter NA if the recommendation was never reviewed.</p> | <p>HH:MM AM/PM</p> <p>Enter NA if the recommendation was never reviewed.</p> | <p>(Yes/No)</p>   |

Section 4 - This information is to be completed if the Impact Analysis is being requested for: Review of All Other Recommendations

| Review of All Other Recommendations   | Recommended Services   | Source of Recommendations  | Date of Recommendation | Date Recommendation Reviewed by IDT   | If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to review recommended services and/or determine if they were necessary to meet the participant's needs within 7 calendar days from the date the recommendation was made? |
|---|--|--|------------------------|---|---|
| <p>Did the appropriate member(s) of the IDT review all recommendations from other employees and contractors and determine if the recommended services are necessary to meet the participant's medical, physical, social, or emotional needs as expeditiously as the participant's health condition requires, but no later than <u>  </u> calendar days from the date the recommendation was made?</p> <p>(Yes/No)</p> <p>If <b>Yes</b>, enter NA in all remaining columns in Section 4.</p> <p>If the auditor did not select Review of All Other Recommendations on the instructions tab the PO may enter NA in all columns in Section 4.</p> | <p>If the IDT <u>did not</u> review all recommendations from other employees and contractors and determine if the services were necessary within 7 calendar days from the date the recommendation was made, enter <u>each recommended service</u> in a <u>new row</u>.</p> <p>Only include recommended services that were <u>not</u> reviewed within 7 calendar days from the date the recommendation was made.</p> <p>Please note: Impact analyses will be <u>returned</u> for correction if each service is not listed in a new row.</p> | <p>Identify the employee or contractor that made the recommendations.</p> <p>Examples include, but are not limited to: PCP, RN, MSW, dietitian, rheumatologist, cardiologist, dentist, audiologist, SNF, home care provider, wound care specialist, etc.</p> | <p>MM/DD/YYYY</p>      | <p>MM/DD/YYYY</p> <p>Enter NA if the recommendation was never reviewed.</p> | <p>(Yes/No)</p>   |

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| Section 5 - General Information: This information is to be completed for all Impact Analyses  |  |
| <p>If the participant experienced any negative outcomes, please describe the negative outcomes.</p> <p>Enter NA if there were no 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 appeal, please enter the information in this column.</p> |