

<b>Audit Review Period:</b>		
<b>Issue(s) of non-compliance:</b>	<b>Auditors: Select All that Apply</b>	<b>Issue:</b>
		Restriction of Services
		Cost-Sharing
<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>• Respond to the questions 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>Restriction of Services:</b></p> <ul style="list-style-type: none"> <li>• Review the selected medical records to determine if any limitations were applied to Medicare or Medicaid benefits.</li> </ul> <p><b>Cost Sharing:</b></p> <ul style="list-style-type: none"> <li>• Review the selected medical records to determine if deductibles, copayments, coinsurance, or other cost-sharing were applied to any services determined necessary by the IDT.</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	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY  Enter NA if the participant is still enrolled.

Section 2 - This information is to be completed if the Impact Analysis is being requested for: Restriction of Services			
<p>During the audit review period, were any limitations applied to the amount, duration, or scope of Medicare or Medicaid benefits that were:</p> <ul style="list-style-type: none"><li>• determined necessary by the IDT or an IDT member;</li><li>• approved by IDT;</li><li>• included in the participant's care plan; or</li><li>• ordered by a PCP?</li></ul> <p>(Yes/No)</p> <p>These limitations may include, but are not limited to, Home Care, DME, Medications, Dental Services, Hearing Services, Nursing Facility stays/placement, ER use, etc.</p> <p>If the auditor did not select Restriction of Services on the instructions tab the PO may enter NA in all columns in Section 2.</p>	<p>Describe the <u>service</u> that was:</p> <ul style="list-style-type: none"><li>• determined necessary by the IDT or an IDT member;</li><li>• approved by IDT;</li><li>• included in the participant's care plan; or</li><li>• ordered by a PCP.</li></ul> <p>(Example: Glasses, home care, hearing aids, etc.)</p> <p>Enter <u>each</u> service that was limited in a <u>new row</u>.</p> <p>Please note: Impact analyses will be <u>returned</u> for correction if each limitation is not listed in a <u>new row</u>.</p>	<p>Indicate whether the service was:</p> <ul style="list-style-type: none"><li>• determined necessary by the IDT or an IDT member;</li><li>• approved by IDT;</li><li>• included in the participant's care plan; or</li><li>• ordered by a PCP.</li></ul> <p>If another scenario applies, please enter a brief description.</p>	<p>Date the service was:</p> <ul style="list-style-type: none"><li>• determined necessary by the IDT or an IDT member;</li><li>• approved by IDT;</li><li>• included in the participant's care plan; or</li><li>• ordered by a PCP.</li></ul> <p>MM/DD/YYYY</p>

Describe the limitation that was applied.  (Examples: Glasses only provided once a year, or home care is not provided overnight, etc.)	Describe <u>why</u> the limitation was applied.	Who applied the limitation (or determined that the limitation should apply)?  (Example: IDT, PCP, Center Manager, Executive Director, PACE Governing Body, etc.)	What date was the determination to limit the service rendered?  MM/DD/YYYY	Did the participant ever receive the service without limitation (per the original request or determination)?  (Yes/No)	If yes, date the participant received the service without limitations (as determined necessary, approved, care planned or ordered).  MM/DD/YYYY  Enter NA if there was a limitation applied.	If the participant experienced negative outcomes, did they occur, in some part, as a result of the restriction of a service?  (Yes/No)  Enter NA if there were no negative outcomes

Section 3 -This information is to be completed if the Impact Analysis is being requested for: Cost-Sharing		
During the audit review period, did the participant, their family members, caregivers, etc. pay for any service determined necessary by the IDT?  This includes any deductibles, copayments, coinsurance, or other cost-sharing.  This does not include any post-eligibility treatment of income amount that is determined by the State Administering Agency.  (Yes/No)  If the auditor did not select Cost-Sharing on the instructions tab the PO may enter NA in all columns in Section 3.  If the response to this question is No enter NA in all remaining columns in Section 3.	Describe the <u>service</u> .  Enter <u>each</u> service in a <u>new row</u> .  Please note: Impact analyses will be <u>returned</u> for correction if each service is not listed in a <u>new row</u> .	Enter the amount the participant, their family members, caregivers, etc. paid for the service.

Date the participant, their family members, caregivers, etc. paid for the service.  MM/DD/YYYY  If the date is not known enter, 'Unknown.'	Did the PO reimburse the participant, their family members, caregivers, etc. for the amount paid (in full)?	Date the PO reimbursed the participant, their family members, caregivers, etc. for the amount paid (in full).  MM/DD/YYYY	If the participant experienced negative outcomes, did they occur, in some part, as a result of cost-sharing?  (Yes/No)  Enter NA if there were no negative outcomes
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Section 4 - 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 participant, please enter the information in this column.</p>