Audit Review Period:	

Issue of non-compliance:	Home care services

Scope:	• The scope of this Impact Analysis is limited to 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:	• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab. • Review the selected medical records to determine if home care services were not provided, delayed, or reduced at any point during the audit review period. • The review timeframe is the audit review period. Issues noted before or after the audit review period should not be included. • Respond to the questions in the participant impact tab for all participants. If a participant was not impacted by the condition (i.e., they received all home care services in a timely manner), the PO should enter No in Column F and NA in all additional blue fields. Please do not leave any blank spaces. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the changes in the RCA tab.

Impact Analysis Due Date:	

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)

Detailed Description of the Issue (Explain what happened) (Remaining fields to be Completed by PACE Organization)	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)

Participant First Name	Participant Last Name	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY

During the Audit Review Period a. Did the IDT determine home care was necessary; b. Did a provider order home care; or c. Was home care included in the care plan? Enter Yes if any of the above are true. Enter No if home care services were not determined necessary, approved or ordered. If No is entered, the organization may enter NA in all remaining fields.	If the answer to column F is Yes, please indicate whether the home care was: a. Determined necessary by the IDT; b. Approved as part of a service delivery request; c. Approved as part of an appeal; d. Ordered by a provider?	If the answer to column F is Yes, was home care included in the care plan? (Yes/No)

Enter the type of home care that was determined necessary, approved or ordered (e.g., chore services, medication administration, etc.). If the participant was approved for multiple types of home care services, please identify each on a separate line in the IA.	Enter the date when home care was first determined necessary, approved, ordered, or care planned (start date).	Please enter the participant's home care schedule (how many days a week, etc.).

Enter the total number of hours per week home care services were determined necessary, approved, ordered, or care planned.	**If there was a delay in providing home care, enter Delayed.** **If home care services were never provided enter Not Provided.** **If home care services were reduced, enter Reduced.** **Enter NA if home care services were promptly provided as approved/ordered.**	**If there was a delay, when did the participant begin receiving the number of home care hours/schedule determined necessary, approved, ordered, or care planned?** **If home care services were never provided enter Not Provided.** **Enter NA if home care services were promptly provided as approved/ordered.**

At any point during the audit review period was there any reduction in home care hours that resulted from staffing, financial, or resource issues? (Yes/No/NA) Do not include decreases requested by the participant or caregiver.	If the answer to column O is yes, when did the participant begin receiving reduced home care hours?	If the answer to column O is yes, how many hours of homecare was the participant actually receiving?

If the participant's necessary, approved, ordered, or care planned home care services were delayed or reduced or not provided, please explain the cause.	Were there any negative outcomes resulting from: a. a delay in the start of home care; b. Not providing home care; or c. a reduction in the number of hours of home care? (Yes/No/NA)	If Yes, 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 participant, please enter the information in this column.