

<b>Audit Review Period:</b>	
<b>Issue of non-compliance:</b>	IDT remaining alert to pertinent input
<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>	<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>• Review documentation during the audit review period identified in this tab (Instructions).</li> <li>• Determine if the IDT remained alert to pertinent information from any individual with direct knowledge of or contact with the participant, including: other team members, participants, caregivers, employees, contractors, and designated representatives.</li> <li>• Respond to the questions in the Participant Impact tab.</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>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 1F.02 Only. 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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Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID

<div>Date of Enrollment</div> <div>MM/DD/YYYY</div>	<div>Date of Disenrollment</div> <div>MM/DD/YYYY</div> <div>Enter NA if the participant is still enrolled.</div>
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During the audit review period, did the IDT (or any member of the IDT) fail to remain alert to pertinent information from any individual with direct knowledge of or contact with the participant?

(Yes/No)

If NO, enter NA in all remaining columns.



**When was the information initially reported (the date the information was first documented)?**

**MM/DD/YYYY**

**Enter NA if the IDT remained alert to all pertinent information during the audit review period.**

Provide a brief description of the information.

Enter NA if the IDT remained alert to all pertinent information during the audit review period.

<p><b>Who initially reported the information?</b></p> <p>Examples include, but are not limited to: PCP, RN, MSW, RT, OT, PT, HCC, dietitian, center manager, PCA, driver, participant, caregiver, other employees, contractors, and designated representative.</p> <p>Enter NA if the IDT remained alert to all pertinent information during the audit review period.</p>	<p><b>Which IDT member initially received the information (PCP, RN, MSW, RT, OT, PT, dietitian, HCC, center manager, PCA, driver)?</b></p> <p>If not communicated to the IDT or a member of the IDT, enter Not Communicated.</p> <p>Enter NA if the IDT remained alert to all pertinent information during the audit review period.</p>
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<p>Did the appropriate members of the IDT take action in response to the information at some point (even if the action was delayed)?</p> <p>(Yes/No)</p> <p>If not communicated to the IDT, enter Not Communicated.</p> <p>Enter NA if the IDT remained alert to all pertinent information during the audit review period.</p>	<p>Date the appropriate members of the IDT took action in response to the information.</p> <p>MM/DD/YYYY</p> <p>Enter NA if the IDT did not take any actions in response to the information or if the IDT remained alert to all pertinent information during the audit review period.</p>
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<p>Did the failure to remain alert to pertinent information cause a delay in or failure to: assess the participant, provide necessary care and/or services, provide access to emergency care, etc.?</p> <p>(Yes/No)</p> <p>Enter NA if the IDT remained alert to all pertinent information during the audit review period.</p>	<p>If the failure to remain alert to pertinent information caused a delay in or failure to: assess the participant, provide necessary care and/or services, provide access to emergency care, etc., <u>please describe</u> the care and/or services that were not provided or delayed.</p> <p>Enter NA if all necessary care and services were provided without delay or if the IDT remained alert to all pertinent information during the audit review period.</p>
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<p>Were the services delayed or not provided?</p> <p>Enter Delayed or Not Provided</p> <p>Enter NA if all necessary care and services were provided without delay or if the IDT remained alert to all pertinent information during the audit review period.</p>	<p>If delayed, what date did the participant receive the appropriate care and/or services?</p> <p>MM/DD/YYYY</p> <p>Enter Not Provided if the services were never provided.</p> <p>Enter NA if all necessary care and services were provided without delay or if the IDT remained alert to all pertinent information during the audit review period.</p>
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<p>What documentation or evidence does the PO have to demonstrate that the necessary care and/or services were provided?</p> <p>(i.e., progress note in the medical record, record from a specialist, etc.).</p> <p>Enter NA if all necessary care and services were provided without delay or if the IDT remained alert to all pertinent information during the audit review period.</p>	<p>If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide or a delay in the provision of care and/or services?</p> <p>(Yes/No)</p> <p>Enter NA if the IDT remained alert to all pertinent information during the audit review period.</p>
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If yes, describe the negative outcomes.

Enter NA if there were no negative outcomes or if the IDT remained alert to all pertinent information during the audit review period.



**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.**