Audit Review Period:	

Issue of non-compliance:	Provision of 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 any limitations were applied to Medicare, Medicaid, or PACE benefits. • Respond to the questions 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 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, were any limitations applied to the amount, duration, or scope of Medicare or Medicaid benefits that were: **• requested by the participant/participant representative ;** **• determined necessary by the IDT or an IDT member;** **• Approved by IDT;** **• Included in the participant's care plan; or** **• ordered by a PCP or physician extender?** **(Yes/No)** **These limitation may include but are not limited to, Home Care, DME, Medications, Dental Services, Hearing Services, Nursing Facility stays/placement, ER use, etc.** **If No, the PO may enter NA in all remaining fields.**	**Date of initial request/determination/approval.** **MM/DD/YYYY** **Each limitation must be described on a new line.**

Was the service: • requested by the participant/participant representative ; • determined necessary by the IDT or an IDT member; • Approved by IDT; • Included in the participant's care plan; • ordered by a PCP or physician extender; or • ordered or recommended by a contracted or non-contracted provider? If another scenario applies, please enter a brief description.	Describe the service or item to which the limitation was applied. (Example: Glasses, home care, hearing aids, etc.)	If the service was requested or determined necessary by the IDT, what was the request or determination? (Example: participant requested overnight home care)

Describe the limitation that was applied. (Examples: Glasses only provided once a year, or home care is not provided overnight, etc.)	Describe why the limitation was applied.	Who applied the limitation (or determined that the limitation should apply)?

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 unlimited service (per the original request or determination). MM/DD/YYYY Enter NA if there was a limitation applied.	Were there any negative participant outcomes? (Yes/No)

If yes, describe the negative outcomes. Enter NA if the participant did not experience 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.