| Audit Review Period: | |
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| Issue(s) of non-compliance: | Auditors: Select All that Apply | Issue: |
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| | | Restriction of Services |
| | | Cost-Sharing |

| Scope: | • 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.<br><br>• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab. |
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| Instructions: | **General:**<br>• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.<br>• Respond to the questions in the Participant Impact tab.<br>• The review timeframe is the audit review period. Errors noted before or after the audit review period should not be included.<br>• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.<br><br>**Restriction of Services:**<br>• Review the selected medical records to determine if any limitations were applied to Medicare or Medicaid benefits.<br><br>**Cost Sharing:**<br>• 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. |
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| Impact Analysis Due Date: | |
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| 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 1P.02 Only.<br>For all other conditions enter N/A) | Detailed Description of the Issue<br><br>(Explain what happened) |
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| 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) |
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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 |
| --- | --- | --- | --- |

| 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 | | | | | | Section 2 - This information is to be completed if the Impact Analysis is being requested for: Restriction of Services | |
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| Participant First Name | Participant Last Name | Medicare Beneficiary Identifier | Participant ID | Date of Enrollment<br><br>MM/DD/YYYY | Date of Disenrollment<br><br>MM/DD/YYYY<br><br>Enter NA if the participant is still enrolled. | During the audit review period, were any limitations applied to the amount, duration, or scope of Medicare or Medicaid benefits that were:<br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP?<br><br>(Yes/No)<br><br>These limitations may include, but are not limited to, Home Care, DME, Medications, Dental Services, Hearing Services, Nursing Facility stays/placement, ER use, etc.<br><br>If the auditor did not select Restriction of Services on the instructions tab the PO may enter NA in all columns in Section 2. | Describe the service that was:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP.<br><br>(Example:  Glasses, home care, hearing aids, etc.)<br><br>Enter each service that was limited in a new row.<br>Please note: Impact analyses will be returned for correction if each limitation is not listed in a new row. |

| Indicate whether the service was:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP.<br><br>If another scenario applies, please enter a brief description. | Date the service was:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP.<br><br>MM/DD/YYYY | Describe the limitation that was applied.<br><br>(Examples: Glasses only provided once a year, or home care is not provided overnight, etc.) |
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| Describe _why_ the limitation was applied. | Who applied the limitation (or determined that the limitation should apply)?<br><br>(Example: IDT, PCP, Center Manager, Executive Director, PACE Governing Body, etc.) | What date was the determination to limit the service rendered?<br><br>MM/DD/YYYY | Did the participant ever receive the service without limitation (per the original request or determination)?<br><br>(Yes/No) | If yes, date the participant received the service without limitations (as determined necessary, approved, care planned or ordered).<br><br>MM/DD/YYYY<br><br>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?<br><br>(Yes/No)<br><br>Enter NA if there were no negative outcomes |
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| Section 3 -This information is to be completed if the Impact Analysis is being requested for: Cost-Sharing | | | | | | |
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| During the audit review period, did the participant, their family members, caregivers, etc. pay for any service determined necessary by the IDT?<br><br>This includes any deductibles, copayments, coinsurance, or other cost-sharing.<br><br>This does not include any post-eligibility treatment of income amount that is determined by the State Administering Agency.<br><br>(Yes/No)<br><br>If the auditor did not select Cost-Sharing on the instructions tab the PO may enter NA in all columns in Section 3.<br><br>If the response to this question is No enter NA in all remaining columns in Section 3. | Describe the service.<br><br>Enter each service in a new row.<br><br>Please note: Impact analyses will be returned for correction if each service is not listed in a new row. | 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.<br><br>MM/DD/YYYY<br><br>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).<br><br>MM/DD/YYYY | If the participant experienced negative outcomes, did they occur, in some part, as a result of cost-sharing?<br><br>(Yes/No)<br><br>Enter NA if there were no negative outcomes |

| Section 4 - General Information: This information is to be completed for all Impact Analyses | |
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| If the participant experienced any negative outcomes, please describe the negative outcomes.<br><br>Enter NA if there were no negative outcomes. | Optional: Please note, you do not have to complete this column.<br><br>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. |