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IN LCAR Provider Manual

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About Maximus

Since 1975, Maximus has pioneered innovative healthcare management solutions for programs that serve people with complex diagnostic profiles. Since 2000, Maximus has partnered with state agencies to assess people with mental illness and intellectual and developmental disabilities. We incorporate evidence-based practices into public sector healthcare management by combining information technologies, quality improvement and management initiatives, service oversight, provider training, and management of healthcare datasets.

Maximus' assessment process captures each person's needs and goals helping facility staff plan services and supports in a person-centered way. We combine our leadership team's experience with program staff and independent contractors who comprehensively assess people and identify services that will best meet their needs.

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Have Questions?

For questions about AssessmentPro™ including system access and password assistance: email INLCAR@Maximus.com, phone the help desk at 833.597.2777, or fax number 877.431.9568.

For clinical questions about a specific person or assessment, use the **communicate with clinical reviewer** feature within AssessmentPro.

For more information about Maximus, visit our website at www.maximusclinicalservices.com

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Level of Care (LOC) Background and Scope

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. States administer their Medicaid programs according to federal requirements and state statutes. Medicaid is funded jointly by both state funding and federal funding and is the largest source of health coverage in the United States.

Many people, either due to the need for increased care related to aging, or because of disabling conditions or chronic illnesses at any age, need long-term care, or long-term services and supports (LTSS). Although Medicaid is typically the payer of last resort (meaning that if a person has other healthcare coverage, that coverage should pay its share before Medicaid pays), Medicaid is the primary payer in the United States for LTSS and allows for coverage of LTSS across a continuum of settings and specific types of care and range from institutional care, such as nursing facility care, to community-based LTSS. Centers for Medicare & Medicaid Services (CMS) have a goal that LTSS is a person-centered system in which people who are aging and people with disabilities have choice, control, and access to a full array of services that support independence, health, and quality of life.

All states are required to provide nursing facility services as a Medicaid service, and many states provide Medicaid funded home and community-based services (HCBS), known as HCBS Waivers. In determining eligibility for nursing facility and HCBS services, states must provide these services for people that meet eligibility, both functionally and financially. However, each state individually sets their own limits within the federal parameters through their CMS-approved Medicaid state plan, which means eligibility varies from state to state.

States are also required to include in their Medicaid state plan the methods and procedures that they use to safeguard against the unnecessary use (referred to as utilization) of Medicaid services. Failure to have an effective program to control utilization of services (especially services provided in institutional settings) puts a State at risk for a reduction in the amount of federal Medicaid funds paid to the State. Accessing LTSS covered by Medicaid typically involves an assessment of needs and a determination of eligibility for services for Medicaid to cover the service, known as nursing facility level of care (NFLOC). In Indiana, the NFLOC assessment is used to access nursing facility services, HCBS Waivers that require individuals to meet nursing facility level care (NFLOC), and the Program for All-Inclusive Care for the Elderly (PACE). It is also needed for all nursing facility applicants or residents who have been referred for a Level II evaluation through the Preadmission Screening and Resident Review (PASRR) process.

Maximus has contracted with the Indiana Family and Social Services Administration (FSSA), Bureau of Better Aging (BBA), in partnership with the Division of Disability and Rehabilitative Services (DRS) and the Office of Medicaid Policy and Planning (OMPP) to complete NFLOC assessments and determinations for individuals seeking Medicaid funded nursing facility care, one of Indiana's HCBS Waivers that requires NFLOC to qualify, or services through PACE. Indiana's HCBS Waivers that require NFLOC to qualify for services include:

- PathWays for Aging Waiver (for individuals ages 60+)
- Health & Wellness Waiver (for individuals under age 60)
- TBI Waiver (for individuals of any age with a traumatic brain injury)

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About interRAI

There is no formal federal definition of NFLOC, so each state has the task of defining the NFLOC criteria for their state. Indiana's skilled care NFLOC criteria can be found at 405 IAC 1-3-1 and their intermediate care NFLOC criteria can be found at 405 I-A-C 1-3-2. As with the definition of NFLOC criteria, there is also no federal requirement for states to use a specific long-term care assessment to determine if NFLOC is met, so states choose functional assessment tools that support these determinations. For their NFLOC assessments, Indiana has selected comprehensive assessment instruments from interRAI™, a collaborative network of researchers and practitioners in the field of improving care for persons who are disabled or have medically complex needs. The interRAI™ assessment tools in use in Indiana for NF LOC are:

- **interRAI™ Home Care (HC):** Used for age 18+
- **interRAI™ Child and Youth Pediatric Home Care (PEDS-HC):** Used for ages 4-17
- **interRAI™ Early Years (EY):** Used for ages 0-4

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Who is Responsible for Completing interRAI assessments for NFLOC?

The IN Bureau of Better Aging (BBA), the IN Division of Disability and Rehabilitative Services (DDRS), and the IN Division of Mental Health and Addiction (DMHA) collaborate to administer long-term care services. The Indiana FSSA oversees these agencies. BBA oversees Level I and LOC. DDRS serves people with intellectual and developmental disabilities. DMHA serves people with mental health disabilities.

Depending on the individual's situation, different entities may complete the interRAI NFLOC assessment. Tables 1 and 2 provides details on the Maximus submission process. Table 1 explains who completes the interRAI NFLOC, while Table 2 explains who requests Maximus to complete the interRAI NFLOC.

Table 1: Submission Process for Maximus to Complete LOC Determination on a Completed interRAI HC LOC

Submitter	Process
Area Agencies on Aging (AAAs)	Completes appropriate LOC Assessment in AssessmentPro **only IF** the individual is already engaged in the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program and is now requesting NFLOC
Hospitals	Completes appropriate LOC Assessment in AssessmentPro for people seeking nursing facility admission (or readmission after a psychiatric admission) **only** and submits to Maximus for determination
Nursing Facilities (NFs)	Completes appropriate LOC Assessment for their residents in AssessmentPro for determination
PathWays Managed Care Entities (MCEs)	Completes MCE Comprehensive Health Assessment Tool (CHAT) in their own system for their members, and CHAT integrates into AssessmentPro for determination

Table 2: Submission Process for Maximus to Complete the interRAI HC LOC Assessment

Submitter	Process
Area Agencies on Aging (AAAs)	Requests LOC via phone, or Assessment Request form in AssessmentPro
Dual Eligible Special Needs Plans (DSNP)	Requests LOC via phone
Individual, Individual's Authorized Representative, or Others in Community (e.g. Individual's Provider)	Requests LOC via phone
Medicare Advantage Organizations (MAOs)	Requests LOC via phone
PACE Providers	Requests LOC via phone or Assessment Request form in AssessmentPro
State Agencies (with the exception of BDS)	Requests LOC via phone or Assessment Request form in AssessmentPro
Bureau of Disability Services (BDS)	Assessment requests occur via integration with BDS Portal system (in limited circumstances, BDS may submit an Assessment Request form in AssessmentPro)
State Health Insurance Assistance Program (SHIP)	Requests LOC via phone

Providers can monitor the progress of screens for any person in their facilities 24/7. To ensure efficient screening processes, providers should actively monitor AssessmentPro and respond promptly to communications from Maximus reviewers.

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Maximus' Role in LCAR Outcomes and Provider Support

Maximus provides and maintains a web-based assessment platform that hospitals, nursing facility, MCE, PACE, and AAA providers use to complete or request assessments and screens as appropriate. This platform, known as AssessmentPro, offers PASRR Pro-I™, LOC Pro™, and PathTracker™, which provides Maximus' web-based PASRR screening and tracking services.

Maximus' Program Support Staff (PSS) can answer non-clinical questions about things like workflow and timelines. They can provide direction to providers as needed and route technical questions about the website to the State's technical assistance provider or to Maximus' IT team as needed. Questions should be directed to INLCAR@maximus.com and will be routed as appropriate.

Maximus' Clinical Reviewers **clinically review** all NFLOC assessments completed by hospitals, nursing facilities, AAAs, and MCEs as outlined above. They also review all PASRR Level I screens that do not result in an immediate approval for nursing facility placement. For PASRR Level I screens, Clinical Reviewers also write an outcome that the provider can print directly from PASRR Pro-I™ and give to the assessed person. Clinical Reviewers may also use AssessmentPro to ask submitters to clarify or add information specific to that individual's assessment or screen.

Providers can also begin a NFLOC assessment or Level I screen and save it without submitting it. Doing this creates a "draft screen" that the provider can access for up to 72 hours. This lets providers return to the draft screen to correct it and to upload documentation before submitting the screen. Providers can also withdraw draft and submitted screens (for example, when a person dies or decides they no longer are seeking LTSS).

Please note all screens are subject to quality review by one of Maximus' Clinical Reviewers.

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Additional Resources

To access trainings, frequently asked questions, and other helpful resources about IN LCAR and AssessmentPro, visit the Indiana PASRR User Tools page at https://www.Maximusami.com/ami/Providers/YourState/IndianaPASRRUserTools.aspx.

You can find the federal HCBS Waiver regulations at 42 CFR 441 Part G and PASRR regulations at 42 CFR 483 Part C.

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Level of Care (LOC) Process

Submitting a Level of Care (LOC) Screen

Submitting a complete and prompt level of care screen to Maximus tees up the right services and supports for the person. To consider a screen complete, Maximus needs different information depending on who submits it (a nursing facility, hospital, MCE, or AAA). The table below lists how LOC assessments and/or assessment requests are submitted based on the individual's current location.

Table 4: LOC Submission Requirements by Individual's Location

Individual's Location	LOC Submission Type	LOC Submission Method

Hospital	**Hospital staff is responsible for:**
	• Level I screen
	• LOC for the following:
	  ○ All individuals who have a positive Level I
	  ○ All individuals who use Medicaid as the pay source for the nursing facility stay unless the individual has a valid LOC within the last 11 months
	  ○ Out-of-State individuals [in IN hospital whose Level I did not result in an automatic approval (requires both a LOC screen and Level II evaluation)]
	  ○ PASRR Categorical criteria met and individual does not have a valid LOC within the last 11 months
	  ▪ Provisional emergency
	  ▪ Respite when an individual is in the ER only
	  ▪ Terminal
	  ▪ Convalescent
	Note: Hospital staff only submit LOCs for individuals seeking nursing facility admission. If an individual is seeking waiver services, hospital staff contacts Maximus to request an LOC assessment.
		• Electronic

Nursing Facility	**Nursing facility staff is responsible for:**
	• Level I screens
	• LOC for the following:
	  ▪ Preadmission for only respite or Emergency unless the individual has a valid LOC within the last 11 months
	  ▪ Out-of-State individuals - if individual requires a Level II, must also complete an Assessment Request form to Maximus to complete the LOC
	  ▪ Otherwise, LOC is completed once Medicaid becomes the individual's pay source for the nursing facility stay
	  ○ Emergency or Categorical criteria met and the individual does not have a valid LOC within the last 11 months
	  ▪ Provisional Emergency
	  ▪ Respite
	  ○ Status Change, regardless of pay source with a valid LOC with the past 11 months
		• Electronic

	○ Continued Stay - applies when the individual requires nursing facility care beyond the approval end date and they have Medicaid as the payor source and/or a PASRR condition. ▪ If the person has a PASRR condition, a new Level I is required.	
Assisted Living Facilities (ALFs)	**ALF staff is responsible for:** • Completing the Assessment Request form	• Electronic
Community Receiving CHOICE Services	**AAA staff is responsible for:** • Submitting the LOC assessment **only IF** the individual is receiving Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) services and is now requesting NFLOC	• Electronic where internet access is available. • If no internet access is available, the paper interRAI HC is completed onsite, then transferred to the electronic version once internet access is regained.
Community with a Pathways MCE regardless of Service Choice	**MCE is responsible for:** • Completing the LOC assessment • Maximus completes the Level I if an individual is seeking a nursing facility admission	• CHAT
Community Seeking Waiver Services without a PathWays MCE	• **Individual contacts Maximus** and requests LOC assessment OR • **Provider, such as AAA, completes Assessment Request form** on behalf of the individual	• Phone • Electronic
Community Seeking PACE Services	**PACE staff is responsible for:** • Completing the Assessment Request form for initial assessments • Completing the LOC assessment for their members when annual reassessments are needed	• Electronic
Community Seeking Nursing Facility	**Individual contacts Maximus** and requests LOC assessment, unless the individual has a PASRR condition and meets PASRR categorial criteria (the nursing facility completes in this instance)	• Phone

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When is a LOC Screen Required?

The following LTSS require a LOC screen for Medicaid to provide funding for the service:

- Nursing facility
- PathWays for Aging Waiver
- Health & Wellness (H&W) Waiver
- Traumatic Brain Injury (TBI) Waiver
- PACE

Table 5: LOC Screens Needed by Service Type

Service	Situation(s) that Require LOC screen	Reason for LCAR in AssessmentPro
Nursing Facility	• Medicaid recipient is seeking admission to a Medicaid-certified nursing facility and is using Medicaid as pay source (and there has not been a valid LOC completed within the last 11 months)	Initial
Nursing Facility	• Individual is seeking admission to a Medicaid-certified nursing facility and requires a PASRR Level II, regardless of pay source	Initial
Nursing Facility	• Nursing facility resident becomes Medicaid-active and will be using Medicaid as the pay source for the nursing facility stay	Change of Status
Nursing Facility	• Nursing facility resident experiences a significant change in condition ("status change"), indicating the person has experienced: ○ a medical decline and may require a higher level of care, ○ a behavioral/psychiatric episode resulting in an exacerbation of symptoms and may require alternative services and/or supports. **Note:** A new LOC screen for status change referrals must be submitted within 14 days of the significant change event. For more details about status changes, see Federal Requirements of PASRR.	Change of Status
Nursing Facility	• Nursing facility resident had a prior short-term approval that is expiring and additional time in the nursing facility is being requested	Change of Status
Nursing Facility	• Nursing facility resident that has a PathWays for Aging MCE requires a routine reassessment every 3 years	Annual
• **PathWays for Aging Waiver** • **Health & Wellness Waiver** • **TBI Waiver**	• Individual is newly seeking Waiver services	Initial
• **PathWays for Aging Waiver** • **Health & Wellness Waiver** • **TBI Waiver**	• Individual is on a Waiver waitlist and receives a waiver invitation and has not had a valid LOC within the last 11 months	Change of Status **Note:** Maximus receives these referrals directly from FSSA's waiver management system, Integrated Management Portal (IMP). Providers DO NOT need to submit a request in this circumstance.
• **PathWays for Aging Waiver** • **Health & Wellness Waiver** • **TBI Waiver**	• Individual is actively receiving Waiver services requires a routine reassessment every year	Annual **Note:** Maximus automatically queues these based on the next assessment due date. Providers DO NOT need to submit a request in this

		circumstance.
• **PathWays for Aging Waiver** • **Health & Wellness Waiver** • **TBI Waiver**	• Individual is actively receiving Waiver services and has experienced a change in status that might result in them no longer meeting LOC for Waiver services	Change of Status
PACE	• Individual is newly seeking PACE	Initial
PACE	• Individual is actively receiving PACE services requires a routine assessment every year	Annual

Refer to the IN LCAR website for more information on when to submit a level of care screen.

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Needed Documentation

Providers need to upload any additional documentation that provides a complete and accurate picture of the person's needs at the time of submission. Nursing facilities and hospitals must include a History and Physical (H&P). Examples of other supporting documents include medication administration records (or MARs), sections A, C, G, and H of the current or most recent minimum data set (MDS), certified nursing assistant (CNA) flow sheets, and notes like behavioral therapy notes, nursing notes, progress notes, occupational therapy notes, and physical therapy notes.

Providers should monitor *Action Required* queue regularly for requests for additional information from Maximus. If specific information or documentation is needed, the system alerts you through this queue. You can open the individual's screen and upload any additional documents.

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Draft Screens and Turnaround Time

AssessmentPro saves draft level of care screens for 72 hours. Once a draft screen has expired, you cannot return to it. Your work is lost, and you need to start a new screen. See Draft Screen Expiration of this manual for more information.

AssessmentPro queues level of care screens to Maximus' Clinical Reviewers in chronological order. If a screen needs a clinical review, AssessmentPro typically notifies you of its outcome within 4 calendar days from when Maximus receives all the information we need to complete the review. If Maximus' Clinical Reviewer requests more information, the Clinical Reviewer puts the assessment on hold. Our turnaround clock's time stops ticking until we receive all the information we need. You should check the *Action Required* queue regularly for feedback and questions from our clinicians so you can respond and promptly upload any requested documentation or answer questions. Responding promptly to requests for information expedites the screening process. **If you do not respond to a request for more information in 10 business days or 14 calendar days, AssessmentPro cancels the Level I or LOC screen.** You need to submit a new level of care screen, and we must make a decision **before** the person can be admitted to a Medicaid-certified nursing

facility.

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LOC Clinical Review and Outcomes

For all completed LOC screens received from a hospital, nursing facility, MCE, or AAA, a Maximus Clinical Reviewer conducts a clinical review of the screen and supporting documentation, and issue one of the following outcomes:

- **Short Term Approval** (with a specified duration of 90 calendar days OR 7, 30, or 60 calendar days for an individual with an accompanying PASRR with a categorical outcome),
- **Long Term Approval**
- **Long Term Approval-TBI Waiver Approval/Denial** (this decision requires further evaluation as described below).

Note: **Regarding potential LOC denials:** Maximus does not make final determinations for an individual who does not appear to meet level of care. When this happens, Maximus' Clinical Reviewer selects the Potential Denial outcome and AssessmentPro queues the screen to the Medical Director and if the denial is upheld, to FSSA for a determination.

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Printing & Distributing Outcome Letters

When an outcome has been issued, AssessmentPro generates letters for providers to print off and distribute to applicable persons. Providers are responsible for printing and distributing outcome letters to the assessed person and their guardian, if applicable. If an individual is admitting to a facility and the individual's current location has been updated in AssessmentPro, the admitting facility can also view and print the outcome letter. All letters (approvals and denials) include a notice of the person's or guardian's right to appeal the decision.

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Intake Counseling

Once an individual receives a Level of Care determination, an individual may need to complete required intake counseling depending on their circumstances. The individual and/or their authorized representative must be present to complete the intake counseling session with Maximus or a local AAA depending on the individual's circumstances.

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Preadmission Screening and Resident Review (PASRR) Process

Background

PASRR stands for **P**re**a**dmission **S**creen and **R**esident **R**eview. PASRR began in the 1980s as part of an initiative to improve nursing facility care. In 1987 congress enacted the Omnibus Reconciliation Act of 1987 (OBRA-87), also known as the Nursing Home Reform Act. OBRA-87 protects individual rights, improves the quality of care and the quality of life for people who need nursing facility care.

A portion of this Act, known as PASRR, clarifies the role that nursing facility providers have in addressing their residents' behavioral health needs. PASRR:

- Identifies people who have or might have a serious mental illness (SMI), intellectual disability (ID), or a condition related to intellectual disability [referred to as related condition (RC)], based on the information available through a **Level I**. The Level I is a short screen that tries to answer this question: "Does this person have a known or suspected serious mental illness, an intellectual disability, or a related condition?" If the answer is **no**, then the nursing facility may admit the person if they meet the State's criteria for nursing facility level of care. If the answer is **yes** or **maybe**, further evaluation is required before the person can go into the nursing facility. Per federal requirements, every person who is seeking admission to a Medicaid-certified nursing facility must be screened for the presence of an MI, ID or RC condition before the provider can admit them into a Medicaid-certified nursing facility.
- Determine services and supports any person with MI/ID/RC need. The PASRR **Level II** evaluation identifies the rehabilitative or specialized services that the person needs. **Nursing facilities must plan for and deliver or arrange for the delivery of all rehabilitative services that the PASRR Level II identifies.**
- Determine the most appropriate setting for any person with MI/ID/RC. Assessors should consider two factors: what is the least restrictive setting necessary that also meets the person's needs. In its *Olmstead v. L.C. (1999)* decision, the US Supreme Court found that the Americans with Disabilities Act protects mental illness as a form of disability. The Supreme Court also held that people with mental disabilities have the right to live in the community instead of in an institution when the person wants to live in the community and when the State's treatment professionals have deemed community-based services appropriate for the person's needs. Additionally, the Supreme Court held that unjust segregation based on a disability is discrimination.

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Federal Requirements of PASRR

The Centers for Medicare and Medicaid Services (CMS) require PASRR assessments. These PASRR assessments must:

- Identify people with SMI, ID, or RC
- Determine the appropriate placement for those people and identify the services they need

Nursing facility providers must address both the medical and behavioral needs of any resident with SMI, ID, or RC. The PASRR process must be completed before a person admits and when a person's status significantly changes, which is referred to as a Status Change review.

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Who is Evaluated through PASRR?

Persons with Serious Mental Illness (SMI)

The Level I screen gathers information about people with SMIs. This information includes the person's mental health diagnoses, their symptoms and intensity, and how much the condition and its symptoms have impacted the person's life and well-being.

The federal definition for SMI is:

- **Diagnosis:** Of a major mental illness, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, psychotic disorder, panic disorder, obsessive compulsive disorder and **any other disorder** that could lead to **a chronic disability** that is not a primary diagnosis of dementia.
- **Duration:** A significant life disruption or major treatment episode during the past two years because of the disorder. **A disruption or major treatment episode includes hospitalization but is not limited to it.** A disruption might include needing more services (like case management) because the condition intensified **regardless of whether the services were identified or delivered**. More example scenarios that reveal intervention needs include:
  - Psychiatric treatment more intensive than outpatient care (like partial hospitalization, inpatient psychiatric hospitalization, or crisis unit placement) within the past two years
  - A major psychiatric episode
  - A suicide attempt or suicidal gestures
  - Other safety concerns
- **Disability:** Referred to as *Level of Impairment* in regulatory language, disability is characterized by active behavioral health symptoms within the preceding six-month period that significantly interfere with the person's ability to:
  - Interact interpersonally
  - Concentrate
  - Follow through with goals or needs
  - Adapt effectively to change

In other words, the person's symptoms have impacted their life over the past 6 months.

Using these criteria, how would we assess a person with a first-time episode of serious depression?

To answer that, let us first look at the data:

19%-55% of people in nursing facilities have mental disorders. Elders attempt and accomplish suicide more often than anyone else.

While people living in nursing facilities attempt *violent* suicide less often, they think *more* often about suicide. Many of these people die from *indirect* suicide by refusing to eat or take medicine. This data means that the people whom PASRR assesses have a high risk for suicide.

PASRR does not target people with a brief episode of depression. Having said that, these facts demand caution. If someone's depression is more severe than or lasts longer thana typical grief reaction, give Maximus' clinicians enough information to decide if PASRR should identify treatments to improve the person's symptoms.

As a general guideline, if a person's depressive episode lasts longer than three months, it may be a first-time episode of serious depression.

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Persons with Intellectual Disability

The *Diagnostic and Statistical Manual, Fifth Edition* defines intellectual disability (ID) as a disorder with intellectual and adaptive functioning limitations that begins during childhood or adolescence, prior to age 18. Intellectual disability may be associated with other conditions, such as a genetic syndrome, or traumatic brain injury (TBI) sustained during the developmental period. A person's condition must meet three criteria to be ID. The person must show:

- Deficits in intellectual functioning (reasoning, abstract thinking, learning, etc.)
- Deficits in adaptive functioning that require ongoing support (social skills, relating to others, personal independence, etc.)
- Deficit onset during the developmental period

The intellectual disability's severity rests on adaptive functioning in three domains: the conceptual domain, social domain, and practical domain. Healthcare professionals can classify severity in one of four ranges: mild, moderate, severe, and profound.

Good evaluations tease out how and when lower cognition began. Lower cognition may have started during the developmental phase or if a medical issue (like a stroke, transient ischemic attack, or an accident or injury) caused it later in life.

Figuring this out is complicated. Decades ago, formal IQ testing happened less frequently, especially in rural areas. Because of this, PASRR evaluations often must research developmental information and medical history to uncover when symptoms began.

The dementia exemption does not apply to persons diagnosed with intellectual disability or related condition.

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Persons with a Related Condition (RC)

Federal code refers to conditions that affect people like intellectual disabilities as "Related Conditions" (RC). PASRR evaluations for people with RC must confirm that the condition limits three or more major areas

of life activity. They also must confirm that the condition began before age 22 (see §435.1009).

People with RC have needs like people who have intellectual disabilities. RC is defined as a severe, chronic disability that meets the following conditions:

- Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness, found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to ID and requires treatment or services similar to ID
- Is present prior to age 22
- Is expected to continue indefinitely
- Results in substantial functional limitations in three or more of the following major life activities:
    - Self-care
    - Understanding and use of language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for independent living (Diagnosis alone is not a qualifier for a RC)

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Who Receives a Level I?

A Level I screen is required for **all** individuals seeking admission to a Medicaid-certified nursing facility, regardless of how the person is paying for their stay (i.e., Medicare/Medicaid, private insurance, etc.). Providers submit Level I screens through PASRR Pro-I, Maximus' web-based Level I tool in AssessmentPro. A Level I screen is required:

- Before admission to any Medicaid-certified nursing facility (this includes Program of All-Inclusive Care to the Elderly (PACE) participants seeking admission to any Medicaid-certified nursing facility)
- For residents of a Medicaid-certified nursing facility who have experienced a significant change in mental status that suggests the need for a first-time Level I review, a subsequent Level I review, or updated PASRR Level II evaluation
- Before a time-limited stay ends for people with MI and/or ID/RC who need to stay after approved stay expires, requiring a Level II evaluation

The Nursing Facility's Medicaid certification, not the person's payment method, determines if PASRR is required. If a person tries to admit to a Medicaid-certified nursing facility, regardless of whether they are paying for their stay with Medicaid/Medicare or private payment, the person **must** have a PASRR Level I screen, and if applicable a Level II evaluation, before admitting and whenever a resident's status significantly changes, requiring a Level II evaluation.

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Who Submits a Level I Screen?

Hospital, AAA, and nursing facility providers are responsible for submitting Level I screens. Typically, the provider of record submits the Level I screen. If the person is in a hospital setting, the hospital provider submits the Level I screen; if the person is in the community, the AAA or nursing facility provider can submit the screen. For individuals who live in the community, Maximus assessors may also complete Level I screens following a LOC referral/intake counseling session when the individual indicates they are seeking nursing facility admission. The nursing facility provider is responsible for submitting the Level I screen for anyone in their facility who:

- Has a significant change in mental status,
- Needs to stay in the nursing facility after the approved end date of a categorical determination or exemption. The nursing facility must also submit a LOC screen to initiate the required onsite Level II (regardless of the individual's pay source),
- Is admitted to their facility from out of state, or
- Needs an updated Level I screen because of a change in medication, diagnoses, etc. The screen may not be associated with a Level II condition, but if the existing Level I screen is no longer accurate, you must submit a new Level I.

AssessmentPro lets any authorized user in your facility begin and *enter* a screen, but only a qualified provider may *submit* a screen to Maximus. The healthcare professional submitting the Level I or LOC screen is attesting that the information is accurate to the best of their knowledge. The **submitter accepts full responsibility** for the submitted content.

When you start a Level I screen, PASRR Pro-I guides you through questions about the person's medical and behavioral diagnoses, history, and current symptoms. PASRR Pro-I typically decides the Level I's outcome immediately, which means you can instantly print the outcome determination. But, if the Level I indicates that the person may have a Level II condition, PASRR Pro-I automatically queues the screen I to a Maximus clinician who reviews it, possibly requests more information, and decides its outcome.

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Submitting Level I for Mental Status Change

If a nursing facility resident's behavioral or mental status **significantly changes**, the nursing facility must submit a new Level I to report the change through the PASRR process. This applies to people who have a known Level II condition **and** to people with a previous negative Level I. Nursing facilities must submit mental status change referrals within 14 days of the significant change event. Examples of a mental status change event include:

- A new mental health diagnosis that is not listed on previous Level I or Level II.
- A new psychotropic medication for mental illness. For PASRR purposes, a psychotropic medication for a medical condition (like for regulating sleep or appetite) does **not** trigger a new Level I or need for a

Level II.

- A significant increase in existing symptoms or new symptoms (like depression, anxiety, hallucinations, or refusal to eat).

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Draft Screens and Turnaround Time

AssessmentPro saves draft Level I screens for 72 hours. Once a draft screen has expired, you cannot return to it. You lose your work, and you need to start a new screen. See Draft Screen Expiration section of this manual for more information.

PASRR Pro-I puts Level I screens in Maximus' clinical review queue in chronological order. If a screen needs a clinical review, AssessmentPro typically notifies you of its outcome within 6 business hours from when Maximus receives all the information we need to complete the review. If Maximus' Clinical Reviewer requests more information, the Clinical Reviewer puts the assessment on hold. Our turnaround clock's time stops ticking until we receive all the information we need. You should check the *Action Required* queue regularly for feedback and questions from our clinicians so you can respond and promptly upload any requested documentation or answer questions. Responding promptly to requests for information expedites the Level I screening process. **If you do not respond to a request for more information in 10 business days or 14 calendar days, AssessmentPro cancels the Level I or LOC screen.** You need to submit a new Level I, and we must make a decision **before** the person can admit to a Medicaid-certified nursing facility.

Be sure to frequently monitor the screens you have submitted in AssessmentPro.
The ***Action Required*** queue alerts you to any requests for information or other clarification to complete an accurate and expedient screen.

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Level I Outcomes

The possible outcomes for a Level I screen in Indiana are:

- Cancelled – Expired – Information Not Received
- Cancelled Type 2
- Custom Categorical
- Emergency Categorical
- Respite Categorical
- Terminal Illness Categorical
- Exempted Hospital Discharge
- Convalescent Categorical
- Level I Negative No Status Change
- Level I Positive No Status Change
- No Level II Required, No SMI/ID/RC

- No Level II Required, Situational Symptoms
- Refer for Level II DBR
- Refer for Level II Onsite
- Refer for Level II Onsite (via Quality Review)

If the Level I screen indicates that the person does **not** have a possible MI, ID, and/or RC condition, PASRR Pro-I automatically approves the person for nursing facility placement. If the Level I indicates that the person has, or may have an MI, ID, and/or RC, then the PASRR Pro-I queues the referral to a Maximus clinician for review.

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Negative Level I and Emergency Admissions

For people wanting to enter a nursing facility from their homes or another community-based setting, the submitter (nursing facility, AAA, hospital emergency department/observation bed unit, or Maximus assessor) logs into AssessmentPro to complete the Level I screen to determine if a Level II is required.

If the person does not require a Level II **but is Medicaid active**, then the provider also completes the LOC assessment or referral for the LOC assessment (See Table 1: Submission Process for Maximus to Complete LOC Determination on a Completed interRAI HC LOC for details on which submitters complete the assessment and Table 2: Submission Process for Maximus to Complete the interRAI HC LOC Assessment for details on which submitters complete requests for assessments). Maximus issues the Level I and LOC determinations.

If the person does not need a Level II **and is not Medicaid active**, the person can enter the nursing facility after AssessmentPro has issued a Level I outcome.

Due to the tight time frames, you receive a determination within six hours (during normal business hours) after Maximus receives all required information.

Providers can submit screens in AssessmentPro at any time, including nights and weekends. However, Maximus may not issue a determination until the next business day. Admitting people before Maximus has finished the PASRR is a risk because the Maximus Clinical Reviewer may not approve nursing facility placement.

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PASRR Dementia Exclusion

PASRR excludes some people with dementia. This **dementia exclusion** applies to:

- **People with a sole diagnosis of dementia,** or
- **People with a primary dementia with a secondary MI diagnosis**

When a person has co-morbid dementia and mental illness, deciding which condition is *primary* takes more than deciding if the dementia is *currently* the most prominent. The dementia's symptoms

must be more advanced than the co-occurring behavioral health conditions. Or in other words, the dementia has advanced so much that the co-occurring mental illness never becomes the primary focus of treatment again, and the person would not benefit from specialized services.

Because serious mental illness and dementia both impair executive functioning and change personality, the screening process focuses on dementia's *progression*. As a part of the Level I, Maximus determines if dementia is the sole diagnosis or primary over a secondary mental illness diagnosis.

The provider submitting the Level I must include information that clearly supports that the dementia is primary over any mental health diagnosis. When diagnoses co-occur, federal guidelines dictate that **an exemption cannot happen unless enough evidence clearly confirms the progression of the dementia as primary.** Providers should upload any documents to the person's Level I screen that support the dementia's primacy over an SMI. Examples of supporting documents include neurocognitive test results, a series of Mini Mental Status Exams (MMSEs), or a History & Physical (H&P) outlining the progression.

When you request a dementia exclusion, you must prove that the person's treatment primarily focuses on dementia, because it has progressed. For Maximus to approve, your request must include documents that prove this.

For information on weekend and after-hours dementia exemption Level I screens, see Weekend, Holiday, and After-Hour Screenings of this manual.

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PASRR Exempted Hospital Discharge

In some situations, federal code exempts people with MI, ID, or RC from PASRR or lets them admit to a nursing facility through an abbreviated Level II evaluation process. The term **exemption** describes some of these situations.

The **Exempted Hospital Discharge (EHD)** decision is a *short-term* exemption from the PASRR process for a person with known or suspected MI, ID, or RC who:

- Received acute inpatient treatment in a medical hospital and is discharging from the hospital to a nursing facility after receiving medical (non-psychiatric) services, and
- Needs short-term treatment of **30 calendar days or less** in a nursing facility for the same condition the person was hospitalized for. Emergency Department discharges to the nursing facility do not qualify for the EHD decision.

For Maximus to apply the EHD decision:

- The person must **meet both criteria** listed above, and
- The hospital provider must:
    - Complete a Level I screen,
    - Nursing facility to submit a Level of Care within 48 hours of admission, unless there is a valid LOC in the last 11 months.

- Upload a current H&P to the person's Level I in AssessmentPro

A Maximus Clinical Reviewer may request more documents to decide the Level I's outcome. **All** requests for an exempted hospital discharge require an H&P. To expedite an EHD request, upload the H&P when you submit the screen.

When Maximus approves someone for an EHD nursing facility admission, **the admitting facility must** submit an **updated Level I and new LOC** before the 30-calendar-day approval ends if the person needs to stay longer for medical reasons, if there is not a current valid Level of Care within the last 11 months. The admitting facility needs to submit a LOC within 48 hours utilizing the admission date as the assessment reference date (ARD). You should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days before the approval ends so that Maximus can complete a full Level II PASRR determination by that date. Doing that keeps your nursing facility compliant with state and federal requirements.

Maximus only applies exemptions to people with stable symptoms who do not threaten themselves or others.

For information on weekend and after-hours EHD Level I screens, see Weekend, Holiday, and After-Hour Screenings of this manual.

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PASRR Level II Categorical Decisions

Federal PASRR regulations allow for an abbreviated Level II process for people who fall into certain **categories** that exempting them from a Level II evaluation before they admit to a nursing facility. We call these **categorical** PASRR decisions.

If someone has a confirmed or suspected PASRR disability and meets criteria for one of these categories, it means that providers can request, or Maximus clinicians can decide if that person is appropriate for a nursing facility and if they do not need specialized services.

As with exemptions, Maximus only applies categorical decisions for people with stable behavioral symptoms who do not pose a threat to themselves or others. For more details, see Exemption and Categorical Admissions. Maximus may potentially apply four categorical Level II determinations in Indiana:

- **Provisional Emergency Categorical**
- **Respite Categorical**
- **Terminal Categorical**
- **Convalescent Categorical**

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Provisional Emergency Categorical

Maximus may grant a Provisional Emergency categorical when a person has a Level II condition (MI, ID, or

RC) **and** the person:

- Suddenly, unexpectedly, and urgently needs placement (typically because of losing a caregiver, losing a home, or suspected abuse or neglect)
- Cannot receive a lower level of care

If the person reports abuse, neglect, or you suspect it, you must report to the Adult Protective Services (APS) hotline by dialing 800.992.6978 or completing a report online or through the Department of Child Service (DCS) hotline at 800.800.5556. After business hours, you may leave reports on voicemail. Your report must contain the following:

- Name of the person making the report,
- Name, address, and phone number of the facility from which you are making a report,
- Individual's name,
- Individual's address, including the city and county (can be the facility where the individual will reside),
- Individual's phone number (can be the facility where the individual will reside),
- Description of why you suspect abuse, neglect, or exploitation is suspected, and
- Indicate the APS or Child Protective Services (CPS) report is for the APS or CPS 7-calendar-day emergency admission.

Both 455 IAC I-2-2, which governs APS, and IC-31-34-1, which governs DCS, define abuse and neglect. Neglect includes self-neglect.

Provisional Emergency categoricals allow for up to 7 calendar days in a nursing facility. If the person needs more than 7 calendar days, the nursing facility must submit a new Level I and LOC screen in AssessmentPro **before** the approval ends.

If you request a Provisional Emergency categorical during normal business hours, include the following:

- The person's demographic information, including their name, address, and current location,
- The reason for the emergency request (a condition's change or the situation warranting APS or CPS involvement),
- Name of APS or CPS personnel contacted & date of contact if indicated,
- History and Physical (H&P),
- Primary and secondary diagnoses (include medical and/or mental health diagnoses),
- Prescribed medications w/ dosage, frequency, and reason for prescribed,
- Description of ADL impairment,
- Any family and/or community services the individual is receiving,
- Name of any family member or legal representative who is knowledgeable about the individual's needs and situation,
- Level I screen,

- Level of Care screen,
- History of recent hospitalizations or other inpatient care, including treatments received and reason for treatment, and
- Any other information needed to make a placement decision.

Providers may need to request a Provisional Emergency categorical outside of normal business hours like during evenings or weekends. When this happens, AssessmentPro queues the screen to a Clinical Reviewer on the next business day. If you admit a person to your nursing facility before PASRR Pro-I or Maximus issues a decision, you should know that a Maximus clinician may deny placement.

You may have limited documentation for emergency request referrals during evenings or weekends, particularly for people living in the community. At a minimum, you should upload the following information with the screen:

- Identifying demographic information, including the person's name, address, and current location
- The reason for the emergency request [how the person's condition has changed, why the person needs emergency placement, and the current Adult Protective Services (APS) or Child Protective Services (CPS) involvement/intervention]
- The name of APS or CPS personnel contacted and date of contact.
- If indicated, Providers should submit any available documentation with the referral.

After looking at the referral, Maximus' Clinical Reviewer uses PASRR Pro-I to request any extra information which you can submit during normal business hours.

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus completes a full onsite Level II. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen before the approval ends so that Maximus can issue a PASRR determination by that date. Doing that keeps your nursing facility compliant with state and federal requirements.

For information on weekend and after-hours provisional emergency Level I screens, see Weekend, Holiday, and After-Hour Screenings of this manual.

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Respite Categorical

The Respite categorical is available for people in the community. Community settings include a person's home, Emergency/observation room, and assisted living and residential care facilities. Hospital admissions, nursing facilities and psychiatric facilities are **not** community settings. The respite categorical lets a person stay in a nursing facility for 30 calendar days to give relief to family members or caregivers. The respite categorical can apply when a person has a Level II condition (MI, ID, or RC), and:

- Lives in the community, and
- Is expected to return to the community from the nursing facility

Respite categoricals only allow a person **to stay in a nursing facility for 30 calendar days per calendar quarter. If the person stays 15 calendar days or more, 30 calendar days must pass before they can admit again.**

For Maximus to apply the Respite Categorical:

- The person must **meet the criteria** listed above
  AND
- The provider must:
  - Complete a Level I screen,
  - Level of care screen prior to nursing facility admissions
  - Upload a current H&P to the person's Level I in AssessmentPro

You may need to request a respite categorical outside of normal business hours like during evenings or weekends. When this happens, AssessmentPro queues the screen to a Clinical Reviewer the next business day. If you admit a person to your nursing facility before PASRR Pro-I or Maximus issues a decision, you should know that a Maximus clinician may deny placement.

Providers should submit any available documentation with the referral. After looking at the referral, Maximus' Clinical Reviewer uses PASRR Pro-I to request any extra information which you can submit during normal business hours.

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus completes a full onsite Level II. If they have a valid Level of Care completed within 11 months, then a new Level of Care is not required. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days prior to the approval end date so that Maximus can issue a PASRR determination by that date. Doing that keeps your Nursing Facility compliant with state and federal requirements.

For information on weekend and after-hours Respite Categorical Level I screens, see Weekend, Holiday, and After-Hour Screenings.

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Terminal Illness Categorical

The Terminal Illness categorical is available when a person has a medical condition, that when running its normal course, would have a life expectancy of 6 months or less. The person must be psychiatrically stable and does not present a risk of harm to self or others.

All terminal illness categorical requests seeking nursing facility care require the following documents.

- History & Physical within 12 months
- Level I screen
- Level of Care screen
  AND

- **One** of the following documents:
    - Hospice certification (this document can be found on the Indiana FSSA website)
      OR
    - Physician's documentation stating a terminal illness or life expectancy of 6 months or less is present

Providers should submit any available documentation with the referral. After looking at the referral, Maximus' Clinical Reviewer uses PASRR Pro-I to request any extra information which you can submit during normal business hours.

For information on weekend and after-hours terminal illness categorical Level I screens, see Weekend, Holiday, and After-Hour Screenings of this manual.

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Convalescent Categorical

The Convalescent categorical is a **short-term** exemption from the PASRR process for a person with known or suspected MI, ID, or RC who:

- Received acute inpatient treatment in a medical hospital and is discharging from the hospital to a nursing facility after receiving medical (non-psychiatric) services, and
- Needs short-term treatment between **31 to 60 calendar days** in a nursing facility for the same condition in which the person was hospitalized. Emergency Department discharges to the nursing facility do not qualify for the Convalescent situations.
- Are psychiatrically stable and does not present a risk of harm to self or others

For Maximus to apply the Convalescent categorical:

- The person must **meet the criteria** listed above, and
- The hospital provider must:
    - Complete a Level I screen,
    - Level of care screen prior to nursing facility admissions unless the individual already has a valid Level of Care within the past 11 months, and
    - Upload a current H&P within the past 12 months to the person's Level I in AssessmentPro

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus completes a full onsite Level II. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days prior to the approval end date so that Maximus can issue a PASRR determination by that date. Doing that keeps your Nursing Facility compliant with state and federal requirements.

For information on weekend and after-hours Convalescent Categorical Level I screens, see Weekend, Holiday, and After-Hour Screenings of this manual.

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Level I Outcome Letters

You can print outcome letters from AssessmentPro 24 hours a day. You must keep each person's letter in their record, and the letter must accompany the person if they transfer to a different nursing facility.

All outcome letters (both approvals and denials) include a notice of the individual's or guardian's right to appeal the decision.

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Transfers and Out-of-State Referrals

Inter-Facility Transfers

So long as a person's mental health status and medical care needs stay the same, their Level I and level of care screens are indefinitely good.

Because of this, people transferring to a different facility do not need new level of care screens, unless they discharge to a lower level of care or their conditions significantly change.

This means you do not need a new screen if the person:

- Transferred from one nursing facility in Indiana to another nursing facility in Indiana
- Transferred from a nursing facility in Indiana to a hospital and back to any nursing facility in Indiana (including the one the person came from)

There are exceptions to this rule. You need to complete a new level of care screen if:

- The person's condition significantly changes,
- The person discharges to a lower level of care (like the community) and needs to return to the same or different nursing facility
- The approved length of stay is about to expire

Nursing facilities can update discharges, transfers, and admissions in PathTracker, a service within AssessmentPro that tracks people with Level II conditions.

When a person's mental health status significantly changes, they must have a new Level I before transferring to a new nursing facility. If the person has a Level II condition or if the status change review uncovers a Level II condition, the person needs a Level I and a level of care screen before receiving a Level II evaluation.

If a person discharges from a nursing facility to a lower level of care, like the community, and then needs to return to the same or different nursing facility, they need a new Level I. If the person has a Level II condition (regardless of pay source) or receives Medicaid and pays for their nursing facility stay with it, the person needs a new Level I and level of care.

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Out of State Transfers

If an Indiana hospital is treating an out-of-state resident and that resident wants to admit to a Medicaid-certified nursing facility in Indiana, the hospital provider must submit a Level I screen. If the person needs a Level II, the hospital provider must also submit a level of care. The nursing facility in Indiana must also complete the level of care for people who do *not* require a Level II. They must do this when the person becomes Medicaid-active in Indiana and decides to use Medicaid to pay for their nursing facility stay.

If a person resides in another state, is in an out-of-state facility, and is seeking admission to an Indiana nursing facility, then the nursing facility completes the Level I. If a Level II is required, the nursing facility in Indiana also completes the Assessment Request form. If a Level II is **not** required, the nursing facility completes the LOC if the person becomes Medicaid-active in Indiana and decides to use Medicaid to pay for their nursing facility stay.

If a person is an Indiana resident, is Medicaid-active in Indiana, is at an out-of-state nursing facility, is seeking to transfer to a nursing facility in Indiana, and will pay using Medicaid, then the nursing facility in Indiana must submit a Level I, and if the person needs a Level II, a LOC.

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Weekend, Holiday, and After-Hour Screenings

Providers have access to LOC Pro 24 hours a day, 7 days a week. Providers can always:

- Start, resume, submit, or withdraw requests for screen
- Add, remove, and manage users
- Monitor the status of a screen
- Upload documentation

Please note that Maximus completes clinical reviews during regular business hours: Monday-Friday, 7:00 AM CT (8:00 AM ET) to 4:00 PM CT (5:00 PM ET).

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Exemption and Categorical Admissions

Providers can submit screens outside of normal business hours; however, a Maximus Clinician must review all LOC assessments not from AAAs, which includes Exempted Hospital Discharges (EHDs) and Categoricals. If the person receives any outcome other than an approval outside of normal business hours, the nursing facility may admit but should note that Maximus could reverse the outcome after reviewing the screen. Any nursing facility that admits someone before Maximus reviews the screen is at risk.

For exemptions and categoricals, the approved length of stay begins the day Maximus determines an outcome and ends on the final calendar day of the approved length of stay. The outcome date appears on each person's notification letter.

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Delayed Admissions

PASRR and long-term care LOC approvals are valid for 90 calendar days. Short-term stays are valid for their approval periods. If a person does not admit to the nursing facility within that timeframe, they need a new Level I, LOC screen, and determination before admitting to a Medicaid-certified nursing facility.

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Refer for Level II Outcomes

When Maximus provides the outcome *Refer for Level II*, AssessmentPro queues the referral up for an onsite Level II assessment performed by a Maximus subcontractor or independent contractor. After the face-to-face assessment, a Maximus Clinical Coordinator reviews assessment and documentation, and write a summary of findings that determines if a nursing facility is appropriate and the services and supports that the nursing facility must provide. For people who have intellectual disabilities or related conditions, Indiana's Bureau of Disability Services (BDS) makes the final decision. A Maximus psychiatrist also reviews adverse decisions for all disability types.

After the summary is finalized, AssessmentPro automatically generates an outcome letter, which providers can print directly from the system.

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Important AssessmentPro General Information

User Registration & Maintenance

AssessmentPro Access Coordinators can add and remove users, approve requests for user access, update user profiles, update facility information, and do all basic user functions. Maximus recommends that facilities limit AssessmentPro Access Coordinators access to two or three users.

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Important Information About Electronic Screening Submission

Multi-Facility Users

Some users are associated with multiple facilities in AssessmentPro. If you can submit screens under more than one facility, you must be sure you are submitting screens under the correct facility name. Click on the gear icon to view your current facility settings and switch facilities when you need to.

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Draft Screen Expiration

In AssessmentPro, a draft screen is a screen someone has started but has not submitted. AssessmentPro saves a draft of your Level I or LOC screen so you can start a screen and come back to it later if you cannot

finish it. Unsubmitted Level I and level of care screens are available for 72 hours.

Once a draft has expired, AssessmentPro deletes it, and you need to enter a new screen. To avoid losing your work, prepare ahead of time. Gathering the person's record for reference during the screen saves you time.

Refer to the IN Level I/LOC Frequently Asked Questions for more information on using AssessmentPro and managing user and for when and how to submit Level I and LOC screens.

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Declared States of Emergency and Widespread Outage

If Maximus or Indiana Bureau of Better Aging (BBA) declares a state of emergency or identifies an emergency situation (like a natural disaster or widespread power outages), the state and Maximus may implement an emergency admission approval. Maximus and BBA discuss the emergency and decide if using the emergency admission approval is appropriate. Maximus and BBA may officially authorize providers to deploy this process and give providers and Maximus staff instructions on both the Maximus and the BBA websites.

Providers may only use the state of emergency admission option with prior approval. Attempting to use this option outside of prior BBA and Maximus approval will result in non-payment to the nursing facility. You may **not** use this option because you or your facility did not register for AssessmentPro or because of routine upgrades to the system.

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Admission and Discharge Tracking

Nursing facilities must update all residents' admission dates in PathTracker when they admit. Nursing facilities may **not** update PathTracker until the person admits. After the admission date is entered, the system alerts the Medicaid LOC data entry process through BBA.

Providers must also update PathTracker with each PACE recipient's start date once the state determines it. After the provider enters the program start date, the system prompts the Medicaid LOC data entry process through BBA. If the individual discontinues the PACE program, you must also update the program discharge date in PathTracker.

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Appeal Rights Notifications

The assessed person or guardian has the right to appeal all Level II and Level of Care decisions. All Level II and LOC outcome letters include a notice of the person's appeal rights.

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