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DHS and MCO Resource Allocation Decision (RAD) and Notice of Adverse Benefit Determination Guidelines

Introduction

This guideline is organized into four areas: History and Background, RAD Process, RAD Documentation, and the Notice of Adverse Benefit Determination.

History and Background

Family Care[1] is a comprehensive and flexible service delivery system, which strives to foster the independence and quality of each member's life, while recognizing the need for interdependence and support. Family Care is a capitated Medicaid managed care program for the delivery of all Medicaid long-term care benefits. Family Care Partnership is a capitated integrated Medicaid and Medicare managed care program that, in addition to the Family Care long-term care benefits, provides health care benefits, and all applicable Medicare Advantage Special Needs Plan and Medicare Part D prescription drug benefits. PACE is a capitated integrated Medicaid and Medicare managed care program. All benefits—whether Medicare or Medicaid—are delivered through the PACE model.

A fundamental principle of the Family Care, Family Care Partnership, and PACE programs is to promote member empowerment, independence, and the ability to live in the most integrated manner possible. To this end, the programs encourage and support members to self-direct as many of their services as possible.

The member is an integral part of the Interdisciplinary Team (IDT), which includes managed care organization (MCO) or contracted staff to provide care management services. The IDT works with the member to identify what is needed to support the member's long-term care outcomes. This may include MCO paid supports and services as well as natural and community supports that are identified during the assessment process. Natural supports include the member's social network of family, friends, neighbors, and others who voluntarily provide unpaid assistance to the member. Community supports are services that are readily available to all people in the community and thus do not need to be authorized by or paid for by the MCO.

It is critical for the entire IDT, which includes the member, to understand the importance of identifying and maintaining both the natural and community supports that have been a part of

[1] Unless stated otherwise, references to the Family Care program include Family Care, Family Care Partnership, and PACE.

their lives prior to enrollment in Family Care. This is one of the ways members stay connected to their communities and create daily routines that are unique to each individual.

Members enrolling in Family Care, Family Care Partnership, or PACE have the right to be informed about the source of funding for the program. This allows members to participate fully in making cost-effective decisions, along with their IDT, regarding their services. Members can participate in decisions regarding available services and supports, including the cost of these options. It also ensures that members have involvement and responsibility in their care plan and outcomes.

The service authorization process for these programs is the Resource Allocation Decision (RAD) process. The RAD process fosters critical thinking as it relates to service authorization decision-making and helps to ensure the development of the most supportive and cost-effective member centered plan (MCP). It ensures that the IDT follows a consistent process in authorizing services that takes into account each member's needs, desired outcomes, and preferences.

The RAD process is only used to authorize services that are part of the long-term care benefit package. Family Care may pay for services and items that are outside of the benefit package, based on options that are cost-effective and effective to support the member's long-term care outcome. The cost of these services may or may not be included in the capitation paid to the MCO.

I. Resource Allocation Decision Process

The RAD process encompasses:

- Collaboration facilitated by the IDT staff with inclusion of the member and/or the legal decision maker.
- Identification and understanding of the member's role and responsibility as part of the IDT.
- Exploration of natural and community supports available to the member.
- Clarification of the long-term care need and outcome associated with the request.
- Exploration of the most effective and cost-effective way to support the long-term care outcome.
- Submission of specific documentation by the MCO per DHS contract requirements.

The DHS RAD tool is located at the end of this document, A member-friendly version is available at https://www.dhs.wisconsin.gov/publications/p02705.pdf.

Consultation with other health care experts such as physical or occupational therapists, may help the IDT achieve perspective and generate new ideas for effective management of a specific condition or situation. This would include decision making tools developed by the MCOs. Any decisions made regarding the recommendations/suggestions must include the member and anyone else the member would like involved in their plan of care.

A. Definition of a long-term care outcome

The RAD process must identify the member's long-term care needs/outcomes because they are the basis for decision-making. The member's long-term care outcomes are

generally identified during the assessment and are documented, along with the member's personal experience outcomes, in the member-centered plan.

*A **long-term care outcome** is a situation, condition, or circumstance that a member or IDT staff identifies that maximizes a member's highest level of independence. This outcome is based on the member's identified clinical and functional needs.*

***Personal-experience outcome** is a desirable situation, condition, or circumstance that a member identifies as important to them. A personal experience outcome is measurable primarily by the member.*

Functional needs include the psychosocial needs for community integration, self-reliance, and autonomy, and recognizing the member's right to take reasonable risk while maximizing member health and safety. The member's identified long-term care needs/outcomes drive the authorization of services within the RAD process.

Personal experience outcomes are always identified by the member and speak to the member's desired situation, condition, or circumstances that are important to them.

Often, support for a long-term care outcome, such as assistance with personal care needs, will also help support a member's personal experience outcome. For example, a member may desire to feel better so that they can visit with friends. Members' long-term care needs and outcomes must be supported for them to achieve their personal experience outcomes, which are expressions of what a quality life means to them.

B. Member messaging

It is imperative that members understand the RAD process is applied when long-term care services within the Family Care, Family Care Partnership, or PACE benefit package are needed. Members should understand the RAD process and when it is used. MCOs should help members understand their role and responsibility in the RAD process. See Attachment A for member messaging suggestions.

II. RAD Documentation

The IDT must always follow the RAD process, or other DHS approved decision-making processes, when authorizing services. This section of the guideline clarifies when RAD documentation may be streamlined to ensure an efficient process that is valuable to the member and IDT staff.

A. Full RAD documentation:

DHS requires full RAD documentation for home and community-based waiver (HCBW) services identified in Addendum VI.A. of the DHS-MCO Contract, with the exception of case management services.

Full RAD documentation includes:

- Evidence that the member was involved in the RAD process.
- Identification of the member's request, including defining the core issue and the long-term care outcome being addressed.

- Options available to help support the identified long-term care outcome.
- Evidence that the IDT staff and member explored, discussed, and negotiated various options.
- Final outcome of the discussion.

Each MCO may determine its documentation requirements to provide evidence of this process. MCOs may opt to include this information in the member record notes or on the RAD tool. The MCO must identify the documentation that it is using to verify the RAD process as part of the MCO's Service Authorization Policy.

B. Reduced RAD documentation:

For long-term care services/supports within the Family Care Benefit Package, MCOs may develop guidelines and/or tools that when applied demonstrate adherence to the RAD process. This streamlines documentation of the RAD process. Approval is required by DHS when the MCO intends to utilize these guidelines and/or tools as a substitute for certain portions of RAD documentation.

DHS approved guidelines/tools may be used for RAD documentation for steps three, four and five of the RAD tool (See Appendix A: options available to support the long-term care outcome, the review of options with members, and any guideline or policy considerations the MCO takes into account when making service authorization decisions). MCOs shall inform members when an approved guideline is being applied, and upon request, the MCO shall provide members with the written guideline/tool and the assessment results from use of the guideline/tool.

C. Waiver of RAD documentation requirements:

1. **Durable Medical Equipment or Supplies that support a member's diagnosed medical conditions**
   Certain durable medical equipment/supplies (DME/DMS) are more medical in nature and documentation related to application of the RAD process may be waived. The MCO's policies and procedures should clearly delineate these items which may include, but are not limited to:
   - Diabetic supplies
   - Wound care supplies/dressings
   - Incontinence supplies
   - Catheter supplies
   - Oxygen
   - Nebulizer
   - CPAP/BIPAP
   - Trachea humidification system
   - Tracheostomy supplies
   - Orthotics (including shoes)
   - Enteral feeding equipment/supplies
   - Compression hose
   - Eyeglasses (Partnership/PACE only)
   - Hearing aids (Partnership/PACE only)
   - Ostomy supplies

2. **Medicare Coinsurance Benefit**
   For dual eligible Family Care members (not applicable to Family Care Partnership or PACE) and upon DHS approval, the MCO may determine reduced or waived RAD documentation for Medicare covered services. The MCO's policies and procedures should clearly delineate this process.

3. **Primary and Acute Services**
   RAD documentation is not required for primary and acute services that are not included in the Family Care benefit package.

   Family Care Partnership and PACE should refer to the DHS-MCO contract Addendum VI.C. on service authorization requirements for acute and primary services.

4. **Minimal increases to service/support levels when there is not a significant change in condition or circumstances.**
   The RAD process that was completed upon initiation of the service will suffice for initial documentation of the steps. It is expected that changes will be documented in the member's record indicating why the amount of service is being increased.

   For example, if a member currently has 10 hours of approved supportive home care (SHC), an increase to 12 hours would not necessitate documentation of the RAD; however, IDT staff must still document the reason for the change in service levels in the member's record.

   For any reductions, terminations, or denials, even those that are minimal, IDT staff must document the RAD process and provide a notice of adverse benefit determination (NOA) to the member.

D. Services/items outside of the benefit package

RAD documentation is not required for items or services outside of the benefit package that are requested by the member. The IDT still retains responsibility for exploring the reason for the member's request. The IDT should use the RAD process to determine the core issue and the services/items within the benefit package that may support the member's long-term care outcome. If the member's long-term care outcome related to the request is NOT being clearly addressed, RAD documentation is expected. The IDT and member may always consider utilizing a service, even if it is outside of the benefit package, when evidence is present that it may support a member's long-term care outcome effectively and cost-effectively. The cost of the service may or may not be included in the MCO's capitation payment.

III. Notice of Adverse Benefit Determination (NOA)

The NOA ensures that members receive timely consideration of all requests for services in the benefit package, and that they receive information on their right to appeal adverse decisions.

Decisions about whether a service will be authorized, reduced, or terminated should always be made by using the RAD process, or other DHS-approved service authorization policy. Step six, the final step in the RAD process, directs the IDT and the member to negotiate a shared understanding of the decision. A member should never learn about a termination, reduction, or denial of a service for the first time via the NOA.

The MCO must inform the member that they may receive a copy of the decision-making documentation, including any guidelines/tools used. In addition, if members are working with an ombudsman [i.e., Disability Rights Wisconsin (DRW) or Board on Aging and Long Term Care (BOALTC) or advocate and the ombudsman or advocate requests RAD documentation, the MCO will provide the approved guideline that has been used and the assessment results from use of the guideline.

An NOA must be provided when:

- A member requests a service in the benefit package and the request is denied or provided in an amount or duration that is less than the member requested.
- Any reduction, termination, or suspension of service occurs.
- A service is reduced or terminated within the nursing home level of care benefit package even if the member is now only eligible at the non-nursing home level of care.
- The MCO denies payment for a service in the benefit package.

An NOA does not need to be provided when:

- A member has a request for something that is not included in the benefit package because a member is not able to appeal the denial of that item or service. The MCO must provide written correspondence to the member to inform them that their request is not part of the benefit package. The written correspondence does not contain appeal language. (Refer to the Notification of Non-Covered Benefit template at www.dhs.wisconsin.gov/library/collection/f-01283);
- A member who is at a non-nursing home level of care requests an item or service that is only included in the benefit package for members who are eligible at the nursing home level of care; or
- A provider or licensed consultant makes a recommendation to the IDT staff or member, it is determined via the RAD process that this recommendation is not the most cost-effective or effective way to support a member's long-term care outcome, and it is confirmed the member did not request the item or service recommended by the provider or consultant.

A. Re-requesting the same service or item

When the member re-requests the same item or service within sixty (60) calendar days from when the original NOA was provided to the member, a second NOA is not required unless there is a relevant change in the member's condition or circumstances. This is because the member retains appeal rights for up to 60 calendar days from the date on the adverse benefit determination notice.

However, when a re-request is received, the IDT staff must:

- Ask the member what change(s) prompted the re-request.
- If the member does not identify a change, and IDT staff can document that they have assessed this and concur that no change has occurred from the original RAD process, then the initial RAD is upheld and no additional NOA would be issued.

- Document in the member record the re-request, discussion, and assessment.
- Exception: If the member reports that a change occurred or the team assessment indicates that further evaluation of the re-request is required, then the request will be reconsidered, the RAD process followed, and, if denied, then a second NOA is provided to the member.

Attachment A

RESOURCE ALLOCATION DECISION (RAD) PROCESS

Member Messaging Expectations

- The process the Family Care, Family Care Partnership, and PACE program uses to make decisions with you about services and supports you may need is called the "RAD" (or the Resource Allocation Decision process). The goal of using the RAD is to help you and your care team look at the most effective and cost-effective services, supports, and community resources for you to help you meet your long-term care outcomes.

- Family Care, Family Care Partnership, and PACE defines "long-term care outcomes" as goals that help you be as healthy and independent as possible.

- The RAD is a series of questions that will help explore what you need and what options are available for you. This includes which friends, family, or other community and volunteer organizations may be available to help you. It also helps us talk about how you would like to be involved in directing your care and services.

- As a member of the Family Care, Family Care Partnership, or PACE program, you have the right and responsibility to know and understand all options, including how much things cost, as you make decisions with your team about your plan.

- Your responsibility is to talk with your care team about these options, so you can make decisions together. This includes asking questions and sharing your opinions.

RESOURCE ALLOCATION DECISION (RAD) TOOL

With the exception of #5, all steps in this process must be conducted with the member and/or legal decision maker.

1. **What is the core issue/concern/need?**

2. **How does the core issue relate to the member's *long-term care outcome*?**
   - Does the core issue affect the member's health or safety?
   - Does the core issue affect the member's independence, activities of daily living (ADLs), or instrumental activities of daily living (IADLs)?

3. **What options address the core issue while supporting the *long-term care outcome*?**
   - Member, guardian/legal decision maker and the IDT identify and consider all potential options (including the requested item/service) to address the core issue.

     - Assess the current interventions in place.
     - Review interventions from the past—what has worked previously?
     - Explore the role of natural supports, such as family and friends.
     - Explore community resources that may be appropriate, such as supports and services that are not authorized or paid for by the MCO and are readily available to the general public.
     - Explore solutions to address the core issue as if the member were not in a managed/long-term care program (e.g., how would this issue be met if the member was not in the program?).
     - Identify the member's ability and responsibility to address the core issue.
     - Explore loaner programs and rental versus purchase options.

4. **Review these options with the member and legal decision maker to determine:**
   a. The most effective options to support the member's long-term care outcome.
   b. The most cost-effective option to support the member's long-term care outcome. *Cost-effective means effectively supporting an identified long-term care outcome at a reasonable cost and effort.*

5. **What organizational policy or guidelines apply?** *The IDT will utilize the MCO policies, procedures, and guidelines within the RAD process.*

6. **Negotiate with the member or member's legal decision maker to reach a decision that best supports the member's long-term care outcome.**