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DHS and MCO Resource Allocation Decision (RAD) and Notice of Action (NOA) Guideline

Introduction

As part of the Department's long-term care sustainability plan, the DHS/MCO Care Management workgroup reviewed the Resource Allocation Decision (RAD) process. This review has resulted in improvements that strengthen the process and provide for administrative efficiencies related to Managed Care Organization (MCO) documentation requirements.

This guideline is organized into four areas: History and Background, RAD Process, RAD Documentation, and the Notice of Action (NOA).

I. History and Background

Family Care[1] is a comprehensive and flexible long-term care 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 publicly funded through Medicaid and is a managed long-term care program for frail elders and adults with disabilities. Family Care Partnership is publicly funded through both Medicaid and Medicare and is a managed long-term care program that, in addition to long-term care benefits, provides primary and acute care managed health care benefits to its members.[2]

A fundamental principle of Family Care is to promote member empowerment and independence to the degree possible for each individual member. To this end, the program encourages and supports members to self-direct as many of their services as possible. In Family Care, the member is part of an Interdisciplinary Team (IDT) consisting of a Registered Nurse and a Social Services Coordinator, and in Partnership, the IDT includes a Nurse Practitioner. IDT staff work 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 that may be available to assist 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 Family Care members to understand the importance of identifying and maintaining both the natural and community supports that have been a part of their lives prior

[1] Unless stated otherwise, references to the Family Care program include Family Care, Family Care Partnership, and PACE.
[2] References to members always imply the inclusion of guardians and authorized representatives.

to enrollment in Family Care. This is one of the ways members stay connected to their communities.

Members enrolling in Family Care 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 staff, regarding their services. This provides maximum flexibility for a member to participate in decisions around available services and supports, including the cost of these options. It also ensures that members take on significant involvement and responsibility in their care plan and outcomes.

The service authorization process utilized for the Family Care program is the Resource Allocation Decision (RAD) process

The RAD is used to authorize services that are within the Family Care benefit package. The RAD process:

- Always includes the member and is a collaborative process facilitated by IDT staff.
- Clarifies the identified long-term care need and **outcome** associated with the request.
- Assists in determining the most effective and cost-effective way to support the long-term care outcome that IDT staff clarifies during their conversation and assessment with the member.
- Includes specific documentation by the MCO, either in the RAD format, or in the absence of a DHS-approved RAD guideline, in case notes. After DHS approves a RAD guideline, the guideline serves as documentation along with the IDT staff's summary of the discussion with member.

The RAD process is used to authorize services that are part of the 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.**

IDT staff **always applies the RAD process when talking with members about how to provide or authorize services. However, for certain authorizations, the RAD *documentation* may be eliminated, or reduced.** Refer to the "RAD Guidelines and Documentation Process" procedure for further information.

II. Resource Allocation Decision Process

The RAD process is intended to foster critical thinking as it relates to service authorization decision-making. It ensures that IDT staff follows a consistent process when making decisions about authorization of services.

Improvements to this process were made with two guiding principles in mind:

- Supporting an understandable and uniform process that IDT staff can consistently replicate and that members can understand; and
- Ensuring that this process responsibly uses public funds to support members' long-term care outcomes within the Family Care program.

The RAD process was modified to incorporate further information on:

- The member's role and responsibility as a Family Care team member.
- The processes used by IDT staff and the member are expected to fully explore natural and community supports as part of the process of reviewing all options in supporting/authorizing a member's long-term care outcomes.
- Processes used by the IDT staff to explore self-directed supports with members are also critical.
- Reinforces cost-effectiveness is a critical component to consider in all decision-making.

A. Definition of a long-term care outcome

It is required that the member's long-term care needs/outcomes are identified through the RAD process because these are the basis for decision-making. These outcomes are generally identified during the assessment and are documented, along with the member's personal experience outcomes, in the Member Centered Plan (MCP).

Long-term care outcomes are defined as 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.

Functional needs include the psychosocial needs for community integration. This is because the long-term care outcomes are related to the member's clinical and functional needs, including self-reliance and autonomy, as well as recognizing the member's right to take reasonable risk while addressing member health and safety

The member's identified long-term care needs/outcomes drive the authorization 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 desire to feel better so the member can get out to visit with friends. Basically, people's long-term care needs and outcomes must be supported for them to achieve their personal experience outcomes, which is an expression of what a quality life means to them.

B. Member messaging

It is imperative that members understand that the RAD is applied when services within the Family Care 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.

Member messaging could be as follows:

The process the Family Care program uses to make decisions about your services and supports is called the "RAD." This refers to the Resource Allocation Decision process. The RAD helps you and your care team decide on the most effective services, supports

and community resources to help you support your long-term care outcomes, and to do it cost-effectively.

The RAD is a series of questions that will assist you, and the staff working with you, to look at the available options that will help support what is important to you. This includes ways your friends, family or other community and volunteer organizations may help support you, or ways in which you can do more for yourself. As a member of the Family Care program, you have the right to know and understand all options, including how much things cost, as you make decisions with your care team about what is needed as part of your plan.

Your responsibility in the RAD process is to talk with your care team about these options so that you can make decisions together about your care plan. This includes availability of natural supports like family and friends, other community services and your preferences about how you want your needs met. The care team will also work with you to identify your role in meeting your identified needs and outcomes.

III. RAD Documentation

The IDT staff must always follow the RAD, or other DHS approved authorization processes, during discussions with members about service authorization. This section of the guideline clarifies when RAD documentation may be streamlined to assure that the process is as efficient as possible and is valuable to the member and IDT staff.

DHS defines a "full and complete" RAD documentation as follows:

- Evidence that the member was involved in the RAD process.
- Identification of the member's request or the results of the discussion, including the reasons behind the member's request. In other words, defining the core issue and the LTC outcome being addressed.
- The options available to help support the identified LTC outcome.
- Evidence that IDT staff and the member have discussed various options, and that exploration and negotiation, as defined in the RAD process, have occurred.
- The final outcome of the discussion.

Each MCO may determine their documentation requirements to provide evidence of this process. MCOs may opt to include this information in the member-record notes, or on a RAD tool. The documentation which the MCO opts to utilize to verify the RAD process must be identified as part of the MCO's Service Authorization Policy, which is required to be submitted to and approved by DHS on an annual basis.

DHS recognizes that opportunities exist to streamline documentation of the full RAD process in certain situations. Note: In situations where IDT staff are uncertain about whether RAD documentation is required, they should err on the side of documenting the process.

Circumstances where MCOs may eliminate or streamline RAD documentation include the following:

A. Full RAD documentation is required:

For services identified in the Family Care Contract, Benefit Package Service Definitions Home and Community-Based Waiver (HCBW) services (Addendum XII.A) with the exception of Case Management Services, DHS requires full RAD documentation.

However, when a service that is part of the HCBW is also under Medicaid State Plan Services, it is acceptable to submit a guideline to DHS that once approved, may be applied to the reduced documentation described below (III.B.) One example is Supportive Home Care. An MCO using a DHS approved guideline or tool to help determine number of hours authorized would be able to utilize this tool as part of the RAD documentation.

B. RAD documentation may be reduced:

For all other services/supports within the Family Care Benefit Package, MCOs may develop guidelines and/or tools. Approval is required by DHS when the MCO intends to utilize these guidelines as a substitute for certain portions of RAD documentation.

RAD documentation may be reduced for steps three, four and five (options available to support the LTC outcome; the review of options with members; and any guideline or policy considerations the MCO takes into account when making service authorization decisions) when the MCO is using a DHS-approved guideline/tool. The IDT staff must inform members when they are using this guideline in conjunction with the RAD process. Upon request, the MCO shall provide members with the written guideline or tool and the assessment results from use of the guideline or tool.

If a reduction, termination or denial of service occurs results following application of the RAD, then the RAD documentation, including any approved guideline that has been applied, will be provided if requested by the member. The MCO will inform the member that he/she may receive a copy of this documentation. In addition, if members are working with an Ombudsman (DRW, BOALTC) or advocate and the Ombudsman or advocate requests RAD documentation, then the approved guideline that has been used and the assessment results from use of the guideline will be provided.

These DHS approved guidelines may be referenced when documenting the RAD discussion, rather than duplicating documentation. IDT staff must still summarize other core elements of required documentation in the member's record.

The IDT staff should always use critical thinking in exploration of how to best address the member's expressed concerns.

C. RAD Documentation may be waived for:

DME/DMS that supports a member's diagnosed medical conditions

Certain durable medical equipment/supplies (DME/DMS) items are more medical in nature and for that reason documentation related to application of the RAD process may be waived. The list below, while not exhaustive, provides some examples. The MCOs policies and procedures should clearly delineate these items.

Items include:

- 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
- Eye glasses (Partnership/PACE only)
- Hearing aids (Partnership/PACE only)
- Ostomy supplies

Primary and Acute Services

The RAD documentation for primary and acute services is not required for Partnership or PACE MCOs.

The IDT staff must still apply critical thinking related to all decisions regarding acute and primary services. It is important to consider other options. A physician, Nurse Practitioner, or therapist's order may not be enough to assure that the planned service is the most effective and cost-effective option. For example, the IDT staff may want to seek a second opinion or require further review of medical necessity or efficacy prior to approval.

Process:

1. IDT staff and member apply the RAD process to determine the most effective and cost-effective option.
2. Documentation in the member's record must provide evidence that that IDT staff discussed the item with the member, that the item is medically needed, and is approved or denied.
3. Enter a follow up note to document the effectiveness of the item.

If the member does not require the requested item because the member does not have a medical need for such an item, then the IDT staff must document this in the member record and must provide a Notice of Action (NOA).

It is always the IDT staff's responsibility to ensure that there is understanding of the nature of the request—or the "core issue." Therefore, if a member is requesting DME/DMS that is more medical in nature, but the request does not meet a medical need, further exploration of why the member made the request must be evidenced in the documentation.

D. RAD documentation is required on the initial service decision, but not for minimal increases to service/support levels when there is not a significant change in condition or circumstances.

a. MCOs will have the option not to document the RAD process for small, incremental **increases in level of service** for services such as supportive home care, personal care, home delivered meals, daily living skills, respite and financial management. 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 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 record.

b. IDT staff **should apply the RAD when the increase is greater than a "minimal" amount**. For increases to service/support levels, it is up to the MCO to define what "minimal" means in their Service Authorization policy and procedure. Note: DHS must review and approve this policy and procedure.

Also, for or any reductions, terminations or denials, even those that are minimal, IDT staff must document the RAD process and provide an NOA to the member.

E. Services/items outside the benefit package

The RAD and NOA are not required for items or services outside of the benefit package that are **requested** by the member. For Family Care, this includes services at both nursing home and non-nursing home levels of care. Members do not have appeal rights for items or services that are not within the Family Care benefit package.

Process

1. MCOs will send a written correspondence to the member informing them that the request is for an item or service that is not in the benefit package. This applies to members who have a nursing home or non-nursing home level of care. Information about member rights does not need to be included in this letter. Refer to Attachment B: "Notification of Non Covered Benefit" for the template that must be used.
2. IDT staff still retains responsibility for exploring the reason for the member's request. If the member's long-term care outcome related to the request is NOT being clearly addressed, the RAD documentation is expected. The IDT should use the RAD to determine the core issue and the services/items within the benefit package that may support the member's long-term care outcome.

NOTE: IDT staff and members 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.

F. Licensed Health Care Provider Consultations that Result in Specific Recommendations

1. Consultation with other health care providers/experts, such as Physical or Occupational therapists may help IDT staff gain perspective and may generate new ideas for effective management of a specific condition or situation. However, the recommendations/suggestions made by the consultant need to be considered as part of the overall plan for the member, and any decisions made regarding the recommendations **must include the member, and caregivers** (staff and natural supports) who are most directly involved with the member's plan of care.
2. It is the IDT staff's responsibility to review all recommendations with members and their representatives to ensure they understand the recommendation, how it fits into their overall plan of care, and the other options which may be appropriate to best support the member's needs/long-term care outcomes, or may be the most cost-effective option.
3. If the member confirms that he/she is requesting the recommendation, and it is something within the benefit package, then documentation of the RAD process is needed. If the request is denied, then an NOA must be sent.
4. In addition to communicating with the member, IDT staff retains responsibility for ensuring the health care consultant is aware of the follow up based on their recommendations. This should be documented in the member record.
5. This section does NOT apply to orders received from a physician.

IV. Notice of Action (NOA)

The NOA ensures that members receive timely consideration of all requests for services, and that they receive information on their rights 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 staff and the member **negotiate** together to reach 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.**

A. An NOA must be provided when:

1. 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 agrees to in the member-centered plan (MCP).
2. Any reduction or termination of service occurs unless, per the MCP, it was a time-limited authorization.
3. An NOA would be required to reduce or terminate a service within the NH LOC benefit package even if the member is now only eligible at the NON NH LOC.

B. An NOA does not need to be provided when:

1. A member has a request for something that is not included in the Family Care benefit package, because a member is not able to appeal denial of that item or service. A written correspondence is provided to the member/representative informing them that his/her request is not part of the benefit package. No appeal language is be contained in the written correspondence. (Refer to Attachment B: Notification of Non Covered Benefit letter template.)

2. A member who is at a non-nursing home level of care requests an item or service included in the benefit package for individuals eligible at the nursing home LOC.
3. When a provider or licensed consultant makes a recommendation to the IDT staff or member and 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 the member does not request the item or service recommended by the provider or consultant.

It is the responsibility of the IDT staff to ensure they fully understand the reason for the request and whether it is related to support of a long-term care outcome, and when indicated, apply the RAD process.

C. Re-requesting the same service or item

1. When the member re-requests the same item or service within a forty-five (45) calendar days from when the original NOA was provided to the member, a second NOA is not required except if a relevant change in the member's condition or circumstances has occurred (see 3. below). This is because the member retains appeal rights for up to 45 calendar days following issuance of the original request.
2. However, when a re-request is received, the IDT staff must:
   a. Ask the member what change(s) prompted the re-request.
   b. 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.
   c. Document in the member record the re-request, discussion and assessment.
3. Exception: If the member reports that a change occurred, or the team assessment indicates that more 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.

D. RAD documentation and NOA

Documentation of the RAD process or other decision-making tool typically precedes a Notice of Action so that it is clear the IDT, including the member, followed RAD processes prior to issuing a denial, reduction or termination of a service. There are exceptions when RAD documentation may not precede or accompany an NOA, including:

1. A written member request to reduce or terminate a service.
2. A change in level of service based on use of a DHS-approved assessment guideline or tool, in which case the assessment guideline or tool, and findings, will be made available upon request to the member or others identified by the member as part of the NOA.

DHS supports members and others the member identifies as being part of their team, to receive, upon request, information utilized in the decision-making process. This includes any DHS approved guidelines or assessment tools used in lieu of the RAD documentation.

Developed by the DHS/MCO Care Management Workgroup, December 2012

Attachment A

RESOURCE ALLOCATION DECISION (RAD) PROCESS

Member Messaging Expectations

- The process the Family Care 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 the entire Interdisciplinary Team (including you, your nurse, and your social worker) to look at the most effective and cost-effective services, supports and community resources to help support you.

- Family Care 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 the options that are available to support you. This includes how your 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 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 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 guardian.

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, ADLs, or IADLs?

3. **What options address the core issue while supporting the *long-term care outcome*?**
   - Member, guardian/legal representative and IDT staff 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 you were not in the program?).
     - Identify the member's ability and responsibility to address the core issue.
     - Explore loaner programs and rental vs. purchase options.

4. **Review these options with the member 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?** *(MCO staff may need to look into this and get information back to the member regarding applicable MCO policies or guidelines.)*

6. **Negotiate with the member or guardian to reach a decision that best supports the member's long-term care outcome.**
   - If a service is to be authorized, then explore the option for the member to self-direct this part of the plan of care.

Attachment B

Template for
Notification of Non Covered Benefit Letter

<<Date mailed>>

<<Member's name>>
<<Street address>>
<<City>> <<State>> <<Zip Code>>

Dear <<Member Name>>

On <<Date>>, you requested <<Non-Covered Benefit>>. This notification is to inform you that the service/item you requested is not included in the Family Care benefit package and therefore will not be provided to you by <<name of the MCO>>.

If you have further questions, please contact a member of your interdisciplinary team at the numbers listed below.

Sincerely,

<<Care Manager's Name>>
Care Manager
<<Telephone Number>>

<<RN Care Manager's Name>>
RN Care Manager
<<Telephone Number>>