APPENDIX H – MEDICAID ADMINISTRATIVE REVIEWS OVERVIEW

POLICY STATEMENT	Medicaid records are subject to review by the Department of Community Health/Division of Medical Assistance/Quality Control, the Georgia Office of Audits and by supervisory and administrative staff of the Georgia Department of Human Resources/Division of Family and Children Services.
BASIC CONSIDERATIONS	
DCH/DMA QC	Quality Control Reviewers from the DCH/DMA will read randomly selected cases for accuracy. County Staff will receive a Quality Control Communicator discussing the findings. County Staff are expected to take appropriate action in a timely manner as specified in the Communicator.
QC Rebuttals	Counties wishing to rebut QC findings should send a request for rebuttal to: Jwalker@dch.ga.gov. In the request, counties should include the following: • Case name • AU ID number • Review number • County name, contact person, and phone number • Reason for rebuttal
Department of Audits and Accounts	The Georgia Department of Audits and Accounts will conduct yearly reviews on a randomly selected sample of cases. Auditors reviewing cases are looking for the following: • Application form • Form 297A, if applicable • Verification/Documentation of Citizenship/Alien Status • Verification/Documentation of Georgia Residency • Verification/Documentation of Income • Verification/Documentation of Resources • Child Support Enforcement forms, if applicable • Third Party Liability Documentation/Form 285 • CCSP and other Communicators, if applicable • Medical bills for spend-down budgets • Timely reviews and review forms Findings from this review are shared with the Division of Family and Children Services and are generally not case specific.

BASIC CONSIDERATIONS (cont.)

Administrative Review

County supervisors, administrative staff and Medicaid Program Specialists also review Medicaid records. Each Medicaid supervisor completes first level reviews on staff under their supervision. County Program Directors (CPD), Economic Support Administrators (ESA) or Medicaid Program Specialists, in the absence of a CPD/ESA, will complete second level reviews. The sample size for second level reviews will be 5% of the total cases read per supervisor and/or unit (not to exceed 3 per unit or supervisor) monthly. Cases will be selected from all first level reviews completed in the previous month. In counties with second level administrative positions, Program Specialists will review randomly selected second level reviews to ensure correctness and verify all required corrections were completed in a timely manner.

The objectives of the supervisory review are as follows:

- To provide supervisory staff with a formalized tool for evaluation of worker performance
- To provide second level supervisory staff with a formalized tool for evaluation of supervisor performance
- To provide information necessary to identify problem areas and formulate program improvement plans
- To provide county departments with information necessary to request technical assistance from the State Office
- To provide the State Office with information necessary to offer technical assistance to county departments and to develop program improvement plans

FAMILY MEDICAID READING REQUIREMENT

For Family Medicaid, review requirements, please refer to the CAR Selection Process Guide. All Medicaid specific elements are explained in the Family Medicaid Reading Guide.

For Family Medicaid, the following definitions are used in case reading:

- Correct Case- Medicaid eligibility is correctly determined for all eligible AU members in the correct COA.
- Deficient Case- Review item incorrectly or insufficiently addressed, and/or case approved in the wrong COA *but* all eligible members are receiving correctly. (Ex. LIM vs. TMA)

FAMILY MEDICAID READING REQUIREMENT (cont.)

- Error Case- Can be any of the following:
  - Ineligible for and receiving benefits OR
  - Eligible for and not receiving benefits OR
  - Approved an AU with an ineligible member OR
  - Denied or terminated an AU member that was actually eligible OR
  - Approved an AU in a COA that resulted in an eligible AU member not receiving benefits (EX. LIM vs. RSM)

REVENUE MAXIMIZATION READING REQUIREMENTS

Supervisors will select the cases to be read based on the activity completed in the month under review. This may be the previous or current month's case actions. Do NOT permit staff to select the cases to be read. The supervisor will select a variety of case actions and COAs for review. However, as needed, the Medicaid Policy Unit and/or the Medicaid Field Program Specialist may indicate specific targeted policy issues, elements or COAs for review, which may override the usual selection criteria.

For Children in Placement review requirements, please refer to the CAR Selection Process Guide, Revenue Maximization Unit. All Medicaid specific elements are explained in the Family Medicaid Reading Guide, Revenue Maximization Unit. Both are found in Appendix H – Administrative Review.

For Children in Placement, the following definitions are used in case reading:

- Correct Case – Medicaid eligibility, COA, funding source and reimbursability are correctly determined and thoroughly documented in case record and SUCCESS.
- Deficient Case – Initial, review or change element insufficiently addressed in case record and/or SUCCESS documentation *and* all eligibility and reimbursability elements are correctly determined.
- Error Case – May be any of the following:
  - Incorrect eligibility and/or reimbursability determination
  - Eligible for and not receiving benefits.
  - Incorrect AFDC Relatedness criteria determination: financial need, deprivation, specified relative, living with/removal from, age
  - Ineligible for but receiving benefits
  - Denial or closure of a case that was actually eligible

ABD READING REQUIREMENT

Selection Criteria

Supervisors will select the cases to be read based on the activity completed in the month under review. This may be the previous or current month's case actions. Do NOT permit staff to select the cases to be read. The supervisor will select a variety of case actions and COAs for review. However, as needed, the Medicaid Unit and/or the Medicaid Program Specialist may indicate specific targeted policy issues, elements or COAs for review, which may override the usual selection criteria. The reading of a dually eligible case (full Medicaid and Q Track COA only) count as one review, not two. However, two full Medicaid COAs count as two supervisory reviews.

There are two selection standards depending on whether the supervisor manages ABD/FS staff only or multiple programs. The number of cases selected will depend on the number of workers supervised as well as supervision being program specific or multi-program. If the supervisor is reading FS cases, it is permissible to include the related ABD case as part of the ABD reading requirement. However, not all ABD cases read should have a related FS case.

NOTE: Consult your Medicaid Program Specialist for reading requirements on specialized caseloads, such as intake only or QMB/AMN case loads only.

A supervisor of ABD and related FS staff only will read four times the number of workers s/he supervises, not to exceed 30 ABD cases per month. This does not necessarily mean four cases per worker. For example, for a new MES or a MES on a work plan, more than four cases each may need to be read per month. For every four cases reviewed, read two applications, one negative action (closure or denial, and one annual review or special.

A multi-program supervisor (covers ABD Medicaid and program(s) other than related FS) will read three times the number of MES staff supervised, not to exceed 25 ABD cases. This does not necessarily mean three cases per worker. For example, for a new MES or a MES on a work plan, more than three cases each may need to be read per month. For every three cases reviewed, two should be applications (one of which may be a denial) and one a special or annual review.

ABD READING REQUIREMENT (cont.)

How to Read

Supervisor's review findings will be as of the moment the case is read. Do **NOT** withhold supervisory review findings to give the MES an opportunity to make corrections. The accuracy rate is based on the findings as of the initial supervisory review. Corrections are made after the accuracy rate is determined.

Applications: Read for all affected months, beginning with the earliest of the prior months (if any) through the ongoing benefit month.

Annual Reviews: Read only the month of the review for all data elements required for the COA. Errors which occurred in months other than the month read will be counted incorrect only if the error affects the month being read for the review/special.

Specials: A "Special" is any case action taken other than application, annual review or denial. Read the entire case. However, only consider elements in error that were the result of the action taken by the current worker when calculating the accuracy rate of the case. All errors must be corrected.

Denials: Read all screens applicable to the denial and the reason for the denial. This includes at a minimum: Case Record, NARR, ADDR, STAT, AREP, and Notice Requirements.
Refer to the instructions accompanying Form 965 and Form 974 for specifics on how to complete. It is important to strictly adhere to the guidelines to ensure statewide standards and fairness.

Supervisory Review Forms

The supervisor may complete Form 974, Supervisory Review Summary Sheet, and keep a copy in a central file. It is not necessary to submit a copy to the State Office. Report the findings on each case reviewed via the ABD Medicaid Supervisory Review Database to the State Office Evaluation and Reporting Section, who will complete monthly reports on a county, regional and state level.