Ohio Revised Code

Section 5164.911 Integrated care delivery system evaluation.

Effective: March 20, 2014
Legislation: Senate Bill 206 - 130th General Assembly

(A) If the medicaid director implements the integrated care delivery system and except as provided in division (C) of this section, the director shall annually evaluate all of the following:

(1) The health outcomes of ICDS participants;

(2) How changes to the administration of the ICDS affect all of the following:

(a) Claims processing;

(b) The appeals process;

(c) The number of reassessments requested;

(d) Prior authorization requests for services.

(3) The provider panel selection process used by medicaid managed care organizations participating in the ICDS.

(B) When conducting an evaluation under division (A) of this section, the director shall do all of the following:

(1) For the purpose of division (A)(1) of this section, do both of the following:

(a) Compare the health outcomes of ICDS participants to the health outcomes of individuals who are not ICDS participants;

(b) Use both of the following:

(i) A control group consisting of ICDS participants who receive health care services from providers not participating in ICDS;

(ii) A control group consisting of ICDS participants who receive health care services from alternative providers that are not part of a participating medicaid managed care organization's provider panel but provide health care services in the geographic service area in which ICDS participants receive health care services.

(2) For the purpose of division (A)(2) of this section, do all of the following:

(a) To the extent the data is available, use data from all of the following:

(i) The fee-for-service component of the medicaid program;

(ii) Medicaid managed care organizations;

(iii) Managed care organizations participating in the medicare advantage program established under Part C of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et seq.

(b) Identify all of the following:

(i) Changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes;

(ii) The impact that changes to the administration of the ICDS had on the appeals process and number of reassessments requested;

(iii) The number of prior authorization denials that were overturned and the reasons for the overturned denials.

(3) Require medicaid managed care organizations participating in the ICDS to submit to the director any data the director needs for the evaluation.

(C) The director is not required to conduct an evaluation under this section for a year if the same evaluation is conducted for that year by an organization under contract with the United States department of health and human services.