Since the 1970s, Ohio has utilized public-private partnerships. The state leverages managed care to achieve value for the Ohio Medicaid program through increased taxpayer savings, flexibility, accountability, member support, and innovation. Ohio’s responsible approach to program structure, regulation, and rate setting have created a stable and mature environment where the state and managed care plans have been able to focus on improving efficiency and effectiveness.

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A recent analysis by Wakely found that Ohio managed care saved taxpayers $3.6 to $4.4 billion in 2016 and 2017 compared to what would have been spent in the government run fee-for-service program.”

✓ PRIVATE INDUSTRY IS HELD ACCOUNTABLE FOR COST SAVINGS
When setting annual premiums, the state’s actuary reduces premiums to reflect actual achieved savings and saving targets that plans should be able to achieve through better management. Cost saving factors used in Ohio include potentially avoidable ED utilization, preventable inpatient hospital admissions, and increased generic drug utilization. Together, these factors reduced state spending by more than $100 million in FY 2018.

✓ PRIVATE INDUSTRY HAS REDUCED UTILIZATION IN KEY AREAS
Between FY 2015 and FY 2017, utilization in some of the most high-cost settings, inpatient hospitalization, emergency room, and ambulance services dropped by -0.7%, -2.3%, and -9.3%, respectively, while office visits increased by 0.4%. These trends reflect the efficiencies that come with providing the right care in the right place at the right time.

✓ PRIVATE INDUSTRY HAS INCREASED MEDICATION ADHERENCE
Ohio’s Medicaid plans offer prescription drugs to their members without copays as a strategy to increase medication adherence. Because copays are required in Medicaid, plan premiums are reduced to account for this policy; however, plans use their own dollars to provide this popular benefit to members. This supplemental benefit saves Medicaid managed care members more than $20 million per year and reduces Medicaid costs to the state related to untreated or undertreated health conditions.

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is key as states look to drive quality throughout the entire health care delivery system. Ohio managed care plans are on track to exceed the current goal of having 50% of payments to providers be value-oriented by 2020. Value-based purchasing reduces state costs by reducing unwarranted price variation between products and services, reducing duplicative and wasteful services, and holding providers accountable for the total cost of care that they provide.

FEES LEVIED ON PRIVATE INDUSTRY HELPS TO OFFSET THE COST OF THE PROGRAM AND BRING IN ADDITIONAL FEDERAL FUNDS
Medicaid managed care plans pay a tax on the total amount of premiums received and a fee specific to Medicaid managed care. Together these raise just under $1 billion per year and reduce reliance on state revenues. Additionally, when these dollars are spent on Medicaid services, the state earns additional federal revenue that is used to support the Medicaid program.

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MANAGED CARE PROVIDES BUDGET PREDICTABILITY
By minimizing fluctuations in spending due to changes in utilization, managed care provides greater budget predictability for policymakers who must set appropriations for a two-year period. Plans hold the financial risk for the care provided to enrollees, so the state is held harmless in the short run for increases in spending in instances such as a bad flu season or changes in patient health.

PLAN-DIRECTED PILOT PROGRAMS INFORM LARGER SCALE INNOVATIONS
Unlike fee-for-service, private industry has the flexibility to test many innovative strategies to improve the health and well-being of their members, while delivering value to the state. Lessons learned from these pilots are disseminated across plans and can be brought to scale and more quickly thereby changing the way care is delivered.

STATE OVERSIGHT PENALIZES PLANS FOR POOR PERFORMANCE
Having an efficient and effective managed care program provides greater value for the state. Using sanctions, penalties, and an ultimate expulsion from the program, the state holds plans accountable for meeting a series of performance standards for health care quality, patient outcomes, provider network management, program integrity, and program compliance. No other provider in the Medicaid health care delivery system is held to such stringent and prescriptive program requirements.