OHIO MEDICAID MANAGED CARE:

Protecting Taxpayers, Combating Fraud And Delivering Better Care

Ohio Association of Health Plans

For more than two decades, Ohio has steadily shifted its Medicaid program away from paying for the volume of services delivered under fee-for-service (FFS) and toward paying for value through managed care. Over that period, the Ohio Department of Medicaid (ODM) has moved additional populations and services into mandatory managed care, and today more than 90% of Ohio Medicaid members receive coverage through a managed care organization (MCO).

Under this model, the state contracts with private health plans to coordinate care, manage costs and improve outcomes. Unlike a traditional FFS or Administrative Services Organization (ASO) model, managed care does not simply process claims after services have been delivered. It gives Ohio a group of accountable partners that have financial incentive to protect taxpayer dollars, strengthen Medicaid program integrity, create accountability for quality and cost, support members with complex needs, encourage innovation in care delivery and improve health outcomes for Ohioans.

Ohio's measured approach to program design, oversight and rate setting has helped create a stable, mature managed care environment in which the state and participating plans can focus not only on coverage, but also on improving efficiency, quality and long-term value. Moving away from managed care would shift financial risk and operational responsibility back to the state, weaken incentives to prevent fraud, waste and abuse, and expose taxpayers to greater uncertainty as healthcare costs rise.

ADVANTAGES OF MANAGED CARE

Medicaid is a joint federal and state program that provides free or low-cost health coverage to millions of Americans, including many low-income individuals, families and children, pregnant women, the elderly and people with disabilities. States may provide Medicaid services through FFS, managed care or a mixture of both.

The fundamental difference among these models is accountability. Under FFS or an ASO arrangement, the state remains self-insured and responsible for the full cost of care. Under managed care, MCOs assume financial risk and are accountable for claims administration, program integrity, care coordination, provider access and health outcomes.

ONE Combats Fraud, Waste and Abuse Before Taxpayer Dollars Are Lost

Every dollar lost to Medicaid fraud, waste and abuse is a dollar that can't be used to care for the Ohioans whom Medicaid is designed to serve. Managed care creates a stronger first line of defense because MCOs have both the tools and the financial incentive to identify suspicious activity early and prevent improper payments.

Each Ohio MCO maintains a Special Investigations Unit staffed by trained investigators who use claims analytics, provider screening, prepayment review, utilization monitoring and other data to identify abnormal billing, unnecessary services, provider misconduct and emerging fraud schemes.

This is an important structural advantage over FFS and ASO arrangements. In those models, the state retains the financial risk and often relies more heavily on retrospective audits and recovery efforts after claims have already been paid. Managed care adds multiple private-sector detection systems, investigative teams and payment controls to the state's own program-integrity efforts.

Because MCOs operate under fixed payments, improper and unnecessary claims directly affect the resources available to manage care. Plans therefore have a strong incentive to stop suspect payments, remove bad actors from their networks, recover overpayments, and refer credible cases to ODM and law enforcement.

Learning from Other States

The value of early intervention is illustrated by a major behavioral-health fraud scheme in Arizona. Billions of dollars flowed through the state's FFS system, while managed care plans were able to identify suspicious activity earlier and substantially limit their exposure through risk controls. In Ohio, MCOs report prevention activities, investigations, recoveries, cost avoidance, provider terminations and planned initiatives. They also meet regularly with ODM and law-enforcement partners to share intelligence and respond to emerging risks. This creates a layered program-integrity system: the state retains oversight and enforcement authority, while MCOs contribute specialized personnel, technology, claims intelligence and financial accountability. Replacing managed care with an ASO would not eliminate the need for these functions; it would shift more of their cost, responsibility and financial risk directly to the state.

TWO Protects Taxpayers Through Financial Risk Transfer and Budget Certainty

Under a traditional FFS or ASO model, providers are generally paid a set amount for each service they deliver. That structure rewards volume rather than outcomes and offers limited flexibility to address the unique medical, behavioral and social needs of individuals or the communities in which they live.

It also leaves the state financially exposed when utilization rises because the state remains responsible for covering the full cost of additional services. In other words, under both FFS and ASO arrangements, the state retains 100% of the financial risk, with fewer built-in incentives for care coordination, accountability or measurable quality improvement.

The state retains 100% of the financial risk

Under Medicaid managed care, MCOs are paid a fixed monthly amount to cover the medical needs of enrolled members. If healthcare utilization or costs exceed expectations — because of rising drug prices, increased service use or other pressures — the MCO, not the state, absorbs those additional costs within the terms of its contract.

This transfers significant financial risk away from taxpayers and gives state policymakers greater certainty when constructing the Medicaid budget. Under an ASO model, administrative expenses may appear lower as a separate line item, but the state remains exposed to open-ended medical claims and utilization increases. Lower administrative spending does not guarantee lower total program spending.

The managed care structure instead rewards plans for keeping members healthy, coordinating services earlier and reducing preventable high-cost care.

THREE Creates Accountability for Cost, Quality and Results

Ohio's managed care contracts allow the state to establish clear expectations for access, quality, member experience, care coordination, program integrity, network adequacy and financial performance. MCO performance can be measured, compared, rewarded or penalized.

Unlike an ASO monopoly that principally performs functions on the state's behalf, Ohio's managed care structure uses competition among plans to encourage better performance. MCOs must demonstrate value to the state and members through quality outcomes, member service, provider access and operational performance. This gives Ohio more tools to hold contractors accountable and tie compensation and contract decisions to measurable results.

FOUR

Better Manages Complex Conditions and High-Cost Populations

MCOs integrate preventive services, chronic disease management, behavioral health, pharmacy services, and care coordination across providers and settings. This reduces fragmentation, improves adherence, and can lower avoidable hospitalizations and emergency use.

They also provide value-added services such as medically tailored meals, transportation assistance, housing supports, and enhanced behavioral-health coordination when those investments can improve health and prevent more expensive interventions.

These capabilities are especially important for members with disabilities, older adults, individuals with multiple chronic conditions, and people who receive both Medicare and Medicaid. These members often require intensive, ongoing coordination across physicians, hospitals, behavioral-health providers, pharmacies, home- and community-based services, and social-service organizations. An ASO can process claims for these services, but it does not integrate them or manage their total cost.

FIVE

Accelerates Innovation and Value-Based Care

MCOs have the flexibility, infrastructure and capital to develop innovative value-based payment arrangements with providers that reward better outcomes rather than a higher volume of services.

Unlike FFS, which relies on a uniform fee schedule, managed care can more quickly test, refine and scale new approaches to care delivery. That flexibility helps accelerate improvements in quality, supports provider partnerships and can produce meaningful cost savings over time. MCOs can also use claims information, pharmacy data, care-management records, and provider-performance information to identify gaps in care and target interventions. An ASO may supply administrative data to the state, but the state must still build or procure the infrastructure, staffing, clinical expertise and provider relationships necessary to turn that information into coordinated action.

SIX

Supports Provider Access and Flexible Payments

Managed care gives the state and MCOs more flexibility to support provider access than a uniform FFS fee schedule alone. Because MCOs must meet network-adequacy requirements, they negotiate with providers to maintain sufficient access across regions and specialties. Many negotiated arrangements pay above the state's base FFS rate.

The managed care structure also allows Ohio to use state-directed payments to support hospitals and other providers in ways that may not be available under a pure FFS system. Additionally, Ohio's Next Generation program has centralized provider credentialing and claims processing, addressing common provider concerns while retaining the care management, accountability and risk-transfer advantages of managed care. This allows Ohio to improve administration without abandoning the MCO model's core benefits.

OHIO'S MANAGED CARE PROGRAM SUCCESSES

Ohio's managed care program is established, statewide and results-driven. Mandatory enrollment in managed care has been in place for most major Medicaid populations since the early 2000s, giving Ohio many years of experience refining how the model works in practice. Over time, the program has helped the state strengthen program integrity, improve health outcomes, manage financial risk and deliver substantial savings for taxpayers. The examples below illustrate how managed care has produced measurable results in Ohio.

Cost Savings

From 2020 to 2025, Medicaid managed care is estimated to have saved Ohio between $15 billion and $20 billion compared with what the state likely would have spent under a traditional FFS approach. Those savings are driven by better care coordination, stronger emphasis on prevention and primary care, management of unnecessary utilization, and reduced reliance on avoidable high-cost services such as emergency department care.

Reinvesting in Ohio Communities

Since 2022, MCOs have reinvested over $37 million into the communities they serve through the Community Reinvestment program. These investments have expanded access to prenatal services, stable housing, lead mitigation, access to healthy food and much more. These investments demonstrate a central advantage of managed care: Plans can use their resources, data, and community partnerships to address problems before they result in more serious illness and more expensive care. An ASO or FFS model does not provide the same combination of financial responsibility, local investment and accountability for outcomes.

MCOs have reinvested over $37 million into their communities

Improved Health Outcomes

- **Connecting Expectant Mothers with Care:** MCOs worked with providers to increase the submission of Pregnancy Risk Assessment Forms, or PRAFs, to quickly connect expectant mothers with prenatal services and care coordination. Because of these efforts, in 2025, two out of three expectant mothers enrolled in Medicaid had a PRAF submitted during pregnancy.
- **Outcome Acceleration for Kids:** This collaborative initiative between Ohio's MCOs and children's hospitals aims to improve the behavioral and physical health of Ohio's children. As a result of these efforts:
  - Well-child visit rates increased by 12% among infants and 5% among adolescents.
  - Asthma-controller medication coverage increased by approximately 5%.
  - Follow-up visits after emergency department encounters for mental illness increased by 6%.
- **OhioRISE:** OhioRISE is a specialized Medicaid program for children and youth with complex behavioral healthcare needs. Youth receiving behavioral health services through OhioRISE have decreased behavioral health emergency room visits, decreased inpatient behavioral health hospitalizations, and decreased out-of-home treatment.
- **MyCare Ohio:** Individuals receiving care through Ohio's MyCare program for people enrolled in both Medicare and Medicaid have shorter long-term nursing-facility stays, fewer inpatient admissions and more primary-care visits than those not participating in the program.
- **Diabetes Care:** MCOs led a collaborative effort to improve outcomes for adults with diabetes through self-management education and greater access to continuous glucose monitors (CGM), contributing to a 43% increase in CGM use.

BOTTOM LINE

The question for Ohio is not simply which model has the lowest administrative line item. It is which model best protects the entire Medicaid program — and the taxpayers and Ohioans who depend on it.

Ohio's managed care program offers a stronger and more sustainable framework. It creates direct incentives to prevent fraud and unnecessary spending, gives policymakers greater budget certainty, uses competition to improve performance, supports flexible provider partnerships and delivers specialized care coordination for Ohioans with the greatest needs.

Managed care is more than a method for paying Medicaid claims. It is a comprehensive system for protecting taxpayer dollars, holding organizations accountable, improving care and preserving Medicaid for the Ohioans it was created to serve.