

EXECUTIVE BRIEFING

Medicaid procurement outlook: Trends, delays, and what's next

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Medicaid managed care procurements slowed materially in 2025 as states faced fiscal pressure, evolving federal policy expectations, administrative capacity constraints, and heightened legal scrutiny. Instead of advancing new solicitations, many states are extending existing contracts, postponing re-procurements, and reassessing long-term program designs.

However, this slowdown does not signal that states are less committed to managed care. Instead, it reflects a recalibration toward more durable, defensible procurement structures better suited to withstand policy volatility, litigation risk, and operational complexity. For managed care organizations (MCOs), these shifts alter how and when to compete, how to demonstrate value, and how to sustain financial viability in Medicaid markets.

This brief explores the evolving Medicaid procurement landscape and the implications for MCOs that are evaluating whether or how they should participate. Those that do participate must navigate delayed timelines, elevated scrutiny, and rising performance and accountability expectations.

Procurement delays and contract extensions are becoming the norm

States are prioritizing stability and operational readiness over speed as they prepare for new federal requirements and expanded oversight. They are using longer contract cycles, optional renewals, and phased implementation timelines to reduce churn, manage transition risk, and ease the administrative burden while ensuring program continuity for high-need populations.

For example:

- Indiana extended Hoosier Care Connect through June 2028 to align its next procurement with the PathWays for Aging Initiative under a single, integrated solicitation, reducing duplicative procurement activity.
- Louisiana extended most Medicaid MCO contracts through 2026.

- North Carolina delayed re-procurement by 2 years due to funding constraints and the complexity of concurrent reforms.

Escalating protest activity is reshaping procurement design

Protest activity and litigation have become structural risks within Medicaid procurements. Once episodic, protests are now increasingly anticipated components of competitive procurements, often delaying implementation by 6 months or more.

For example:

- In Georgia, incumbent protests have delayed the anticipated July 2025 go-live to late 2026 or early 2027.
- Rhode Island's managed Medicaid procurement was disrupted by bidder protests between 2024 and 2025, prompting the state to reevaluate proposals, cancel the solicitation, and extend incumbent contracts while preparing a revised RFP.
- In Texas, STAR and CHIP procurement has been tied up in litigation for nearly 2 years, with courts ultimately pausing the process due to noted deficiencies in the state's evaluation methodology.

While some protests are dismissed, others expose legitimate procedural gaps, including flawed scoring, insufficient documentation, conflicts of interest, or unclear evaluation criteria. Even unsuccessful protests impose material administrative costs and inject uncertainty into readiness activities, particularly for programs serving complex or high-acuity populations.

In response, states are strengthening evaluation frameworks, clarifying scoring criteria, and emphasizing transparency and defensibility. For MCOs, this elevates the importance of demonstrable performance, well-documented outcomes, and operational credibility as core competitive differentiators.

What's new: Forces shaping the 2026–2027 procurement cycle

Several converging forces are reshaping how states design managed care programs and how MCOs must position themselves to compete effectively.

Market force

What to expect

Market examples

Federal alignment requirements reshaping D-SNP markets

Beginning in 2027, federal rules will significantly alter the Medicare-Medicaid landscape.

Medicare Advantage organizations offering both a Dual-Eligible Special Needs Plan (D-SNP) and a Medicaid MCO in the same county may enroll dual-eligible beneficiaries only if they are enrolled, or imminently enrolling, in its affiliated Medicaid plan.

This represents a fundamental shift from prior practice and materially raises the stakes of Medicaid participation for MCOs operating in duals markets.

In anticipation of these requirements—and given the attractive margin profile of aligned duals—many plans have accelerated D-SNP growth under current rules.

[Read more about the final rule and the implications for MCOs.](#)

States such as Illinois, Michigan, Ohio, Rhode Island, and Texas are preparing to implement Highly Integrated Dual Eligible (HIDE) and Fully Integrated Dual Eligible (FIDE) structures in 2026.

They aim to support tighter integration and position themselves for the 2027 requirements.

Accelerated integration of behavioral health, LTSS, and complex care

States continue to advance benefit integration to reduce fragmentation and improve outcomes for high-need populations.

Behavioral health and long-term services and supports (LTSS) integration remains a focal point. This is driven by quality and cost considerations and signals sustained momentum toward consolidated, accountable care models nationwide.

For instance, New Jersey historically has included LTSS in managed care while keeping behavioral health services separate.

In January 2025, the state initiated Phase 1 of behavioral health integration, bringing outpatient mental health and substance use disorder services under managed care for all NJ FamilyCare members.

Technology modernization and digital evaluation tools

Technology modernization is becoming a defining feature in Medicaid procurements. States are investing in digital procurement platforms and AI-enabled evaluation tools to enhance transparency, efficiency, and oversight. At the same time, they are also modernizing infrastructure to support more integrated, technology-enabled MCO operations.

For example, some states are accelerating adoption of Fast Healthcare Interoperability Resources (FHIR)-based interoperability infrastructure and application programming interface (API) management to meet 2027 data-exchange requirements.

Oklahoma has deployed AI-enabled tools to automate procurement reviews, flag errors, and increase transparency and efficiency in statewide purchasing.

Washington has advanced technology modernization through state action requiring adoption of FHIR-based APIs for prior authorization and administrative exchange.

Preparation for federal community engagement requirements

States are beginning to prepare for the upcoming federal Medicaid community engagement requirements. As part of this, MCOs must support eligibility verification, reporting, member communications, and compliance monitoring at scale.

Ohio issued a 2025 request for information (RFI) focused on Medicaid work requirement compliance—an early signal of the operational and technological complexity states anticipate.

Perspective on MCO exits

In 2025, several MCOs announced their intention to withdraw from Medicaid markets due to growing financial strain, rising care costs, and state payment levels that no longer aligned with expenditures. These withdrawals highlight a significant challenge for states and MCOs alike:

aligning program expectations with reimbursement structures that support long-term sustainability.

PacificSource's decision to exit Lane County, Oregon, effective January 2026, indicates the magnitude of these pressures. UCare's plan to withdraw from all Medicaid business further reflects the difficult strategic decisions MCOs must make to preserve financial viability.

Together, these developments expose growing vulnerabilities in Medicaid managed care markets. Tightening margins, expanded compliance requirements, and emerging plan exits underscore the need for disciplined strategy and sustained investment.

Positioning for success: Strategic recommendations for MCOs

To remain competitive and financially viable, MCOs must move beyond episodic bid preparation toward a more deliberate, continuous strategy that aligns market participation, compliance strength, and operational agility.

The following three imperatives reflect how leading organizations are responding to current dynamics:

1. Market participation and portfolio strategy

Delayed procurements, extended contract cycles, and fiscal pressure are forcing states to be more deliberate about when—and how—they rebid programs. For MCOs, this means fewer entry points, longer commitments, and greater financial exposure when markets underperform.

In response, MCOs must apply disciplined, forward-looking assessments to determine where to compete and under what conditions participation remains sustainable. Rigorous bid/no-bid evaluations should be grounded in rate adequacy, service mix, acuity trends, administrative cost expectations, and scenario-based cost modeling that accounts for uncertain timelines and evolving market conditions.

Ongoing engagement with state agencies and legislators is also critical. Early visibility into legislative priorities, budget dynamics, waiver activity, and policy direction enables more informed participation decisions well before an RFP is released.

Regional and new entrant MCOs

For local or single-state MCOs, market participation decisions are less about geographic selectivity and more about whether to remain in Medicaid at all. For these organizations, disciplined portfolio strategy means:

- *Clearly defining the conditions required to sustain participation*
- *Understanding break-even thresholds*
- *Engaging early with state partners to shape program expectations where possible*

2. Compliance, integrity, and operational readiness

Escalating protest activity and judicial scrutiny have raised the bar for procurement defensibility. In response, states are tightening evaluation criteria, strengthening documentation requirements, and deploying digital and AI-enabled tools that surface inconsistencies, gaps, and unsupported claims.

In this environment, compliance, data integrity, and documentation are no longer merely regulatory obligations. They are core elements of bid competitiveness.

MCOs should invest in audit readiness, encounter data quality, and documentation practices. They should also adopt more compliance-oriented procurement strategies with clear controls and reporting mechanisms. Demonstrating robust safeguards against improper payments and inaccurate billing is increasingly essential to procurement success.

States are refining scoring methodologies and elevating expectations for defensibility. In this environment, MCOs that can clearly demonstrate historical performance, compliance maturity, and operational reliability will be better positioned to avoid disruption and maintain continuity.

National MCOs

National MCOs must ensure enterprise compliance frameworks translate effectively at the state and local levels. This is becoming particularly important as states tailor evaluation criteria, oversight requirements, and documentation expectations to program-specific priorities.

3. Agility, innovation, and continuous readiness

Several factors are increasing operational complexity while compressing implementation timelines:

- Delayed and phased procurements
- Accelerated integration of behavioral health and LTSS
- Technology modernization
- Forthcoming federal requirements (including HR-1)

At the same time, extended contracts heighten the importance of provider stability, particularly for high-need populations.

Sustained success will depend on operational agility supported by data-driven decision-making. MCOs must be able to rapidly operationalize new benefits, policy changes, integration requirements, and models of care while maintaining existing program performance.

Continuous procurement readiness is also essential. MCO must keep current narratives, staffing models, financials, and operational plans so they can respond quickly and credibly as opportunities emerge.

Finally, as states place greater emphasis on minimizing provider disruption, MCOs must demonstrate the ability to sustain stable provider relationships over time, particularly for dual-eligible members and individuals receiving behavioral health services or LTSS.

HR-1 readiness

MCOs should explicitly incorporate HR-1 preparedness into their continuous readiness strategies, including:

- *Monitoring evolving federal guidance*
- *Conducting internal gap assessments*
- *Developing operational workstreams to support potential changes in eligibility verification, reporting, documentation standards, and member communications*

Technology platforms must be sufficiently flexible to support new compliance workflows, data exchanges, and integrity controls with limited lead time.

Reposition for sustainability and value in the new landscape

The next wave of Medicaid procurements represents a pivotal reset for managed care. As states proceed cautiously and elevate expectations, success will be defined less by speed and more by sustained performance, risk management, and measurable value.

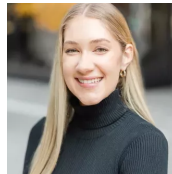
MCOs that invest now in disciplined strategy, strong compliance, and operational agility will be best positioned to compete effectively in the increasingly demanding procurement cycles ahead.

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