Medicaid managed care trends

What payers should know about state priorities and the competitive procurement landscape

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Medicaid managed care has remained a highly competitive space in the last 2–3 years, with at least 18 procurements released across 15 states in 2023 and 2024 alone. Procurements are a critical tool for state agencies as they seek to drive program priorities, address emerging challenges, and innovate across the Medicaid program. For example, states have recently been pushing for additional focus on advancing integration of Dual Medicare Medicaid beneficiaries (duals), expanding use of in lieu of services and/or services that address social drivers of health (also known as “health related social needs” or “HRSN” and “social determinants of health” or “SDOH”), addressing healthcare workforce gaps and challenges, and improving management of program quality and financing. As the Trump Administration begins to further define and implement its healthcare agenda, states will need to react to programmatic and financing changes with shifts likely occurring across these priorities.

States releasing these solicitations have offered managed care organizations (MCOs) the opportunity to manage more than 16 million members, representing more than $100 billion in annual contract value. Nationals and smaller payers alike have responded actively to these recent procurements, establishing a highly competitive environment in which state agencies are willing to consider new market entrants offering innovative strategies. In this environment, there is increasing pressure on incumbents to retain, let alone expand, their market share without a proactive approach.

Why it matters

Medicaid managed care is a dynamic, evolving, and highly competitive space

Medicaid agencies continue to seek solutions to address program integrity, population health, workforce, and other strategies through managed care contracts. They are also executing new mandates from the federal level, including integration of dual Medicare Medicaid beneficiaries (dual beneficiaries). A lack of diligence and attention on these dynamics puts incumbents at risk of losing significant, billion-dollar contracts and new entrants behind in their ability to strategically plan disruptive market strategies.

Attention to these details is especially important as Medicaid increasingly represents a key component of plans' government program product portfolios, given recent integration requirements and churn across Medicare Advantage, dual eligible special needs plans (D-SNPs), Medicaid, and Affordable Care Act (ACA) plans. Thoughtful planning around Medicaid is necessary to ensure stability of the plan's overall government programs business.

States have outlined clear priorities in recent procurements that payers can leverage to plan for upcoming procurements in 2025 and future years. Beyond strategic alignment, innovation and a payer's ability to meet the evolving needs of the Medicaid population through integrated care models (e.g., physical and behavioral health integration, dual beneficiary care model integration) are critical to secure and grow market share.

With at least 11 collective losses among nationals (both incumbent and new markets) and 13 incumbent losses among local and regional plans, recent awards pose a clear message in this highly competitive space. MCOs must prepare effective strategies to address state priorities in innovative and practical ways that neutralize the competition.

For this brief, we analyzed 18 procurements and 15 subsequent awards between 2023 and 2024 to capture trends in the evolving state priorities and identify considerations for payers as they look toward upcoming solicitations in 2025 and beyond. We will explore the potential changes and implications of the new Trump Administration on Medicaid managed care in a forthcoming brief.

Key procurement and award trends to know

The dynamics in Medicaid managed care can be assessed from two perspectives—evolving state priorities and award trends considering the highly competitive landscape.

EVOLVING STATE PRIORITIES DEMAND INNOVATION

States are establishing clear priorities for Medicaid managed care across access, quality, and other performance indicators while pushing new expectations for network management and non-traditional services (e.g., HRSN services). Drivers behind these priorities include but are not limited to financial, covered population, and regulatory changes at the state and federal levels.

Medicaid agencies are consistently focused on priority populations across recent contracts, with enhanced attention on certain populations for which outcomes and costs are increasingly important. Beyond standard benefits delivery, states are seeking to address emerging health disparities or access to care challenges, while advancing care integration and outcomes.

PRIORITY POPULATIONS AS DRIVERS OF STATE MEDICAID PRIORITIES

Priority population	Considerations	Common state priorities
Pregnant and postpartum members and infants	■ Rising maternal and infant mortality and poor birth outcomes in many states ■ Significant and/or increasing disparities among Black enrollees	■ Improve prenatal care access as well as social care needs during pregnancy ■ Enhance education and holistic approaches that improve birth outcomes (e.g., increasing use of doulas)
Members with behavioral health (BH) needs, including substance use disorder (SUD)	■ Rising challenges with BH conditions across the population ■ High incidence of co-occurring conditions ■ Consistent challenges with SUD service access	■ Fill BH workforce gaps and/or use telehealth services ■ Increase screening and referral support ■ Enhance SUD capabilities and/or systems to improve access, especially in rural areas
Justice-involved populations	■ Short-term jail stays as well as longer-term incarceration impacting individuals' eligibility for Medicaid services ■ Increasing focus on reentry supports and services to support long-term success, including adequate access to BH/SUD supports and other healthcare needs	■ Offer services in advance of release, including care coordination and care management services and intensive case management post-release to address high social support needs ■ Pilot additional policies, such as streamlined Medicaid eligibility suspension and reactivation through reentry 1115 waiver programs
Dual beneficiaries	■ Long-standing challenges with benefits coordination ■ New regulations requiring integration of services under unified enrollment models ■ Growing duals population exposing growing challenge in long-term services and supports (LTSS)/home and community-based services (HCBS) space, including workforce gaps	■ Increase in migration to fully integrated dual eligible special needs plan (FIDE D-SNP) and highly integrated dual special needs plan (HIDE D-SNP) models for contracting ■ Significant focus on integrated care models, and continued use of community-based services ■ Emphasis on holistic care and needs, including HRSNs

Key procurement and award trends to know

States are consistently focused on improving care around and outcomes for key populations as highlighted above. They are charging MCOs with addressing SDOH and advancing access to care through new approaches to program delivery and oversight. The following are common levers states are using within new MCO contracts to drive program goals across the populations served:

- **Integration of HRSN.** Direct integration of HRSN and broader community-based health and wellness strategies (e.g., family/caretaker needs) into the model of care (MOC).
- **Access beyond adequacy.** Ability to offer statewide services, meet rural access requirements, and ensure access regardless of network capacity. This requires innovative solutions considering geography, SDOH barriers, workforce initiatives, and collaboration with community-based organizations (CBOs) and LTSS providers.
- **Advancement of value-based care.** Inclusion of advanced payment models in provider contracts, including target thresholds for downside risk in some cases.
- **Network enablement.** Encouraging direct provider support (e.g., education on specialty population needs, performance monitoring tools, support identifying/addressing care gaps) to enable success in the program.
- **Dual beneficiary operating model integration.** Moving to integrated D-SNP models and ensuring adequate support and coordination of benefits through Medicare and Medicaid. In fact, holding a Medicaid contract is now a critical requirement for market entry for serving this population.

AWARD TRENDS EMPHASIZE A HIGHLY COMPETITIVE LANDSCAPE

National payers as well as smaller local and regional payers have been extremely active in recent procurements. This underscores interest in maintaining presence or entering the Medicaid space, despite a highly competitive landscape and complex regulatory environment. Payers' interest in Medicaid is likely driven by opportunities to serve parallel and/or overlapping populations (e.g., marketplace and duals) as well as revenue diversification and market growth.

Key procurement and award trends to know

States' contract awards in response to this activity demonstrate a willingness to engage with new players as they seek innovative solutions to emerging challenges and priorities. However, both incumbents and new entrants face significant competitive challenges.

Significant nationals activity

National payers like Centene, UnitedHealthcare, Molina, and Humana have participated in most procurements in the last 2 years, emphasizing significant and sustained interest in the line of business. Collectively, nationals have been awarded 47 contracts across the awards we reviewed. However, in established markets, nationals also experienced losses, with at least eight market losses across the six organizations.

These recent losses highlight potential challenges for nationals, including their ability to adequately address existing operational or performance issues from agency perspectives, as well as offering innovative solutions to evolving state priorities and challenges.

MARKET HIGHLIGHTS

Iowa Total Care (Centene) has established a housing command center and an app to address challenges with homelessness. The initiative will house and support unsheltered individuals and use an app to deliver real-time directions to housing, food, and other resources.

Molina is collaborating with home health providers to enhance care coordination for members with complex care BH conditions through data-driven care models. Under the model, Molina and Innovive will aim to enhance supports across the care continuum while reducing unnecessary emergency room visits and in-patient readmissions.

Key procurement and award trends to know

Local and regional payers compete

Local and regional payers face many challenges competing against national plans' experience and economies of scale. However, strong local partnerships and positioning in the market provide local and regional plans with the ability to win.

In fact, across the markets reviewed, more than 40% of contracts have been awarded to local or regional plans. While each local/regional plan has varying abilities to support and deliver comprehensive proposals, they tend to emphasize the following areas when competing against national plans:

- Long-term understanding and engagement in the local market
- Committed relationships with local providers focused on experience and sustainability
- Local community partnerships that enhance the ability to drive more holistic member supports

However, across the markets reviewed, seven local incumbent payers also lost their contracts in recent procurements. Local and regional payers often have fewer resources dedicated to developing response strategies. They also potentially lag the nationals in their ability to demonstrate experience in areas such as payment integrity and may have less capacity to bring forth significant innovations, in which they would benefit from economies of scale.

MARKET HIGHLIGHTS

Partnerships between local and national plans is a winning strategy that led Healthy Blue and Elevance to win a new contract in Kansas. Healthy Blue is an alliance between **BCBS Kansas** and **BCBS Kansas City** supported by Elevance to newly expand the collective organizations' reach to Kansas Medicaid.

WellSense, a provider-sponsored health plan (PSHP) serving New Hampshire and Massachusetts Medicaid members, set up a program to analyze prior authorization trends to identify disparities and inform health equity efforts. The plan is also assessing patterns in grievances and appeals to identify underrepresented members in the data who may benefit from receiving additional information and support to empower self-advocacy.

Community Care Plan in Florida has opened a community resource center to address community and members' HRSNs, extending its impact and local capacity to address social care needs. The center will focus on improving maternal outcomes and addressing HRSN through classes, support groups, job search support, and other resources while offering onsite group prenatal care service through a provider partnership.

Eight proactive steps to position for Medicaid market success

Medicaid managed care remains a key strategy for care delivery and financing. States will increasingly rely on payers to partner with them in developing innovative solutions that address evolving needs and expectations. These award trends underscore how seriously the agencies will consider their potential partners in Medicaid program implementation and their ability to support critical state priorities.

While procurement activity is expected to rebound later this year and at least 14 procurements are anticipated through 2027, delays may occur as state agencies navigate uncertainty under Trump Administration policies. Despite this, payers should assess readiness and prepare in their target markets as policies evolve. Incumbents should begin preparing at least 12 months before a procurement release, while new market entrants need at least 24 months. Business development and operational leaders should proactively convene their teams to:

> Reprocurement cycles are taking longer—sometimes 5-10 years—for managed care contracts, requiring new payers to act on current opportunities quickly or face a long wait to vie for a position in the market. Missing a cycle could directly impact a plan's government programs product portfolio strategy for the next decade or more.

1. Evaluate upcoming opportunities in conjunction with broader government programs strategy (Medicare Advantage, Duals Special Needs Plans, and Individual Market) to ensure strong alignment.
2. Understand their current market performance and reputation, identify key challenge areas and priorities (e.g., PIPs or ongoing state agency relationship challenges, indicators of member experience, provider experience, financial performance, and/or quality).
3. Engage state agencies and regulators through government affairs teams to gain insight into evolving priorities and challenges while offering support.
4. Analyze evolving market priorities and existing operational gaps that must be filled to address market priorities, including potential changes forthcoming from policy and financing changes.
5. Assess the competitive landscape to understand relative market positioning in relation to market priorities.
6. Design, prioritize, and implement critical initiatives that will serve as the backbone for an effective and differentiated response; these initiatives should address potential reputation or operational challenges to neutralize the competition (e.g., quality performance, VBC capabilities and related network enablement, and care integration models).

Eight proactive steps to position for Medicaid market success

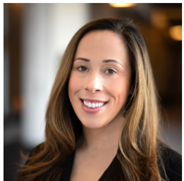
7. Identify and engage potential partners that could advance market goals and close key gaps, such as local relationships and development of provider champions.
8. Assemble a comprehensive bid preparation and response team to ensure that the procurement response is compliant, competitive, and reflective of the plan's comprehensive offerings that support the state's priorities and goals.

Payers that proactively plan for these opportunities will be better equipped to succeed in their bids.

HealthScape can help:

How is your organization navigating this competitive landscape? Leveraging these insights, HealthScape can offer participating plans support across Medicaid market entry and growth, contract capture and retention, and performance optimization.

Authors



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