

THE VBP ERA:

States are
requiring more
risk in managed
care contracts

A Guidehouse study explores how Medicaid managed care RFPs have changed in the last four years—and what healthcare leaders need to know





In 2022, Guidehouse [examined](#) how states were beginning to require value-based purchasing (VBP) models in Medicaid managed care contracts. At the time, many of those requirements were directional, leaving significant discretion to plans.

Four years later, the Medicaid managed care landscape has continued to evolve quite significantly.

Since then, there have been nine new state requests for proposals (RFPs) for full-scope managed Medicaid contracts. Insights from these newly released RFPs offer a glimpse into the shift states are making to having more explicit arrangement types, expectations to scale, and new perspectives on how progress will be measured. In contrast to the 2022 analysis, fewer Medicaid agencies are relying on broad statements of intent or leaving key design choices undefined, with the overall intent to control costs, improve quality, integrate health equity, and optimize care coordination.

For executives at managed care organizations (MCOs), the implication is real: VBP capability is now being evaluated at the point of procurement. Winning plans can show how they will meet defined targets, support and manage provider participation, and track performance against state requirements. Plans that cannot do this are not just at risk of underperforming post-award—they are at risk of not having a competitive bid.





Insights from post-2022 Medicaid MCO RFPs

While states vary in how prescriptive their requirements are, our analysis of the latest RFPs (as shown in Table 1) found common themes in how value-based purchasing expectations are being communicated to MCOs:

- 1. Just participating is no longer sufficient.** Medicaid agencies are now explicitly requiring MCOs to implement VBP arrangements as part of their managed care contracts. Prior to 2022, requirements often emphasized participation or good-faith effort. Now, more state RFPs include saturation targets, glidepaths, or timelines describing how quickly VBP arrangements should expand.
- 2. LAN is the common model.** States are increasingly using the alternative payment model (APM) framework established by The Health Care Payment Learning & Action Network (LAN) as the organizing framework for describing VBP expectations. Most states expect MCOs to move beyond Category 1—fee-for-service with no link to quality, risk, and value—and instead align with Categories 2 through 4. These categories reflect a progressively more value-based approach to payment. Differences across recent RFPs are less about the framework itself and more about how explicitly states define thresholds and timelines.
- 3. Downside risk expectations are more explicit.** Several of the RFPs reference downside risk as an expectation within the contract period. Texas, for example, using LAN as guidance, is requiring 25% of value-based payments to include downside risk by year four (2026).
- 4. Two distinct procurement styles are emerging.** Some RFPs—like those from Florida, Michigan, and Oklahoma—are prescriptive, setting minimum percentages of payments, glidepaths, and timelines for adoption. Other states emphasize flexibility, referencing LAN without setting minimum saturation targets. For example, Georgia's RFP requires plans to share 50% of incentive payments with providers but does not define a glidepath for risk adoption.
- 5. Even flexible states apply pressure.** Some states stop short of requiring VBP outright but still push plans toward alignment. Kansas does not require MCOs to implement VBP arrangements, but if providers request such arrangements, plans are expected to make a good faith effort to enter into a VBP arrangement with the provider.

Table 1 | Evolution of VBP requirements in Medicaid Managed Care RFPs since 2022

State	Evolving Requirements		LAN-Specific Requirements		
	As of 2022	As of 2026	LAN Category 2	LAN Category 3	LAN Category 4
Florida 	Qualitative VBP requirement, no LAN-based targets	Glidepath for minimum targets for VBP in categories 3A, 3B, and 4A over six years		From CY26 to CY31, 10% to 40% in category 3A+; 5% to 30% in category 3B+	From CY26 to CY31, 0% to 10% in category 4A+
Georgia 	No VBP requirements	Required standard PCP VBP model with minimum 10% upside incentive; additional VBP models permitted	Does not have specific LAN framework/at-risk requirements		
Kansas 	No VBP requirements	No requirements for percentage of reimbursements in VBP. Must use LAN when entering arrangement.	Does not specify LAN category requirements		
Michigan 	Minimum 30% of reimbursements in VBP. Plus, a requirement that 1.5% of total reimbursement is paid as performance-based provider incentives under VBP contracts.	Includes minimum requirements tied to LAN. Plus, a requirement that 2.5% of total reimbursement is paid as performance-based provider incentives under VBP contracts.	Requires minimum of 50% of provider reimbursement in category 2C or higher	Requires minimum of 12.5% of reimbursement under category 3 and 4	
Nevada 	Align with LAN framework	Align with LAN framework	Does not reference specific LAN framework/at-risk requirements		

Evolving Requirements		LAN-Specific Requirements			
State	As of 2022	As of 2026	LAN Category 2	LAN Category 3	LAN Category 4
New Hampshire 	Requires minimum of 50% of all provider reimbursement in category 2C or greater	Requires minimum of 50% of all provider reimbursement in category 2B or greater	Requires 50% of all provider reimbursement in category 2B or greater, but doesn't specify requirements by category		
Oklahoma 	Not applicable, managed care not implemented until 2024	From CY25 to CY30, glidepath 0% to 50% VBP. Requirements shift over time from reporting to performance to risk, with $\geq 25\%$ of spend in shared savings/risk. Plus, plans can earn back up to 1% of capitation payments by meeting VBP performance targets.	In CY26, requires 20% VBP in Category 2B or higher. In CY27 requires 35% in Category 2B or higher, with half in 2C or higher. From CY28, requires 50% in Category 2C or higher.	In CY29 and later, requires 25% in Category 3A or higher	
Texas 	Minimum 50% of expenditures in VBP by 2021; minimum 25% downside risk by 2021	Glidepath to minimum 50% of reimbursements to providers in VBP agreements, and 25% in risk-based agreements by 2026	Requires 25% of downside risk-based VBP by 2026		
Virginia 	Annual improvement toward 25% of spending under VBP arrangements using the LAN framework	Minimum provider payment penetration target for LAN-based VBP arrangements, plus annual implementation of advanced categories	Requires minimum of 25% of provider reimbursement in category 2 or greater		Must implement at least one new provider agreement with a Category 3A or greater requirement every year

National focus areas for VBP requirements

VBP requirements increasingly are being used as a mechanism to align plans with a state's key public health priorities. States are using requirements to reinforce accountability and define measurable outcomes, and improve coordination with MCOs and providers across four key focus areas:

Maternal and child health

Several states are tying plan accountability, and therefore provider performance, to measurable improvements in prenatal and postpartum care, encouraging providers to expand services and assume longer accountability for continuity-of-care. Financial mechanisms such as withholds, performance rebates, and bonuses are being tied to standardized maternal measures, including timely prenatal and postpartum visits and birth outcomes. Several procurements also establish expectations that plans integrate behavioral health and substance use interventions into maternal strategies, particularly for pregnant enrollees with opioid use disorder.



TAKEAWAY

Maternal health is no longer a supplemental quality focus. States expect plans and providers to manage it as a data-driven performance priority with real financial consequences.

Behavioral health and substance use disorders

Behavioral health requirements—with a focus on substance use disorders—are moving beyond general integration guidelines to enforceable operational expectations. Procurements now push plans toward using VBP and contract compliance to require coordination across physical health, substance use disorder (SUD) treatment, and crisis services, with explicit attention to compliance with [The Mental Health Parity and Addiction Equity Act](#). In several procurements, failure to meet behavioral health standards triggers penalties, corrective actions, or quality withholds tied to measures such as depression remission or SUD treatment engagement. Medicaid agencies also specify expectations around crisis response infrastructure, staffing, and care transitions.



TAKEAWAY

Behavioral health performance is treated as a baseline requirement. VBP is being used as an enforcement tool, not just an incentive.

Primary care and chronic disease

RFPs now position primary care as the operational backbone of value-based delivery. VBP requirements emphasize enhanced primary care models, care coordination for members with chronic and complex needs, and proactive population health management. Many procurements tie VBP expectations to primary care spending, preventive care completion, and longitudinal accountability rather than episodic utilization. Financial levers include withholds, performance rebates, and, in some cases, primary care spend floors or capitation models.



TAKEAWAY

States expect plans to demonstrate how primary care-led models will drive outcomes over time, supported by data sharing, attribution, and closed-loop coordination.

Health equity and social determinants of health

Health equity is now often embedded as an integrated expectation rather than a standalone initiative. RFPs require plans to demonstrate governance, data maturity, and the ability to stratify performance by race, ethnicity, language, disability status, and other factors. VBP requirements often link payment and incentives to reducing disparities, supporting community partnerships, and addressing health-related social needs through mechanisms such as in-lieu-of services. Some procurements also require formal accreditation or reinvestment in community infrastructure.

TAKEAWAY

Equity is becoming a measurable performance domain. States expect plans to show how VBP arrangements support disparity reduction, not just describe equity programs.

Implications for Medicaid MCOs

Ultimately, these RFPs are shepherding in the next chapter of VBP, pushing MCOs from pilot activity to execution. The operational implications for payers are significant and will require extensive planning leading up to a bid response.

- 1. Procurement expectations are forcing VBP operationalization.** RFPs look for plans to demonstrate specific VBP penetration levels, shifting expectations from experimentation to scale. As a result, plans must move away from isolated pilot arrangements and operate VBP as a core portfolio strategy aligned to state requirements. This includes setting clear targets for LAN Categories 3 and 4 and prioritizing provider segments for risk-based arrangements.
- 2. VBP targets require active provider portfolio management.** To effectively meet state thresholds, MCOs must be able to understand which providers can currently manage financial risk and build enablement strategies for those providers that demonstrate relatively poorer performance. Most plans lack a systematic way to assess provider readiness, which will become a problem as VBP expectations rise. Payers need to engage provider partners and request financial performance data, including cost and quality performance at both the system and attributed provider levels.
- 3. Scaling VBP will require a reconfiguration of data and reporting infrastructure.** Traditional Medicaid reporting systems were designed for claims payment and quality reporting, not for managing risk-based provider contracts. As VBP scales, payer systems and analytics will need to be reconfigured to support provider attribution and panel management, cost and quality measurement, opportunity identification, and financial reconciliation, all tied to individual arrangements.

BOTTOM LINE FOR PAYERS: Medicaid VBP expectations are now testing execution capability. Competitive plans will be those that can manage provider portfolios, financial risk, and contract-level performance at scale, not those with the most pilot programs.

Implications for Medicaid providers

The expansion of VBP requirements in Medicaid procurements is changing how providers engage with Medicaid MCOs. Given the VBP momentum across states, Medicaid providers should focus on how quickly they can adapt to new expectations, considering whether it's practical for them to participate in the immediate and short term and how best to position and enhance capabilities for long-term expectations and regulatory requirements.

- 1. Participation in VBP is becoming harder to avoid.** As MCOs are pushed to meet state-defined VBP targets, providers will face increasing pressure to move beyond fee-for-service into value-based, as well as at-risk, arrangements. Provider leaders should define a clear VBP contracting strategy across Medicaid payers by assessing current performance, prioritizing lower-risk models where appropriate, and identifying feasible opportunities for downside risk as they become better at managing the total cost of care without compromising quality.
- 2. Care delivery expectations are expanding beyond episodic services.** Providers are being asked to manage outcomes across the full continuum of care, including prevention, coordination, and follow-up. This requires a shift away from encounter-based models. Providers will need to expand care management capabilities, strengthen primary care models, and better integrate behavioral health and social services where possible.
- 3. Scale is becoming a requirement for managing financial risk.** Taking on downside risk requires sufficient patient volume to absorb variation in cost and outcomes. Smaller providers may struggle to participate independently. Providers will need to pursue scale through strategic collaborations such as clinically integrated networks and/or affiliations with larger systems and physician groups.

BOTTOM LINE FOR PROVIDERS: Medicaid VBP is moving from optional participation to an expectation. Providers that are unable to demonstrate the ability to manage risk, coordinate care, and operate at sufficient scale will be limited in how they engage with Medicaid MCOs or may incur financial losses as a result of performance and state regulations.

Implications for state Medicaid agencies

As states expand VBP requirements through procurements, they are also taking on a more active role in defining, monitoring, and pacing adoption.

- 1. Adoption of enhanced VBP requirements will vary.** While recent RFPs indicate that state Medicaid agencies are increasing VBP requirements, states should consider and evaluate payer and provider performance in their markets. This helps them understand the likelihood of success and develop effective VBP implementation strategies without sacrificing care quality for Medicaid beneficiaries.
- 2. Oversight requirements are increasing.** States with strict VBP requirements will need to be able to assess whether arrangements are actually shifting risk and improving outcomes. Medicaid directors will need to invest in stronger reporting, monitoring, and audit capabilities and MCO requirements, with a focus on tracking cost, quality, and utilization outcomes tied to VBP arrangements.
- 3. Provider readiness is a limiting factor.** Provider ability to take on risk varies significantly by market—particularly in rural areas and markets with provider capacity constraints—and by volume of attributed beneficiaries. Aggressive requirements can create access challenges if providers are not prepared to participate. States should consider pairing VBP expectations with transformation support, infrastructure investment, or targeted technical assistance for providers. Initiatives such as the Rural Health Transformation Program may offer states another mechanism to support provider readiness where network stability is most at risk.

BOTTOM LINE FOR STATES: Expanding VBP through procurement places the onus for enhancing plan operations and support on the provider community. It also increases the state's responsibility to define clear and transparent VBP requirements, validate reported arrangements, monitor outcomes and access, and phase expectations to match current payer/provider performance with capacity.

The future of Medicaid value-based purchasing

Recent Medicaid managed care procurements reflect a clear shift toward more defined, measurable VBP expectations without sacrificing quality of care. States are using procurement to clarify requirements, set targets, and reinforce accountability across priority areas such as maternal health, behavioral health, and primary care. For plans and providers alike, competitiveness in Medicaid increasingly depends on the ability to operationalize VBP at scale, manage risk across provider portfolios, and demonstrate performance against state-defined outcomes.

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