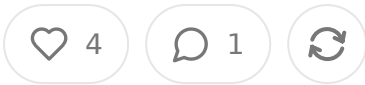


# The Medicaid Tech Pledge: Why 600 Million in Savings Means Almost Nothing for Innovation

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## Abstract

CMS announced a voluntary pledge from major Medicaid technology vendors to deliver \$600M in savings to support community engagement implementation across state programs. The commitment involves major players like Conduent, Maximu Gainwell offering discounted services for eligibility verification, benefit coordination and administrative functions. While framed as public-private partnership success, the pledge reveals structural dysfunction in Medicaid technology procurement, creating minimal incentive for innovation, and fundamentally misunderstands where value creation opportunities exist in the program. The arrangement perpetuates incumbent advantages, does little to address core technology deficiencies in state systems, and represents political theater rather than meaningful reform. For health tech investors and entrepreneurs, the announcement clarifies which problems remain unsolvable through traditional procurement and where disruptive approaches might gain traction outside legacy vendor relationships.

## Table of Contents

- Introduction: Theater Over Substance
- The Pledge Mechanics: What 600 Million Actually Represents
- Why Legacy Vendors Made This Deal
- Community Engagement as Policy Graveyard

- Where the Real Medicaid Tech Problems Live
- Procurement Dynamics and Innovation Barriers
- What This Means for Startups and Investors
- Conclusion: Following the Actual Money

## **Introduction: Theater Over Substance**

CMS rolled out a press release that probably seemed brilliant in some policy meeting about how Medicaid technology vendors would voluntarily pledge \$600M in savings in states implementing community engagement requirements. The announcement hit all the right notes for people who care about announcements instead of outcomes, positioning the commitment as evidence that public-private collaboration works and that technology companies want to be good partners to states struggling with administrative modernization. The reality looks considerably less inspiring when you understand what these vendors actually committed to, why they made these commitments, and what problems in Medicaid technology infrastructure remain completely unaddressed by this arrangement.

The timing matters because community engagement requirements, the ostensible beneficiary of these pledged savings, exist in a policy environment where courts are striking down implementations and political support swings wildly based on which administration currently runs CMS. Arkansas tried community engagement and lost something like 18,000 people from coverage before a federal court blocked the program. Kentucky got approval, then lost it, then the whole framework got rescinded under one administration and potentially revived under another. Building technology infrastructure to support a policy that might not exist in eighteen months represents exactly the kind of project that states hate funding and vendors love exploiting, which makes this pledge particularly interesting as a case study in how Medicaid procurement dysfunction works.

For investors trying to understand where opportunities exist in Medicaid technology, this announcement functions more as a map of where not to look rather than highlighting viable market entry points. The vendors making these pledges occupy positions so entrenched that they can afford to offer discounts on services that states probably don't need for programs that might not survive legal challenge. Understanding why this makes business sense for legacy players while offering nothing to innovative startups tells you most of what you need to know about business companies in this market.

## **The Pledge Mechanics: What 600 Million Actually Represents**

The \$600M figure sounds substantial until you break down what vendors actually committed to providing. The pledges involve discounted rates on specific services related to community engagement implementation, not \$600M in cash or even \$600M in measured savings from reduced state spending. The math works more like vendors saying they would normally charge states X dollars for eligibility verification systems, benefit coordination platforms, and administrative support functions, but for community engagement programs they will charge something less than X, and if you add up all those potential discounts across all potential state implementations you get to \$600M over some unspecified timeframe.

The participant list reads like a who's who of companies already completely embedded in state Medicaid operations. Conduent runs eligibility systems in multiple states and processes billions in healthcare payments. Maximus operates customer contact centers and handles eligibility determination for numerous state programs. Gainwell (the former DXC Medicaid business that got sold to Veritas Capital) provides claims processing and program integrity services across a massive state footprint. These companies don't need to acquire new customers to fulfill their pledges because they already work with the states that might implement community engagement requirements. The discount structure effectively just adjusts pricing on contract modifications or renewals that would happen anyway.

The specific services being discounted fall into categories that legacy vendors already deliver at scale. Eligibility verification systems need modifications to track work requirements, volunteer hours, or educational participation. Customer service operations need training on new program rules and potentially expanded call center capacity. Data integration work needs to happen to verify that beneficiaries meet community engagement criteria through employment records, school enrollment, or approved exemptions. All of this represents incremental additions to existing infrastructure rather than net new technology development, which means the marginal cost to vendors of providing these services runs considerably lower than the stated discount value.

The accounting gets even more creative when you consider how vendor pricing works in Medicaid contracts. States often pay based on per-member-per-month fees, transaction volumes, or percentage-of-spend arrangements that include built-in flexibility for scope changes. When a vendor commits to providing services “at reduced rates,” the baseline rate used for comparison might already include substantial margins or might represent a theoretical price that states would negotiate down anyway through normal procurement processes. The \$600M savings number assumes states would pay full freight for these services absent the pledge, which represents a pretty generous assumption about how Medicaid technology procurement actually functions.

## **Why Legacy Vendors Made This Deal**

The strategic logic for existing vendors making these commitments becomes clear once you map out their competitive positioning and relationship to state procurement processes. These companies already hold multiyear contracts worth hundreds of millions or billions of dollars across their Medicaid footprints. Offering discounted services for community engagement implementation strengthens relationships with state officials, demonstrates responsiveness to policy priorities, and creates opportunities to expand contract scopes in ways that might not otherwise get approved through standard procurement channels.

The political optics matter enormously when you operate in a market where government buyers control 100 percent of the demand. State Medicaid directors constant pressure to demonstrate fiscal responsibility, find administrative efficiencies and implement federal policy priorities without blowing budgets. A vendor that proactively offers savings on politically important initiatives becomes easier to do when procurement competitors complain about contract renewals or when state legislators question sole-source agreements. The pledge functions as relationship insurance that costs vendors relatively little in actual margin but provides substantial protection against competitive threats.

The timing also coincides with broader contract renewal cycles across multiple states. Medicaid technology contracts typically run five to seven years with extension options, which means states periodically need to either rebid major systems or exercise renewal options with incumbent vendors. An incumbent offering proactive savings on emerging policy priorities creates strong incentives for states to avoid expensive rebid processes in favor of contract modifications that incorporate the services. This dynamic explains why vendors structured pledges around specific implementations rather than general cost reductions, it ties the savings to net new work that justifies contract expansions.

The competitive barrier creation matters more than the immediate financial impact startup trying to enter the Medicaid eligibility or claims processing market faces: extraordinary difficulty displacing entrenched vendors who already integrate with fifty different state systems, employ thousands of workers with security clearances and maintain decades of institutional knowledge about program rules. When the incumbents offer to absorb community engagement implementation costs at discounted rates, states have even less incentive to consider alternatives that would require system migrations, staff retraining, and integration work with uncertain timelines. The pledge effectively fortifies moats that already keep new entrants out of core Medicaid technology infrastructure.

## **Community Engagement as Policy Graveyard**

The fundamental problem with building technology infrastructure around community engagement requirements comes down to the policy instability and legal vulnerability that has characterized every major implementation attempt. Arkansas launched a community engagement work requirement program that resulted in over 18,000 people losing coverage, 10% of whom actually met the requirements but failed to properly document compliance or navigate the reporting systems. A federal court eventually struck down the Arkansas waiver on grounds that CMS had failed to properly consider how the requirements would affect coverage levels and program objectives. Kentucky went through multiple rounds of approval and rescission before eventually abandoning implementation after years of legal challenges.

The administrative burden created by community engagement reporting falls disproportionately on populations least equipped to handle complex documentation requirements. People working irregular hourly shifts, managing chronic health conditions, or dealing with housing instability face systematic challenges in tracking volunteer hours, maintaining employment verification, or proving exemption status through the kinds of digital systems that Medicaid technology vendors typically deploy. The Arkansas experience showed that technical barriers to compliance, not actual failure to meet requirements, drove most coverage losses. Building more technology to create more documentation requirements probably makes this problem worse rather than better.

The legal framework remains fundamentally unstable because courts have consistently ruled that work requirements undermine Medicaid's core statutory purpose of providing healthcare coverage to low-income populations. The Trump administration approved multiple state waivers for community engagement programs, but the Biden administration rescinded those approvals, and future administrations may reverse course again. Technology vendors building systems to support these requirements face the prospect that their work product becomes obsolete based on election outcomes or appellate court decisions that have nothing to do with system quality or vendor performance.

States investing significant resources in community engagement infrastructure also face opportunity costs relative to other Medicaid technology priorities that might

deliver more durable value. Eligibility systems need modernization to reduce churn from procedural denials. Provider payment infrastructure requires updates to support value-based contracting and alternative payment models. Data analytics capabilities lag behind what commercial payers deploy for utilization management and care coordination. All of these represent technology needs that will remain relevant regardless of which party controls federal health policy, which makes them considerably more attractive long-term investments than systems built specifically for community engagement tracking.

## **Where the Real Medicaid Tech Problem Live**

The actual technology deficiencies in state Medicaid programs look nothing like the community engagement implementation challenges that vendors pledged to discuss. Many states run eligibility systems built on COBOL codebases from the 1980s that require mainframe programmers to modify basic business logic. Claims processing platforms struggle to handle encounter data from managed care organizations in standardized formats. Provider enrollment processes that should take days stretch into months because verification workflows depend on manual data entry across disconnected systems. These problems cost states billions of dollars annually in administrative waste and create beneficiary friction that drives coverage churn and access barriers.

The eligibility modernization challenge alone represents a multibillion-dollar problem that has resisted decades of attempted fixes. The federal government funded substantial enhanced matching for states to replace legacy systems under the Affordable Care Act, and most implementations ran years behind schedule while delivering systems that barely met minimum functional requirements. The core problem stems from the reality that Medicaid eligibility rules vary dramatically across states, change frequently based on policy decisions, and interact with federal tax data, Social Security records, and state wage systems in ways that create enormous integrative complexity. Building truly modern eligibility platforms requires both technical sophistication and deep domain expertise that few vendors possess.

The claims and payment infrastructure presents equally severe problems for states trying to manage costs and improve care quality. Managed care organizations still encounter data in formats that don't match fee-for-service claims structures, making it nearly impossible to build comprehensive views of utilization patterns or spend trends. States need analytics capabilities to identify high-cost members who might benefit from care management interventions, but data quality issues and system integration gaps make this analysis difficult even for states with substantial resources. The downstream effects ripple through everything from rate setting to fraud detection to policy evaluation.

Provider-facing technology creates enormous friction in Medicaid participation decisions. Doctors evaluate whether to accept Medicaid patients based partly on administrative burden, and states running enrollment systems that require mountains of paperwork, in-person verification, or weeks-long approval processes systematically discourage participation. Prior authorization platforms that force providers to submit clinical documentation through fax machines or web portals that log out after ten minutes of inactivity drive practices toward commercial insurance and away from Medicaid lives. Fixing these problems requires rebuilding large portions of the technology stack that connects providers to payment systems, credentialing data and utilization management platforms.

## **Procurement Dynamics and Innovation Barriers**

The vendor pledge illuminates why Medicaid technology procurement systematically favors incumbent players and resists innovation from new entrants. States face enormous switching costs when considering transitions away from existing vendors because Medicaid operations cannot tolerate downtime and integration requirements span dozens of systems. A state might theoretically want to replace a claims processing platform that runs on decades-old technology, but the risk of payer disruptions, provider relations problems, or federal compliance issues makes continuing with a known-but-bad solution preferable to attempting migration to something potentially better.

The procurement process itself creates barriers that startups cannot easily overcome. Requests for proposals in Medicaid technology typically include requirements for vendor experience with specific transaction volumes, system certifications that take years to obtain, or incumbent knowledge that only existing contractors possess. A requirement that bidders demonstrate experience processing 50 million claims annually effectively excludes every company except the three or four vendors currently operating at that scale. States justify these requirements as risk mitigation, but the practical effect keeps new technology approaches from ever getting evaluated on technical merit.

The financial structure of Medicaid technology contracts makes venture-scale revenue difficult even for companies that successfully win business. States pay based on cost-plus models, fixed-fee arrangements, or percentage-of-savings frameworks that limit upside potential and create incentive misalignment. A vendor that dramatically improves eligibility processing efficiency might get paid less under a per-transaction model, not more. Companies that reduce improper payments might negotiate small shares of documented savings, but proving attribution and sustaining those savings over multiyear contract periods creates measurement challenges that usually benefit states rather than vendors. This economic reality explains why private equity firms dominate Medicaid technology vendors while venture capital largely avoids the sector.

The regulatory compliance burden adds another layer of difficulty for companies trying to innovate in Medicaid infrastructure. Technology systems processing Medicaid data need to meet HIPAA security requirements, state-specific privacy and federal certification standards, and audit frameworks that vary across programs and jurisdictions. Building compliant infrastructure requires legal expertise, security investments, and operational overhead that consumes capital better spent on product development. Large vendors spread these costs across massive contract values, but startups attacking narrow problems with better technology struggle to absorb compliance expenses that might exceed engineering budgets.

## **What This Means for Startups and Investors**

The strategic takeaway for health tech investors evaluating Medicaid opportunities comes down to avoiding head-on competition with entrenched vendors in core infrastructure and instead finding problems where better technology creates value that states or health plans will actually pay for. The vendor pledge demonstrates incumbents own the relationship layer with state procurement officials and can offer discounts that startups cannot match. Competing for eligibility system contracts, claims processing platforms represents a losing strategy unless you somehow solve switching cost and risk perception problems that keep states locked into existing vendors.

The more promising opportunities exist in areas where new technology enables capabilities that states currently cannot access through legacy infrastructure. Real-time eligibility verification that reduces provider abrasion and improves access probably has buyer interest if delivered through lightweight integration rather than requiring system replacement. Analytics platforms that help managed care organizations identify members needing behavioral health interventions might create enough value to justify standalone purchases outside state procurement processes. Tools that reduce member churn by improving renewal completion rates address a problem that states care about but have struggled to solve through existing vendor relationships.

The managed care channel offers better near-term prospects than direct state sales for most health tech startups. Medicaid managed care organizations operate more like commercial health plans than government agencies, with faster procurement cycles, greater willingness to pilot new technology, and clearer ROI frameworks for evaluating vendor performance. A company solving prior authorization friction or improving care coordination might sell to Medicaid MCOs using essentially the same approach that works with commercial payers, then potentially expand to state direct relationships once the technology proves out at scale. This path avoids the incumbent vendor problem and lets startups build traction before attempting to navigate state procurement complexity.

The adjacency strategy also makes sense for companies with core technology that applies across payer types but offers particular value in Medicaid contexts. Social

determinants of health screening tools, housing navigation platforms, or transportation coordination services might sell to commercial plans and Medicare Advantage programs while creating disproportionate impact for Medicaid populations. Building a business model that depends on Medicaid revenue creates excessive concentration risk given procurement timelines and policy instability, incorporating Medicaid as one customer segment within a broader payer strategy. Companies capture value from solving relevant problems without betting everything on state buying patterns.

The impact investment angle sometimes unlocks capital for Medicaid-focused health tech companies that would struggle to attract pure venture dollars. Investors willing to accept venture-like risk with below-market return expectations can back companies addressing social determinants, improving maternal health outcomes, and reducing racial disparities in care access even when the underlying business model looks unattractive from a pure IRR perspective. This capital source requires founders comfortable with impact measurement frameworks and investors genuinely aligned with social mission rather than just using impact language to justify marginal deals, but it represents a viable path for companies solving real problems that traditional markets underprice.

## **Conclusion: Following the Actual Money**

The Medicaid technology vendor pledge tells you everything you need to know about where innovation happens and where it doesn't in public program infrastructure. Legacy vendors pledging discounted services for politically volatile policy implementations represent rational behavior within a broken procurement system that rewards incumbency over technical merit. States accepting these pledges demonstrate the constraint set they operate under when trying to modernize technology while managing enormous operational complexity and political risk. Startups largely excluded from this dynamic need to find different paths to market that avoid direct competition with vendors who own the relationship layer and can absorb margin compression that would kill venture-backed companies.

The actual money in Medicaid technology flows through multibillion-dollar contracts with states and managed care organizations that value reliability and incumbent relationships over innovation and cost efficiency. Trying to displace Conduent or Maximus or Gainwell in core eligibility and claims processing probably requires capital and longer timelines than venture economics support, which means most health tech investors should avoid these markets entirely. The exceptions live in specific problem areas where new technology creates measurable value that someone with budget authority cares enough about to fund outside existing vendor relationships.

The broader pattern across healthcare infrastructure markets suggests that government programs systematically underinvest in technology innovation relative to private sector comparables. Commercial health plans spend billions on analytics, member engagement, and care management platforms because better technology directly improves margins through medical cost savings and administrative efficiency. State Medicaid programs operate under constraints that make long-term technology investment difficult to justify even when payback periods look attractive, because budget cycles rarely extend beyond current fiscal years and procurement processes favor known vendors over technical risk-taking. This dynamic creates persistent quality gaps between Medicaid and commercial infrastructure that technology alone cannot solve without corresponding changes to how states fund and procure systems.

For founders building in this space, the vendor pledge represents a useful reminder that good technology rarely wins on merit alone in markets where buying decisions depend more on relationships, risk tolerance, and political considerations than on product quality or cost efficiency. The companies succeeding in Medicaid technology tend to either become large enough to compete directly with legacy vendors through acquisition and consolidation, or find narrow problems where better solutions create enough value that buyers can justify purchases outside traditional procurement channels. The middle ground where venture-backed startups usually operate is particularly difficult in Medicaid infrastructure, which explains why smart investors mostly hunt elsewhere for healthcare technology opportunities.





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Jim StClair  Jan 31

Another note, CMS promoted these vendors through existing or planned offerings GSA Schedule. Not all (many?) states do not use the GSA MAS, and it's not necessary to be st contract for any given state to use.

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