State-Level Variations in Medicaid Fee-for-Service Use and Spending Patterns in TAF

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TAF methodology brief

Summary

This data brief examines how fee-for-service (FFS) delivery and payment systems are distributed and used within Medicaid using the T-MSIS Analytic Files (TAF). The analysis shows that Medicaid FFS delivery and payment systems are not consistently used across all states, with some states relying on FFS heavily, others using FFS minimally, and the rest showing a mixed approach based on their specific policies and needs. The use of FFS is especially important for dual eligible beneficiaries and for services like long-term care that are not always covered by managed care. The findings highlight that FFS is still a key component of Medicaid, serving as either a main delivery method in some states or a way to cover specific services (such as behavioral health services or prescription drugs) in states that rely more on managed care.

Introduction

Medicaid provides healthcare coverage to millions of individuals in the United States using two primary delivery and payment models: managed care and fee-for-service (FFS).[1] While managed care has become the dominant model—a previous analysis of Medicaid managed care enrollment found that almost all states delivered Medicaid services via some form of managed care and about three-quarters of Medicaid beneficiaries were enrolled in comprehensive managed care plans in 2022[2]—FFS remains an essential component,

[1] FFS reimburses providers directly for each service, and Medicaid beneficiaries can choose any participating provider. Managed care involves state contracts with managed care organizations (MCOs), which are paid a fixed amount per beneficiary and are required to establish provider networks that meet access, quality, and beneficiary choice standards. For more detailed information on these delivery and payment models, see the Medicaid and CHIP Payment and Access Commission (MACPAC) fact sheet, *Federal Requirements and State Options: Delivery Systems*, available at https://www.macpac.gov/wp-content/uploads/2017/10/Federal-Requirements-and-State-Options-Delivery-Systems.pdf.

[2] For detailed state-specific data on managed care enrollment, refer to the report *Medicaid Managed Care Enrollment and Program Characteristics: 2022*, available at https://www.medicaid.gov/medicaid/managed-care/downloads/2022-medicaid-managed-care-enrollment-report.pdf.

particularly for specific populations and services that are reimbursed outside managed care arrangements for various reasons such as "carve-out" services.[3]

Because Medicaid is a jointly administered federal-state program, states operate within federal guidelines but have considerable flexibility to adapt their programs to reflect state-specific circumstances. This flexibility leads to wide variation in how FFS functions, either as a primary service delivery and payment method or to cover services often carved out of managed care contracts, such as behavioral health services, prescription drugs, and long-term services and supports. Even in states with extensive managed care, the scope of services covered by managed care organizations (MCOs) can vary widely, and FFS may fill the gaps for transitional coverage or for wraparound benefits. As a result, FFS continues to play a critical role, functioning alongside managed care as an important part of Medicaid's service delivery and financing landscape but is not consistently implemented in the same way across states.

In this data brief, we use the term "FFS use" to capture a comprehensive view of how FFS functions in Medicaid within each state. It encompasses both FFS as a delivery system, where beneficiaries receive care outside of managed care structures, as well as FFS as a payment method, where services are reimbursed individually rather than through capitation. "FFS use" can be measured using different data elements, and depending on the data source, these distinctions can vary. For example, when eligibility or enrollment records are used, it may be appropriate to view the measurement as "FFS coverage," as it indicates that some beneficiaries' potential care—if it occurs—would be covered under FFS rather than managed care. On the other hand, claims data that correspond to actual service utilization and include specific payment amounts may reflect "FFS utilization" or "FFS payments." These different perspectives informed our decision to adopt "FFS use" as a broader term for clarity and consistency in this brief.

This brief is intended for two primary audiences: evaluators of innovative healthcare initiatives, particularly those assessing Medicaid-focused models within the Center for Medicare & Medicaid Innovation (CMS Innovation Center), as well as general Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) data users looking to assess the extent of Medicaid FFS use for coverage and reimbursement. Evaluators who are accustomed to Medicare's traditional FFS structure may find that Medicaid's use of FFS is more complex and varied than commonly perceived. For TAF data users, this data brief also provides an overview of different metrics that can be used to measure FFS use and the associated considerations of each approach.

[3] A "carve-out" refers to a specific scenario where a service or subpopulation is formally excluded from a managed care arrangement and administered separately via FFS (or limited benefit plans). However, FFS arrangements can coexist with capitation payments and do not always indicate an intentional carve-out. For example, FFS may operate as transitional coverage for newly enrolled beneficiaries or for retroactive coverage (see *Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule*, July 2024, available at https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf). Another example of FFS outside carve-outs is wrap-around payments for services not covered by managed care plans, such as supplemental payments to Federally Qualified Health Centers (FQHCs) to meet full reimbursement requirements under the prospective payment system (see *Wraparound Benefits in Premium Assistance Demonstrations*, available at https://www.medicaid.gov/medicaid/downloads/wraparound-benefits.pdf).

This brief quantifies the extent of FFS use across states over time from 2017 to 2022 (Figures 1 and 2). We examine how FFS use varies by beneficiary characteristics and its role within Medicaid's payment structure to highlight the role that FFS continues to play alongside managed care in Medicaid programs. We also examine two additional topics:

- **Variation in FFS use by beneficiary characteristics.** This analysis explores how Medicaid FFS use differs by dual-eligible and non-dual populations (Figure 3). It provides an example of how beneficiary characteristics, such as dual status, can be used to stratify FFS use. TAF users interested in assessing FFS use at the beneficiary level could consider extending this analysis to other characteristics, such as scope of benefits or rural-urban residence.
- **Role of FFS in Medicaid payment systems.** We also assessed whether FFS primarily functions as a distinct payment model for specific carve-outs and specialized services, or if it plays a broader role within state Medicaid programs (Figure 4). The analysis identifies how FFS integrates with broader Medicaid payment systems while highlighting its specialized uses.

Methods

This brief uses data from the 2017–2022 TAF. These files provide the most comprehensive national standard data on Medicaid beneficiaries and their service utilization captured in FFS claims and managed care encounter records. The data also cover FFS payments and non-claims-based monthly beneficiary payments. This analysis focuses specifically on Title XIX Medicaid beneficiaries, including those in the Medicaid-expansion Children's Health Insurance Program (M-CHIP).[4]

Approach and inclusion criteria for measuring Medicaid FFS use

To understand the extent of variations in the use of Medicaid FFS across states, this brief primarily focuses on using an eligibility-based approach to classify and measure FFS use. The TAF provide multiple ways to measure FFS, including at the beneficiary level (i.e., using only eligibility/enrollment records), as well as through claims and expenditure data. In Appendix A, we discuss two alternative measures—one claims-based and the other aggregated expenditure-based—each providing a different perspective on FFS use.

In the eligibility-based approach, beneficiaries are **indirectly** identified as potential FFS users by excluding those enrolled in comprehensive managed care (CMC) plans at the beneficiary-month level. CMC status is determined using specific managed care plan types[5] documented

[4] In this analysis, we exclude Title XXI CHIP beneficiaries. TAF includes monthly CHIP codes to distinguish between Title XIX Medicaid beneficiaries (Medicaid and M-CHIP) and Title XXI CHIP beneficiaries. In certain states and years, these codes are affected by data quality issues and considered unusable, as noted in the *DQ Atlas*. We exclude such states and years from the analyses in this brief, and these exclusions are noted in the corresponding figure or table notes. For more information, refer to the "CHIP Code" topic in the *DQ Atlas*, available at https://www.medicaid.gov/dq-atlas/.

[5] These plan types include Comprehensive MCOs, Health Insuring Organizations (HIOs), Programs of All-Inclusive Care for the Elderly (PACE), Accountable Care Organizations (ACOs), and Integrated Care for Dual Eligibles.

in the beneficiary eligibility summary data. This approach aims to identify beneficiaries who are likely to receive services through FFS because there is no evidence of them being enrolled in a CMC plan in the month.

One of the key strengths of this approach is that it relies solely on eligibility data, capturing all beneficiaries regardless of whether they use any services and avoiding the need to link beneficiaries to their service utilization data. It is simpler and often more consistent across states and over time because it uses fewer variables. Additionally, month-level data help capture dual eligibility more accurately, which is particularly relevant for the analysis of state-level FFS use by dual and non-dual populations. However, this approach is not without limitations. Managed care plan types have their own data quality issues across states and over time.[6] In addition, as an indirect method, it may misclassify some beneficiaries. For example, those enrolled in CMC may still use some services that are carved out and delivered via FFS, and vice versa.

In adopting the eligibility-based approach to measure FFS use, we included Medicaid beneficiaries who had at least one full month of Medicaid coverage during the relevant calendar year. The FFS measures were aggregated at the beneficiary-month level and then summarized to the calendar year level. Effectively, this approach uses beneficiary-months as weights, accounting for beneficiary enrollment duration.[7]

Approach and inclusion criteria for measuring Medicaid FFS payments

This study also analyzes the mean FFS spending per beneficiary at the state level (Figure 4). The primary objective is to capture the extent and distribution of FFS spending across different service categories within the Medicaid program. In this approach, we include all FFS claims for services received by beneficiaries during 2022. For each beneficiary, all Medicaid payments associated with these FFS claims are summed. The total FFS payments for all beneficiaries in each state are then divided by the number of included beneficiaries to calculate the mean FFS spending for the year. This approach provides a comprehensive measure of how much Medicaid spends on average at the beneficiary level in each state.

One notable strength of calculating mean FFS spending is that it allows for a detailed decomposition of FFS spending patterns. For this data brief we used the Federal Assigned Service Category (FASC) field from each claim header in TAF, which categorizes services into

[6] For measuring FFS use using the eligibility-based approach, we exclude states and years with an “Unusable” Assessment for the topic “Enrollment in CMC Plans” from the *DQ Atlas* (see https://www.medicaid.gov/dq-atlas/).

[7] Additionally, this approach provides flexibility and allows for a comprehensive assessment of beneficiaries’ FFS use, as certain beneficiary characteristics, such as dual eligibility and benefit scope are also recorded more accurately at the monthly level. Using monthly data avoids the need to apply annual cutoffs, such as determining a minimum number of months required to classify a beneficiary as a Title XIX or XXI beneficiary, covered in FFS, dual eligible, or having full-scope benefits, which can introduce imprecision. Each additional variable included in annual-level measures compounds potential imprecision. By using monthly data, we avoid the biases that can arise from setting arbitrary thresholds at the annual level.

specific types such as physician services, nursing facilities, and prescription drugs.[8] By breaking down mean expenditures into granular service categories, the analysis helps identify Medicaid's role in covering services that are sometimes carved out of managed care contracts. While calculating mean expenditures by service category provides useful perspectives, it's important to consider potential issues when comparing across service categories within a state or examining expenditure distributions across states. For example, mean expenditures can be skewed by high-cost beneficiaries, which may disproportionately affect categories like long-term care or inpatient hospital services.

For this analysis, we applied a more restrictive eligibility criterion compared to the approach used for measuring FFS use. The analysis focused on beneficiaries who were continuously enrolled for all 12 months in 2022 with comprehensive/full-scope benefits. This restriction helps to maintain that every beneficiary included in the analysis had consistent coverage throughout the year and allows for more accurate calculations of mean FFS spending and the decomposition of those expenditures by service categories.

Results

In this section, we first examine the extent of Medicaid FFS use across states, focusing on state-level variations in 2022 and changes from 2017 to 2022. Next, we explore how Medicaid FFS use varies by dual eligibility status by comparing Medicaid FFS use patterns between dual-eligible and non-dual populations. Finally, we assess whether Medicaid FFS operates as a distinct payment model or is integrated into broader Medicaid payment systems by analyzing FFS expenditures and breaking them down by service categories to understand its role within the overall payment structure.

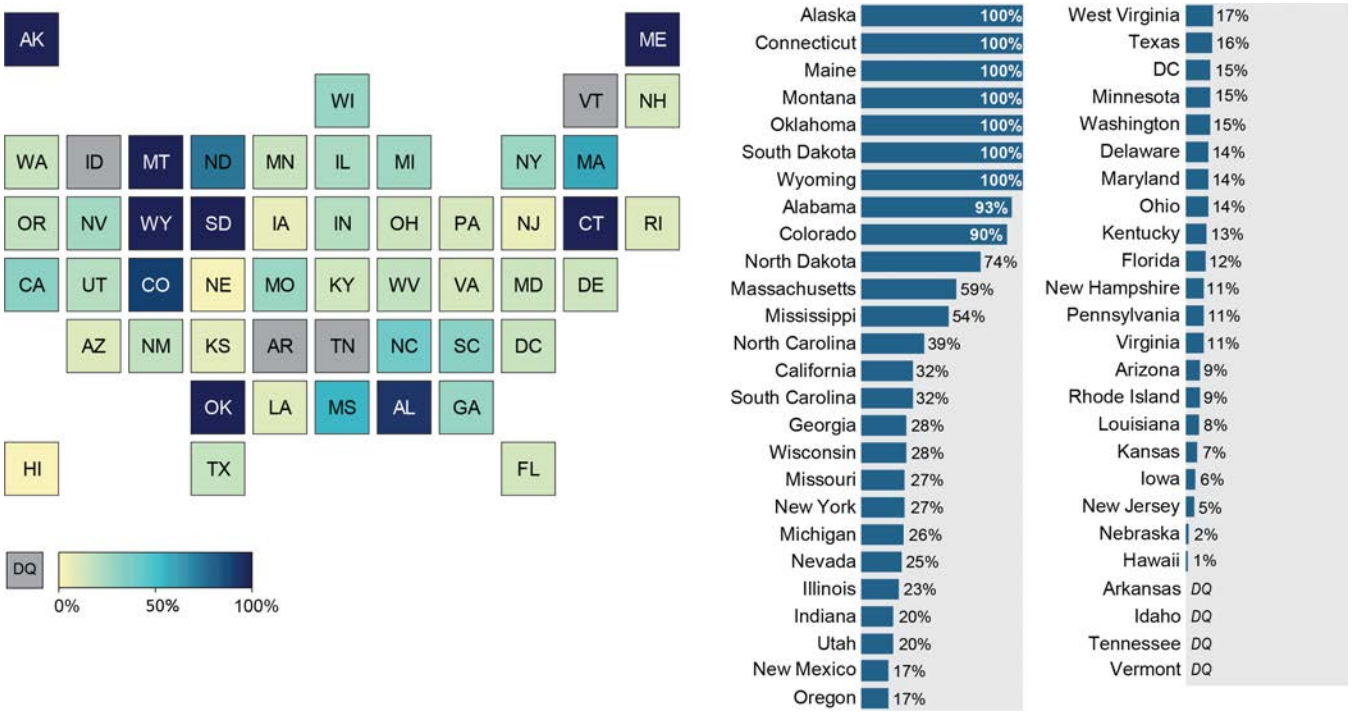
Variation in Medicaid FFS use by state

Figure 1 illustrates the variation in the percentage of Medicaid beneficiaries not enrolled in a CMC plan (indicating potential FFS use) across states in 2022 using the eligibility-based approach. Seven states—Alaska, Connecticut, Maine, Montana, Oklahoma, South Dakota, and Wyoming—rely almost entirely on FFS. Other states, like Alabama and Colorado, still exhibit relatively high FFS use, with FFS use rates of 93% and 90%, respectively. In contrast, most states, such as North Carolina, South Carolina, and Georgia, have less than 50% of their Medicaid population covered under FFS. At the lower end of the spectrum, states including Arizona, Rhode Island, Louisiana, Kansas, Iowa, New Jersey, Nebraska, and Hawaii have FFS use rates below 10%, where Medicaid is predominantly delivered through CMC rather than FFS models.

[8] The FASC field includes 17 service use categories: Inpatient hospital, Nursing facility, Intermediate care stay, All other overnight facility claims, Hospice, Outpatient facility, Clinic, All other outpatient institutional claims, Radiology, Laboratory, Home health, Transportation services, Dental, Home and community-based services (HCBS) not otherwise specified, Durable medical equipment and supplies (DMES), Physician and all other professional claims, and Prescription drug. For clarity in the analysis, we focus on the top 10 categories with the highest FFS spending in percentage terms across all states included. For this measure, we also reviewed the "Total FFS Expenditures" topic in the *DQ Atlas* and excluded states with an "Unusable" assessment in 2022 (see https://www.medicaid.gov/dq-atlas/).

Overall, Figure 1 highlights significant variation in the degree of Medicaid FFS use across states, ranging from full reliance on FFS to minimal use. It reflects diverse approaches to Medicaid delivery nationwide and suggests that state-specific factors, such as state policies, demographic characteristics, urbanization, availability of healthcare providers, or competition among health plans, may contribute to the varying prevalence of the Medicaid service models in each state.

Figure 1. Variation in percentage of fee-for-service (FFS) use across states in 2022



Source: TAF 2022 (Release 1).

Note: This figure shows the percentage of the Medicaid population potentially covered under FFS. Four states are not reported due to TAF data quality concerns and labeled as "DQ" (Data Quality): Arkansas, Idaho, Tennessee, and Vermont. They were identified as having a *DQ Atlas* DQ Assessment of "Unusable" for the topic "Enrollment in CMC Plans" in 2022. The heat map and bar chart display underlying FFS use percentages. The associated numerators and denominators for each state are provided in Appendix Table B.1.

Tracking FFS use over time

Figure 2 builds on the cross-sectional presentation shown in Figure 1 by examining FFS use patterns across states longitudinally from 2017 to 2022. Figure 2 indicates three groups of states based on their FFS use percentages over time:

1. **States with consistently high FFS percentages.** Alaska, Maine, Montana, South Dakota, Connecticut, and several others exhibit minimal change and maintain high levels of FFS use throughout the entire 2017–2022 period. This stability suggests that FFS has remained the dominant model in these states.

2. **States with consistently low FFS percentages.** States like California, New Jersey, and Kansas have maintained low FFS percentages throughout the observed period. For example, Kansas's FFS use is consistently around 7% across years, which reflects sustained managed care systems over time.
3. **States with varying FFS percentages.** A few states, including Arizona, North Carolina, and Virginia, show notable fluctuation in state-level FFS use over the years. These changes may indicate that their Medicaid service models may be influenced by evolving state policies, changes in managed care penetration, or shifts in healthcare provider participation.

Some of the states in Figure 2 exhibit large fluctuations (>10%) in year-over-year changes in FFS use. Three primary factors may explain these changes at the state level: TAF data quality issues, major state-level delivery system reforms, and subtle state policies interacting with the classification method for FFS use. A notable example of data quality issues occurred in 2016, when states began submitting records in the new T-MSIS. This transition was accompanied by a certain level of incomplete or inconsistent reporting for fields related to managed care plan type codes. To mitigate these concerns, we did not include 2016 TAF for this analysis, which helped reduce several large fluctuations.[9]

Beyond data quality, major delivery system reforms can also drive significant changes in FFS use. For example, North Carolina's transition to Medicaid managed care in July 2021 shifted approximately 1.6 million beneficiaries to managed care plans, resulting the percentage of FFS use in North Carolina dropping substantially between 2020 and 2022.[10] Lastly, more subtle state-specific policies can influence classification patterns in less obvious ways. These policies may include consolidating limited-benefit plans and transitioning beneficiaries into comprehensive managed care plans, leading to the reclassification of managed care plan type codes for particular groups, such as newly eligible adults under the Affordable Care Act (ACA) expansion or for certain geographic areas. While these changes are less visible than major reforms, they can still affect FFS trends over time.

[9] Although the exclusion of 2016 TAF data addressed many of these concerns, anomalies may still occur at the monthly level. For example, in California, the managed care plan type codes for two months in 2022 indicated nearly 100% FFS classification for those months alone, likely reflecting a data quality issue rather than actual program changes.

[10] For additional information, see https://www.ncdhhs.gov/news/press-releases/2021/06/30/nc-medicaid-managed-care-launch-statewide-july-1.

Figure 2. State-level percentages of fee-for-service (FFS) use from 2017 to 2022

	2017	2018	2019	2020	2021	2022
Alaska	100%	100%	100%	100%	100%	100%
Connecticut	100%	100%	100%	100%	100%	100%
Maine	100%	100%	100%	100%	100%	100%
Montana	100%	100%	100%	100%	100%	100%
Oklahoma	100%	100%	100%	100%	100%	100%
South Dakota	100%	100%	100%	100%	100%	100%
Wyoming	100%	100%	100%	100%	100%	100%
Alabama	96%	95%	95%	94%	94%	93%
Colorado	20%	54%	90%	89%	89%	90%
North Dakota	77%	77%	77%	74%	75%	74%
Massachusetts	54%	57%	58%	58%	57%	59%
Mississippi	36%	39%	39%	39%	41%	54%
North Carolina	100%	100%	100%	100%	69%	39%
California	25%	24%	24%	22%	20%	32%
South Carolina	39%	39%	37%	34%	32%	32%
Georgia	34%	34%	35%	32%	30%	28%
Wisconsin	35%	35%	35%	32%	29%	28%
Missouri	40%	33%	37%	35%	32%	27%
New York	26%	27%	28%	28%	26%	27%
Michigan	27%	27%	27%	25%	24%	26%
Nevada	23%	25%	28%	27%	26%	25%
Illinois	38%	31%	27%	23%	20%	23%
Indiana	23%	24%	27%	25%	DQ	20%
Utah	22%	23%	26%	21%	20%	20%
New Mexico	22%	21%	20%	18%	17%	17%
Oregon	24%	22%	20%	19%	18%	17%
West Virginia	17%	17%	18%	17%	17%	17%
Texas	10%	8%	11%	17%	17%	16%
DC	28%	29%	28%	25%	19%	15%
Minnesota	24%	20%	19%	17%	15%	15%
Washington	16%	16%	17%	16%	15%	15%
Delaware	16%	16%	16%	15%	14%	14%
Maryland	16%	16%	15%	15%	14%	14%
Ohio	17%	14%	13%	12%	11%	14%
Kentucky	19%	19%	20%	22%	13%	13%
Florida	31%	33%	33%	23%	17%	12%
New Hampshire	34%	33%	9%	10%	11%	11%
Pennsylvania	21%	19%	14%	8%	12%	11%
Virginia	32%	26%	16%	13%	11%	11%
Arizona	14%	13%	10%	9%	9%	9%
Rhode Island	13%	DQ	16%	12%	10%	9%
Louisiana	8%	8%	8%	7%	7%	8%
Kansas	8%	8%	8%	7%	7%	7%
Iowa	10%	11%	8%	6%	6%	6%
New Jersey	8%	7%	8%	7%	4%	5%
Nebraska	3%	2%	2%	2%	2%	2%
Hawaii	2%	2%	2%	2%	2%	1%
Arkansas	100%	100%	DQ	DQ	DQ	DQ
Idaho	100%	DQ	DQ	DQ	DQ	DQ
Tennessee	7%	8%	8%	7%	7%	DQ
Vermont	100%	100%	100%	100%	100%	DQ

Source: TAF 2017–2018 (Release 2 for each year) and 2019–2022 (Release 1 for each year).

Notes: States are sorted by their 2022 percentage of FFS use in descending order. Some state percentages in this table are labeled as "DQ" (Data Quality) due to TAF data quality concerns. This occurred for states with an "Unusable" DQ Assessment in the corresponding year, based on two topics: "CHIP Code" and "Enrollment in CMC Plans." States with unusable data for either topic were excluded from reporting, including Idaho (2018–2022), Arkansas (2019–2022), Indiana (2021), Rhode Island (2018), Tennessee (2022), and Vermont (2022).

Variation in Medicaid FFS use by dual eligibility status

Figure 3 compares state-level Medicaid FFS use between dual eligible and non-dual eligible Medicaid beneficiaries across states. This analysis examines how FFS use extends to dual eligible beneficiaries, whose primary payer is Medicare. This application also demonstrates how eligibility-based measures are particularly useful for examining FFS use by beneficiary characteristics, especially when claims and expenditure data for dual eligible beneficiaries are incomplete in TAF.

Figure 3 shows that dual eligible beneficiaries are generally more likely to be covered under FFS compared to non-dual eligible beneficiaries across most states. In high FFS states, such as Alaska, Connecticut, and Montana, FFS enrollment is nearly universal for both dual and non-dual eligible beneficiaries. In states where FFS plays a less dominant role, dual eligible beneficiaries consistently have higher FFS enrollment rates than non-dual eligible beneficiaries.

The gap between dual and non-dual FFS enrollment also varies across states. In some states, such as Maryland, the difference is substantial, with dual eligible beneficiaries showing markedly higher FFS rates. This difference may be because dual eligible beneficiaries tend to be a specific “carve-out” subpopulation for managed care plans, or due to the nature of services that Medicaid covers for dual eligible beneficiaries in these states, such as long-term care, behavioral health, or other specific carve-out services that are not typically included in managed care plans.

Additionally, the higher FFS rates among dual eligible beneficiaries can be partly attributed to their complex medical needs, which often require services that remain in the FFS model due to provider preferences or reimbursement arrangements. In states where the gap between dual and non-dual FFS enrollment is narrower, it may reflect state efforts or policies aimed at integrating dual eligible beneficiaries into managed care plans.

Figure 3. State-level percentages of fee-for-service (FFS) use for dual-eligible and non-dual-eligible beneficiaries in 2022

	Non-Dual Eligible Beneficiaries			Dual Eligible Beneficiaries		
	Total FFS Beneficiary-Months	Total Beneficiary-Months	FFS Use Percentages	Total FFS Beneficiary-Months	Total Beneficiary-Months	FFS Use Percentages
Alaska	2,913,334	2,913,334	100%	272,987	272,987	100%
Connecticut	11,848,734	11,848,737	100%	2,485,678	2,485,678	100%
Montana	3,189,486	3,189,486	100%	394,415	394,415	100%
Oklahoma	13,527,405	13,534,620	100%	1,592,421	1,593,795	100%
South Dakota	1,512,575	1,512,575	100%	258,818	258,818	100%
Wyoming	877,623	877,623	100%	148,139	148,139	100%
Colorado	15,993,567	17,758,536	90%	1,582,255	1,784,601	89%
North Dakota	931,263	1,319,333	71%	203,585	206,688	98%
Massachusetts	12,069,699	21,329,048	57%	3,217,318	4,736,066	68%
Mississippi	3,410,818	7,933,700	43%	2,009,138	2,013,386	100%
North Carolina	8,902,237	29,025,613	31%	4,106,317	4,199,924	98%
California	51,501,763	166,374,751	31%	8,075,048	20,659,318	39%
South Carolina	4,015,352	16,396,629	24%	1,832,294	2,082,100	88%
Michigan	6,288,325	32,535,327	19%	3,269,198	4,436,507	74%
Nevada	1,636,858	9,680,809	17%	1,078,168	1,088,051	99%
New York	13,148,913	77,029,823	17%	11,211,109	13,994,732	80%
Illinois	6,373,779	37,695,686	17%	3,450,742	5,246,113	66%
Wisconsin	2,347,494	14,516,146	16%	2,579,313	2,854,958	90%
Georgia	3,848,698	25,547,544	15%	4,772,747	4,777,759	100%
Missouri	2,041,833	13,986,856	15%	2,498,593	2,568,571	97%
Oregon	1,741,847	13,445,310	13%	791,393	2,138,579	37%
New Mexico	1,213,679	10,393,177	12%	785,543	1,348,704	58%
Minnesota	1,784,186	14,419,232	12%	614,549	1,825,430	34%
Texas	7,063,611	66,382,525	11%	5,025,566	9,271,967	54%
Indiana	2,199,561	21,861,022	10%	2,784,663	3,079,398	90%
Delaware	315,102	3,254,240	10%	202,164	371,577	54%
Florida	4,705,638	52,524,712	9%	3,135,415	12,346,988	25%
Pennsylvania	2,867,254	35,317,890	8%	1,661,270	6,657,164	25%
Rhode Island	294,630	3,899,121	8%	114,205	675,101	17%
DC	208,573	3,109,109	7%	316,689	486,566	65%
Ohio	2,665,116	36,242,379	7%	2,876,766	4,620,449	62%
Kentucky	1,273,024	18,156,531	7%	1,503,517	2,725,708	55%
Virginia	1,430,227	20,727,497	7%	1,074,898	3,030,935	35%
Arizona	1,754,947	24,919,129	7%	784,303	3,539,062	22%
Maryland	952,294	18,763,123	5%	1,927,264	1,990,379	97%
New Hampshire	143,146	2,716,344	5%	193,922	455,328	43%
Washington	950,334	22,533,793	4%	2,787,825	3,015,455	92%
Iowa	305,349	8,405,634	4%	278,800	1,212,511	23%
New Jersey	778,807	21,151,243	4%	412,743	3,430,103	12%
West Virginia	172,238	6,547,459	3%	1,114,864	1,209,009	92%
Louisiana	244,802	20,473,442	1%	1,557,531	3,297,183	47%
Kansas	51,643	4,669,729	1%	345,592	928,642	37%
Nebraska	8,773	4,023,247	0%	77,909	527,395	15%
Hawaii	2,659	4,739,283	0%	76,404	696,495	11%

Source: TAF 2022 (Release 1).

Notes: FFS use is measured using enrollment and eligibility records and is not affected by service data incompleteness for dual eligible beneficiaries in TAF. FFS Use Percentages represents Total FFS Beneficiary-Months divided by Total Beneficiary-Months, expressed as a percentage. The following states are not included in the figure due to an "Unusable" DQ Assessment for the "Enrollment in CMC Plans" topic in 2022: Arkansas, Idaho, Tennessee, and Vermont. Additionally, Alabama, Maine, and Utah are excluded due to an "Unusable" DQ Assessment for both the "Dual Eligible Code" and "Dually Enrolled in Medicare" topics in 2022.

Role of FFS in Medicaid payment systems

Figure 4 demonstrates FFS spending among Medicaid beneficiaries who were enrolled for all 12 months in 2022 and also had comprehensive benefits throughout the year. The figure presents the mean FFS spending per beneficiary for each state and decomposes FFS payments into specific service types using the TAF Federal Assigned Service Category (FASC).

The results show considerable variation in mean Medicaid FFS spending across states. States with consistently high FFS percentages, such as Alaska, North Dakota, and Connecticut, exhibit the highest average FFS spending per beneficiary at over $9,000. These states allocate a substantial portion of their FFS expenditures to long-term care-related services, particularly those delivered in nursing facilities. For instance, in North Dakota, 32% of average FFS spending is on nursing facility services. In addition to long-term care services, physician and other professional claims account for a significant share of FFS spending across all states. For example, states like Vermont and Maine allocate 43% and 37%, respectively, of their FFS spending to physician and professional services. Prescription drug costs are also a notable component of FFS spending.

Overall, Figure 4 highlights how FFS operates within state Medicaid systems, particularly in terms of which services are more likely to be covered under FFS rather than integrated into managed care models. The decomposition by specific service categories shows that FFS often plays a role in covering high-cost or specialized services, such as long-term care and prescription drugs, that are often less integrated into managed care plans.

Figure 4. Mean FFS spending and percentages of FFS spending by top 10 Federally Assigned Service Categories (FASC) across states in 2022

	Mean FFS Spending (% Mean Total Medicaid Spending)	Physician and all other professional claims (%)	Prescription drug (%)	Nursing facility (%)	HCBS not otherwise specified (%)	Inpatient hospital (%)	Outpatient facility (%)	Home health (%)	Intermediate care (%)	Clinic (%)	Dental (%)
All States Included	$2,876 (35%)	32%	13%	13%	9%	7%	5%	4%	3%	2%	2%
Alaska	$9,318 (DQ)	41%	10%	6%	2%	14%	10%	0%	0%	0%	4%
North Dakota	$9,143 (71%)	28%	13%	32%	7%	6%	6%	1%	2%	1%	2%
Connecticut	$9,045 (DQ)	27%	21%	14%	6%	11%	10%	2%	0%	0%	2%
Maine	$8,850 (100%)	37%	17%	11%	7%	7%	8%	1%	1%	3%	1%
Vermont	$7,542 (88%)	43%	17%	15%	1%	6%	5%	7%	0%	0%	2%
Wyoming	$7,436 (100%)	28%	16%	14%	9%	11%	9%	2%	0%	2%	3%
South Dakota	$7,237 (100%)	37%	16%	14%	2%	11%	10%	1%	0%	0%	3%
Montana	$6,885 (98%)	25%	21%	7%	3%	8%	13%	0%	0%	5%	5%
Minnesota	$6,302 (48%)	50%	2%	10%	18%	1%	2%	2%	1%	0%	1%
Missouri	$6,180 (68%)	31%	23%	13%	15%	6%	4%	1%	1%	1%	0%
DC	$6,086 (48%)	37%	10%	22%	10%	5%	1%	11%	0%	0%	0%
Idaho	$5,722 (73%)	36%	25%	4%	3%	12%	13%	1%	0%	0%	0%
Massachusetts	$5,478 (52%)	29%	12%	11%	13%	10%	7%	5%	1%	0%	5%
Colorado	$5,260 (77%)	25%	18%	7%	9%	9%	9%	8%	1%	3%	0%
Oklahoma	$4,932 (99%)	30%	21%	10%	3%	11%	13%	1%	2%	2%	3%
Alabama	$4,632 (98%)	28%	21%	19%	3%	14%	4%	1%	0%	0%	2%
Maryland	$4,533 (51%)	50%	8%	15%	7%	7%	4%	2%	0%	0%	3%
West Virginia	$4,494 (53%)	8%	36%	28%	20%	2%	1%	1%	0%	0%	0%
Indiana	$4,323 (48%)	20%	6%	20%	10%	4%	2%	3%	4%	0%	0%
New Hampshire	$3,832 (42%)	34%	2%	22%	27%	0%	0%	1%	1%	0%	4%
Mississippi	$3,742 (51%)	12%	8%	31%	20%	5%	8%	1%	6%	1%	2%
Wisconsin	$3,681 (47%)	18%	39%	5%	14%	6%	3%	6%	0%	0%	2%
Utah	$3,471 (41%)	38%	23%	16%	2%	9%	3%	1%	0%	0%	2%
New York	$3,377 (34%)	1%	3%	21%	0%	12%	14%	23%	3%	9%	0%
Washington	$3,369 (43%)	20%	2%	10%	43%	2%	1%	0%	0%	0%	6%
California	$3,318 (47%)	51%	21%	4%	0%	4%	1%	1%	0%	6%	4%
Nebraska	$3,142 (32%)	55%	0%	36%	1%	0%	0%	0%	8%	0%	0%
Arkansas	$2,974 (DQ)	0%	15%	22%	7%	8%	5%	1%	1%	1%	0%
North Carolina	$2,940 (38%)	15%	9%	27%	7%	11%	6%	12%	0%	0%	7%
Georgia	$2,869 (55%)	20%	16%	21%	19%	11%	6%	2%	0%	0%	0%
Rhode Island	$2,817 (31%)	46%	1%	29%	11%	9%	1%	0%	0%	0%	1%
Nevada	$2,367 (41%)	34%	21%	10%	8%	13%	2%	2%	1%	1%	2%
New Jersey	$2,340 (25%)	41%	0%	3%	3%	2%	8%	0%	0%	1%	0%
Kentucky	$2,171 (15%)	34%	4%	31%	9%	3%	1%	11%	4%	0%	0%
South Carolina	$2,001 (38%)	28%	6%	20%	16%	8%	2%	1%	6%	0%	6%
Ohio	$1,944 (23%)	19%	5%	18%	24%	4%	2%	4%	12%	0%	9%
Tennessee	$1,921 (17%)	13%	48%	0%	0%	1%	24%	0%	7%	1%	5%
Delaware	$1,768 (15%)	58%	0%	7%	15%	5%	1%	1%	0%	0%	12%
Pennsylvania	$1,632 (13%)	67%	1%	2%	15%	2%	0%	0%	12%	0%	0%
Louisiana	$1,493 (21%)	6%	3%	37%	34%	2%	1%	1%	15%	1%	0%
Arizona	$1,427 (13%)	47%	12%	2%	3%	7%	21%	0%	0%	1%	0%
Virginia	$1,407 (14%)	54%	1%	4%	12%	3%	1%	3%	6%	0%	12%
Michigan	$1,374 (24%)	3%	39%	29%	13%	3%	2%	1%	0%	1%	1%
Illinois	$1,358 (22%)	29%	2%	9%	17%	10%	3%	1%	11%	2%	0%
New Mexico	$1,272 (16%)	52%	12%	0%	4%	5%	14%	4%	3%	0%	1%
Texas	$810 (10%)	46%	0%	3%	12%	3%	1%	1%	26%	1%	0%
Florida	$787 (14%)	59%	6%	2%	10%	5%	1%	2%	7%	5%	0%
Hawaii	$516 (7%)	53%	0%	0%	19%	0%	0%	7%	5%	0%	17%
Iowa	$360 (4%)	41%	5%	12%	20%	5%	3%	4%	0%	0%	0%
Kansas	$217 (1%)	29%	2%	3%	0%	4%	0%	1%	62%	0%	0%

Source: TAF 2022 (Release 1).

Notes: This figure presents the state-level mean FFS spending, FFS spending as a percentage of mean total Medicaid spending, and percentages of FFS spending for the top 10 FASC in 2022. The percentages in each row do not sum up to 100%, as they represent only the top 10 service categories rather than the complete distribution. The following seven service categories are excluded: Durable medical equipment and supplies, All other outpatient institutional claims, Clinic, Laboratory, Radiology, Hospice, and All other overnight facilities. Oregon is not included in the figure due to an "Unusable" DQ Assessment for the "Total FFS Expenditures" topic in 2022. Percentages of mean total Medicaid spending (in parentheses) are not reported and are labeled as "DQ" for states with an "Unusable" DQ Assessment for the "Total Monthly Beneficiary Payments" topic in 2022.

Conclusion

This brief examines the extent of FFS use within Medicaid and highlights how FFS functions across states in an increasingly managed care-dominated environment. The use of FFS in Medicaid varies significantly across states and represents an active payment mechanism within Medicaid, rather than an outdated or residual payment system. These findings show that FFS continues to play a key role, particularly for services that are carved out or not fully integrated into managed care. States vary widely in their use of FFS, reflecting local needs, policy choices, and gaps in managed care coverage. The analysis also demonstrates that dual eligible beneficiaries are generally more likely to be covered under FFS compared to non-dual eligible beneficiaries. Overall, the results suggest that FFS is not just a supplementary payment model but also serves as a primary delivery mechanism in some states, such as Alaska, Connecticut, and Maine. FFS remains an important option for covering specialized services that managed care may exclude based on state-specific circumstances.

Researchers using TAF data to examine the degree to which states rely on FFS should consider the limitations of this data source. Due to data quality issues or limitations of the eligibility-based analytic criteria, beneficiaries may be misclassified as being covered under a FFS arrangement when it's determined indirectly based on the absence of enrollment in a CMC plan. Variability in the quality of managed care plan-type fields in TAF data across states and years may contribute to differences in the measured extent of FFS use. Additionally, limitations in how CMC enrollment is defined can lead to further misclassification. In some cases, a specific plan-type used to identify CMC enrollment may be broader than intended and capture beneficiaries enrolled in plans (such as certain subtypes of integrated dual eligible plans) that do fully function as CMC. In other cases, beneficiaries may be enrolled in multiple limited-benefit plans that, in combination, approximate a CMC plan, but if these plan types are not considered collectively, such individuals may be misclassified as FFS beneficiaries.

Researchers who choose to examine the extent of FFS use based on claims or expenditure data should be aware that such analyses are highly dependent on the completeness and accuracy of claim submissions, as well as the added complexities involved in linking data across multiple files or accounting for various types of financial transactions that may not reflect typical beneficiary-attributed claims. A summary of these limitations is provided in Appendix Table A.1.

Appendix A: Comparison of Approaches for Measuring Medicaid FFS Use

In addition to the eligibility-based approach discussed in the Methods section, this appendix outlines two additional methods for measuring Medicaid FFS use: a claims-based approach and an expenditure-based approach. All three approaches provide a different perspective on FFS use and present different strengths and limitations when compared to the eligibility-based measure. To organize the key characteristics of each approach, Table A.1 provides a high-level comparison of the eligibility-based, claims-based, and expenditure-based measures of Medicaid FFS use. Each method's definition, strengths, and limitations are summarized.

Appendix Table A.1. Summary of three primary methods for measuring Medicaid FFS use

Approach	Definition	Strengths	Limitations
Eligibility-based	Classifies beneficiaries as (potential) FFS users when they are not enrolled in any comprehensive managed care (CMC) plan during a beneficiary-month	• Captures all beneficiaries, even if they do not use services • Simple approach that requires few variables • Monthly enrollment data allow more granular identification of coverage patterns (e.g., scope of benefits, dual eligibility)	• Indirect measure can misclassify beneficiaries • Data quality of managed care plan-type fields in TAF can vary across states and years • Certain plan-type groupings (e.g., for integrated dual plans) may be broader than intended (e.g., some subtypes may not function as fully comprehensive managed care) • Some beneficiaries might be enrolled in several limited-benefit plan types that collectively approximate comprehensive coverage, but they could still be identified as FFS under the current approach[a]
Claims-based	Classifies beneficiary-months (or years) with any FFS claim (based on the TAF claim type code) as FFS use; denominator includes all relevant months (or years) with either FFS claims or managed care encounters	• Direct measurement of actual FFS utilization • Captures beneficiaries who use FFS services even if also enrolled in managed care • Flexibility allows focus on specific service types[b]	• Underestimates FFS coverage for people who do not use services • Heavily reliant on completeness and accuracy of TAF claims data • More complex to implement and requires linking multiple TAF file types (inpatient, long-term care, outpatient, and pharmacy)
Expenditure-based	Calculates the proportion of total Medicaid spending attributable to FFS using TAF	• Broad, system-level perspective • Useful for examining cost impact of FFS across states and over time	• Dependent on accurate and complete claims and expenditure reporting in TAF • FFS share may reflect price differences rather than coverage or utilization differences • Differences in supplemental payments or other financial transaction claims may not be fully captured in TAF or cannot be attributed to specific beneficiaries

[a] Beneficiaries can have up to 16 managed care plan-type indicators in a given month, which opens possibilities for unique combinations of limited benefit health plans that approximate a comprehensive managed plan. A possible refinement of the eligibility-based approach to measuring Medicaid FFS use would be to aggregate or group these limited benefit plan types to determine whether, together, they effectively provide comprehensive managed care coverage.

[b] TAF users can isolate specific service categories (e.g., behavioral health or dental) and delivery systems to understand how FFS is used for those types of services.

For reference, Appendix Tables B.1–B.3 separately present state-level percentages of FFS use based on the eligibility-based, claims-based, and expenditure-based approaches. In practice, these methods can yield similar estimates of FFS use for states that have very low or very high numbers of FFS enrollees yet diverge for other states depending on factors such as managed care carve-outs, data quality, and service patterns.

For example, a state may appear to have higher FFS use under the claims-based approach if beneficiaries enrolled in comprehensive managed care nevertheless obtain certain carved-out services via FFS (when measured using the claims-based approach). Similarly, a state may show a higher FFS percentage of total spending if FFS is used disproportionately for high-cost services, even though relatively few beneficiaries are enrolled in FFS coverage. In some analyses, combining eligibility-based and claims-based approaches can provide a more nuanced view, such as identifying specific services covered under FFS while still recognizing overall managed care assignment. Accordingly, the choice of approach depends on the specific analytic objective and the aspects of FFS use that the TAF user aims to capture.

Appendix B: Supplementary Tables

Appendix Table B.1. State-level fee-for-service (FFS) use metrics using the eligibility-based approach in 2022

State	FFS beneficiary-months	Total beneficiary-months	FFS percentage	Total FFS beneficiaries	Total Medicaid beneficiaries
All states included	306,580,684	1,115,932,247	27%	43,995,961	100,645,207
Alabama	14,791,317	15,842,229	93%	1,314,085	1,393,697
Alaska	3,186,321	3,186,321	100%	282,544	282,544
Arizona	2,539,250	28,458,191	9%	248,520	2,547,241
California	59,576,811	187,034,069	32%	16,842,827	17,085,486
Colorado	17,605,038	19,572,394	90%	1,638,528	1,798,990
Connecticut	14,334,412	14,334,415	100%	1,283,169	1,283,169
Delaware	517,266	3,625,817	14%	76,398	326,250
District of Columbia	525,262	3,595,675	15%	75,687	311,515
Florida	7,841,053	64,871,700	12%	1,160,879	5,869,380
Georgia	8,621,445	30,325,303	28%	866,516	2,743,376
Hawaii	79,063	5,435,778	1%	7,667	484,415
Illinois	9,824,521	42,941,799	23%	1,354,090	3,973,321
Indiana	5,017,509	24,973,882	20%	565,363	2,247,963
Iowa	584,149	9,618,145	6%	66,804	871,263
Kansas	398,461	5,648,281	7%	41,049	512,489
Kentucky	2,776,654	20,882,352	13%	307,551	1,831,015
Louisiana	1,802,333	23,770,625	8%	186,170	2,086,537
Maine	5,246,191	5,246,191	100%	474,276	474,276
Maryland	2,879,558	20,753,502	14%	354,807	1,836,191
Massachusetts	15,291,772	26,069,890	59%	1,448,342	2,335,674
Michigan	9,557,523	36,971,834	26%	1,170,670	3,270,176
Minnesota	2,398,735	16,244,662	15%	359,116	1,483,760
Mississippi	5,419,956	9,947,086	54%	573,018	886,504
Missouri	4,540,426	16,555,427	27%	574,340	1,514,351
Montana	3,583,901	3,583,901	100%	321,824	321,824
Nebraska	86,682	4,550,642	2%	15,114	422,166
Nevada	2,715,155	10,769,010	25%	298,262	1,010,121
New Hampshire	337,068	3,171,697	11%	36,789	287,138
New Jersey	1,206,536	24,596,453	5%	321,058	2,232,668
New Mexico	1,999,749	11,742,670	17%	195,093	1,037,217
New York	24,360,079	91,024,628	27%	2,934,318	8,227,612

State	FFS beneficiary-months	Total beneficiary-months	FFS percentage	Total FFS beneficiaries	Total Medicaid beneficiaries
North Carolina	13,019,249	33,391,642	39%	1,285,231	2,994,553
North Dakota	1,134,848	1,526,021	74%	109,592	142,879
Ohio	5,542,769	40,864,193	14%	694,965	3,638,641
Oklahoma	15,119,826	15,128,415	100%	1,391,626	1,392,353
Oregon	2,730,288	15,781,339	17%	342,121	1,480,846
Pennsylvania	4,528,524	41,975,054	11%	682,785	3,763,761
Rhode Island	408,835	4,574,222	9%	49,057	404,502
South Carolina	5,847,646	18,478,729	32%	593,710	1,623,118
South Dakota	1,771,393	1,771,393	100%	160,456	160,456
Texas	12,089,177	75,654,492	16%	1,506,153	6,691,831
Utah	1,174,581	5,893,830	20%	184,946	544,682
Virginia	2,505,166	23,759,113	11%	420,313	2,144,352
Washington	3,824,434	25,635,734	15%	406,942	2,339,105
West Virginia	1,287,162	7,756,614	17%	120,687	690,527
Wisconsin	4,926,807	17,371,104	28%	557,573	1,550,342
Wyoming	1,025,783	1,025,783	100%	94,930	94,930

Source: TAF 2022 (Release 1).

Notes: FFS Percentage represents FFS Beneficiary-Months divided by Total Beneficiary-Months, expressed as a percentage. The following four states are not included in the table due to an “Unusable” DQ Assessment for the “Enrollment in CMC Plans” topic in 2022 Release 1: Arkansas, Idaho, Tennessee, and Vermont.

Appendix Table B.2. State-level fee-for-service (FFS) use metrics using the claims-based approach in 2022

State	Beneficiary-months with any FFS claim	Beneficiary-months with any FFS claim/encounter	FFS percentage
All states included	198,042,829	494,487,099	40%
Alabama	5,609,819	5,609,819	100%
Alaska	1,127,518	1,127,518	100%
Arizona	1,208,771	11,228,726	11%
Arkansas	3,591,906	4,265,819	84%
California	44,895,518	65,262,969	69%
Colorado	6,366,380	7,644,244	83%
Connecticut	6,700,046	6,701,324	100%
Delaware	341,263	1,587,868	21%
District of Columbia	578,392	1,517,033	38%
Florida	2,407,458	21,986,677	11%
Georgia	3,581,863	11,645,383	31%
Hawaii	237,473	2,014,121	12%
Idaho	1,813,649	2,129,953	85%
Illinois	4,263,411	17,453,676	24%
Indiana	3,247,490	11,396,787	28%
Iowa	197,728	4,716,843	4%
Kansas	267,442	2,711,752	10%
Kentucky	1,195,741	10,129,474	12%
Louisiana	1,893,337	10,995,060	17%
Maine	2,338,977	2,338,977	100%
Maryland	5,383,345	9,678,970	56%
Massachusetts	7,702,262	12,578,150	61%
Michigan	6,340,230	15,943,681	40%
Minnesota	2,630,775	8,323,171	32%
Mississippi	2,138,050	4,407,852	49%
Missouri	5,582,151	7,253,477	77%
Montana	1,663,283	1,663,283	100%
Nebraska	212,760	2,263,668	9%
Nevada	1,317,331	4,047,010	33%
New Hampshire	560,775	1,607,814	35%
New Jersey	2,298,096	12,597,794	18%
New Mexico	765,627	4,929,360	16%
New York	14,169,443	41,662,381	34%
North Carolina	5,835,102	24,187,798	24%
North Dakota	678,507	728,880	93%

State	Beneficiary-months with any FFS claim	Beneficiary-months with any FFS claim/encounter	FFS percentage
Ohio	4,380,041	20,301,944	22%
Oklahoma	6,014,295	6,020,400	100%
Oregon	2,255,625	6,540,692	34%
Pennsylvania	1,591,256	20,851,619	8%
Rhode Island	491,673	2,208,354	22%
South Carolina	2,893,765	7,006,985	41%
South Dakota	787,396	798,739	99%
Tennessee	6,745,025	9,481,384	71%
Texas	5,762,233	30,058,138	19%
Utah	1,229,772	2,435,400	50%
Vermont	1,258,470	1,323,759	95%
Virginia	1,798,048	10,089,968	18%
Washington	3,920,237	10,952,050	36%
West Virginia	3,091,519	3,894,673	79%
Wisconsin	6,202,535	7,706,662	80%
Wyoming	479,020	479,020	100%

Source: TAF 2022 (Release 1).

Note: FFS Percentage represents Beneficiary-Months with Any FFS Claim divided by Beneficiary-Months with Any FFS Claim/Encounter, expressed as a percentage.

Appendix Table B.3. State-level fee-for-service (FFS) use metrics using the expenditure-based approach in 2022

State	Medicaid total FFS expenditures	Monthly beneficiary payments	Medicaid beneficiary expenditures	FFS percentage
All states included	$247,909,283,821	$441,366,052,467[a]	$689,459,431,576	36%
Alabama	$5,320,985,918	$130,994,584	$5,451,980,502	98%
Arizona	$3,316,340,782	$15,736,849,799	$19,053,190,581	17%
California	$44,642,481,634	$50,347,608,547	$94,990,090,180	47%
Colorado	$8,467,212,610	$2,117,179,316	$10,584,391,927	80%
Delaware	$522,304,304	$2,662,142,069	$3,184,446,373	16%
District of Columbia	$1,798,924,821	$1,678,312,751	$3,477,237,572	52%
Florida	$5,078,062,403	$22,087,200,865	$27,165,263,267	19%
Georgia	$6,765,033,446	$5,563,772,756	$12,328,806,202	55%
Hawaii	$215,114,996	$2,795,111,051	$3,010,226,047	7%
Idaho	$2,378,348,727	$837,571,629	$3,215,920,356	74%
Illinois	$5,228,874,725	$17,141,865,302	$22,370,740,026	23%
Indiana	$9,009,233,411	$8,986,524,708	$17,995,758,119	50%
Iowa	$304,689,716	$6,029,634,288	$6,334,324,004	5%
Kansas	$128,621,572	$4,333,855,767	$4,462,477,340	3%
Kentucky	$3,779,947,787	$10,715,887,560	$14,495,835,347	26%
Louisiana	$2,973,079,963	$10,484,624,109	$13,457,704,072	22%
Maine	$3,231,503,915	$12,971,969	$3,244,475,884	100%
Maryland	$7,775,956,225	$6,952,062,775	$14,728,018,999	53%
Massachusetts	$10,746,657,934	$9,593,893,989	$20,340,551,923	53%
Michigan	$4,326,141,962	$13,337,649,147	$17,663,791,109	24%
Minnesota	$8,334,752,283	$8,931,868,888	$17,266,621,171	48%
Mississippi	$2,873,619,816	$2,334,882,686	$5,208,502,501	55%
Missouri	$8,471,034,712	$4,150,352,022	$12,621,386,733	67%
Montana	$2,043,412,758	$43,633,865	$2,087,046,623	98%
Nebraska	$1,176,178,995	$2,491,660,432	$3,667,839,427	32%
Nevada	$2,011,208,353	$2,876,034,385	$4,887,242,738	41%
New Hampshire	$958,489,520	$1,297,540,795	$2,256,030,314	42%
New Jersey	$4,389,812,136	$14,410,113,230	$18,799,925,366	23%
New Mexico	$1,159,937,603	$6,043,797,125	$7,203,734,728	16%
New York	$25,894,633,642	$47,345,683,402	$73,240,317,043	35%
North Carolina	$7,284,956,103	$10,300,261,602	$17,585,217,705	41%
North Dakota	$1,166,430,905	$489,124,680	$1,655,555,585	70%
Ohio	$7,193,309,649	$20,762,617,194	$27,955,926,842	26%
Oklahoma	$6,488,591,444	$128,452,753	$6,617,044,197	98%
Pennsylvania	$5,651,827,312	$38,121,171,007	$43,772,998,319	13%

State	Medicaid total FFS expenditures	Monthly beneficiary payments	Medicaid beneficiary expenditures	FFS percentage
Rhode Island	$1,083,552,734	$1,971,537,765	$3,055,090,499	35%
South Carolina	$2,840,528,333	$3,670,068,676	$6,510,597,010	44%
South Dakota	$1,030,948,170	$1,886,172	$1,032,834,342	100%
Tennessee	$3,305,804,345	$7,535,528,933	$10,841,333,278	30%
Texas	$6,488,520,426	$41,155,378,749	$47,643,899,175	14%
Utah	$1,869,094,424	$2,345,178,418	$4,214,272,843	44%
Vermont	$1,528,934,864	Unclassified	$1,713,030,158	89%
Virginia	$2,817,317,030	$16,057,398,936	$18,874,715,966	15%
Washington	$7,063,118,792	$9,104,196,626	$16,167,315,418	44%
West Virginia	$2,909,144,010	$2,258,053,010	$5,167,197,019	56%
Wisconsin	$5,251,339,329	$5,992,271,120	$11,243,610,449	47%
Wyoming	$613,269,282	$1,647,015	$614,916,297	100%

Source: TAF 2022 (Release 1), as used in the *DQ Atlas* topics "Total FFS Expenditures" and "Total Monthly Beneficiary Payments" for 2022.

Notes: FFS Percentage represents Medicaid Total FFS Expenditures divided by Medicaid Beneficiary Expenditures, expressed as a percentage. The following four states are not included in the table due to an "Unusable" DQ Assessment for the "Total FFS Expenditures" and the "Total Monthly Beneficiary Payments" topics in 2022 Release 1: Alaska, Arkansas, Connecticut, and Oregon.

[a] Vermont is not included in the national row for "Monthly Beneficiary Payments" because its entry is labeled "Unclassified."

JJ Chen,[1] Wendy Qi,[1] and Chris Luchterhand.[1] "State-Level Variations in Medicaid Fee-for-Service Use and Spending Patterns in TAF." Baltimore, MD: CMS, 2025.

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