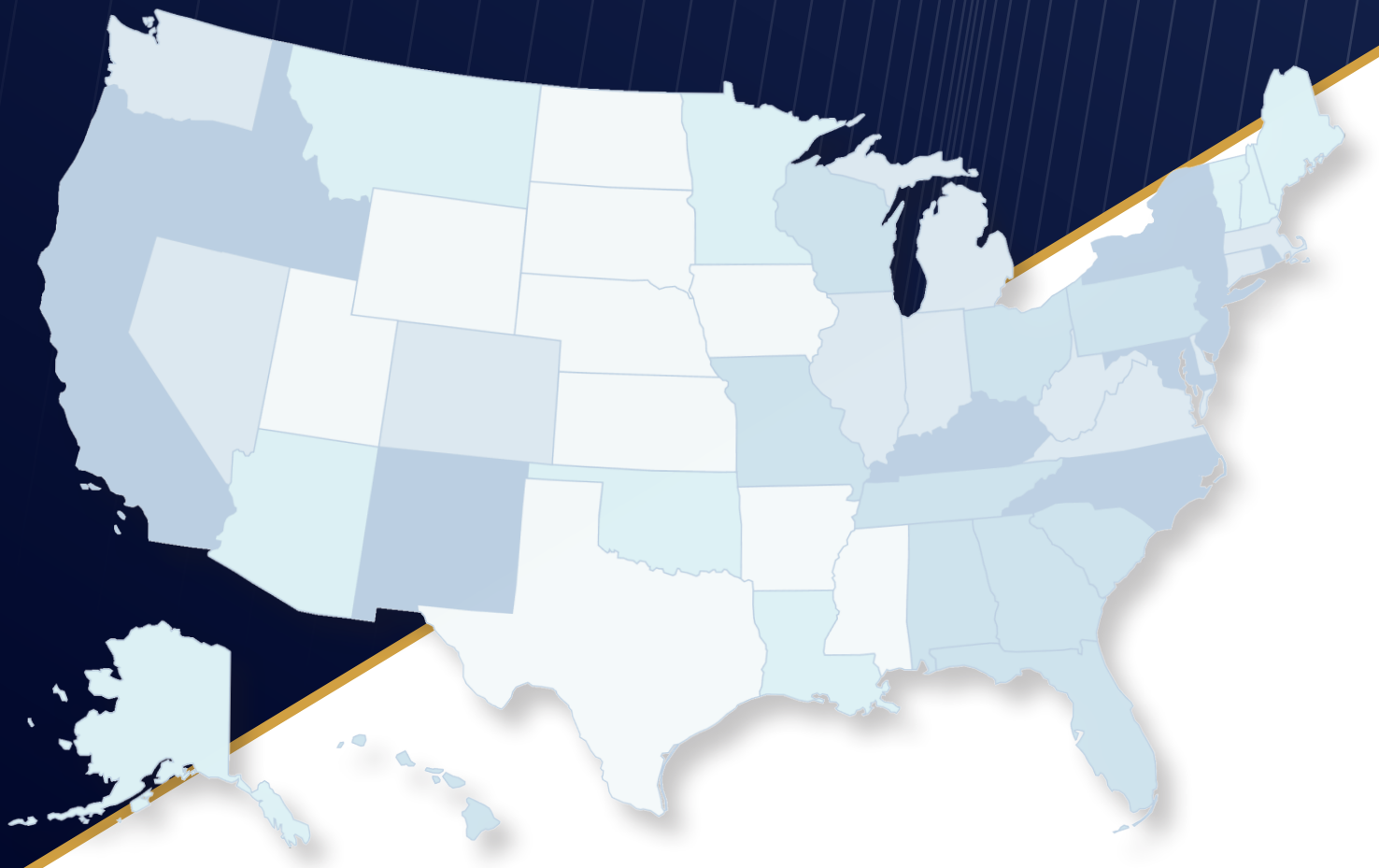
# MEDICAID REPORT CARD

STATE INSIGHTS. BETTER GOVERNANCE.



THE HEARTLAND INSTITUTE

A 50-STATE ANALYSIS OF MEDICAID POLICY, SPENDING, AND GOVERNANCE

2026 EDITION

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POLICY STUDY

# MEDICAID REPORT CARD

STATE INSIGHTS. BETTER GOVERNANCE.

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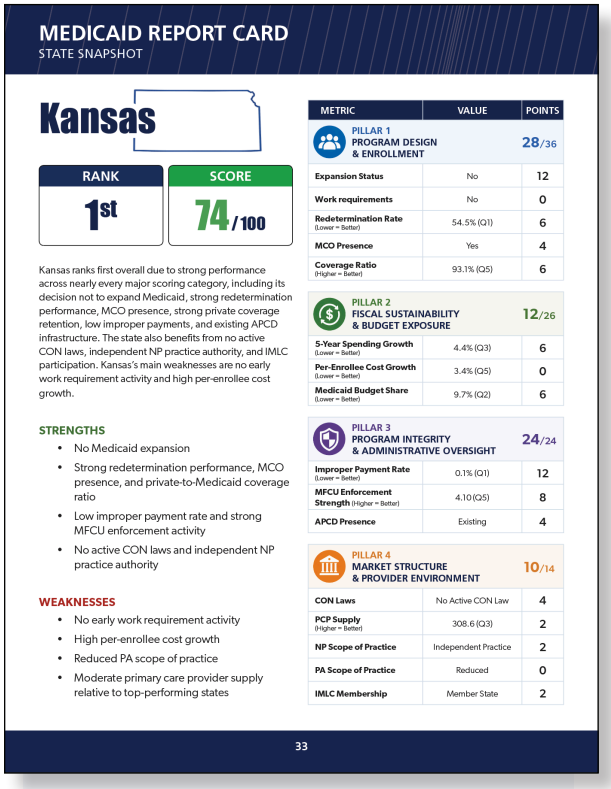
# EXECUTIVE SUMMARY

Medicaid covers roughly 75 million Americans and represents one of the largest lines in both federal and state budgets. Within a shared federal framework, states control eligibility, program design, administration, delivery systems, and provider regulation, which produces 50 systems with distinct fiscal trajectories, administrative capacity, and policy environments.

This report scores each state across four dimensions of Medicaid governance: Program Design and Enrollment (36 points), Fiscal Sustainability and Budget Exposure (26 points), Program Integrity and Administrative Oversight (24 points), and Market Structure and Provider Environment (14 points). There are 16 metrics in total, which add up to a maximum of 100 points.

The scorecard rewards states that keep Medicaid closer to a targeted safety-net program, exercise fiscal discipline, minimize improper payments and fraud, run competent eligibility systems, and keep provider markets open. It is not a measure of health outcomes, beneficiary satisfaction, or overall system quality. The goal is narrower: to make differences in policy design, fiscal exposure, administrative performance, and provider-market conditions comparable across states.



MEDICAID REPORT CARD
STATE SNAPSHOT

Kansas

| RANK | SCORE |
|---|---|
| 1st | 74/100 |

Kansas ranks first overall due to strong performance across nearly every major scoring category, including its decision not to expand Medicaid, strong redetermination performance, MCO presence, strong private coverage retention, low improper payments, and existing APCD infrastructure. The state also benefits from no active CON laws, independent NP practice authority, and IMLC participation. Kansas's main weaknesses are no early work requirement activity and high per-enrollee cost growth.

STRENGTHS
- No Medicaid expansion
- Strong redetermination performance, MCO presence, and private-to-Medicaid coverage ratio
- Low improper payment rate and strong MFCU enforcement activity
- No active CON laws and independent NP practice authority

WEAKNESSES
- No early work requirement activity
- High per-enrollee cost growth
- Reduced PA scope of practice
- Moderate primary care provider supply relative to top-performing states

| METRIC | VALUE | POINTS |
|---|---|---|
| PILLAR 1 PROGRAM DESIGN & ENROLLMENT | | 28/36 |
| Expansion Status | No | 12 |
| Work requirements | No | 0 |
| Redetermination Rate (Lower = Better) | 54.5% (Q1) | 6 |
| MCO Presence | Yes | 4 |
| Coverage Ratio (Higher = Better) | 93.1% (Q5) | 6 |
| PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE | | 12/26 |
| 5-Year Spending Growth (Lower = Better) | 4.4% (Q3) | 6 |
| Per-Enrollee Cost Growth (Lower = Better) | 3.4% (Q5) | 0 |
| Medicaid Budget Share (Lower = Better) | 9.7% (Q2) | 6 |
| PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT | | 24/24 |
| Improper Payment Rate (Lower = Better) | 0.1% (Q1) | 12 |
| MFCU Enforcement Strength (Higher = Better) | 4.10 (Q5) | 8 |
| APCD Presence | Existing | 4 |
| PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT | | 10/14 |
| CON Laws | No Active CON Law | 4 |
| PCP Supply (Higher = Better) | 308.6 (Q3) | 2 |
| NP Scope of Practice | Independent Practice | 2 |
| PA Scope of Practice | Reduced | 0 |
| IMLC Membership | Member State | 2 |

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Individual State Snapshots start on page 19.

## Methodology

States are scored using binary, ordinal, or quintile methods depending on the metric, with continuous measures benchmarked against the national distribution rather than fixed targets. Data come from KFF, the Census Bureau, MACPAC, CMS, the HHS Office of Inspector General, and other national trackers of state health policy and provider regulation.

## Overall Results

Scores range from 74 (Kansas, first) to 22 (California, last), with a state average of 45.5 and a median of 45. No state comes close to a perfect score—even the top performers carry real weaknesses.

**Top 10:** Kansas (74), Texas (67), Wyoming (64), Nebraska (62), South Dakota (61), Arkansas (60), Iowa (59), Mississippi (59), North Dakota (57), Utah (57).

**Bottom 10:** Kentucky, Oregon, Maryland, New Jersey, Idaho, New York, New Mexico, North Carolina, Rhode Island, and California.

The top 10 average 62 points; the bottom 10 average 29.8. The gap is not attributable to any single metric; high-ranked states tend to combine strength across design, fiscal management, and integrity, while low-ranked states tend to accumulate weaknesses across all four pillars at once.

## Key Findings

The single biggest split in the data is expansion status. States that had not adopted the Affordable Care Act's Medicaid expansion at the time of analysis average 57.7 points against 42.4 for expansion states, and every state within the bottom 10 has expanded. All 10 non-expansion states land in the top 18, a result that partly reflects the methodology's treatment of expansion as a major driver of enrollment, spending, federal dependence, and departure from Medicaid's traditional safety-net focus.

That said, Nebraska, South Dakota, Arkansas, Iowa, North Dakota, and Utah all expanded and still cracked the top 10, mostly on the strength of fiscal discipline, program-integrity performance, or eligibility administration. A few non-expansion states land outside the top 10 once fiscal exposure or improper payments catch up with them.

There is no single formula for a strong score, either. Kansas ranks first on a combination of tight program design, perfect integrity performance, and an open provider market. Texas gets to second almost entirely on design and integrity, despite substantial weaknesses in budget exposure and provider supply. Wyoming and Mississippi climb the rankings mostly through fiscal performance; South Dakota through integrity and provider-market strength; Arkansas through fiscal management and administrative oversight.

Fiscal sustainability does the most to separate the top and bottom tiers: the top 10 average 18 of 26 fiscal points, the bottom 10 average 7. Wyoming and Mississippi take the full 26; New York takes zero. States that combine fast spending growth, rising per-enrollee costs, and heavy Medicaid budget exposure tend to see those problems compound, often enough to erase advantages elsewhere in the scorecard.

Program integrity carries similar weight. Kansas earns all 24 points available; Arkansas, Missouri, South Dakota, Texas, Minnesota, Pennsylvania, and Washington all score well too. High improper payment rates and weak fraud enforcement substantially reduce scores in many other states.

Provider-market policy—certificate-of-need repeal, scope-of-practice expansion, interstate licensure, primary care supply—moves the needle, but not enough on its own. North Dakota takes all 14 points here. New Mexico and Colorado do well on this pillar specifically and still finish near the bottom overall, because provider-market strength cannot offset weak fiscal or program-integrity numbers.

Weak performance is almost always compounding rather than isolated. California is near the bottom on every pillar; design, spending growth, improper payments, provider supply, and provider flexibility all pull in the same direction. New York does better on administration and providers but scores zero on fiscal sustainability. Most of the other low-ranked states show the same pattern: some expansive program design, some fiscal pressure, some administrative gaps, some provider-market restriction, all stacking up at once.

## Policy Implications

Some reforms can be pursued through relatively direct legislative or administrative action—repealing certificate-of-need laws, expanding NP/PA scope of practice, joining interstate licensure compacts, implementing an all-payer claims database, or moving early on work requirements. Others—improper payments, spending growth, provider supply, redetermination systems, overall budget exposure—take longer and require sustained institutional follow-through.

The throughline is that no state has solved Medicaid governance by getting one thing right. Program scope, fiscal exposure, eligibility administration, payment accuracy, fraud enforcement, provider capacity, and market regulation all move somewhat independently, and a state has to manage all of this simultaneously to score well. The point of this scorecard is to make those differences visible and comparable, and to give future editions a consistent baseline for tracking how state policy and administrative performance shift over time.

# INTRODUCTION

Medicaid is one of the largest and most consequential public programs in the United States. Jointly financed by the federal government and the states, it now provides health coverage to approximately 75 million Americans and consumes a substantial share of both federal and state public spending.[1] In many states, Medicaid represents one of the single largest categories of government expenditure, with implications that extend well beyond health policy alone. The program affects state budgets, labor-market incentives, provider markets, insurance coverage patterns, administrative capacity, and the broader structure of the American health care system.

**MEDICAID IS ONE OF THE LARGEST AND MOST CONSEQUENTIAL PUBLIC PROGRAMS IN THE UNITED STATES. JOINTLY FINANCED BY THE FEDERAL GOVERNMENT AND THE STATES, IT NOW PROVIDES HEALTH COVERAGE TO APPROXIMATELY 75 MILLION AMERICANS AND CONSUMES A SUBSTANTIAL SHARE OF BOTH FEDERAL AND STATE PUBLIC SPENDING.**

At the same time, Medicaid occupies a distinctive place within the American constitutional system. Unlike purely federal entitlement programs, Medicaid operates through a model of cooperative federalism in which federal law establishes broad program parameters while states retain substantial discretion over implementation and program design. States make consequential decisions regarding eligibility standards, benefit structures, delivery systems, managed care arrangements, provider regulation, administrative procedures, and supplemental reforms. The result is not a single national Medicaid program, but rather a collection of state-administered systems operating within a shared federal framework.[2]

Since its creation in 1965, Medicaid has expanded substantially in both scale and scope. Originally designed primarily to provide medical assistance to low-income children, pregnant women, elderly individuals, and people with disabilities, the program has evolved into a much broader component of the American health coverage system. Legislative changes over several decades, particularly the Affordable Care Act's expansion of eligibility for able-bodied adults, significantly increased enrollment and federal Medicaid spending. More recently, the COVID-19 public health emergency and accompanying continuous-coverage requirements temporarily suspended routine eligibility redeterminations, further accelerating enrollment growth and highlighting the administrative complexity involved in managing large public insurance programs.[3]

As Medicaid's fiscal and institutional footprint has grown, so too has the importance of how states administer and structure their programs. Differences in eligibility systems, managed care arrangements, provider regulation, program-integrity enforcement, and spending growth now carry major implications not only for beneficiaries, but also for state budgets, provider markets, and the long-term sustainability of public health financing. States also differ significantly in administrative effectiveness, provider availability, regulatory barriers, and broader health policy environments. These differences make Medicaid particularly well suited to comparative analysis.

While numerous organizations track individual aspects of Medicaid performance, relatively few attempt to evaluate state Medicaid programs through a unified framework that incorporates fiscal sustainability, administrative performance, program integrity, and provider-market structure simultaneously. Evaluating these dimensions together provides a more comprehensive view of how state Medicaid programs are governed and how they are likely to perform over time.

1 KFF.org, "Medicaid Enrollment and Unwinding Tracker," May 29, 2026, https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/

2 Nicole Huberfeld, "Federalizing Medicaid," *Journal of Constitutional Law,* Volume 14, Issue 2, December 2011, https://scholarship.law.bu.edu/faculty_scholarship/899/

3 KFF.org, "Medicaid 101," accessed June 2, 2026, https://www.kff.org/medicaid/health-policy-101-medicaid/

The size and complexity of the program create difficult governance challenges. Medicaid must balance competing objectives that are not always easily reconciled: expanding access while maintaining fiscal sustainability; enforcing eligibility rules while minimizing unnecessary administrative disruption; increasing coverage while preserving provider participation and system capacity; balancing federal requirements with state flexibility; and maintaining public oversight without creating excessive bureaucracy, distortion, or dependency. Reasonable policymakers may disagree about how those tradeoffs should be resolved. Nevertheless, the existence of tradeoffs does not eliminate the need for serious comparative evaluation of how states administer and structure their programs.

This report presents a 50-state Medicaid scorecard designed to evaluate how states differ across a range of fiscal, administrative, structural, and market-oriented indicators. Drawing from publicly available national datasets, the report provides a comparative framework for assessing the governance, trajectory, and long-term sustainability of state Medicaid programs. The sections that follow explain the methodology used to construct the scorecard, present detailed state profiles, and summarize broader national patterns revealed by the data.

**THIS REPORT PRESENTS A 50-STATE MEDICAID SCORECARD DESIGNED TO EVALUATE HOW STATES DIFFER ACROSS A RANGE OF FISCAL, ADMINISTRATIVE, STRUCTURAL, AND MARKET-ORIENTED INDICATORS.**

# METHODOLOGY

This report evaluates state Medicaid programs using a 50-state scorecard designed to measure the extent to which each state's program reflects principles of program integrity, administrative competence, fiscal restraint, and a competitive health care environment affecting Medicaid access. The scorecard does not attempt to measure every dimension of Medicaid performance, nor does it claim to capture all normative goals that may be brought to bear in debates over public insurance. Rather, it provides a clear, comparable framework for assessing how state Medicaid programs differ in structure, trajectory, and governance.

The scorecard assigns each state a total score out of 100 points across 16 metrics grouped into four major pillars: Program Design and Enrollment, Fiscal Sustainability and Budget Exposure, Program Integrity and Administrative Oversight, and Market Structure and Provider Environment. These pillars were selected to reflect core policy concerns relevant to Medicaid's long-term performance: whether the program is tightly targeted, whether it is fiscally sustainable, whether it is administered with appropriate discipline and oversight, and whether the broader health policy environment supports access, competition, and efficient care delivery.

**THIS REPORT EVALUATES STATE MEDICAID PROGRAMS USING A 50-STATE SCORECARD DESIGNED TO MEASURE THE EXTENT TO WHICH EACH STATE'S PROGRAM REFLECTS PRINCIPLES OF PROGRAM INTEGRITY, ADMINISTRATIVE COMPETENCE, FISCAL RESTRAINT, AND A COMPETITIVE HEALTH CARE ENVIRONMENT AFFECTING MEDICAID ACCESS.**

## Conceptual Approach

The central premise of this report is that Medicaid should function as a targeted safety-net program while remaining fiscally sustainable, administratively effective, and compatible with a functional and accessible health care market. States that maintain tighter eligibility structures, exercise greater cost discipline, enforce stronger integrity safeguards, and remove unnecessary barriers to provider participation and market competition score more favorably under this framework. Conversely, states that have expanded the size and fiscal footprint of Medicaid, tolerated higher levels of waste or administrative dysfunction, or maintained more restrictive provider-market rules score less favorably.

The scorecard evaluates state Medicaid programs primarily through the lenses of fiscal sustainability, program integrity, administrative competence, and broader health care market structure. Reasonable policymakers may disagree about the ideal size and scope of Medicaid or the appropriate balance between public and private coverage. The report does not attempt to resolve every normative debate surrounding public insurance. Instead, it seeks to provide a transparent and comparable framework for evaluating how states differ across a set of measurable fiscal, administrative, and structural indicators relevant to long-term program performance and governance. Every effort was made to ensure that individual metrics are transparent, grounded in publicly available data, and applied consistently across states.

## Metric Selection, Data Sources, and Scoring Framework

The 16 metrics included in this report were chosen for four reasons. First, each metric was intended to reflect a meaningful aspect of Medicaid policy, administration, fiscal exposure, or the health care market in which Medicaid operates. Second, the metric needed to vary across states in a way that would produce informative comparisons. Third, the underlying data had to be publicly available and sufficiently comparable across states. Fourth, the metric needed to be simple enough to explain clearly in a scorecard format.

The final set of metrics includes both direct Medicaid-policy variables and a limited number of adjacent structural indicators. Some metrics measure explicit policy choices, such as Medicaid expansion status, early work requirement activity, managed care organization presence, and all-payer claims database status.

Others measure fiscal or administrative outcomes, such as improper payment rates, Medicaid spending growth, per-enrollee cost growth, budget exposure, and procedural disenrollment during redeterminations. Still others measure features of the surrounding provider and regulatory environment that affect whether Medicaid beneficiaries can access care, including certificate-of-need laws, provider supply, scope-of-practice rules, and Interstate Medical Licensure Compact participation.

Not every potentially relevant variable was included. Some candidate measures were excluded because the data were too inconsistent, too burdensome to collect, too difficult to defend methodologically, or too duplicative of stronger indicators already in the model. In general, the report favors measures that are directionally strong and readily explainable over highly elaborate indices that may create a false sense of precision.

The scorecard relies on publicly available state-level data drawn from national datasets, policy trackers, and official federal or state-oriented sources. Major sources include KFF (formerly the Kaiser Family Foundation) Medicaid trackers; the U.S. Census Bureau's American Community Survey (ACS); Medicaid and CHIP Payment and Access Commission (MACPAC) MACStats files; Centers for Medicare & Medicaid Services (CMS) improper payment reporting; Department of Health and Human Services (HHS) Office of Inspector General (OIG) Medicaid Fraud Control Unit (MFCU) data; the All-Payer Claims Database (APCD) Council; the Cicero Institute certificate-of-need dataset; America's Health Rankings; the American Association of Nurse Practitioners (AANP); the American Academy of Physician Associates (AAPA); and the Interstate Medical Licensure Compact (IMLC) Commission.

Where possible, the scorecard uses a single consistent national source per metric rather than mixing multiple sources for the same measure. This approach improves comparability and reduces the risk that differences in underlying methodology, update cycles, or definitions will distort the rankings. In several cases, raw source values required additional construction before scoring. For example, the private-to-Medicaid coverage metric was constructed from American Community Survey coverage categories, the spending-growth metrics were calculated from MACPAC time-series data, and the Medicaid Fraud Control Unit metric was normalized relative to Medicaid enrollment.

The scorecard awards a maximum of 100 points. Metric weights were determined based on substantive importance rather than statistical equalization. Some measures, such as Medicaid expansion status and improper payment rate, were weighted more heavily because they reflect especially consequential program choices or outcomes. Others, such as APCD status or IMLC participation, were given more modest weights because they are best understood as supporting indicators rather than core drivers of performance.

The four pillars and their associated weights are:

**PILLAR 1**
**PROGRAM DESIGN & ENROLLMENT**
36 points

**PILLAR 2**
**FISCAL SUSTAINABILITY & BUDGET EXPOSURE**
26 points

**PILLAR 3**
**PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT**
24 points

**PILLAR 4**
**MARKET STRUCTURE & PROVIDER ENVIRONMENT**
14 points

Within those pillars, individual metrics were scored using one of three methods: binary scoring, ordinal scoring, or quintile-based scoring.

Binary scoring was used where the relevant policy condition is best understood as present or absent. Under this method, a state either receives the full number of points assigned to the metric or receives zero. Examples include Medicaid expansion status, early work requirement activity, MCO presence, and certificate-of-need status.

Ordinal scoring was used where policy differences are real but are better represented by a small number of categories than by a continuous variable. Under this method, states are grouped into discrete tiers and assigned points accordingly. APCD status, nurse practitioner scope of practice, physician assistant scope of practice, and IMLC participation are scored using this approach.

Quintile scoring was used for continuous variables. States were ranked from best to worst based on the substantive direction of the variable. For some measures, higher values are better; for others, lower values are better. Because the scorecard evaluates 50 states, quintiles were generally constructed by grouping states into sequential performance bands based on their rank within the national distribution.

Quintiles were chosen for several reasons. First, they preserve broad relative performance groupings across states without creating the appearance of excessive precision. Second, they provide a consistent and easily interpretable framework for comparing states across multiple continuous variables. Third, they simplify presentation for nontechnical readers by translating raw numeric distributions into standardized performance bands.

The score allocations within quintile-based metrics are not always linear. This was done to preserve the relative weight of stronger and weaker performance while avoiding fractional scores. For example, some six-point metrics use a 6-4-3-1-0 distribution, while some ten-point metrics use a 10-8-6-2-0 distribution. These distributions reflect a judgment that stronger and weaker relative performance categories should receive greater differentiation than middle-tier categories.

For each quintile-based metric, performance is evaluated relative to other states rather than against an absolute benchmark. A state's score therefore reflects its position within the national distribution, not whether it meets a predefined target level. This approach is intended to facilitate consistent cross-state comparison within a uniform relative ranking framework.

In cases where multiple states shared identical values at a quintile boundary, quintile group sizes may vary slightly to avoid assigning tied observations to different scoring categories.

The complete set of underlying values, quintile assignments, and scoring calculations for all 50 states is presented in the tables beginning on page 76. The full Excel dataset used to construct the scorecard is available upon request.

## PILLAR 1
## PROGRAM DESIGN & ENROLLMENT

**Program Design and Enrollment** is worth 36 points. This pillar evaluates whether a state's Medicaid program remains relatively targeted, whether the state has taken steps to connect Medicaid eligibility to work or economic participation, whether it administers eligibility redeterminations competently, whether it uses managed care, and whether private coverage remains strong relative to Medicaid coverage.

### Medicaid Expansion Status

Medicaid expansion status is worth 12 points and is scored as a binary variable. States that have not adopted Medicaid expansion receive 12 points. States that have adopted expansion receive 0 points.

This metric receives the largest single weight in the scorecard because expansion is treated as the most consequential structural driver of Medicaid program size and long-term fiscal exposure. Medicaid expansion fundamentally changes the program from a targeted safety net for low-income children, pregnant women, people with disabilities, and other vulnerable populations into a broader coverage program for able-bodied adults. Although expansion may increase insurance coverage, it also increases enrollment, spending, and federal dependence while expanding the program beyond its original safety-net focus.

The source for this metric is the KFF Medicaid Expansion Tracker.[4] Current expansion status was extracted directly for each state.

### Work Requirements

Work requirement activity is worth 8 points and is scored as a binary variable. States receive 8 points if they had any early work requirement activity identified by KFF in connection with the new

4 KFF.org, "Status of State Action on the Medicaid Expansion Decision," accessed February 22, 2026, https://www.kff.org/affordable-care-act/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

federal guidelines established by the 2025 federal reconciliation bill.[5,6] States with no early activity receive 0 points.

For purposes of this scorecard, "early work requirement activity" includes states classified by KFF as adopting early through a state plan amendment, having an approved waiver, having a pending waiver, or having a waiver at the state level. These categories represent different stages of policy development, but all receive equal credit because the metric is intended to capture early policy movement rather than implementation outcomes.

This metric is included because work requirements reinforce the link between public benefits and economic participation, helping limit dependency and better target scarce Medicaid resources. The report recognizes that this is a transition period. As states implement federal changes, the proper way to evaluate work requirement policy may change in future scorecard editions. For example, once baseline compliance becomes mandatory nationwide, future updates may need to assess whether states go beyond federal minimum requirements, how strictly they implement exemptions, or whether their systems are designed to promote employment rather than simply satisfy federal compliance.

## Redetermination Performance

Redetermination performance is worth 6 points and is scored by quintile, with lower procedural disenrollment rates scoring better. States in the best quintile receive 6 points, followed by 4, 3, 1, and 0 points for progressively worse quintiles.

This metric reflects state performance during the Medicaid unwinding period following the COVID-19 public health emergency, when states were required to resume eligibility redeterminations after a period of continuous coverage. The data come from KFF Medicaid unwinding reports and use the cumulative value from the most recent complete reporting period.[7]

The metric specifically measures the share of disenrollments classified as "terminated for procedural reasons." It is important to distinguish procedural terminations from individuals who were formally "determined ineligible." Ineligibility determinations reflect substantive eligibility enforcement, while procedural disenrollment generally reflects terminations tied to administrative or renewal-process failures, including incomplete paperwork, unsuccessful contact attempts, verification problems, or unresolved documentation requirements.

This scorecard focuses on procedural disenrollment because it is intended to measure the efficiency and accuracy of a state's renewal system rather than the aggressiveness of eligibility enforcement alone. States with lower procedural disenrollment rates are treated as demonstrating stronger administrative performance, more effective renewal infrastructure, and a greater ability to distinguish between truly ineligible beneficiaries and individuals terminated for non-substantive procedural reasons. High procedural disenrollment rates may indicate administrative friction, weak renewal systems, communication failures, or excessive reliance on procedural termination mechanisms rather than accurate eligibility determination.

At the same time, this metric should not be interpreted as discouraging eligibility enforcement. States are expected to remove individuals who no longer qualify for Medicaid coverage. A state can aggressively enforce eligibility rules while still minimizing unnecessary procedural churn through effective verification systems, automated renewals, and clear beneficiary communication. Because this metric focuses specifically on procedural terminations rather than overall disenrollment levels or formal ineligibility determinations, it is best understood as an administrative-performance measure rather than a direct measure of enrollment reduction.

The scorecard addresses broader eligibility enforcement and program-integrity concerns through other metrics, particularly improper payment rates, work requirement activity,

5 KFF.org, "Tracking Implementation of the 2025 Reconciliation Law: Medicaid Work Requirements," accessed February 25, 2026, https://www.kff.org/medicaid/medicaid-work-requirements-tracker-1115-waivers/

6 KFF's classification of states with early work requirement activity changed after the completion of data collection for this report. The scorecard uses KFF's February 2026 classifications to maintain a consistent evaluation period across all states.

7 KFF.org, "Medicaid Enrollment and Unwinding Tracker," accessed March 1, 2026, https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8

fiscal-growth measures, and MFCU enforcement strength. Collectively, those measures evaluate whether states maintain appropriate controls over program size, spending growth, and improper enrollment while still administering renewals competently and consistently.

## Managed Care Organization Presence

Managed care organization presence is worth 4 points and is scored as a binary variable. States receive 4 points if they have at least one comprehensive Medicaid managed care organization (MCO) in place. States without a comprehensive MCO receive 0 points.

The source for this metric is KFF's Medicaid MCO data, which are based on KFF analysis of CMS managed care enrollment information.[8] This report uses KFF rather than relying directly on the CMS dataset because KFF identified and adjusted for apparent classification discrepancies in the underlying CMS data. The metric includes comprehensive MCOs, not limited-benefit plans, prepaid ambulatory health plans, prepaid inpatient health plans, Programs of All-Inclusive Care for the Elderly, or public managed care arrangements that do not function as comprehensive private MCOs. Oregon's Coordinated Care Organizations are counted as MCOs. Idaho is not credited as an MCO state because, although Idaho's plans for dual-eligible individuals are categorized by CMS as MCOs, KFF does not treat Idaho as an MCO state in its broader Medicaid managed care work because those plans are secondary to Medicare.

This metric is a modest indicator and should not be overstated. MCO presence alone is not a direct measure of competition, quality, or cost control. The report considered using the number of MCOs in each state but rejected that approach because a larger number of MCOs does not necessarily indicate greater competition. In some states, multiple MCOs reflect regional contracting structures rather than meaningful beneficiary choice. Still, the presence of comprehensive MCOs indicates that a state has introduced some degree of private-sector administration, capitated payment, and risk-bearing into its Medicaid program rather than relying exclusively on a fully state-administered fee-for-service model.

## Private-to-Medicaid Coverage Ratio

The private-to-Medicaid coverage ratio is worth 6 points and is scored by quintile, with higher values scoring better. States in the highest quintile receive 6 points, followed by 4, 3, 1, and 0 points for progressively lower quintiles.

This metric is constructed from 2024 American Community Survey state-level data for adults ages 19 to 64.[9] The calculation uses two mutually exclusive coverage categories: individuals with employer-sponsored insurance only and individuals with Medicaid or means-tested public coverage only. The final measure is constructed as the share of combined employer-sponsored and Medicaid coverage accounted for by employer-sponsored insurance.

This metric is intended to capture the relative balance between private coverage and Medicaid dependence. A higher value suggests that, among the relevant coverage categories, a larger share of adults are covered through employer-sponsored insurance rather than Medicaid. This may reflect stronger labor-market attachment, less crowd-out of private coverage, and a more sustainable balance between private insurance and public coverage.

The metric does not assume that all variation is driven exclusively by Medicaid policy itself. Broader economic conditions, labor-market structure, demographic composition, and employer coverage patterns also affect the ratio. Nevertheless, the measure provides a useful directional indicator of the role Medicaid occupies relative to employer-based coverage within a state's broader health coverage system. States with higher private-to-Medicaid coverage ratios are treated as maintaining a more targeted safety-net structure and a less expansive reliance on public coverage among the nonelderly adult population.

8 KFF.org, "Medicaid Managed Care Tracker," accessed March 1, 2026, https://www.kff.org/data-collections/medicaid-managed-care-tracker/

9 U.S. Census Bureau, American Community Survey, "types of Health Insurance Coverage by Age," accessed March 3, 2026, https://data.census.gov/table/ACSDT1Y2024.B27010?q=B27010+2024+ACS+1-year+state

## PILLAR 2
## FISCAL SUSTAINABILITY & BUDGET EXPOSURE

**Fiscal Sustainability and Budget Exposure** is worth 26 points. This pillar evaluates the growth trajectory of Medicaid spending, the growth in per-enrollee costs, and Medicaid's share of state-funded budgets. Together, these metrics assess both the pace at which Medicaid spending is rising and the degree to which Medicaid consumes state fiscal capacity.

### Five-Year Medicaid Spending Growth

Five-year Medicaid spending growth is worth 10 points and is scored by quintile, with lower growth scoring better. States in the lowest-growth quintile receive 10 points, followed by 8, 6, 2, and 0 points for progressively higher-growth quintiles.

The source for this metric is MACPAC MACStats, using total Medicaid spending data from Exhibit 16 for 2019 through 2023.[10] The metric uses a compound annual growth rate calculated from the beginning and ending values over the five-year period. In Excel, this was calculated using the RRI function, based on the number of periods, starting value, and ending value. Spending values are reported in millions.

This metric reflects the broader long-term trajectory of each state's Medicaid program. States with lower spending growth are treated as more fiscally sustainable because they are less likely to crowd out other state priorities or require future tax increases, benefit reductions, or provider-payment constraints. The metric does not by itself explain why spending has grown. Spending growth may reflect enrollment changes, benefit design, provider rates, health care inflation, demographic shifts, or policy choices. For that reason, this measure is paired with per-enrollee cost growth and Medicaid budget share to provide a broader picture of fiscal exposure.

### Per-Enrollee Cost Growth

Per-enrollee cost growth is worth 8 points and is scored by quintile, with lower growth scoring better. States in the lowest-growth quintile receive 8 points, followed by 6, 4, 2, and 0 points for progressively higher-growth quintiles.

The source for this metric is MACPAC MACStats, using spending per full-year-equivalent enrollee from Exhibit 23 for 2019 through 2023.[11] Like the total spending growth metric, per-enrollee cost growth was calculated as a compound annual growth rate using the RRI function in Excel.

This metric measures cost growth independent of enrollment growth. A state may experience rising total Medicaid spending because more people enroll, because the average cost per enrollee rises, or both. Per-enrollee cost growth isolates the second factor. Lower per-enrollee cost growth suggests stronger cost discipline, better pricing dynamics, or a more sustainable program structure. Higher growth suggests that Medicaid is becoming more expensive even after accounting for changes in enrollment.

### Medicaid Share of State Budget

Medicaid share of state budget is worth 8 points and is scored by quintile, with lower shares scoring better. States in the lowest-share quintile receive 8 points, followed by 6, 4, 2, and 0 points for progressively higher-share quintiles.

The source for this metric is MACPAC MACStats, using Exhibit 5.[12] The extracted value is state-funded Medicaid spending as a share of the state-funded budget. This reflects state budget shares from fiscal year 2023, the most recent year from which data were available.

This metric captures Medicaid's burden on state fiscal capacity. Even if a state's Medicaid spending growth is moderate, Medicaid may still consume a large share of the state budget. A larger budget share reduces fiscal flexibility and can crowd out other priorities, including education, transportation, public safety, tax relief, and other state responsibilities. For that reason, this metric complements the spending-growth measures by capturing Medicaid's current budgetary footprint rather than only its trajectory.

10 MACPAC.gov, "MACStats Archive," Exhibit 16, 2019-2023, accessed March 7, 2026, https://www.macpac.gov/publication/macstats-archive/

11 MACPAC.gov, "MACStats Archive," Exhibit 23, 2019-2023, accessed March 7, 2026, https://www.macpac.gov/publication/macstats-archive/

12 MACPAC.gov, "MACStats Archive," Exhibit 5, 2023, accessed March 7, 2026, https://www.macpac.gov/publication/macstats-archive/

## PILLAR 3
## PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT

**Program Integrity and Administrative Oversight** is worth 24 points. This pillar evaluates whether states administer Medicaid with appropriate discipline, minimize improper payments, enforce fraud and abuse laws, and maintain data infrastructure that can support better oversight.

### Improper Payment Rate

Improper payment rate is worth 12 points and is scored by quintile, with lower rates scoring better. States in the lowest-rate quintile receive 12 points, followed by 9, 6, 3, and 0 points for progressively higher-rate quintiles.

The source for this metric is the CMS Payment Error Rate Measurement (PERM) program.[13] Because PERM reviews state Medicaid programs on a rolling three-year cycle, not every state has a new improper payment rate in the same year. This report uses the most recent available improper payment rate for each state, drawn from the 2023–2025 PERM reporting cycle. The values for states reported in 2023, 2024, and 2025 were combined into a single cross-sectional dataset for scoring purposes.

Improper payments do not necessarily indicate fraud in every case. They may include documentation errors, eligibility mistakes, coding issues, or payments made without sufficient verification. Nevertheless, improper payment rates are among the clearest available indicators of waste, error, and weak administrative controls in Medicaid. Because Medicaid is a large public program involving substantial federal and state spending, a high improper payment rate is a serious program-integrity concern even when it does not prove intentional misconduct.

This metric receives one of the highest weights in the scorecard because it directly reflects whether taxpayer dollars are being spent in accordance with program rules. Lower improper payment rates indicate stronger administrative oversight and better payment discipline.

### MFCU Enforcement Strength

MFCU enforcement strength is worth 8 points and is scored by quintile, with higher enforcement strength scoring better. States in the strongest quintile receive 8 points, followed by 6, 4, 2, and 0 points for progressively weaker quintiles.

The source for this metric is the HHS OIG's Annual MFCU report for fiscal year 2024,[14] supplemented by Medicaid enrollment data from data.medicaid.gov.[15] The enforcement measure uses fraud convictions reported in the OIG statistical chart and normalizes those convictions relative to total Medicaid enrollment—per 100,000 enrollees—during the same fiscal-year period. Enrollment data correspond to FY 2024, defined as October 2023 through September 2024.

This normalization is important. Raw conviction totals would systematically favor larger states simply because they have more Medicaid enrollees and more providers. By measuring convictions relative to Medicaid enrollment, the scorecard evaluates enforcement intensity rather than sheer volume. The metric is intended to capture how actively states investigate and prosecute Medicaid fraud and abuse while reducing distortion from state size.

The report uses convictions rather than recoveries as the preferred enforcement indicator because recoveries can be distorted by unusually large one-time settlements or cases. Convictions provide a simpler and more stable indicator of active enforcement. This measure complements the improper payment metric. Improper payment rates capture weakness or error in payment systems,

13 CMS.gov, "PERM Error Rate Findings and Reports," Downloads, Medicaid and CHIP Supplemental Improper Payment Data (2023-2025), accessed March 10, 2026, https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports

14 OIG.HHS.gov, "Medicaid Fraud Control Units Annual Report: Fiscal Year 2024," accessed March 12, 2026, https://oig.hhs.gov/reports/all/2025/medicaid-fraud-control-units-annual-report-fiscal-year-2024/

15 Data.Medicaid.gov, "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," FY 2024, accessed March 12, 2026, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360

while MFCU enforcement strength captures the relative intensity with which states investigate and prosecute Medicaid fraud and abuse after potential misconduct is identified.

## APCD Status

APCD status is worth 4 points and is scored as an ordinal variable. States with an existing APCD receive 4 points. States with voluntary APCD activity or strong interest receive 2 points. States with no APCD activity receive 0 points.

The source for this metric is the APCD Council. APCD status was extracted from the Council's state map and converted into ordinal scoring categories.[16]

This metric is included as a modest indicator of transparency and analytic capacity. An APCD does not, by itself, guarantee better Medicaid performance or stronger program integrity. However, claims databases can support better oversight, price transparency, policy analysis, and data-driven decision-making. They can also help policymakers and researchers better understand cost trends, utilization patterns, and market dynamics. Because the effect is indirect, APCD status receives a limited weight compared with core integrity measures such as improper payment rates and MFCU enforcement.

### PILLAR 4
### MARKET STRUCTURE & PROVIDER ENVIRONMENT

**Market Structure and Provider Environment** is worth 14 points. This pillar evaluates whether the broader health policy environment in each state is likely to support provider availability, competition, and care access. These measures are not Medicaid-specific in the narrowest sense, but they affect the environment in which Medicaid beneficiaries actually seek care. A state can provide Medicaid coverage on paper while maintaining regulatory barriers that restrict supply, reduce provider flexibility, or limit access to care.

## Certificate-of-Need Laws

Certificate-of-need (CON) laws are worth 4 points and are scored as a binary variable. States without CON laws receive 4 points. States with CON laws in place receive 0 points.

The source for this metric is the Cicero Institute's certificate-of-need dataset.[17] The scorecard uses the dataset's state classifications and legislative history to construct a binary measure of whether certificate-of-need requirements remain in effect within a state.

CON laws restrict the ability of health care providers to build or expand facilities, add services, or invest in certain equipment without government approval. These restrictions are often justified as tools for cost control or planning, but they can also limit supply, protect incumbent providers, and reduce competition. States without CON restrictions score more favorably because a less restrictive market is generally more conducive to provider availability, innovation, and patient access.

The report recognizes that CON regimes vary substantially in scope and intensity across states. Some states maintain broader and more restrictive systems than others. However, the scorecard uses a binary approach to preserve transparency, comparability, and methodological simplicity across all 50 states.

16 APCDCouncil.org, "State Efforts Map," accessed March 15, 2026, https://www.apcdcouncil.org/state/map

17 CiceroInstitute.org, "Comprehensive Certificate of Need (CON) Laws Dataset," accessed March 15, 2026, https://ciceroinstitute.org/blog/comprehensive-certificate-of-need-con-laws-dataset/

## Primary Care Provider Supply

Primary care provider supply is worth 4 points and is scored by quintile, with higher supply scoring better. States in the highest-supply quintile receive 4 points, followed by 3, 2, 1, and 0 points for progressively lower-supply quintiles.

The source for this metric is America's Health Rankings.[18] The extracted value is primary care providers per 100,000 population.

Provider supply is a core determinant of access. Medicaid coverage is less meaningful if beneficiaries cannot find providers who are available, geographically accessible, or able to accept new patients. Although provider supply is affected by many factors beyond Medicaid policy alone, it remains an important feature of the health care environment in which Medicaid operates. Higher provider supply suggests a stronger access environment and greater system capacity.

The scorecard uses overall primary care provider supply rather than attempting to measure only providers who accept Medicaid patients. While Medicaid participation rates are important, comparable 50-state data on active Medicaid acceptance are less standardized and may not consistently reflect actual provider availability or appointment access. Overall provider supply was selected as a more stable and comparable proxy for whether a state's health care system has sufficient baseline capacity to support patient access, including for Medicaid beneficiaries.

## Nurse Practitioner Scope of Practice

Nurse practitioner scope of practice is worth 2 points and is scored as an ordinal variable. States with independent practice receive 2 points. States with reduced independent practice receive 1 point. States requiring supervision receive 0 points.

Classifications are based on AANP practice-environment categories, with terminology slightly adapted for clarity.[19] Broader scope-of-practice authority allows nurse practitioners to practice more fully according to their training and can increase provider availability, particularly in primary care and other general access settings, especially in rural or underserved areas.

This metric receives modest weight because scope-of-practice reform is not a Medicaid policy in the narrow sense. However, it affects the provider environment in which Medicaid beneficiaries seek care. States that allow nurse practitioners to practice with fewer unnecessary restrictions may improve access, expand system capacity, and reduce bottlenecks in primary care and routine outpatient services.

## Physician Assistant Scope of Practice

Physician assistant scope of practice is worth 2 points and is scored as an ordinal variable. States classified as optimal receive 2 points. States classified as advanced or moderate receive 1 point. States classified as reduced receive 0 points.

The source for this metric is the AAPA Scope of Practice Map.[20] The state classifications were converted into ordinal scoring categories.

As with nurse practitioner scope of practice, physician assistant practice authority affects provider flexibility and system capacity, particularly in primary care and other general access settings. Broader PA authority allows clinicians to operate more fully at the top of their training and can improve access in underserved or provider-shortage areas.

This metric receives a limited weight because it is an indirect Medicaid access measure rather than a direct measure of Medicaid program performance. Nevertheless, it remains relevant to whether a state's broader health care labor market supports timely and efficient access to care.

18 AmericasHealthRankings.org, "Primary Care Providers in United States," September 2025, accessed March 17, 2026, https://www.americashealthrankings.org/explore/measures/PCP_NPPES

19 AANP.org, "State Practice Environment," accessed March 20, 2026, https://www.aanp.org/advocacy/state/state-practice-environment

20 AAPA.org, "PA State Practice Environment," accessed March 20, 2026, https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment/

## IMLC Participation

IMLC participation is worth 2 points and is scored as an ordinal variable. States that are IMLC members receive 2 points. States with compact legislation introduced or passed but not yet fully active receive 1 point. States with no activity receive 0 points.

The source for this metric is the Interstate Medical Licensure Compact Commission's official participating-state list.[21] State status was converted into ordinal scoring categories.

IMLC participation facilitates cross-state physician licensure and can support telehealth expansion, provider mobility, and access to specialized care. Its direct Medicaid impact is limited, which is why the metric receives only 2 points. Still, compact participation reflects whether a state has removed one barrier to physician availability and cross-state care delivery.

*Summary Table*

| PILLAR | METRIC | DATA SOURCE | DIRECTION | MAX POINTS |
|---|---|---|---|---|
| Program Design and Enrollment | Medicaid Expansion Status | KFF | No expansion = better | 12 |
| Program Design and Enrollment | Work Requirement Activity | KFF | Early activity = better | 8 |
| Program Design and Enrollment | Redetermination Performance | KFF | Lower procedural disenrollment = better | 6 |
| Program Design and Enrollment | MCO Presence | KFF / CMS | Comprehensive MCO presence = better | 4 |
| Program Design and Enrollment | Private-to-Medicaid Coverage Ratio | ACS | Higher private-to-Medicaid ratio = better | 6 |
| Fiscal Sustainability and Budget Exposure | Five-Year Medicaid Spending Growth | MACPAC | Lower growth = better | 10 |
| Fiscal Sustainability and Budget Exposure | Per-Enrollee Cost Growth | MACPAC | Lower growth = better | 8 |
| Fiscal Sustainability and Budget Exposure | Medicaid Share of State Budget | MACPAC | Lower share = better | 8 |
| Program Integrity and Administrative Oversight | Improper Payment Rate | CMS | Lower improper payment rate = better | 12 |
| Program Integrity and Administrative Oversight | MFCU Enforcement Strength | HHS OIG / data.medicaid.gov | Higher convictions per enrollee = better | 8 |
| Program Integrity and Administrative Oversight | APCD Status | APCD Council | Existing APCD = better | 4 |
| Market Structure and Provider Environment | CON Laws | Cicero Institute | No CON laws = better | 4 |
| Market Structure and Provider Environment | Primary Care Provider Supply | America's Health Rankings | Higher supply = better | 4 |
| Market Structure and Provider Environment | NP Scope of Practice | AANP | Greater practice authority = better | 2 |
| Market Structure and Provider Environment | PA Scope of Practice | AAPA | Greater practice authority = better | 2 |
| Market Structure and Provider Environment | IMLC Participation | IMLC Commission | Active participation = better | 2 |

*Note: Detailed metric definitions, scoring explanations, and source methodology are discussed in the preceding sections above.*

21 IMLCC.com, "Participating States," accessed March 20, 2026, https://imlcc.com/participating-states/

## Total Score Calculation and Ranking

Each state's total score is calculated by summing its points across all 16 metrics. No additional scaling or post hoc adjustment was applied after the metric-level scores were assigned. Final rankings therefore reflect the straightforward aggregation of weighted metric results.

This approach was chosen to maximize transparency. Readers can see not only each state's final score and rank, but also how the state performed on each underlying metric and within each pillar. The report is intended to be replicable: the state-by-state tables in this report show every metric's underlying value, quintile placement, and point total, and the full Excel dataset used to construct the scorecard is available upon request.

**EACH STATE'S TOTAL SCORE IS CALCULATED BY SUMMING ITS POINTS ACROSS ALL 16 METRICS. NO ADDITIONAL SCALING OR POST HOC ADJUSTMENT WAS APPLIED AFTER THE METRIC-LEVEL SCORES WERE ASSIGNED. FINAL RANKINGS THEREFORE REFLECT THE STRAIGHTFORWARD AGGREGATION OF WEIGHTED METRIC RESULTS.**

## Limitations

Like any scorecard, this report has limitations. First, some state Medicaid outcomes are difficult to capture with perfectly comparable national measures. In several areas, especially administrative performance and provider-market conditions, the scorecard necessarily relies on proxies rather than direct measures of causal impact.

Second, some metrics reflect a mixture of policy choice and implementation quality rather than one or the other alone. For example, redetermination performance reflects administrative capacity, state policy choices, and the unusual circumstances of the Medicaid unwinding period. MCO presence indicates whether a state uses private managed care organizations, but it does not directly measure plan competition, beneficiary experience, or care quality. Similarly, provider-scope and licensure metrics measure structural access conditions rather than Medicaid-specific outcomes.

Third, public data are released on different timetables. The scorecard necessarily synthesizes information that may not all refer to the same exact year. In some cases, such as improper payment rates, the underlying federal reporting structure requires use of the most recent available values across a rolling multi-year cycle. In other cases, such as spending growth, the metric intentionally spans several years to capture trend rather than a single-year snapshot.

Fourth, some variables that would be valuable in principle were not included because consistent 50-state data were unavailable or because the resulting metric would have required excessive methodological subjectivity. The report therefore prioritizes transparency, directional usefulness, and comparative consistency over exhaustive comprehensiveness.

Fifth, as with any categorical scoring framework, quintile-based scoring may compress some underlying numeric differences while accentuating differences near category boundaries.

These limitations do not render the scorecard arbitrary. They simply underscore that the report should be read as a structured comparative framework rather than as a definitive measure of every relevant feature of state Medicaid policy. Its value lies in making interstate differences more visible, more systematic, and more open to scrutiny.

# STATE SNAPSHOTS

The following section provides a 50-state comparative overview based on the methodology described above. Each state profile includes an overall ranking and composite score, followed by a concise summary identifying major strengths and weaknesses across the four scoring pillars: Program Design & Enrollment, Fiscal Sustainability & Budget Exposure, Program Integrity & Administrative Oversight, and Market Structure & Provider Environment.

The purpose of these snapshots is not to provide a definitive judgment on any individual state's Medicaid program. Some states clearly face more significant fiscal, administrative, or structural challenges than others, but even the highest-performing states in this report still exhibit meaningful weaknesses or tradeoffs within particular categories. Likewise, lower-ranked states often perform relatively well in at least a few areas despite broader structural problems.

Importantly, the rankings in this report are comparative rather than absolute. No state received a near-perfect score under the methodology, and even the top-ranked states scored only in 60- and 70-point ranges out of 100 possible points. The scorecard is therefore best understood as a tool for comparing relative performance across states rather than as a certification of overall program quality or effectiveness.

Because the scorecard relies on weighted point allocations and quintile-based scoring, several states received identical overall scores. In such cases, states are still presented in sequential rank order for organizational clarity, though tied states should be understood as effectively equivalent within the scoring framework.

**THE FOLLOWING SECTION PROVIDES A 50-STATE COMPARATIVE OVERVIEW BASED ON THE METHODOLOGY DESCRIBED ABOVE. EACH STATE PROFILE INCLUDES AN OVERALL RANKING AND COMPOSITE SCORE, FOLLOWED BY A CONCISE SUMMARY IDENTIFYING MAJOR STRENGTHS AND WEAKNESSES ACROSS THE FOUR SCORING PILLARS.**

Readers should also note that relatively small differences in composite scores do not necessarily imply large real-world performance differences. The rankings are intended to highlight broad differences in fiscal trajectory, administrative performance, program structure, and provider-market conditions rather than provide a precise measurement of overall Medicaid quality.

Taken together, the profiles illustrate the substantial variation in how states structure, finance, and administer their Medicaid programs. They also demonstrate that strong performance in one category does not necessarily correspond to strong performance in others, reinforcing the importance of evaluating Medicaid programs across multiple dimensions rather than through any single metric alone.

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Alabama

| RANK | SCORE |
|---|---|
| 14th | 53/100 |

Alabama ranks in the upper tier overall, driven primarily by its decision not to expand Medicaid, relatively restrained fiscal growth, and strong performance limiting improper payments. The state also performs well in maintaining private coverage relative to Medicaid enrollment and limiting Medicaid's share of the state budget. However, Alabama's overall performance is constrained by weak redetermination outcomes, no early work requirement activity, and a restrictive provider environment marked by active CON laws and reduced NP/PA scope of practice.

## STRENGTHS

- No Medicaid expansion
- Strong private-to-Medicaid coverage ratio
- Restrained Medicaid spending and per-enrollee cost growth
- Low improper payment rate

## WEAKNESSES

- Weak redetermination performance
- No early work requirement activity or MCO presence
- No APCD activity and low MFCU enforcement activity
- Restrictive provider environment, including active CON laws and reduced NP/PA scope of practice

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **18/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 87.1% (Q5) | 0 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 89.1% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **20/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.9% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.7% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 8.7% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **12/24** |
| **Improper Payment Rate** (Lower = Better) | 0.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.00 (Q1) | 0 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **3/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 250.1 (Q1) | 0 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Alaska

| RANK | SCORE |
|---|---|
| 24th | 46/100 |

Alaska's performance is driven by strong fiscal sustainability indicators, including low Medicaid spending growth, low Medicaid budget exposure, and restrained per-enrollee cost growth. The state also benefits from a comparatively strong provider environment, including high primary care provider supply and independent NP practice authority. However, Alaska's overall performance is held back by Medicaid expansion, no early work requirement activity or MCO presence, weak private coverage retention, and poor performance limiting improper payments.

## STRENGTHS

- Restrained Medicaid spending and per-enrollee cost growth
- Low Medicaid share of the state budget
- Strong provider environment, including high PCP supply and independent NP practice
- Strong MFCU enforcement activity relative to peers

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity or MCO presence
- Weak private-to-Medicaid coverage ratio
- High improper payment rate

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **6/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 50.5% (Q1) | 6 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 78.9% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **24/26** |
| **5-Year Spending Growth** (Lower = Better) | 0.4% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.4% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 7.8% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **8/24** |
| **Improper Payment Rate** (Lower = Better) | 9.7% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.28 (Q4) | 6 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 369.9 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Introduced | 1 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Arizona

| RANK | SCORE |
|---|---|
| 26th | 44/100 |

Arizona performs well on several program design and provider flexibility indicators, including early work requirement activity, MCO presence, and independent NP practice authority. The state also maintains a relatively low Medicaid share of the state budget and demonstrates strong MFCU enforcement activity relative to peers. However, Arizona's overall performance is constrained by Medicaid expansion, rapid spending and per-enrollee cost growth, and weak administrative oversight indicators.

## STRENGTHS

- Early work requirement activity and MCO presence
- Low Medicaid share of the state budget
- Strong MFCU enforcement activity relative to peers
- Independent NP practice and advanced PA practice authority

## WEAKNESSES

- Medicaid expansion
- High Medicaid spending and per-enrollee cost growth
- No APCD activity
- Weak provider supply despite the absence of CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **17/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 68.8% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.3% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **8/26** |
| **5-Year Spending Growth** (Lower = Better) | 8.6% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 6.6% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 5.7% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **9/24** |
| **Improper Payment Rate** (Lower = Better) | 6.4% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.74 (Q4) | 6 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 268.2 (Q2) | 1 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Member State | 2 |

# Arkansas

| RANK | SCORE |
|---|---|
| 6th | 60/100 |

Arkansas ranks near the top overall due to strong fiscal sustainability metrics, low improper payment rates, and robust administrative oversight indicators. The state also performs well on early work requirement activity and MCO presence. However, Arkansas's overall score is constrained by Medicaid expansion, weak private coverage retention, poor provider supply, and weak redetermination outcomes.

## STRENGTHS

- Early work requirement activity and MCO presence
- Restrained Medicaid spending growth and low Medicaid budget exposure
- Low improper payment rate and strong MFCU enforcement activity
- Existing APCD infrastructure

## WEAKNESSES

- Medicaid expansion
- Weak private-to-Medicaid coverage ratio
- Weak redetermination performance
- Low primary care provider supply and reduced NP independence

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **13/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 76.0% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 79.5% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **22/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.2% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.1% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 7.1% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **22/24** |
| **Improper Payment Rate** (Lower = Better) | 0.6% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.26 (Q4) | 6 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **3/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 251.1 (Q1) | 0 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Passed | 1 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# California

| RANK | SCORE |
|---|---|
| 50th | 22/100 |

California ranks last overall due to weak performance across nearly every major scoring category, including Medicaid expansion, rapid spending growth, high per-enrollee cost growth, weak private coverage retention, and high improper payment rates. The state also performs poorly on early work requirement activity, provider flexibility, and interstate licensure participation. California's strongest areas are APCD activity, MCO presence, and the absence of CON laws.

## STRENGTHS

- MCO presence
- Existing APCD infrastructure
- No active CON laws
- Relatively low Medicaid share of the state budget

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- High spending and per-enrollee cost growth
- Weak provider flexibility and low primary care provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 74.9% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 73.1% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.9% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.9% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 12.8% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **6/24** |
| **Improper Payment Rate** (Lower = Better) | 8.1% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.32 (Q2) | 2 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 238.7 (Q1) | 0 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | No Activity | 0 |

# Colorado

| RANK | SCORE |
|---|---|
| 39th | 36/100 |

Colorado performs relatively well on provider flexibility and interstate licensure participation, with strong scores for independent NP practice, advanced PA practice authority, and the absence of CON laws. The state also maintains moderate redetermination performance and strong APCD activity. However, Colorado's overall performance is constrained by Medicaid expansion, high Medicaid budget exposure, no early work requirement activity, and weak performance limiting improper payments.

## STRENGTHS

- No active CON laws
- Independent NP practice and advanced PA practice authority
- Existing APCD infrastructure
- Strong private-to-Medicaid coverage ratio relative to peers

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- High Medicaid share of the state budget
- Weak MFCU enforcement activity and elevated improper payment rate

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **12/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 65.4% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 86.2% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 5.8% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.1% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 20.3% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **7/24** |
| **Improper Payment Rate** (Lower = Better) | 5.4% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.09 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **11/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 305.2 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# Connecticut

| RANK | SCORE |
|---|---|
| 30th | 41/100 |

Connecticut's performance is supported by relatively restrained Medicaid spending growth, low per-enrollee cost growth, existing APCD infrastructure, and strong MFCU enforcement activity relative to peers. The state also benefits from a relatively strong provider supply and broad NP/PA practice authority. However, Connecticut's overall score is constrained by Medicaid expansion, no early work requirement activity or MCO presence, a weak private-to-Medicaid coverage ratio, and elevated Medicaid budget exposure.

## STRENGTHS

- Restrained Medicaid spending and per-enrollee cost growth
- Existing APCD infrastructure and strong MFCU enforcement activity
- Relatively strong primary care provider supply
- Independent NP practice and advanced PA practice authority

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity or MCO presence
- Weak private-to-Medicaid coverage ratio
- Active CON laws and elevated Medicaid share of the state budget

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **4/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 71.8% (Q3) | 3 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 80.8% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.1% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.7% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 14.7% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **13/24** |
| **Improper Payment Rate** (Lower = Better) | 5.6% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.49 (Q4) | 6 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 332.1 (Q4) | 3 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Delaware

| RANK | SCORE |
|---|---|
| 34th | 40/100 |

Delaware's performance is supported by strong redetermination outcomes, low Medicaid budget exposure, existing APCD infrastructure, and strong MFCU enforcement activity relative to peers. The state also benefits from high primary care provider supply and broad NP/PA practice authority. However, Delaware's overall score is constrained by Medicaid expansion, no early work requirement activity, weak private coverage retention, elevated improper payments, and active CON laws.

## STRENGTHS

- Strong redetermination performance
- Low Medicaid share of the state budget
- Existing APCD infrastructure and strong MFCU enforcement activity
- High primary care provider supply and broad provider practice authority

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak private-to-Medicaid coverage ratio
- Elevated improper payment rate and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **11/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 59.3% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.4% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **10/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.6% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.1% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 8.3% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **10/24** |
| **Improper Payment Rate** (Lower = Better) | 6.9% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.54 (Q4) | 6 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **9/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 352.6 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# Florida

| RANK | SCORE |
|---|---|
| 18th | 49/100 |

Florida ranks in the upper half overall, driven primarily by its decision not to expand Medicaid, relatively strong program design indicators, and low per-enrollee cost growth. The state also performs well on MCO presence, private coverage retention, existing APCD infrastructure, and MFCU enforcement activity relative to peers. However, Florida's overall performance is constrained by high Medicaid budget exposure, elevated improper payments, no early work requirement activity, and a restrictive provider environment.

## STRENGTHS

- No Medicaid expansion
- MCO presence and strong private-to-Medicaid coverage ratio
- Low per-enrollee cost growth
- Existing APCD infrastructure and strong MFCU enforcement activity

## WEAKNESSES

- No early work requirement activity
- High Medicaid share of the state budget
- Elevated improper payment rate
- Restrictive provider environment, including active CON laws and supervision requirements

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **24/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 64.5% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 88.0% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **10/26** |
| **5-Year Spending Growth** (Lower = Better) | 5.4% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -1.0% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 20.1% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **10/24** |
| **Improper Payment Rate** (Lower = Better) | 7.0% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.25 (Q4) | 6 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 318.3 (Q4) | 3 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# Georgia

| RANK | SCORE |
|---|---|
| 12th | 54/100 |

Georgia ranks in the upper tier overall, driven primarily by its decision not to expand Medicaid, early work requirement activity, MCO presence, and strong private coverage retention. The state also performs well limiting improper payments and has existing APCD infrastructure. However, Georgia's overall performance is constrained by rapid Medicaid spending and per-enrollee cost growth, weak MFCU enforcement activity, and a restrictive provider environment marked by active CON laws, low primary care provider supply, and reduced NP/PA scope of practice.

## STRENGTHS

- No Medicaid expansion
- Early work requirement activity and MCO presence
- Strong private-to-Medicaid coverage ratio
- Low improper payment rate and existing APCD infrastructure

## WEAKNESSES

- High Medicaid spending and per-enrollee cost growth
- Weak MFCU enforcement activity
- Active CON laws and low primary care provider supply
- Reduced NP and PA scope of practice

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **33/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 74.0% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 90.5% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 6.8% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.2% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 9.3% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **13/24** |
| **Improper Payment Rate** (Lower = Better) | 1.8% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.17 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **2/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 267.2 (Q1) | 0 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# Hawaii

| RANK | SCORE |
|---|---|
| 19th | 49/100 |

Hawaii ranks in the upper half overall due to very strong fiscal sustainability indicators, including low Medicaid spending growth, declining per-enrollee costs, and low Medicaid budget exposure. The state also benefits from MCO presence, low improper payments, existing APCD infrastructure, and independent NP practice authority. However, Hawaii's overall performance is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, and limited provider environment scores outside of NP scope and IMLC participation.

## STRENGTHS

- Strong fiscal sustainability indicators across all three metrics
- MCO presence
- Low improper payment rate and existing APCD infrastructure
- Independent NP practice and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- Limited provider environment scores outside of NP scope and IMLC participation

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 79.9% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.9% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **26/26** |
| **5-Year Spending Growth** (Lower = Better) | 0.8% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -2.1% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 6.4% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **13/24** |
| **Improper Payment Rate** (Lower = Better) | 1.4% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.00 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 283.2 (Q2) | 1 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Idaho

| RANK | SCORE |
|---|---|
| 45th | 31/100 |

Idaho ranks near the bottom overall despite several strengths in fiscal sustainability and provider flexibility. The state benefits from relatively restrained Medicaid spending growth, no active CON laws, independent NP practice authority, advanced PA practice authority, and IMLC participation. However, Idaho's overall score is constrained by Medicaid expansion, no early work requirement activity or MCO presence, weak redetermination performance, and limited program integrity and administrative oversight scores.

## STRENGTHS

- Relatively restrained Medicaid spending growth
- No active CON laws
- Independent NP practice and advanced PA practice authority
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity or MCO presence
- Weak redetermination performance
- No APCD activity and elevated improper payment rate

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 74.4% (Q4) | 1 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 86.5% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **10/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.5% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.6% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 16.3% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **7/24** |
| **Improper Payment Rate** (Lower = Better) | 6.1% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.98 (Q3) | 4 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **9/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 265.6 (Q1) | 0 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Illinois

| RANK | SCORE |
|---|---|
| 31st | 41/100 |

Illinois performs well on program integrity and administrative oversight, driven by a low improper payment rate and meaningful MFCU enforcement activity. The state also benefits from MCO presence, moderate private coverage retention, and IMLC participation. However, Illinois's overall score is constrained by Medicaid expansion, no early work requirement activity, rapid Medicaid spending and per-enrollee cost growth, no APCD activity, and a restrictive provider environment.

## STRENGTHS

- MCO presence
- Low improper payment rate and meaningful MFCU enforcement activity
- Moderate private-to-Medicaid coverage ratio
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- High Medicaid spending and per-enrollee cost growth
- No APCD activity and restrictive provider environment

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **11/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 63.5% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.3% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **8/26** |
| **5-Year Spending Growth** (Lower = Better) | 10.3% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 8.0% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 5.9% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **16/24** |
| **Improper Payment Rate** (Lower = Better) | 1.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.20 (Q3) | 4 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 299.4 (Q3) | 2 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Indiana

| RANK | SCORE |
|---|---|
| 32nd | 41/100 |

Indiana performs well on several fiscal sustainability and administrative oversight indicators, including restrained per-enrollee cost growth, strong MFCU enforcement activity, and existing APCD infrastructure. The state also benefits from MCO presence and IMLC participation. However, Indiana's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, a high improper payment rate and restrictive provider environment indicators.

## STRENGTHS

- MCO presence
- Restrained per-enrollee cost growth
- Strong MFCU enforcement activity and existing APCD infrastructure
- IMLC participation

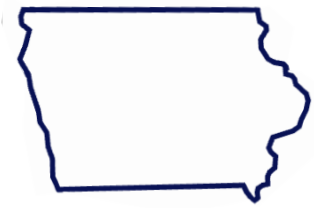
## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- High improper payment rate
- Restrictive provider environment, including active CON laws and reduced practice authority

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **8/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 77.2% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.9% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.4% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -2.8% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 14.6% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **12/24** |
| **Improper Payment Rate** (Lower = Better) | 7.6% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.72 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 285.5 (Q2) | 1 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Iowa



| RANK | SCORE |
|---|---|
| 7th | 59/100 |

Iowa ranks near the top overall due to strong performance on program design, administrative oversight, and provider environment indicators. The state benefits from early work requirement activity, MCO presence, relatively strong private coverage retention, low improper payment rates, meaningful MFCU enforcement activity, and broad provider practice authority. However, Iowa's overall score is constrained by Medicaid expansion, elevated Medicaid budget exposure, and active CON laws.

## STRENGTHS

- Early work requirement activity and MCO presence
- Low improper payment rate and meaningful MFCU enforcement activity
- Strong provider flexibility and IMLC participation
- Relatively strong private-to-Medicaid coverage ratio

## WEAKNESSES

- Medicaid expansion
- Active CON laws
- Elevated Medicaid share of the state budget
- Only strong-interest APCD status rather than existing APCD infrastructure

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **19/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 72.1% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 85.3% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.4% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.4% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 13.5% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **17/24** |
| **Improper Payment Rate** (Lower = Better) | 1.9% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.62 (Q4) | 6 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **7/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 283.3 (Q2) | 1 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# Kansas

| RANK | SCORE |
|---|---|
| 1st | 74/100 |

Kansas ranks first overall due to strong performance across nearly every major scoring category, including its decision not to expand Medicaid, strong redetermination performance, MCO presence, strong private coverage retention, low improper payments, and existing APCD infrastructure. The state also benefits from no active CON laws, independent NP practice authority, and IMLC participation. Kansas's main weaknesses are no early work requirement activity and high per-enrollee cost growth.

## STRENGTHS

- No Medicaid expansion
- Strong redetermination performance, MCO presence, and private-to-Medicaid coverage ratio
- Low improper payment rate and strong MFCU enforcement activity
- No active CON laws and independent NP practice authority

## WEAKNESSES

- No early work requirement activity
- High per-enrollee cost growth
- Reduced PA scope of practice
- Moderate primary care provider supply relative to top-performing states

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **28/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 54.5% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 93.1% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **12/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.4% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.4% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 9.7% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **24/24** |
| **Improper Payment Rate** (Lower = Better) | 0.1% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 4.10 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 308.6 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# Kentucky

| RANK | SCORE |
|---|---|
| 41st | 34/100 |

Kentucky performs relatively well on redetermination performance, MCO presence, and Medicaid budget exposure. The state also benefits from meaningful MFCU enforcement activity and IMLC participation. However, Kentucky's overall score is constrained by Medicaid expansion, no early work requirement activity, weak private coverage retention, rapid Medicaid spending and per-enrollee cost growth, and a restrictive provider environment.

## STRENGTHS

- Strong redetermination performance and MCO presence
- Relatively low Medicaid share of the state budget
- Meaningful MFCU enforcement activity
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak private-to-Medicaid coverage ratio
- High Medicaid spending and per-enrollee cost growth

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **10/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 55.7% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 76.2% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 7.4% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 7.0% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 10.4% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **12/24** |
| **Improper Payment Rate** (Lower = Better) | 2.9% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.04 (Q3) | 4 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 326.1 (Q4) | 3 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# Louisiana

| RANK | SCORE |
|---|---|
| 28th | 43/100 |

Louisiana's performance is supported by strong fiscal growth scores, MCO presence, low improper payments, meaningful MFCU enforcement activity, and some APCD activity. The state also benefits from IMLC participation. However, Louisiana's overall score is constrained by Medicaid expansion, no early work requirement activity, weak private coverage retention, elevated Medicaid budget exposure, and limited provider environment scores.

## STRENGTHS

- MCO presence
- Low improper payment rate and meaningful MFCU enforcement activity
- Restrained Medicaid spending growth
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak private-to-Medicaid coverage ratio
- Elevated Medicaid share of the state budget and limited provider environment scores

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **7/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 71.4% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 72.4% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 0.9% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.8% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 15.9% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **17/24** |
| **Improper Payment Rate** (Lower = Better) | 1.9% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.48 (Q4) | 6 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 274.6 (Q2) | 1 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Maine

| RANK | SCORE |
|---|---|
| 25th | 46/100 |

Maine performs well on redetermination performance, per-enrollee cost growth, existing APCD infrastructure, and provider environment indicators. The state also benefits from high primary care provider supply, independent NP practice authority, advanced PA practice authority, and IMLC participation. However, Maine's overall score is constrained by Medicaid expansion, no early work requirement activity or MCO presence, weak private coverage retention, elevated Medicaid budget exposure, and only modest MFCU enforcement activity.

## STRENGTHS

- Strong redetermination performance
- Restrained per-enrollee cost growth
- Existing APCD infrastructure
- Strong provider environment, including high provider supply and broad practice authority

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity or MCO presence
- Weak private-to-Medicaid coverage ratio
- Elevated Medicaid share of the state budget

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **9/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 37.8% (Q1) | 6 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 84.0% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.9% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -1.9% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 14.9% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **12/24** |
| **Improper Payment Rate** (Lower = Better) | 2.4% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.29 (Q2) | 2 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **9/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 386.1 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Maryland

| RANK | SCORE |
|---|---|
| 43rd | 32/100 |

Maryland performs relatively well on MCO presence, moderate redetermination performance, private coverage retention, existing APCD infrastructure, and provider flexibility. The state also benefits from IMLC participation. However, Maryland's overall score is constrained by Medicaid expansion, no early work requirement activity, rapid Medicaid spending growth, weak MFCU enforcement activity, and active CON laws.

## STRENGTHS

- MCO presence
- Moderate redetermination performance and private-to-Medicaid coverage ratio
- Existing APCD infrastructure
- Independent NP practice and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- High Medicaid spending growth
- Weak MFCU enforcement activity and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **10/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 71.8% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.2% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 7.2% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.6% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 12.3% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **9/24** |
| **Improper Payment Rate** (Lower = Better) | 4.5% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.35 (Q2) | 2 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **7/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 312.3 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# Massachusetts

| RANK | SCORE |
|---|---|
| 40th | 35/100 |

Massachusetts performs relatively well on MCO presence, moderate redetermination performance, private coverage retention, existing APCD infrastructure, and provider supply. The state also benefits from independent NP practice authority and advanced PA practice authority. However, Massachusetts's overall score is constrained by Medicaid expansion, no early work requirement activity, elevated Medicaid budget exposure, weak improper payment performance, and limited MFCU enforcement activity.

## STRENGTHS

- MCO presence
- Moderate redetermination performance and private-to-Medicaid coverage ratio
- Existing APCD infrastructure
- Strong primary care provider supply and broad provider practice authority

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Elevated Medicaid share of the state budget
- High improper payment rate and limited MFCU enforcement activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **9/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 67.5% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 80.4% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **12/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.0% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.6% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 20.9% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **6/24** |
| **Improper Payment Rate** (Lower = Better) | 7.1% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.71 (Q2) | 2 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 400.2 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Introduced | 1 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Michigan

| RANK | SCORE |
|---|---|
| 38th | 38/100 |

Michigan performs well on fiscal sustainability indicators, including restrained Medicaid spending growth, declining per-enrollee costs, and moderate Medicaid budget exposure. The state also benefits from MCO presence, moderate improper payment performance, and IMLC participation. However, Michigan's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, weak private coverage retention, no APCD activity, and a restrictive provider environment.

## STRENGTHS

- Restrained Medicaid spending growth and declining per-enrollee costs
- MCO presence
- Moderate Medicaid share of the state budget
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance and private-to-Medicaid coverage ratio
- No APCD activity and restrictive provider environment

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **4/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 80.8% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 80.0% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **20/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.2% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.3% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 12.9% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **8/24** |
| **Improper Payment Rate** (Lower = Better) | 3.3% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.33 (Q2) | 2 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 332.8 (Q4) | 3 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# Minnesota

| RANK | SCORE |
|---|---|
| 29th | 42/100 |

Minnesota performs strongly on program integrity and administrative oversight, driven by low improper payments, strong MFCU enforcement activity, and existing APCD infrastructure. The state also benefits from strong primary care provider supply, independent NP practice authority, advanced PA practice authority, and IMLC participation. However, Minnesota's overall score is constrained by Medicaid expansion, no early work requirement activity, elevated Medicaid spending and per-enrollee cost growth, and high Medicaid budget exposure.

## STRENGTHS

- Low improper payment rate and strong MFCU enforcement activity
- Existing APCD infrastructure
- Strong primary care provider supply
- Independent NP practice and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Elevated Medicaid spending and per-enrollee cost growth
- High Medicaid share of the state budget

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **8/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 79.0% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.5% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **4/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.7% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.3% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 19.0% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **21/24** |
| **Improper Payment Rate** (Lower = Better) | 2.2% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.89 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **9/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 349.0 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# Mississippi

| RANK | SCORE |
|---|---|
| 8th | 59/100 |

Mississippi ranks in the top tier overall, driven primarily by its decision not to expand Medicaid and very strong fiscal sustainability indicators. The state also benefits from MCO presence, moderate redetermination performance, and IMLC participation. However, Mississippi's overall score is constrained by no early work requirement activity, no APCD activity, active CON laws, limited provider flexibility, and modest program integrity scores.

## STRENGTHS

- No Medicaid expansion
- Strong fiscal sustainability indicators across all three metrics
- MCO presence and moderate private-to-Medicaid coverage ratio
- IMLC participation

## WEAKNESSES

- No early work requirement activity
- No APCD activity
- Active CON laws and limited provider flexibility
- Modest improper payment and MFCU enforcement scores

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **22/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 73.5% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.7% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **26/26** |
| **5-Year Spending Growth** (Lower = Better) | -3.4% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -2.0% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 6.7% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **7/24** |
| **Improper Payment Rate** (Lower = Better) | 4.7% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.86 (Q3) | 4 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **4/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 286.5 (Q2) | 1 |
| **NP Scope of Practice** | Reduced Indep Practice | 1 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Missouri

| RANK | SCORE |
|---|---|
| 15th | 53/100 |

Missouri ranks in the upper tier overall due to strong fiscal growth indicators and strong program integrity performance. The state benefits from declining Medicaid spending and per-enrollee costs, low improper payments, strong MFCU enforcement activity, and some APCD activity. However, Missouri's overall score is constrained by Medicaid expansion, weak redetermination performance, high Medicaid budget exposure, active CON laws, and restrictive provider practice rules.

## STRENGTHS

- Declining Medicaid spending and per-enrollee costs
- Low improper payment rate and strong MFCU enforcement activity
- MCO presence and strong private-to-Medicaid coverage ratio
- Some APCD activity and IMLC participation

## WEAKNESSES

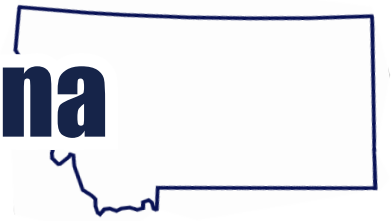
- Medicaid expansion
- Weak redetermination performance
- High Medicaid share of the state budget
- Active CON laws and restrictive provider practice rules

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **9/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 78.8% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 86.4% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **18/26** |
| **5-Year Spending Growth** (Lower = Better) | -0.8% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -2.6% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 26.9% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **22/24** |
| **Improper Payment Rate** (Lower = Better) | 1.3% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.88 (Q5) | 8 |
| **APCD Presence** | Voluntary Activity | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **4/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 296.9 (Q3) | 2 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Montana



| RANK | SCORE |
|---|---|
| 22nd | 47/100 |

Montana performs well on early work requirement activity, moderate redetermination performance, fiscal sustainability, and provider flexibility. The state also benefits from strong MFCU enforcement activity and IMLC participation. However, Montana's overall score is constrained by Medicaid expansion, no MCO presence, weak private coverage retention, a high improper payment rate, no APCD activity, and active CON laws.

## STRENGTHS

- Early work requirement activity
- Restrained Medicaid spending growth and moderate Medicaid budget exposure
- Strong MFCU enforcement activity
- Strong provider flexibility and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No MCO presence
- Weak private-to-Medicaid coverage ratio
- High improper payment rate and no APCD activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **13/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 67.5% (Q2) | 4 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 82.2% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **18/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.0% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.7% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 10.6% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **8/24** |
| **Improper Payment Rate** (Lower = Better) | 7.0% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 3.26 (Q5) | 8 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 304.0 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# Nebraska

| RANK | SCORE |
|---|---|
| 4th | 62/100 |

Nebraska ranks near the top overall due to strong program design indicators, low improper payments, and strong provider environment scores. The state benefits from early work requirement activity, strong redetermination performance, MCO presence, strong private coverage retention, and relatively low Medicaid budget exposure. However, Nebraska's overall score is constrained by Medicaid expansion, moderate fiscal growth scores, active CON laws, and only modest MFCU enforcement activity.

## STRENGTHS

- Early work requirement activity, strong redetermination performance, and MCO presence
- Strong private-to-Medicaid coverage ratio
- Low improper payment rate
- Strong provider flexibility and IMLC participation

## WEAKNESSES

- Medicaid expansion
- Active CON laws
- Moderate Medicaid spending and per-enrollee cost growth
- Modest MFCU enforcement activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **24/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 48.7% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 88.6% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.5% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.1% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 10.1% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **16/24** |
| **Improper Payment Rate** (Lower = Better) | 1.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.62 (Q2) | 2 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 320.4 (Q4) | 3 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Nevada

| RANK | SCORE |
|---|---|
| 33rd | 41/100 |

Nevada performs well on program integrity and administrative oversight, driven by moderate improper payment performance, strong MFCU enforcement activity, and existing APCD infrastructure. The state also benefits from MCO presence, restrained per-enrollee cost growth, and IMLC participation. However, Nevada's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, weak private coverage retention, and limited provider environment scores.

## STRENGTHS

- MCO presence
- Restrained per-enrollee cost growth and moderate Medicaid budget exposure
- Strong MFCU enforcement activity and existing APCD infrastructure
- Independent NP practice and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- Weak private-to-Medicaid coverage ratio and low provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 93.0% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.7% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 5.4% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.3% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 10.2% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **18/24** |
| **Improper Payment Rate** (Lower = Better) | 2.9% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 3.51 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **4/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 235.6 (Q1) | 0 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# New Hampshire

| RANK | SCORE |
|---|---|
| 23rd | 47/100 |

New Hampshire performs well on private coverage retention, provider environment indicators, MFCU enforcement activity, and existing APCD infrastructure. The state also benefits from MCO presence, restrained Medicaid spending growth, independent NP practice authority, optimal PA scope of practice, and IMLC participation. However, New Hampshire's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, and high Medicaid budget exposure.

## STRENGTHS

- Strong private-to-Medicaid coverage ratio
- Strong MFCU enforcement activity and existing APCD infrastructure
- Strong primary care provider supply
- Broad provider practice authority and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- High Medicaid share of the state budget

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **10/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 80.1% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 90.9% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **12/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.7% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.8% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 22.8% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **15/24** |
| **Improper Payment Rate** (Lower = Better) | 3.9% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 3.58 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 370.7 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# New Jersey

| RANK | SCORE |
|---|---|
| 44th | 32/100 |

New Jersey performs moderately on program design indicators, including MCO presence, redetermination performance, and private coverage retention. The state also has some APCD activity and IMLC participation. However, New Jersey's overall score is constrained by Medicaid expansion, no early work requirement activity, weak program integrity scores, active CON laws, low primary care provider supply, and limited provider flexibility.

## STRENGTHS

- MCO presence
- Moderate redetermination performance and private-to-Medicaid coverage ratio
- Some APCD activity
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak improper payment and MFCU enforcement scores
- Active CON laws and low primary care provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **11/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 71.0% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 86.1% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **10/26** |
| **5-Year Spending Growth** (Lower = Better) | 5.1% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.0% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 11.2% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **7/24** |
| **Improper Payment Rate** (Lower = Better) | 5.7% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.77 (Q2) | 2 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **4/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 245.6 (Q1) | 0 |
| **NP Scope of Practice** | Reduced Indep Practice | 1 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# New Mexico

| RANK | SCORE |
|---|---|
| 47th | 28/100 |

New Mexico performs relatively well on APCD infrastructure, CON law status, independent NP practice, and IMLC progress. However, New Mexico's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, low private coverage retention, rapid Medicaid spending and per-enrollee cost growth, and weak MFCU enforcement activity.

## STRENGTHS

- Existing APCD infrastructure
- No active CON law
- Independent NP practice
- IMLC passed

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance and private-to-Medicaid coverage ratio
- Rapid Medicaid spending and per-enrollee cost growth

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **4/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 84.5% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 65.5% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **4/26** |
| **5-Year Spending Growth** (Lower = Better) | 6.3% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 7.4% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 10.7% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **10/24** |
| **Improper Payment Rate** (Lower = Better) | 3.7% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.27 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 296.9 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Passed | 1 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# New York

| RANK | SCORE |
|---|---|
| 46th | 29/100 |

New York performs relatively well on redetermination performance, improper payment performance, existing APCD infrastructure, primary care provider supply, and independent NP practice. However, New York's overall score is constrained by Medicaid expansion, no early work requirement activity, low private coverage retention, rapid Medicaid spending and per-enrollee cost growth, high Medicaid budget exposure, weak MFCU enforcement activity, active CON laws, and no IMLC activity.

## STRENGTHS

- Strong redetermination performance
- Strong improper payment score and existing APCD infrastructure
- Strong primary care provider supply
- Independent NP practice

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Rapid Medicaid spending and per-enrollee cost growth
- High Medicaid share of the state budget and weak MFCU enforcement activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **10/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 46.3% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 73.3% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **0/26** |
| **5-Year Spending Growth** (Lower = Better) | 17.9% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 5.6% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 20.7% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **13/24** |
| **Improper Payment Rate** (Lower = Better) | 1.4% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.27 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 346.9 (Q4) | 3 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | No Activity | 0 |

# North Carolina

| RANK | SCORE |
|---|---|
| 48th | 28/100 |

North Carolina performs moderately on MCO presence, private coverage retention, per-enrollee cost growth, improper payment performance, and APCD activity. However, North Carolina's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, weak MFCU enforcement activity, active CON laws, limited provider flexibility, and high Medicaid budget exposure.

## STRENGTHS

- MCO presence
- Moderate private-to-Medicaid coverage ratio
- Moderate per-enrollee cost growth and improper payment score
- Some APCD activity and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- Active CON laws and limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **7/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 85.1% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.5% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **8/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.9% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.2% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 18.7% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **8/24** |
| **Improper Payment Rate** (Lower = Better) | 3.0% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.22 (Q1) | 0 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 316.6 (Q3) | 2 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# North Dakota

| RANK | SCORE |
|---|---|
| 9th | 57/100 |

North Dakota performs well on private coverage retention, Medicaid spending growth, per-enrollee cost growth, Medicaid budget exposure, provider environment indicators, and IMLC participation. The state also benefits from MCO presence, no active CON law, independent NP practice, optimal PA scope of practice, and strong primary care provider supply. However, North Dakota's overall score is constrained by Medicaid expansion, no early work requirement activity, weak MFCU enforcement activity, and no APCD activity.

## STRENGTHS

- Strong private-to-Medicaid coverage ratio
- Strong fiscal sustainability scores
- No active CON law and strong primary care provider supply
- Broad provider practice authority and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak MFCU enforcement activity
- No APCD activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **13/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 69.6% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 90.7% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **24/26** |
| **5-Year Spending Growth** (Lower = Better) | 2.4% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -2.8% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 8.1% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **6/24** |
| **Improper Payment Rate** (Lower = Better) | 2.7% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.00 (Q1) | 0 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **14/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 352.0 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Ohio

| RANK | SCORE |
|---|---|
| 13th | 54/100 |

Ohio performs well on early work requirement activity, MCO presence, Medicaid spending growth, improper payment performance, MFCU enforcement activity, and IMLC participation. The state also has moderate redetermination performance, per-enrollee cost growth, and primary care provider supply. However, Ohio's overall score is constrained by Medicaid expansion, low private coverage retention, high Medicaid budget exposure, no APCD activity, active CON laws, and limited provider flexibility.

## STRENGTHS

- Early work requirement activity and MCO presence
- Restrained Medicaid spending growth
- Strong improper payment and MFCU enforcement scores
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- Low private-to-Medicaid coverage ratio
- High Medicaid share of the state budget
- No APCD activity and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **16/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 70.5% (Q3) | 3 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 81.8% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 2.5% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.2% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 18.4% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **17/24** |
| **Improper Payment Rate** (Lower = Better) | 2.0% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.92 (Q5) | 8 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **7/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 318.8 (Q4) | 3 |
| **NP Scope of Practice** | Reduced Indep Practice | 1 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Oklahoma

| RANK | SCORE |
|---|---|
| 27th | 44/100 |

Oklahoma performs well on Medicaid spending growth, per-enrollee cost growth, improper payment performance, and IMLC participation. The state also benefits from MCO presence and some APCD activity. However, Oklahoma's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, low private coverage retention, high Medicaid budget exposure, active CON laws, low primary care provider supply, and limited provider flexibility.

## STRENGTHS

- Strong Medicaid spending and per-enrollee cost growth scores
- Strong improper payment score
- Some APCD activity
- IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance and low private-to-Medicaid coverage ratio
- Active CON laws, low primary care provider supply, and limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 81.9% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 82.1% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **20/26** |
| **5-Year Spending Growth** (Lower = Better) | -1.6% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -1.1% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 13.6% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **16/24** |
| **Improper Payment Rate** (Lower = Better) | 0.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.44 (Q2) | 2 |
| **APCD Presence** | Voluntary Activity | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **3/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 249.4 (Q1) | 0 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Oregon

| RANK | SCORE |
|---|---|
| 42nd | 34/100 |

Oregon performs relatively well on Medicaid budget exposure, improper payment performance, MFCU enforcement activity, existing APCD infrastructure, and independent NP practice. The state also benefits from MCO presence. However, Oregon's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, low private coverage retention, rapid Medicaid spending growth, active CON laws, and no IMLC activity.

## STRENGTHS

- Low Medicaid share of the state budget
- Moderate program integrity scores
- Existing APCD infrastructure
- Independent NP practice

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Low private-to-Medicaid coverage ratio
- Rapid Medicaid spending growth and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 78.9% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 77.4% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **10/26** |
| **5-Year Spending Growth** (Lower = Better) | 9.4% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.1% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 6.5% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **14/24** |
| **Improper Payment Rate** (Lower = Better) | 2.9% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.85 (Q3) | 4 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **5/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 290.8 (Q3) | 2 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | No Activity | 0 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Pennsylvania

| RANK | SCORE |
|---|---|
| 20th | 49/100 |

Pennsylvania performs well on redetermination performance, improper payment performance, MFCU enforcement activity, CON law status, primary care provider supply, and IMLC participation. The state also benefits from MCO presence, moderate private coverage retention, and some APCD activity. However, Pennsylvania's overall score is constrained by Medicaid expansion, no early work requirement activity, rapid Medicaid spending growth, high Medicaid budget exposure, and limited provider flexibility.

## STRENGTHS

- Strong redetermination performance
- Strong improper payment and MFCU enforcement scores
- No active CON law
- Strong primary care provider supply and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Rapid Medicaid spending growth
- High Medicaid share of the state budget and limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **13/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 53.4% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 83.9% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.6% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 1.8% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 26.8% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **20/24** |
| **Improper Payment Rate** (Lower = Better) | 0.3% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.22 (Q4) | 6 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 324.5 (Q4) | 3 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Rhode Island

| RANK | SCORE |
|---|---|
| 49th | 28/100 |

Rhode Island performs well on primary care provider supply, existing APCD infrastructure, independent NP practice, and IMLC progress. The state also benefits from MCO presence and moderate Medicaid spending growth. However, Rhode Island's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, low private coverage retention, high Medicaid budget exposure, weak program integrity scores, active CON laws, and limited PA scope of practice.

## STRENGTHS

- Existing APCD infrastructure
- Strong primary care provider supply
- Independent NP practice
- IMLC passed

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak program design scores
- Weak program integrity scores and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | 6/36 |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 74.4% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 80.1% (Q2) | 1 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | 10/26 |
| **5-Year Spending Growth** (Lower = Better) | 3.6% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.1% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 13.6% (Q4) | 2 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | 4/24 |
| **Improper Payment Rate** (Lower = Better) | 8.8% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.00 (Q1) | 0 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | 8/14 |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 379.4 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | IMLC Passed | 1 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

| RANK | SCORE |
|---|---|
| 11th | 55/100 |

South Carolina performs well on Medicaid expansion status, early work requirement activity, redetermination performance, MCO presence, private coverage retention, Medicaid spending growth, per-enrollee cost growth, and Medicaid budget exposure. However, South Carolina's overall score is constrained by weak program integrity performance, active CON laws, low primary care provider supply, limited provider flexibility, and no IMLC activity.

## STRENGTHS

- No Medicaid expansion
- Early work requirement activity
- Strong overall program design scores
- Moderate fiscal sustainability scores

## WEAKNESSES

- Weak improper payment score
- Active CON laws
- Low primary care provider supply
- Limited provider flexibility and no IMLC activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **32/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 61.0% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 87.3% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.7% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.1% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 9.5% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **6/24** |
| **Improper Payment Rate** (Lower = Better) | 20.5% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.13 (Q3) | 4 |
| **APCD Presence** | Voluntary Activity | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **1/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 276.1 (Q2) | 1 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Reduced | 0 |
| **IMLC Membership** | No Activity | 0 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# South Dakota

| RANK | SCORE |
|---|---|
| 5th | 61/100 |

South Dakota performs well on redetermination performance, private coverage retention, fiscal sustainability, program integrity, CON law status, provider flexibility, and IMLC participation. The state also benefits from strong primary care provider supply and some APCD activity. However, South Dakota's overall score is constrained by Medicaid expansion, no early work requirement activity, and no MCO presence.

## STRENGTHS

- Strong redetermination performance and private-to-Medicaid coverage ratio
- Restrained Medicaid spending growth
- Strong improper payment and MFCU enforcement scores
- No active CON law, broad provider practice authority, and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- No MCO presence
- Only emerging APCD activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **12/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 48.5% (Q1) | 6 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 91.0% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 2.3% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 2.2% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 10.8% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **22/24** |
| **Improper Payment Rate** (Lower = Better) | 0.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 2.67 (Q5) | 8 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **13/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 343.3 (Q4) | 3 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# Tennessee

| RANK | SCORE |
|---|---|
| 17th | 50/100 |

Tennessee performs well on Medicaid expansion status, MCO presence, private coverage retention, Medicaid spending growth, per-enrollee cost growth, MFCU enforcement activity, and IMLC participation. The state also has strong primary care provider supply and some APCD activity. However, Tennessee's overall score is constrained by no early work requirement activity, weak redetermination performance, high Medicaid budget exposure, active CON laws, and limited provider flexibility.

## STRENGTHS

- No Medicaid expansion
- MCO presence and strong private-to-Medicaid coverage ratio
- Restrained Medicaid spending and per-enrollee cost growth
- Strong primary care provider supply and IMLC participation

## WEAKNESSES

- No early work requirement activity
- Weak redetermination performance
- High Medicaid share of the state budget
- Active CON laws and limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **21/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 79.3% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 87.0% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.9% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.6% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 19.0% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **9/24** |
| **Improper Payment Rate** (Lower = Better) | 5.6% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.08 (Q3) | 4 |
| **APCD Presence** | Strong Interest | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Actilve CON Law | 0 |
| **PCP Supply** (Higher = Better) | 319.1 (Q4) | 3 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Texas

| RANK | SCORE |
|---|---|
| 2nd | 67/100 |

Texas performs well on Medicaid expansion status, redetermination performance, MCO presence, private coverage retention, Medicaid spending growth, per-enrollee cost growth, improper payment performance, MFCU enforcement activity, existing APCD infrastructure, CON law status, and IMLC participation. However, Texas's overall score is constrained by no early work requirement activity, high Medicaid budget exposure, low primary care provider supply, and limited provider flexibility.

## STRENGTHS

- No Medicaid expansion
- Strong program design scores
- Strong program integrity and administrative oversight scores
- Existing APCD infrastructure, no active CON law, and IMLC participation

## WEAKNESSES

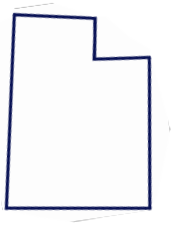
- No early work requirement activity
- High Medicaid share of the state budget
- Low primary care provider supply
- Limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **26/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 68.2% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 91.4% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **12/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.2% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.4% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 23.6% (Q5) | 0 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **22/24** |
| **Improper Payment Rate** (Lower = Better) | 1.3% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 1.73 (Q4) | 6 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **7/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 225.0 (Q1) | 0 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Moderate | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Utah



| RANK | SCORE |
|---|---|
| 10th | 57/100 |

Utah performs well on early work requirement activity, MCO presence, private coverage retention, per-enrollee cost growth, Medicaid budget exposure, improper payment performance, existing APCD infrastructure, CON law status, provider flexibility, and IMLC participation. However, Utah's overall score is constrained by Medicaid expansion, weak redetermination performance, rapid Medicaid spending growth, weak MFCU enforcement activity, and low primary care provider supply.

## STRENGTHS

- Early work requirement activity
- Strong private-to-Medicaid coverage ratio
- Strong per-enrollee cost growth and Medicaid budget exposure scores
- Existing APCD infrastructure, no active CON law, broad provider practice authority, and IMLC participation

## WEAKNESSES

- Medicaid expansion
- Weak redetermination performance
- Rapid Medicaid spending growth
- Low primary care provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **18/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | Yes | 8 |
| **Redetermination Rate** (Lower = Better) | 91.5% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 92.5% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **14/26** |
| **5-Year Spending Growth** (Lower = Better) | 7.7% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.6% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 8.6% (Q2) | 6 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **15/24** |
| **Improper Payment Rate** (Lower = Better) | 1.9% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.63 (Q2) | 2 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **10/14** |
| **CON Laws** | No Active CON Law | 4 |
| **PCP Supply** (Higher = Better) | 240.2 (Q1) | 0 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Vermont

| RANK | SCORE |
|---|---|
| 21st | 48/100 |

Vermont performs well on Medicaid spending growth, MFCU enforcement activity, existing APCD infrastructure, primary care provider supply, independent NP practice, and IMLC participation. The state also has moderate redetermination performance, private coverage retention, per-enrollee cost growth, and Medicaid budget exposure. However, Vermont's overall score is constrained by Medicaid expansion, no early work requirement activity, no MCO presence, active CON laws, and limited PA scope of practice.

## STRENGTHS

- Restrained Medicaid spending growth
- Strong MFCU enforcement activity and existing APCD infrastructure
- Strong primary care provider supply
- Independent NP practice and IMLC participation

## WEAKNESSES

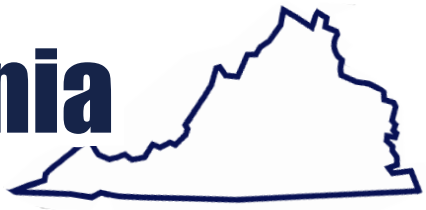
- Medicaid expansion
- No early work requirement activity
- No MCO presence
- Active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **6/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 70.5% (Q3) | 3 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 83.0% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **18/26** |
| **5-Year Spending Growth** (Lower = Better) | 0.9% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 0.9% (Q3) | 4 |
| **Medicaid Budget Share** (Lower = Better) | 12.8% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **15/24** |
| **Improper Payment Rate** (Lower = Better) | 5.6% (Q4) | 3 |
| **MFCU Enforcement Strength** (Higher = Better) | 8.05 (Q5) | 8 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **9/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 349.4 (Q5) | 4 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Virginia



| RANK | SCORE |
|---|---|
| 35th | 39/100 |

Virginia performs well on redetermination performance, MCO presence, private coverage retention, improper payment performance, MFCU enforcement activity, and existing APCD infrastructure. The state also has moderate Medicaid budget exposure. However, Virginia's overall score is constrained by Medicaid expansion, no early work requirement activity, rapid Medicaid spending growth, active CON laws, low primary care provider supply, limited provider flexibility, and no IMLC activity.

## STRENGTHS

- Strong redetermination performance
- MCO presence and strong private-to-Medicaid coverage ratio
- Strong improper payment score and existing APCD infrastructure
- Moderate MFCU enforcement activity

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Rapid Medicaid spending growth
- Active CON laws, low primary care provider supply, and no IMLC activity

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **14/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 54.7% (Q1) | 6 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 86.1% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 8.8% (Q5) | 0 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.1% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 12.0% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **17/24** |
| **Improper Payment Rate** (Lower = Better) | 2.2% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.88 (Q3) | 4 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **2/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 284.0 (Q2) | 1 |
| **NP Scope of Practice** | Supervision Required | 0 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | No Activity | 0 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Washington

| RANK | SCORE |
|---|---|
| 36th | 39/100 |

Washington performs well on MCO presence, improper payment performance, MFCU enforcement activity, existing APCD infrastructure, independent NP practice, and IMLC participation. The state also has moderate private coverage retention and Medicaid budget exposure. However, Washington's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, rapid per-enrollee cost growth, active CON laws, and low primary care provider supply.

## STRENGTHS

- MCO presence
- Strong improper payment score and existing APCD infrastructure
- Moderate MFCU enforcement activity
- Independent NP practice and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance
- Active CON laws and low primary care provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **7/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 84.5% (Q5) | 0 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 84.3% (Q3) | 3 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **6/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.9% (Q4) | 2 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.7% (Q5) | 0 |
| **Medicaid Budget Share** (Lower = Better) | 11.3% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **20/24** |
| **Improper Payment Rate** (Lower = Better) | 0.2% (Q1) | 12 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.93 (Q3) | 4 |
| **APCD Presence** | Existing | 4 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 288.4 (Q2) | 1 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# West Virginia

| RANK | SCORE |
|---|---|
| 37th | 39/100 |

West Virginia performs well on Medicaid budget exposure, improper payment performance, MFCU enforcement activity, primary care provider supply, and IMLC participation. The state also benefits from MCO presence and moderate Medicaid spending growth. However, West Virginia's overall score is constrained by Medicaid expansion, no early work requirement activity, weak redetermination performance, low private coverage retention, no APCD activity, active CON laws, and limited provider flexibility.

## STRENGTHS

- MCO presence
- Low Medicaid share of the state budget
- Moderate program integrity scores
- Strong primary care provider supply and IMLC participation

## WEAKNESSES

- Medicaid expansion
- No early work requirement activity
- Weak redetermination performance and low private-to-Medicaid coverage ratio
- No APCD activity and active CON laws

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **5/36** |
| **Expansion Status** | Adopted | 0 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 75.5% (Q4) | 1 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 76.2% (Q1) | 0 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **16/26** |
| **5-Year Spending Growth** (Lower = Better) | 4.4% (Q3) | 6 |
| **Per-Enrollee Cost Growth** (Lower = Better) | 3.0% (Q4) | 2 |
| **Medicaid Budget Share** (Lower = Better) | 6.8% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **10/24** |
| **Improper Payment Rate** (Lower = Better) | 3.5% (Q3) | 6 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.82 (Q3) | 4 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **8/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 351.6 (Q5) | 4 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD
STATE SNAPSHOT

# Wisconsin

| RANK | SCORE |
|---|---|
| 16th | 52/100 |

Wisconsin performs well on Medicaid expansion status, MCO presence, redetermination performance, private coverage retention, Medicaid spending growth, per-enrollee cost growth, Medicaid budget exposure, and IMLC participation. The state also benefits from some APCD activity and moderate provider environment indicators. However, Wisconsin's overall score is constrained by no early work requirement activity, weak program integrity scores, active CON laws, and limited provider flexibility.

## STRENGTHS

- No Medicaid expansion
- Moderate-to-strong program design scores
- Strong fiscal sustainability scores
- IMLC participation

## WEAKNESSES

- No early work requirement activity
- Weak improper payment and MFCU enforcement scores
- Active CON laws
- Limited provider flexibility

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **24/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 62.8% (Q2) | 4 |
| **MCO Presence** | Yes | 4 |
| **Coverage Ratio** (Higher = Better) | 86.8% (Q4) | 4 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **18/26** |
| **5-Year Spending Growth** (Lower = Better) | 3.4% (Q2) | 8 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -0.1% (Q2) | 6 |
| **Medicaid Budget Share** (Lower = Better) | 12.2% (Q3) | 4 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **4/24** |
| **Improper Payment Rate** (Lower = Better) | 9.1% (Q5) | 0 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.33 (Q2) | 2 |
| **APCD Presence** | Voluntary Activity | 2 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **6/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 317.5 (Q3) | 2 |
| **NP Scope of Practice** | Reduced Indep. Practice | 1 |
| **PA Scope of Practice** | Advanced | 1 |
| **IMLC Membership** | Member State | 2 |

# MEDICAID REPORT CARD

STATE SNAPSHOT

# Wyoming

| RANK | SCORE |
|---|---|
| 3rd | 64/100 |

Wyoming performs well on Medicaid expansion status, redetermination performance, private coverage retention, Medicaid spending growth, per-enrollee cost growth, Medicaid budget exposure, improper payment performance, independent NP practice, optimal PA scope of practice, and IMLC participation. However, Wyoming's overall score is constrained by no early work requirement activity, no MCO presence, weak MFCU enforcement activity, no APCD activity, active CON laws, and low primary care provider supply.

## STRENGTHS

- No Medicaid expansion
- Strong private-to-Medicaid coverage ratio
- Strong fiscal sustainability scores
- Strong improper payment score, broad provider practice authority, and IMLC participation

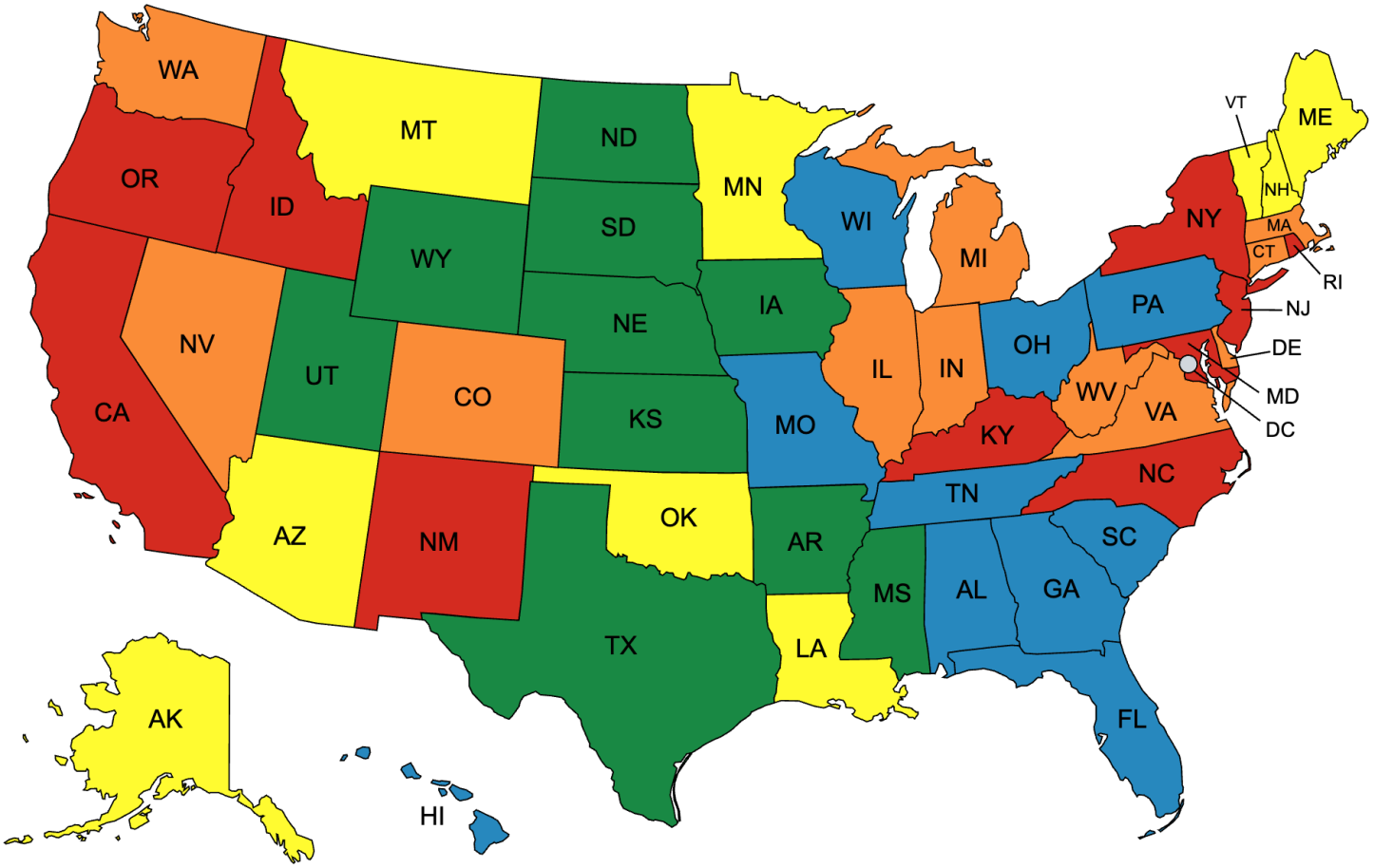
## WEAKNESSES

- No early work requirement activity
- No MCO presence
- Weak MFCU enforcement activity and no APCD activity
- Active CON laws and low primary care provider supply

| METRIC | VALUE | POINTS |
|---|---|---|
| **PILLAR 1 PROGRAM DESIGN & ENROLLMENT** | | **22/36** |
| **Expansion Status** | Not Adopted | 12 |
| **Work requirements** | No | 0 |
| **Redetermination Rate** (Lower = Better) | 63.3% (Q2) | 4 |
| **MCO Presence** | No | 0 |
| **Coverage Ratio** (Higher = Better) | 92.7% (Q5) | 6 |
| **PILLAR 2 FISCAL SUSTAINABILITY & BUDGET EXPOSURE** | | **26/26** |
| **5-Year Spending Growth** (Lower = Better) | 1.3% (Q1) | 10 |
| **Per-Enrollee Cost Growth** (Lower = Better) | -5.7% (Q1) | 8 |
| **Medicaid Budget Share** (Lower = Better) | 5.5% (Q1) | 8 |
| **PILLAR 3 PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT** | | **9/24** |
| **Improper Payment Rate** (Lower = Better) | 2.1% (Q2) | 9 |
| **MFCU Enforcement Strength** (Higher = Better) | 0.00 (Q1) | 0 |
| **APCD Presence** | No Activity | 0 |
| **PILLAR 4 MARKET STRUCTURE & PROVIDER ENVIRONMENT** | | **7/14** |
| **CON Laws** | Active CON Law | 0 |
| **PCP Supply** (Higher = Better) | 269.1 (Q2) | 1 |
| **NP Scope of Practice** | Independent Practice | 2 |
| **PA Scope of Practice** | Optimal | 2 |
| **IMLC Membership** | Member State | 2 |

# STATE RANKINGS AT A GLANCE

This map shows how each state performed overall on the Medicaid Report Card. States are grouped into five performance tiers based on their total scores.



# RESULTS AND CONCLUSIONS

The scorecard reveals substantial variation in how states structure, finance, and administer their Medicaid programs. Scores range from a high of 74 out of 100 in Kansas to a low of 22 in California. The average state score is 45.5, and the median score is 45. This distribution suggests that the scorecard is capturing meaningful differences across states rather than producing a narrow cluster of similar results. At the same time, no state comes close to receiving a perfect score. Even the highest-ranked states have identifiable weaknesses, and many lower-ranked states perform well in at least some areas.

The distribution reinforces that this scorecard is best understood as a comparative framework rather than a declaration that any state has fully solved—or entirely failed—Medicaid governance. The absence of both exceptionally high and exceptionally low scores suggests that Medicaid governance involves tradeoffs rather than simple policy maximization.

**Key findings include:**

- **All 10 non-expansion states rank in the top 18.**
- **Expansion states average 42.4 points compared with 57.7 for non-expansion states.**
- **The bottom 10 states are all expansion states.**
- **High-performing states succeed through multiple pathways rather than a single model of Medicaid governance.**
- **Low-performing states typically exhibit weaknesses across multiple pillars rather than failing because of a single metric.**
- **Every state has identifiable opportunities for improvement under the scorecard framework.**

## Overall Results

Kansas ranks first overall with 74 points, followed by Texas with 67, Wyoming with 64, Nebraska with 62, South Dakota with 61, and Arkansas with 60. Iowa and Mississippi are tied at 59, followed by North Dakota and Utah, which are tied at 57. At the bottom of the rankings, California scores 22, followed by New Mexico, North Carolina, and Rhode Island, each with 28; New York with 29; Idaho with 31; and Maryland and New Jersey, each with 32.

**Top 10 States by Overall Score**

| RANK | STATE | SCORE |
|---|---|---|
| 1 | Kansas | **74** |
| 2 | Texas | **67** |
| 3 | Wyoming | **64** |
| 4 | Nebraska | **62** |
| 5 | South Dakota | **61** |
| 6 | Arkansas | **60** |
| 7 | Iowa | **59** |
| 8 | Mississippi | **59** |
| 9 | North Dakota | **57** |
| 10 | Utah | **57** |

**Bottom 10 States by Overall Score**

| RANK | STATE | SCORE |
|---|---|---|
| 41 | Kentucky | **34** |
| 42 | Oregon | **34** |
| 43 | Maryland | **32** |
| 44 | New Jersey | **32** |
| 45 | Idaho | **31** |
| 46 | New York | **29** |
| 47 | New Mexico | **28** |
| 48 | North Carolina | **28** |
| 49 | Rhode Island | **28** |
| 50 | California | **22** |

While the top and bottom performers attract the most attention, much of the distribution is concentrated in the middle, where many states are separated by only a few points.

Several states received identical overall scores and should be considered substantively tied under the framework. For clarity, tied states are presented in sequential rank order throughout the report, but small differences in rank should not be interpreted as large differences in real-world performance where total scores are identical or very close.

The spread between the top and bottom states is nevertheless meaningful. The top 10 states average 62 points overall, while the bottom 10 states average 29.8. That gap reflects differences across multiple pillars, not simply a single policy variable. The results therefore reinforce the central premise of the scorecard: Medicaid governance is multidimensional, and state performance must be evaluated across program design, fiscal sustainability, administrative oversight, and provider-market structure rather than through any one metric alone.

## Program Design Remains a Major Differentiator

One clear pattern is that Medicaid expansion status remains an important dividing line under this scoring framework. All 10 non-expansion states rank in the top 18. Non-expansion states average 57.7 points, compared with 42.4 points among expansion states. The bottom 10 states are all expansion states. This finding is not surprising given the structure of the scorecard: Medicaid expansion status is worth 12 points, the largest single metric weight, because the methodology treats expansion as a major structural driver of program size, fiscal exposure, and the degree to which Medicaid remains targeted to its traditional safety-net populations.

Expansion status does not fully explain the rankings, however. Several expansion states score near the top. Nebraska ranks fourth, South Dakota fifth, Arkansas sixth, Iowa seventh, North Dakota ninth, and Utah 10th despite having adopted Medicaid expansion. This indicates that expansion states can still score well if they offset expansion-related weaknesses with stronger performance in other areas, such as redetermination performance, work requirement activity, fiscal sustainability, program integrity, or provider-market flexibility.

Conversely, non-expansion status alone does not guarantee a top ranking. Florida, Tennessee, Wisconsin, Alabama, Georgia, and South Carolina all benefit from non-expansion status but are held back by weaknesses in areas such as fiscal exposure, improper payments, program integrity, certificate-of-need laws, provider scope of practice, or redetermination performance. As such, the scorecard does not simply sort states by expansion status. Expansion is a major variable under the framework, but state performance ultimately depends on how each state performs across all 16 metrics.

## High Performance Takes Multiple Forms

One of the central lessons of the scorecard is that state Medicaid performance is multidimensional. The highest-ranked states are not identical, and they do not succeed by following a single model. Some perform well because they maintain tighter program design. Others are carried by unusually strong fiscal performance, program integrity, or provider-market openness. The top states therefore illustrate different pathways to relatively strong Medicaid governance.

Kansas ranks first because it combines strong performance across several major categories: no Medicaid expansion, strong redetermination performance, MCO presence, a strong private-to-Medicaid coverage ratio, low improper payments, strong MFCU enforcement, existing APCD infrastructure, no active CON laws, independent NP practice, and IMLC participation. Kansas does not perform perfectly across the board, however. It receives no points for early work requirement activity, scores poorly on per-enrollee cost growth, and loses points for reduced PA scope of practice. Its first-place ranking therefore reflects breadth of strength rather than perfection.

Texas, ranked second, follows a somewhat different path. Its score is driven largely by program design and program integrity. Texas has not expanded Medicaid, maintains MCO presence, performs well on the private-to-Medicaid coverage ratio, receives strong improper payment and MFCU scores, has existing APCD infrastructure, and has no active CON law. Yet Texas also has weaknesses, including no early work requirement activity, high Medicaid budget exposure, low primary care provider supply, and limited provider flexibility.

Wyoming, ranked third, shows another path to a high score: fiscal

restraint. Wyoming receives the full 26 points available in the fiscal sustainability pillar, reflecting strong performance on Medicaid spending growth, per-enrollee cost growth, and Medicaid share of the state budget. Mississippi also receives the full 26 fiscal points, which helps place it in the top 10 despite weaker program-integrity and provider-environment scores. Hawaii also earns the full 26 fiscal points, although its overall ranking is lower because of Medicaid expansion, weak redetermination performance, and limited provider-market scores. While these examples show that fiscal sustainability can significantly improve a state's standing, it does not by itself determine overall performance.

The top-performing expansion states are also instructive. Nebraska ranks fourth despite Medicaid expansion because it scores well on early work requirement activity, redetermination performance, MCO presence, private coverage relative to Medicaid, improper payments, and provider flexibility. South Dakota ranks fifth because it combines strong redetermination performance, a strong private-to-Medicaid coverage ratio, solid fiscal scores, very strong program-integrity performance, and a strong provider environment. Arkansas ranks sixth because it performs particularly well on fiscal sustainability and program integrity, receiving 22 of 26 fiscal points and 22 of 24 integrity points.

Ultimately, these examples demonstrate that there is no single model of high-performing Medicaid governance. Non-expansion status provides a significant advantage under this framework, but states can also perform well through fiscal discipline, stronger integrity systems, better eligibility administration, provider-market reform, and stronger private coverage relative to Medicaid enrollment.

## Pillar-Level Patterns

The pillar results reinforce the broader pattern. The top 10 states average 62 points overall. They average 19.7 out of 36 in Program Design and Enrollment, 18.0 out of 26 in Fiscal Sustainability and Budget Exposure, 16.0 out of 24 in Program Integrity and Administrative Oversight, and 8.3 out of 14 in Market Structure and Provider Environment.

By contrast, the bottom 10 states average 29.8 points overall. They average only 7.3 in Program Design, 7.0 in Fiscal Sustainability, 9.0 in Program Integrity, and 6.5 in Provider Environment. The largest differences between high- and low-scoring states therefore appear in program design, fiscal sustainability, and program integrity. Provider-market policies can make a difference, but they generally do not dominate the overall rankings because the pillar is intentionally weighted more modestly.

This also explains why some states with strong provider-environment scores still rank relatively low. New Mexico, for example, receives 10 of 14 points in the provider environment pillar because it has no active CON law, independent NP practice, advanced PA practice authority, and IMLC progress. Yet it ranks 47th overall because it performs poorly on program design and fiscal sustainability. Colorado receives 11 of 14 provider-environment points but ranks 39th because of Medicaid expansion, no early work requirement activity, high Medicaid budget exposure, weak MFCU enforcement, and elevated improper payments. North Dakota, by contrast, receives a perfect 14 of 14 in provider environment and ranks ninth overall, but it also benefits from strong fiscal sustainability and a strong private-to-Medicaid coverage ratio.

The lesson is not that provider-market reform is unimportant. Rather, provider-market openness generally cannot compensate for broad weaknesses in program design, fiscal exposure, or administrative oversight. Provider supply, scope-of-practice rules, CON laws, and interstate licensure all affect the environment in which Medicaid beneficiaries seek care. But within the overall scorecard, they are one part of a larger governance picture.

Additional patterns emerge from several of the scorecard's lower-weighted metrics. MCO presence, APCD status, and IMLC participation provide useful information about program structure, transparency infrastructure, and provider-market flexibility, but they do not by themselves determine overall performance. MCO presence is common, with 41 states receiving credit. IMLC participation is also widespread. APCD status varies more, but existing APCD infrastructure appears in both high- and low-ranked states.

These measures are included because they matter, but their modest weights appropriately reflect their indirect relationship to overall Medicaid governance. A state with MCO presence, APCD infrastructure, or IMLC participation may have stronger administrative or market capacity than a state without those features. However, these indicators generally cannot overcome weak fiscal performance, poor integrity scores, expansive program design, or major provider-market restrictions on their own.

## Weak Performance Is Usually Multidimensional

The lower-ranked states tend to be weak across multiple dimensions rather than failing because of a single metric. California ranks last with 22 points because it scores poorly in nearly every major category: 5 out of 36 in Program Design, 6 out of 26 in Fiscal Sustainability, 6 out of 24 in Program Integrity, and 5 out of 14 in Provider Environment. Its few strengths, including MCO presence, existing APCD infrastructure, and the absence of CON laws, are not enough to offset Medicaid expansion, no early work requirement activity, high spending growth, high per-enrollee cost growth, weak provider flexibility, low provider supply, and high improper payments.

New York illustrates a different form of weak overall performance. It receives 13 of 24 points in Program Integrity, including a strong improper payment score and existing APCD infrastructure, and it performs fairly well on redeterminations and primary care provider supply. However, it receives zero out of 26 points in Fiscal Sustainability, reflecting weak performance on all three fiscal metrics. Its overall score of 29 is therefore driven less by a total absence of strengths than by very large weaknesses in fiscal trajectory and budget exposure.

North Carolina, New Mexico, Rhode Island, Idaho, Maryland, and New Jersey similarly have identifiable strengths but are held back by combinations of Medicaid expansion, no early work requirement activity, weak redetermination or private-coverage performance, fiscal pressure, weak MFCU enforcement, CON laws, or restrictive provider-market rules. This pattern is important because it shows that low scores are generally not the result of one isolated weakness; they tend to reflect overlapping problems across program design, fiscal sustainability, integrity, and market structure.

## Opportunities for Improvement

A forward-looking interpretation of the scorecard is that no state's position is fixed. Some policy choices could raise a state's score relatively quickly, while others would require longer-term administrative or fiscal improvement before affecting the underlying data. Binary and ordinal measures, such as early work requirement activity, APCD status, CON laws, NP and PA scope of practice, and IMLC participation, are more directly tied to identifiable policy choices. By contrast, quintile-based outcomes such as improper payment rates, spending growth, per-enrollee cost growth, budget share, redetermination performance, and provider supply may take more time to improve because they depend on implementation quality, fiscal trends, administrative systems, workforce conditions, and/or broader market dynamics.

Even the highest-ranked states have clear opportunities for improvement. Kansas could increase its score by taking early work requirement action, improving per-enrollee cost growth, and broadening PA scope of practice. Texas could improve through early work requirement activity, reducing Medicaid's share of the state budget, increasing provider supply, and broadening NP and PA practice authority. Wyoming, despite ranking third and receiving a perfect fiscal sustainability score, could improve by adopting comprehensive MCO arrangements, increasing MFCU enforcement strength, developing APCD infrastructure, repealing CON restrictions, and strengthening provider supply.

Middle-ranked states also have obvious pathways. Florida ranks 18th and benefits from non-expansion status, MCO presence, a strong private-to-Medicaid coverage ratio, existing APCD infrastructure, and relatively strong MFCU enforcement. Its score would improve if it took early work requirement action, reduced Medicaid budget exposure, lowered improper payments, repealed CON restrictions, and broadened provider scope-of-practice rules. Illinois, ranked 31st, performs well on improper payments but is held back by Medicaid expansion, no early work requirement activity, rapid spending and per-enrollee cost growth, no APCD activity, and restrictive provider-market rules. Colorado, despite strong provider-environment scores and existing APCD infrastructure, would need stronger fiscal and program-integrity performance to move substantially higher.

Lower-ranked states likewise have room to improve. California could raise its score through several discrete policy changes, including early work requirement activity, broader provider scope-of-practice authority, IMLC participation, and continued attention to improper payment reduction. Larger fiscal improvements, such as reducing spending growth or per-enrollee cost growth, would likely take longer but would matter substantially under the framework. New York's clearest path is fiscal: it receives zero points in the fiscal sustainability pillar, so improving spending growth, per-enrollee cost growth, and budget exposure would have a major effect. New York could also improve through stronger MFCU enforcement, CON reform, and IMLC participation. New Mexico, North Carolina, and Rhode Island

all illustrate that while even low-ranked states often have some strengths, sustained improvement requires addressing multiple categories at once rather than relying on one isolated reform.

## Conclusion

The broader conclusion is that Medicaid governance cannot be reduced to any single policy choice or outcome measure. Expansion status matters under this framework, but so do fiscal trajectory, administrative integrity, redetermination performance, private coverage patterns, enforcement activity, provider supply, and regulatory barriers. Some states score well because they maintain tighter program design. Others score well because they have strong fiscal performance or strong program-integrity systems. Some states with expansive Medicaid programs still perform comparatively well because they offset expansion-related weaknesses elsewhere. Conversely, low-scoring states generally exhibit multiple overlapping weaknesses rather than one isolated flaw.

This scorecard should therefore be understood as a comparative governance tool, not as a complete measure of health system quality or beneficiary experience. It does not answer every question one might ask about Medicaid, nor does it attempt to measure every goal that policymakers may value. Its purpose is narrower but important: to make interstate differences systematic and open to scrutiny. By comparing states across program design, fiscal sustainability, administrative oversight, and provider-market structure, the scorecard stresses the choices and tradeoffs that shape Medicaid's long-term trajectory. As new data become available and states continue to modify their programs, future editions can track how those choices affect performance over time. Thus, the value of this framework lies not only in ranking states at a single point in time, but in identifying where states are strong, where they are weak, and where improvement remains possible.

# STATE INDIVIDUAL PILLAR SCORES AND OVERALL RANKINGS

| STATE | PILLAR 1 SCORE | PILLAR 2 SCORE | PILLAR 3 SCORE | PILLAR 4 SCORE | TOTAL SCORE | RANKING |
|---|---|---|---|---|---|---|
| ALABAMA | 18 | 20 | 12 | 3 | **53** | 14 |
| ALASKA | 6 | 24 | 8 | 8 | **46** | 24 |
| ARIZONA | 17 | 8 | 9 | 10 | **44** | 26 |
| ARKANSAS | 13 | 22 | 22 | 3 | **60** | 6 |
| CALIFORNIA | 5 | 6 | 6 | 5 | **22** | 50 |
| COLORADO | 12 | 6 | 7 | 11 | **36** | 39 |
| CONNECTICUT | 4 | 16 | 13 | 8 | **41** | 30 |
| DELAWARE | 11 | 10 | 10 | 9 | **40** | 34 |
| FLORIDA | 24 | 10 | 10 | 5 | **49** | 18 |
| GEORGIA | 33 | 6 | 13 | 2 | **54** | 12 |
| HAWAII | 5 | 26 | 13 | 5 | **49** | 19 |
| IDAHO | 5 | 10 | 7 | 9 | **31** | 45 |
| ILLINOIS | 11 | 8 | 16 | 6 | **41** | 31 |
| INDIANA | 8 | 16 | 12 | 5 | **41** | 32 |
| IOWA | 19 | 16 | 17 | 7 | **59** | 7 |
| KANSAS | 28 | 12 | 24 | 10 | **74** | 1 |
| KENTUCKY | 10 | 6 | 12 | 6 | **34** | 41 |
| LOUISIANA | 7 | 14 | 17 | 5 | **43** | 28 |
| MAINE | 9 | 16 | 12 | 9 | **46** | 25 |
| MARYLAND | 10 | 6 | 9 | 7 | **32** | 43 |
| MASSACHUSETTS | 9 | 12 | 6 | 8 | **35** | 40 |
| MICHIGAN | 4 | 20 | 8 | 6 | **38** | 38 |
| MINNESOTA | 8 | 4 | 21 | 9 | **42** | 29 |
| MISSISSIPPI | 22 | 26 | 7 | 4 | **59** | 8 |
| MISSOURI | 9 | 18 | 22 | 4 | **53** | 15 |
| MONTANA | 13 | 18 | 8 | 8 | **47** | 22 |
| NEBRASKA | 24 | 14 | 16 | 8 | **62** | 4 |
| NEVADA | 5 | 14 | 18 | 4 | **41** | 33 |
| NEW HAMPSHIRE | 10 | 12 | 15 | 10 | **47** | 23 |
| NEW JERSEY | 11 | 10 | 7 | 4 | **32** | 44 |
| NEW MEXICO | 4 | 4 | 10 | 10 | **28** | 47 |
| NEW YORK | 10 | 0 | 13 | 6 | **29** | 46 |
| NORTH CAROLINA | 7 | 8 | 8 | 5 | **28** | 48 |
| NORTH DAKOTA | 13 | 24 | 6 | 14 | **57** | 9 |
| OHIO | 16 | 14 | 17 | 7 | **54** | 13 |
| OKLAHOMA | 5 | 20 | 16 | 3 | **44** | 27 |
| OREGON | 5 | 10 | 14 | 5 | **34** | 42 |
| PENNSYLVANIA | 13 | 6 | 20 | 10 | **49** | 20 |
| RHODE ISLAND | 6 | 10 | 4 | 8 | **28** | 49 |
| SOUTH CAROLINA | 32 | 16 | 6 | 1 | **55** | 11 |
| SOUTH DAKOTA | 12 | 14 | 22 | 13 | **61** | 5 |
| TENNESSEE | 21 | 14 | 9 | 6 | **50** | 17 |
| TEXAS | 26 | 12 | 22 | 7 | **67** | 2 |
| UTAH | 18 | 14 | 15 | 10 | **57** | 10 |
| VERMONT | 6 | 18 | 15 | 9 | **48** | 21 |
| VIRGINIA | 14 | 6 | 17 | 2 | **39** | 35 |
| WASHINGTON | 7 | 6 | 20 | 6 | **39** | 36 |
| WEST VIRGINIA | 5 | 16 | 10 | 8 | **39** | 37 |
| WISCONSIN | 24 | 18 | 4 | 6 | **52** | 16 |
| WYOMING | 22 | 26 | 9 | 7 | **64** | 3 |

# PILLAR 1: PROGRAM DESIGN & ENROLLMENT - RANKED

| STATE | Medicaid Expansion Status | Score (12 pts) | Early Work Requirement Activity | Score (8 pts) | Redetermination Performance | Score (6 pts) | MCO Presence | Score (4 pts) | Private-to-Medicaid Coverage Ratio | Score (6 pts) | Pillar 1 Score (36 pts) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GEORGIA | NOT ADOPTED | 12 | YES | 8 | 74.0 (Q3) | 3 | Yes | 4 | 90.5 (Q5) | 6 | **33** |
| SOUTH CAROLINA | NOT ADOPTED | 12 | YES | 8 | 61.0 (Q2) | 4 | Yes | 4 | 87.3 (Q4) | 4 | **32** |
| KANSAS | NOT ADOPTED | 12 | NO | 0 | 54.5 (Q1) | 6 | Yes | 4 | 93.1 (Q5) | 6 | **28** |
| TEXAS | NOT ADOPTED | 12 | NO | 0 | 68.2 (Q2) | 4 | Yes | 4 | 91.4 (Q5) | 6 | **26** |
| FLORIDA | NOT ADOPTED | 12 | NO | 0 | 64.5 (Q2) | 4 | Yes | 4 | 88.0 (Q4) | 4 | **24** |
| NEBRASKA | ADOPTED | 0 | YES | 8 | 48.7 (Q1) | 6 | Yes | 4 | 88.6 (Q5) | 6 | **24** |
| WISCONSIN | NOT ADOPTED | 12 | NO | 0 | 62.8 (Q2) | 4 | Yes | 4 | 86.8 (Q4) | 4 | **24** |
| MISSISSIPPI | NOT ADOPTED | 12 | NO | 0 | 73.5 (Q3) | 3 | Yes | 4 | 84.7 (Q3) | 3 | **22** |
| WYOMING | NOT ADOPTED | 12 | NO | 0 | 63.3 (Q2) | 4 | No | 0 | 92.7 (Q5) | 6 | **22** |
| TENNESSEE | NOT ADOPTED | 12 | NO | 0 | 79.3 (Q4) | 1 | Yes | 4 | 87.0 (Q4) | 4 | **21** |
| IOWA | ADOPTED | 0 | YES | 8 | 72.1 (Q3) | 3 | Yes | 4 | 85.3 (Q4) | 4 | **19** |
| ALABAMA | NOT ADOPTED | 12 | NO | 0 | 87.1 (Q5) | 0 | No | 0 | 89.1 (Q5) | 6 | **18** |
| UTAH | ADOPTED | 0 | YES | 8 | 91.5 (Q5) | 0 | Yes | 4 | 92.5 (Q5) | 6 | **18** |
| ARIZONA | ADOPTED | 0 | YES | 8 | 68.8 (Q2) | 4 | Yes | 4 | 82.3 (Q2) | 1 | **17** |
| OHIO | ADOPTED | 0 | YES | 8 | 70.5 (Q3) | 3 | Yes | 4 | 81.8 (Q2) | 1 | **16** |
| VIRGINIA | ADOPTED | 0 | NO | 0 | 54.7 (Q1) | 6 | Yes | 4 | 86.1 (Q4) | 4 | **14** |
| ARKANSAS | ADOPTED | 0 | YES | 8 | 76.0 (Q4) | 1 | Yes | 4 | 79.5 (Q1) | 0 | **13** |
| MONTANA | ADOPTED | 0 | YES | 8 | 67.5 (Q2) | 4 | No | 0 | 82.2 (Q2) | 1 | **13** |
| NORTH DAKOTA | ADOPTED | 0 | NO | 0 | 69.6 (Q3) | 3 | Yes | 4 | 90.7 (Q5) | 6 | **13** |
| PENNSYLVANIA | ADOPTED | 0 | NO | 0 | 53.4 (Q1) | 6 | Yes | 4 | 83.9 (Q3) | 3 | **13** |
| COLORADO | ADOPTED | 0 | NO | 0 | 65.4 (Q2) | 4 | Yes | 4 | 86.2 (Q4) | 4 | **12** |
| SOUTH DAKOTA | ADOPTED | 0 | NO | 0 | 48.5 (Q1) | 6 | No | 0 | 91.0 (Q5) | 6 | **12** |
| DELAWARE | ADOPTED | 0 | NO | 0 | 59.3 (Q1) | 6 | Yes | 4 | 82.4 (Q2) | 1 | **11** |
| ILLINOIS | ADOPTED | 0 | NO | 0 | 63.5 (Q2) | 4 | Yes | 4 | 84.3 (Q3) | 3 | **11** |
| NEW JERSEY | ADOPTED | 0 | NO | 0 | 71.0 (Q3) | 3 | Yes | 4 | 86.1 (Q4) | 4 | **11** |
| KENTUCKY | ADOPTED | 0 | NO | 0 | 55.7 (Q1) | 6 | Yes | 4 | 76.2 (Q1) | 0 | **10** |
| MARYLAND | ADOPTED | 0 | NO | 0 | 71.8 (Q3) | 3 | Yes | 4 | 84.2 (Q3) | 3 | **10** |
| NEW HAMPSHIRE | ADOPTED | 0 | NO | 0 | 80.1 (Q5) | 0 | Yes | 4 | 90.9 (Q5) | 6 | **10** |
| NEW YORK | ADOPTED | 0 | NO | 0 | 46.3 (Q1) | 6 | Yes | 4 | 73.3 (Q1) | 0 | **10** |
| MAINE | ADOPTED | 0 | NO | 0 | 37.8 (Q1) | 6 | No | 0 | 84.0 (Q3) | 3 | **9** |
| MASSACHUSETTS | ADOPTED | 0 | NO | 0 | 67.5 (Q2) | 4 | Yes | 4 | 80.4 (Q2) | 1 | **9** |
| MISSOURI | ADOPTED | 0 | NO | 0 | 78.8 (Q4) | 1 | Yes | 4 | 86.4 (Q4) | 4 | **9** |
| INDIANA | ADOPTED | 0 | NO | 0 | 77.2 (Q4) | 1 | Yes | 4 | 82.9 (Q3) | 3 | **8** |
| MINNESOTA | ADOPTED | 0 | NO | 0 | 79.0 (Q4) | 1 | Yes | 4 | 84.5 (Q3) | 3 | **8** |
| LOUISIANA | ADOPTED | 0 | NO | 0 | 71.4 (Q3) | 3 | Yes | 4 | 72.4 (Q1) | 0 | **7** |
| NORTH CAROLINA | ADOPTED | 0 | NO | 0 | 85.1 (Q5) | 0 | Yes | 4 | 84.5 (Q3) | 3 | **7** |
| WASHINGTON | ADOPTED | 0 | NO | 0 | 84.5 (Q5) | 0 | Yes | 4 | 84.3 (Q3) | 3 | **7** |
| ALASKA | ADOPTED | 0 | NO | 0 | 50.5 (Q1) | 6 | No | 0 | 78.9 (Q1) | 0 | **6** |
| RHODE ISLAND | ADOPTED | 0 | NO | 0 | 74.4 (Q4) | 1 | Yes | 4 | 80.1 (Q2) | 1 | **6** |
| VERMONT | ADOPTED | 0 | NO | 0 | 70.5 (Q3) | 3 | No | 0 | 83.0 (Q3) | 3 | **6** |
| CALIFORNIA | ADOPTED | 0 | NO | 0 | 74.9 (Q4) | 1 | Yes | 4 | 73.1 (Q1) | 0 | **5** |
| HAWAII | ADOPTED | 0 | NO | 0 | 79.9 (Q5) | 0 | Yes | 4 | 82.9 (Q2) | 1 | **5** |
| IDAHO | ADOPTED | 0 | NO | 0 | 74.4 (Q4) | 1 | No | 0 | 86.5 (Q4) | 4 | **5** |
| NEVADA | ADOPTED | 0 | NO | 0 | 93.0 (Q5) | 0 | Yes | 4 | 82.7 (Q2) | 1 | **5** |
| OKLAHOMA | ADOPTED | 0 | NO | 0 | 81.9 (Q5) | 0 | Yes | 4 | 82.1 (Q2) | 1 | **5** |
| OREGON | ADOPTED | 0 | NO | 0 | 78.9 (Q4) | 1 | Yes | 4 | 77.4 (Q1) | 0 | **5** |
| WEST VIRGINIA | ADOPTED | 0 | NO | 0 | 75.5 (Q4) | 1 | Yes | 4 | 76.2 (Q1) | 0 | **5** |
| CONNECTICUT | ADOPTED | 0 | NO | 0 | 71.8 (Q3) | 3 | No | 0 | 80.8 (Q2) | 1 | **4** |
| MICHIGAN | ADOPTED | 0 | NO | 0 | 80.8 (Q5) | 0 | Yes | 4 | 80.0 (Q1) | 0 | **4** |
| NEW MEXICO | ADOPTED | 0 | NO | 0 | 84.5 (Q5) | 0 | Yes | 4 | 65.5 (Q1) | 0 | **4** |

# PILLAR 2: FISCAL SUSTAINABILITY & BUDGET EXPOSURE - RANKED

| STATE | Five-Year Medicaid Spending Growth | Score (10 pts) | Per-Enrollee Cost Growth | Score (8 pts) | Medicaid Share of State Budget | Score (8 pts) | Pillar 2 Score (26 pts) |
|---|---|---|---|---|---|---|---|
| HAWAII | 0.8 (Q1) | 10 | -2.1 (Q1) | 8 | 6.4 (Q1) | 8 | **26** |
| MISSISSIPPI | -3.4 (Q1) | 10 | -2.0 (Q1) | 8 | 6.7 (Q1) | 8 | **26** |
| WYOMING | 1.3 (Q1) | 10 | -5.7 (Q1) | 8 | 5.5 (Q1) | 8 | **26** |
| ALASKA | 0.4 (Q1) | 10 | -0.4 (Q2) | 6 | 7.8 (Q1) | 8 | **24** |
| NORTH DAKOTA | 2.4 (Q2) | 8 | -2.8 (Q1) | 8 | 8.1 (Q1) | 8 | **24** |
| ARKANSAS | 1.2 (Q1) | 10 | 1.1 (Q3) | 4 | 7.1 (Q1) | 8 | **22** |
| ALABAMA | 1.9 (Q2) | 8 | 0.7 (Q2) | 6 | 8.7 (Q2) | 6 | **20** |
| MICHIGAN | 1.2 (Q1) | 10 | -0.3 (Q2) | 6 | 12.9 (Q3) | 4 | **20** |
| OKLAHOMA | -1.6 (Q1) | 10 | -1.1 (Q1) | 8 | 13.6 (Q4) | 2 | **20** |
| MISSOURI | -0.8 (Q1) | 10 | -2.6 (Q1) | 8 | 26.9 (Q5) | 0 | **18** |
| MONTANA | 3.0 (Q2) | 8 | 1.7 (Q3) | 4 | 10.6 (Q2) | 6 | **18** |
| VERMONT | 0.9 (Q1) | 10 | 0.9 (Q3) | 4 | 12.8 (Q3) | 4 | **18** |
| WISCONSIN | 3.4 (Q2) | 8 | -0.1 (Q2) | 6 | 12.2 (Q3) | 4 | **18** |
| CONNECTICUT | 3.1 (Q2) | 8 | 0.7 (Q2) | 6 | 14.7 (Q4) | 2 | **16** |
| INDIANA | 4.4 (Q3) | 6 | -2.8 (Q1) | 8 | 14.6 (Q4) | 2 | **16** |
| IOWA | 1.4 (Q2) | 8 | 0.4 (Q2) | 6 | 13.5 (Q4) | 2 | **16** |
| MAINE | 3.9 (Q3) | 6 | -1.9 (Q1) | 8 | 14.9 (Q4) | 2 | **16** |
| SOUTH CAROLINA | 3.7 (Q3) | 6 | 2.1 (Q3) | 4 | 9.5 (Q2) | 6 | **16** |
| WEST VIRGINIA | 4.4 (Q3) | 6 | 3.0 (Q4) | 2 | 6.8 (Q1) | 8 | **16** |
| LOUISIANA | 0.9 (Q1) | 10 | 2.8 (Q4) | 2 | 15.9 (Q4) | 2 | **14** |
| NEBRASKA | 3.5 (Q3) | 6 | 2.1 (Q4) | 2 | 10.1 (Q2) | 6 | **14** |
| NEVADA | 5.4 (Q4) | 2 | -0.3 (Q2) | 6 | 10.2 (Q2) | 6 | **14** |
| OHIO | 2.5 (Q2) | 8 | 1.2 (Q3) | 4 | 18.4 (Q4) | 2 | **14** |
| SOUTH DAKOTA | 2.3 (Q2) | 8 | 2.2 (Q4) | 2 | 10.8 (Q3) | 4 | **14** |
| TENNESSEE | 1.9 (Q2) | 8 | 0.6 (Q2) | 6 | 19.0 (Q5) | 0 | **14** |
| UTAH | 7.7 (Q5) | 0 | -0.6 (Q1) | 8 | 8.6 (Q2) | 6 | **14** |
| KANSAS | 4.4 (Q3) | 6 | 3.4 (Q5) | 0 | 9.7 (Q2) | 6 | **12** |
| MASSACHUSETTS | 4.0 (Q3) | 6 | 0.6 (Q2) | 6 | 20.9 (Q5) | 0 | **12** |
| NEW HAMPSHIRE | 1.7 (Q2) | 8 | 0.8 (Q3) | 4 | 22.8 (Q5) | 0 | **12** |
| TEXAS | 4.2 (Q3) | 6 | -0.4 (Q2) | 6 | 23.6 (Q5) | 0 | **12** |
| DELAWARE | 4.6 (Q4) | 2 | 2.1 (Q4) | 2 | 8.3 (Q2) | 6 | **10** |
| FLORIDA | 5.4 (Q4) | 2 | -1.0 (Q1) | 8 | 20.1 (Q5) | 0 | **10** |
| IDAHO | 3.5 (Q3) | 6 | 2.6 (Q4) | 2 | 16.3 (Q4) | 2 | **10** |
| NEW JERSEY | 5.1 (Q4) | 2 | 2.0 (Q3) | 4 | 11.2 (Q3) | 4 | **10** |
| OREGON | 9.4 (Q5) | 0 | 3.1 (Q4) | 2 | 6.5 (Q1) | 8 | **10** |
| RHODE ISLAND | 3.6 (Q3) | 6 | 3.1 (Q4) | 2 | 13.6 (Q4) | 2 | **10** |
| ARIZONA | 8.6 (Q5) | 0 | 6.6 (Q5) | 0 | 5.7 (Q1) | 8 | **8** |
| ILLINOIS | 10.3 (Q5) | 0 | 8.0 (Q5) | 0 | 5.9 (Q1) | 8 | **8** |
| NORTH CAROLINA | 4.9 (Q4) | 2 | 1.2 (Q3) | 4 | 18.7 (Q4) | 2 | **8** |
| CALIFORNIA | 4.9 (Q4) | 2 | 3.9 (Q5) | 0 | 12.8 (Q3) | 4 | **6** |
| COLORADO | 5.8 (Q4) | 2 | 1.1 (Q3) | 4 | 20.3 (Q5) | 0 | **6** |
| GEORGIA | 6.8 (Q5) | 0 | 3.2 (Q5) | 0 | 9.3 (Q2) | 6 | **6** |
| KENTUCKY | 7.4 (Q5) | 0 | 7.0 (Q5) | 0 | 10.4 (Q2) | 6 | **6** |
| MARYLAND | 7.2 (Q5) | 0 | 2.6 (Q4) | 2 | 12.3 (Q3) | 4 | **6** |
| PENNSYLVANIA | 4.6 (Q4) | 2 | 1.8 (Q3) | 4 | 26.8 (Q5) | 0 | **6** |
| VIRGINIA | 8.8 (Q5) | 0 | 3.1 (Q4) | 2 | 12.0 (Q3) | 4 | **6** |
| WASHINGTON | 4.9 (Q4) | 2 | 3.7 (Q5) | 0 | 11.3 (Q3) | 4 | **6** |
| MINNESOTA | 4.7 (Q4) | 2 | 2.3 (Q4) | 2 | 19.0 (Q5) | 0 | **4** |
| NEW MEXICO | 6.3 (Q5) | 0 | 7.4 (Q5) | 0 | 10.7 (Q3) | 4 | **4** |
| NEW YORK | 17.9 (Q5) | 0 | 5.6 (Q5) | 0 | 20.7 (Q5) | 0 | **0** |

# PILLAR 3: PROGRAM INTEGRITY & ADMINISTRATIVE OVERSIGHT - RANKED

| STATE | Improper Payment Rate | Score (12 pts) | MFCU Enforcement Strength | Score (8 pts) | APCD Status | Score (4 pts) | Pillar 3 Score (24 pts) |
|---|---|---|---|---|---|---|---|
| KANSAS | 0.1 (Q1) | 12 | 4.10 (Q5) | 8 | Existing | 4 | **24** |
| ARKANSAS | 0.6 (Q1) | 12 | 2.26 (Q4) | 6 | Existing | 4 | **22** |
| MISSOURI | 1.3 (Q1) | 12 | 2.88 (Q5) | 8 | Voluntary Activity | 2 | **22** |
| SOUTH DAKOTA | 0.2 (Q1) | 12 | 2.67 (Q5) | 8 | Strong Interest | 2 | **22** |
| TEXAS | 1.3 (Q1) | 12 | 1.73 (Q4) | 6 | Existing | 4 | **22** |
| MINNESOTA | 2.2 (Q2) | 9 | 2.89 (Q5) | 8 | Existing | 4 | **21** |
| PENNSYLVANIA | 0.3 (Q1) | 12 | 2.22 (Q4) | 6 | Strong Interest | 2 | **20** |
| WASHINGTON | 0.2 (Q1) | 12 | 0.93 (Q3) | 4 | Existing | 4 | **20** |
| NEVADA | 2.9 (Q3) | 6 | 3.51 (Q5) | 8 | Existing | 4 | **18** |
| IOWA | 1.9 (Q2) | 9 | 1.62 (Q4) | 6 | Strong Interest | 2 | **17** |
| LOUISIANA | 1.9 (Q2) | 9 | 1.48 (Q4) | 6 | Strong Interest | 2 | **17** |
| OHIO | 2.0 (Q2) | 9 | 2.92 (Q5) | 8 | No Activity | 0 | **17** |
| VIRGINIA | 2.2 (Q2) | 9 | 0.88 (Q3) | 4 | Existing | 4 | **17** |
| ILLINOIS | 1.2 (Q1) | 12 | 1.20 (Q3) | 4 | No Activity | 0 | **16** |
| NEBRASKA | 1.2 (Q1) | 12 | 0.62 (Q2) | 2 | Strong Interest | 2 | **16** |
| OKLAHOMA | 0.2 (Q1) | 12 | 0.44 (Q2) | 2 | Voluntary Activity | 2 | **16** |
| NEW HAMPSHIRE | 3.9 (Q4) | 3 | 3.58 (Q5) | 8 | Existing | 4 | **15** |
| UTAH | 1.9 (Q2) | 9 | 0.63 (Q2) | 2 | Existing | 4 | **15** |
| VERMONT | 5.6 (Q4) | 3 | 8.05 (Q5) | 8 | Existing | 4 | **15** |
| OREGON | 2.9 (Q3) | 6 | 0.85 (Q3) | 4 | Existing | 4 | **14** |
| CONNECTICUT | 5.6 (Q4) | 3 | 1.49 (Q4) | 6 | Existing | 4 | **13** |
| GEORGIA | 1.8 (Q2) | 9 | 0.17 (Q1) | 0 | Existing | 4 | **13** |
| HAWAII | 1.4 (Q2) | 9 | 0.00 (Q1) | 0 | Existing | 4 | **13** |
| NEW YORK | 1.4 (Q2) | 9 | 0.27 (Q1) | 0 | Existing | 4 | **13** |
| ALABAMA | 0.2 (Q1) | 12 | 0.00 (Q1) | 0 | No Activity | 0 | **12** |
| INDIANA | 7.6 (Q5) | 0 | 2.72 (Q5) | 8 | Existing | 4 | **12** |
| KENTUCKY | 2.9 (Q3) | 6 | 1.04 (Q3) | 4 | Strong Interest | 2 | **12** |
| MAINE | 2.4 (Q3) | 6 | 0.29 (Q2) | 2 | Existing | 4 | **12** |
| DELAWARE | 6.9 (Q5) | 0 | 1.54 (Q4) | 6 | Existing | 4 | **10** |
| FLORIDA | 7.0 (Q5) | 0 | 1.25 (Q4) | 6 | Existing | 4 | **10** |
| NEW MEXICO | 3.7 (Q3) | 6 | 0.27 (Q1) | 0 | Existing | 4 | **10** |
| WEST VIRGINIA | 3.5 (Q3) | 6 | 0.82 (Q3) | 4 | No Activity | 0 | **10** |
| ARIZONA | 6.4 (Q4) | 3 | 1.74 (Q4) | 6 | No Activity | 0 | **9** |
| MARYLAND | 4.5 (Q4) | 3 | 0.35 (Q2) | 2 | Existing | 4 | **9** |
| TENNESSEE | 5.6 (Q4) | 3 | 1.08 (Q3) | 4 | Strong Interest | 2 | **9** |
| WYOMING | 2.1 (Q2) | 9 | 0.00 (Q1) | 0 | No Activity | 0 | **9** |
| ALASKA | 9.7 (Q5) | 0 | 1.28 (Q4) | 6 | Strong Interest | 2 | **8** |
| MICHIGAN | 3.3 (Q3) | 6 | 0.33 (Q2) | 2 | No Activity | 0 | **8** |
| MONTANA | 7.0 (Q5) | 0 | 3.26 (Q5) | 8 | No Activity | 0 | **8** |
| NORTH CAROLINA | 3.0 (Q3) | 6 | 0.22 (Q1) | 0 | Strong Interest | 2 | **8** |
| COLORADO | 5.4 (Q4) | 3 | 0.09 (Q1) | 0 | Existing | 4 | **7** |
| IDAHO | 6.1 (Q4) | 3 | 0.98 (Q3) | 4 | No Activity | 0 | **7** |
| MISSISSIPPI | 4.7 (Q4) | 3 | 0.86 (Q3) | 4 | No Activity | 0 | **7** |
| NEW JERSEY | 5.7 (Q4) | 3 | 0.77 (Q2) | 2 | Strong Interest | 2 | **7** |
| CALIFORNIA | 8.1 (Q5) | 0 | 0.32 (Q2) | 2 | Existing | 4 | **6** |
| MASSACHUSETTS | 7.1 (Q5) | 0 | 0.71 (Q2) | 2 | Existing | 4 | **6** |
| NORTH DAKOTA | 2.7 (Q3) | 6 | 0.00 (Q1) | 0 | No Activity | 0 | **6** |
| SOUTH CAROLINA | 20.5 (Q5) | 0 | 1.13 (Q3) | 4 | Voluntary Activity | 2 | **6** |
| RHODE ISLAND | 8.8 (Q5) | 0 | 0.00 (Q1) | 0 | Existing | 4 | **4** |
| WISCONSIN | 9.1 (Q5) | 0 | 0.33 (Q2) | 2 | Voluntary Activity | 2 | **4** |

# PILLAR 4: MARKET STRUCTURE & PROVIDER ENVIRONMENT - RANKED

| STATE | Certificate-of-Need Laws | Score (4 pts) | Primary Care Provider Supply | Score (4 pts) | NP Scope of Practice | Score (2 pts) | PA Scope of Practice | Score (2 pts) | IMLC Participation | Score (2 pts) | Pillar 4 Score (14 pts) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NORTH DAKOTA | No Active CON Law | 4 | 352.0 (Q5) | 4 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **14** |
| SOUTH DAKOTA | No Active CON Law | 4 | 343.3 (Q4) | 3 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **13** |
| COLORADO | No Active CON Law | 4 | 305.2 (Q3) | 2 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **11** |
| ARIZONA | No Active CON Law | 4 | 268.2 (Q2) | 1 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **10** |
| KANSAS | No Active CON Law | 4 | 308.6 (Q3) | 2 | Independent Practice | 2 | Reduced | 0 | Member State | 2 | **10** |
| NEW HAMPSHIRE | Active CON Law | 0 | 370.7 (Q5) | 4 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **10** |
| NEW MEXICO | No Active CON Law | 4 | 296.9 (Q3) | 2 | Independent Practice | 2 | Advanced | 1 | IMLC Passed | 1 | **10** |
| PENNSYLVANIA | No Active CON Law | 4 | 324.5 (Q4) | 3 | Reduced Indep. Practice | 1 | Reduced | 0 | Member State | 2 | **10** |
| UTAH | No Active CON Law | 4 | 240.2 (Q1) | 0 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **10** |
| DELAWARE | Active CON Law | 0 | 352.6 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **9** |
| IDAHO | No Active CON Law | 4 | 265.6 (Q1) | 0 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **9** |
| MAINE | Active CON Law | 0 | 386.1 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **9** |
| MINNESOTA | Active CON Law | 0 | 349.0 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **9** |
| VERMONT | Active CON Law | 0 | 349.4 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **9** |
| ALASKA | Active CON Law | 0 | 369.9 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | IMLC Introduced | 1 | **8** |
| CONNECTICUT | Active CON Law | 0 | 332.1 (Q4) | 3 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **8** |
| MASSACHUSETTS | Active CON Law | 0 | 400.2 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | IMLC Introduced | 1 | **8** |
| MONTANA | Active CON Law | 0 | 304.0 (Q3) | 2 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **8** |
| NEBRASKA | Active CON Law | 0 | 320.4 (Q4) | 3 | Independent Practice | 2 | Moderate | 1 | Member State | 2 | **8** |
| RHODE ISLAND | Active CON Law | 0 | 379.4 (Q5) | 4 | Independent Practice | 2 | Advanced | 1 | IMLC Passed | 1 | **8** |
| WEST VIRGINIA | Active CON Law | 0 | 351.6 (Q5) | 4 | Reduced Indep. Practice | 1 | Advanced | 1 | Member State | 2 | **8** |
| IOWA | Active CON Law | 0 | 283.3 (Q2) | 1 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **7** |
| MARYLAND | Active CON Law | 0 | 312.3 (Q3) | 2 | Independent Practice | 2 | Moderate | 1 | Member State | 2 | **7** |
| OHIO | Active CON Law | 0 | 318.8 (Q4) | 3 | Reduced Indep. Practice | 1 | Moderate | 1 | Member State | 2 | **7** |
| TEXAS | No Active CON Law | 4 | 225.0 (Q1) | 0 | Supervision Required | 0 | Moderate | 1 | Member State | 2 | **7** |
| WYOMING | Active CON Law | 0 | 269.1 (Q2) | 1 | Independent Practice | 2 | Optimal | 2 | Member State | 2 | **7** |
| ILLINOIS | Active CON Law | 0 | 299.4 (Q3) | 2 | Reduced Indep. Practice | 1 | Advanced | 1 | Member State | 2 | **6** |
| KENTUCKY | Active CON Law | 0 | 326.1 (Q4) | 3 | Reduced Indep. Practice | 1 | Reduced | 0 | Member State | 2 | **6** |
| MICHIGAN | Active CON Law | 0 | 332.8 (Q4) | 3 | Supervision Required | 0 | Advanced | 1 | Member State | 2 | **6** |
| NEW YORK | Active CON Law | 0 | 346.9 (Q4) | 3 | Independent Practice | 2 | Moderate | 1 | No Status | 0 | **6** |
| TENNESSEE | Active CON Law | 0 | 319.1 (Q4) | 3 | Supervision Required | 0 | Moderate | 1 | Member State | 2 | **6** |
| WASHINGTON | Active CON Law | 0 | 288.4 (Q2) | 1 | Independent Practice | 2 | Advanced | 1 | Member State | 2 | **6** |
| WISCONSIN | Active CON Law | 0 | 317.5 (Q3) | 2 | Reduced Indep. Practice | 1 | Advanced | 1 | Member State | 2 | **6** |
| CALIFORNIA | No Active CON Law | 4 | 238.7 (Q1) | 0 | Supervision Required | 0 | Moderate | 1 | No Status | 0 | **5** |
| FLORIDA | Active CON Law | 0 | 318.3 (Q4) | 3 | Supervision Required | 0 | Reduced | 0 | Member State | 2 | **5** |
| HAWAII | Active CON Law | 0 | 283.2 (Q2) | 1 | Independent Practice | 2 | Reduced | 0 | Member State | 2 | **5** |
| INDIANA | Active CON Law | 0 | 285.5 (Q2) | 1 | Reduced Indep. Practice | 1 | Moderate | 1 | Member State | 2 | **5** |
| LOUISIANA | Active CON Law | 0 | 274.6 (Q2) | 1 | Reduced Indep. Practice | 1 | Moderate | 1 | Member State | 2 | **5** |
| NORTH CAROLINA | Active CON Law | 0 | 316.6 (Q3) | 2 | Supervision Required | 0 | Advanced | 1 | Member State | 2 | **5** |
| OREGON | Active CON Law | 0 | 290.8 (Q3) | 2 | Independent Practice | 2 | Advanced | 1 | No Status | 0 | **5** |
| MISSISSIPPI | Active CON Law | 0 | 286.5 (Q2) | 1 | Reduced Indep. Practice | 1 | Reduced | 0 | Member State | 2 | **4** |
| MISSOURI | Active CON Law | 0 | 296.9 (Q3) | 2 | Supervision Required | 0 | Reduced | 0 | Member State | 2 | **4** |
| NEVADA | Active CON Law | 0 | 235.6 (Q1) | 0 | Independent Practice | 2 | Reduced | 0 | Member State | 2 | **4** |
| NEW JERSEY | Active CON Law | 0 | 245.6 (Q1) | 0 | Reduced Indep. Practice | 1 | Moderate | 1 | Member State | 2 | **4** |
| ALABAMA | Active CON Law | 0 | 250.1 (Q1) | 0 | Reduced Indep. Practice | 1 | Reduced | 0 | Member State | 2 | **3** |
| ARKANSAS | Active CON Law | 0 | 251.1 (Q1) | 0 | Reduced Indep. Practice | 1 | Advanced | 1 | IMLC Passed | 1 | **3** |
| OKLAHOMA | Active CON Law | 0 | 249.4 (Q1) | 0 | Supervision Required | 0 | Moderate | 1 | Member State | 2 | **3** |
| GEORGIA | Active CON Law | 0 | 267.2 (Q1) | 0 | Supervision Required | 0 | Reduced | 0 | Member State | 2 | **2** |
| VIRGINIA | Active CON Law | 0 | 284.0 (Q2) | 1 | Supervision Required | 0 | Advanced | 1 | No Status | 0 | **2** |
| SOUTH CAROLINA | Active CON Law | 0 | 276.1 (Q2) | 1 | Supervision Required | 0 | Reduced | 0 | No Status | 0 | **1** |

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