# State Medicaid Enterprise Systems

Information technology (IT) systems are an essential tool in administering a modern state Medicaid program. This brief provides information regarding the Medicaid program functions that are supported by IT, details spending on the systems, discusses federal oversight of the systems projects, and highlights challenges for Medicaid IT systems.

## Background

The IT systems that support a state's Medicaid program are known as Medicaid Enterprise Systems (MES). Generally, states use these systems for eligibility determinations and renewals; claims and encounter data processing; provider enrollment; health care quality measurement; value-based payment; pharmacy benefit management; fraud, waste, and abuse analysis; and other functions as needed by a state's Medicaid program.

Financing of Medicaid administrative functions such as IT investments is a shared responsibility between the federal government and states; the share of administrative spending financed by the federal government is called federal financial participation (FFP) or the federal match. Medicaid administrative expenditures are generally matched at a 50 percent rate. In 1972, Congress authorized the federal government to pay enhanced FFP rates of 90 percent for sums attributable to the design, development, or installation (DDI) of such mechanized claims processing and information retrieval systems as the Secretary of the U.S. Department of Health and Human Services determines are likely to provide more efficient, economical, and effective administration of the state's Medicaid plan, and 75 percent for the operations and maintenance (O&M) of such systems (§ 1903(a)(3)(A)-(B) of the Social Security Act (the Act)).[1] States can claim other MES expenditures at the regular administrative matching rate of 50 percent.

MES are made up of many modules and functions. Table 1 summarizes the major types of MES modules, as well as some of the typical program functions for which states may use these modules.

**TABLE 1.** Categories of MES

| MES Category | Description |
|---|---|
| Medicaid Management Information System (MMIS) | The broadest category of MES; typical functions include:<br>• Claims and encounter data processing<br>• Provider enrollment and management<br>• Provider and plan payment, including value-based payments<br>• Managed care plan management and oversight<br>• Pharmacy benefit management<br>• Prescription drug monitoring program<br>• Data analytics and reporting<br>• Fraud, waste, and abuse analysis (program integrity)<br>• Health care quality measurement and Beneficiary care management<br>• Health Information Exchange |

| MES Category | Description |
|---|---|
| Eligibility & Enrollment (E&E) | E&E typically includes:<br>• Eligibility determination<br>• Eligibility renewal processes<br>• Beneficiary enrollment (generally into managed care) |
| Health Information Technology (HITECH) Administration | Established by the HITECH Act, HITECH administrative funding for systems generally ended in 2021. It was used mainly to help achieve goals around provider adoption and use of certified electronic health records. With the end of HITECH funding, CMS worked with states to continue achieving goals of health information exchange through the use of other MES funding, often as health care management. |

**Notes:** MES is Medicaid Enterprise Systems. CMS is the Centers for Medicare & Medicaid Services. E&E systems began receiving enhanced federal match in 2011.

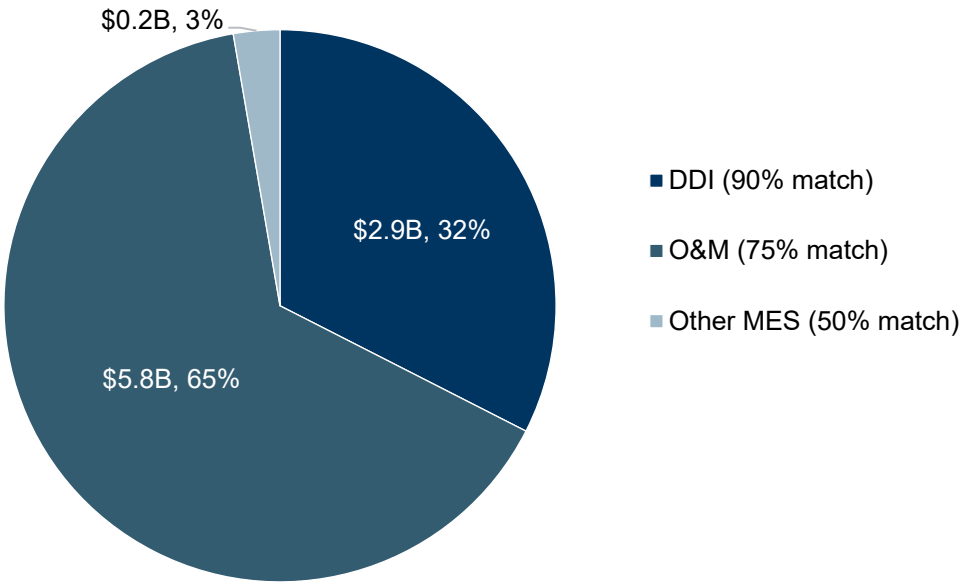
**Source:** CMS 2011a and 2022b.

# MES Spending

In fiscal year (FY) 2025, total federal and state MES spending was $9.0 billion (Figure 1).[2] This was about 20 percent of total Medicaid administrative spending (Table A-1). Of the overall total spent on MES, approximately two-thirds of MES spending is for MMIS-related functions (Table A-2). MES expenditures vary by state, ranging from $672 million in California to about $27 million in South Dakota.

Of total MES spending, approximately 32 percent is DDI, 65 percent is O&M, and the rest is other MES spending matched at the regular administrative rate of 50 percent (Figure 1).

**FIGURE 1.** Total MES Spending by Type and Federal Matching Rate, FY 2025 (Billions)

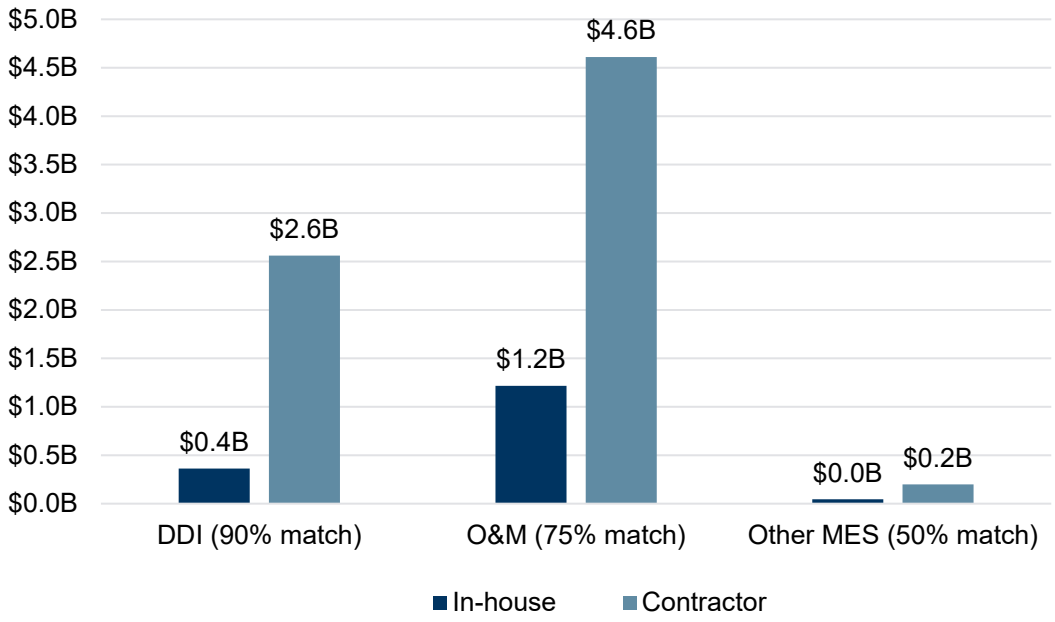


**Notes:** DDI is design development and implementation spending. FY is fiscal year. MES is Medicaid enterprise systems. O&M is operations and maintenance. Spending on DDI receives a 90 percent federal match, while O&M receives a 75 percent federal match. Other MES spending includes DDI and O&M for systems that have not been approved by CMS for enhanced federal match and can include systems shared with other state agencies; these expenditures receive the administrative federal match of 50 percent. Data labels may not add to 100 percent or total spending amount due to rounding.

**Source:** MACPAC, 2026, analysis of CMS-64 financial management report.

States may develop and operate MES using in-house resources or contract some or all of these services to an external vendor. The majority of MES expenditures (82 percent) were spent on contractors in 2025, with the remainder on in-house activities (Figure 2).

**FIGURE 2.** In-house and Contractor Spending by MES Type, FY 2025 (Billions)



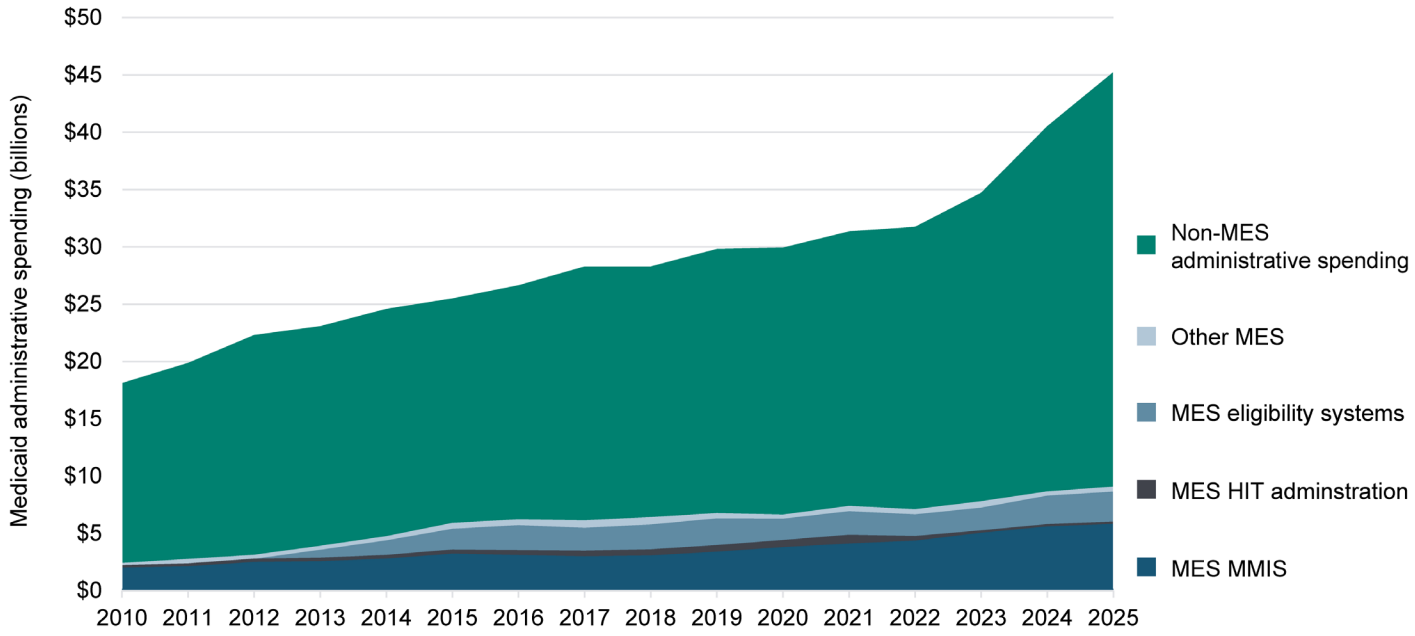

**Notes:** DDI is design development and implementation spending. FY is fiscal year. MES is Medicaid enterprise systems. O&M is operations and maintenance. Spending on DDI receives a 90 percent federal match, while O&M receives a 75 percent federal match. Other MES spending includes DDI and O&M for systems that have not been approved by CMS for enhanced federal match and can include systems shared with other state agencies; these expenditures receive the administrative federal match of 50 percent. $0.0B indicates an amount less than $0.5 billion that rounds to zero.

**Source:** MACPAC, 2026, analysis of CMS-64 financial management report.

## Spending trends

MES spending, as a percentage of overall administrative spending, grew significantly from 2012 through 2015, before slowing to grow at a rate similar to overall administrative spending by 2016 (Figure 3).[3] Some of this growth in spending can be attributed to a 2011 regulation allowing for enhanced funding for E&E systems to support the implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (CMS 2011b). However, the growth in MES spending did not contribute substantially to overall growth in administrative spending, which grew steadily from FY 2010–2025.

**FIGURE 3.** Medicaid Administrative Spending, FY 2010–2025 (Billions)




**Notes**: MMIS is Medicaid Management Information Systems. HIT is health information technology. MES is Medicaid enterprise systems. Administrative spending is state spending associated with administering the Medicaid program.

**Source:** MACPAC, 2026, analysis of CMS-64 financial management reports.

# Federal Oversight of MES Spending

To receive enhanced matching rates for their MES expenditures, states must first request and receive approval from the Centers for Medicare & Medicaid Services (CMS). Although the processes and criteria that CMS uses for oversight and approval of MES spending have evolved over the years, CMS focuses on approving systems that are cost effective and improve the efficiency of operating a state's Medicaid program. After the initial approval, CMS staff continuously engage with states throughout systems development and ongoing operations of states' MES.

## Federal Approval of MES Spending

There are multiple points in a state MES project in which CMS conducts oversight and approval processes:

- **Advanced Planning Document (APD)**: Federal regulations require states to receive approval prior to claiming expenditures at enhanced rates for IT systems and services (45 CFR 95.610). This approval is obtained through an APD, a recorded plan of action that the state will use to conduct the IT project. The state submits APDs for different IT project phases, including Planning APDs, Implementation APDs, and APD Updates, which are due 60 days prior to enhanced FFP expiration (45 CFR 95.610). APDs often include a detailed budget, rationale for enhanced funding, named state personnel who will lead the project, a cost-benefit analysis, and an analysis of alternatives. The APD includes CMS-required outcomes, state outcomes, and the metrics by which those outcomes will be measured. APDs may be for one or more MES modules.

APDs must be submitted at least annually (for systems in O&M) but may be submitted at any time the state wants to request approval for enhanced FFP from CMS. CMS has 60 days to review the APD. During this time, CMS may request additional information from the state which resets the 60-day review deadline. If CMS does not give the state any response during the 60-day period, the APD is deemed approved (CMS 2022a).

- **Procurement Approval:** States often use contractor resources to support MES projects. The state must obtain prior approval from CMS to acquire IT equipment or services when the state anticipates that the contract will have total acquisition costs of $5 million or more in federal and state funds. For both requests for proposals and resulting contracts, CMS has 60 days to either approve or ask the state for additional information (45 CFR 95.611).
- **Assessing Development Project Health:** Throughout the DDI phase of a systems project, states are required to submit monthly progress reports detailing development achievements and testing progress to CMS. As a module is ready to go into official use, the state requests that CMS conduct an operational readiness review (ORR) before releasing a system or module into production. CMS and the state collaborate to determine the appropriate point at which to conduct the ORR, but approximately six months provides sufficient time to prepare for the review. During the ORR preparation period, CMS and the state determine the minimum set of evidence and artifacts needed to demonstrate the project is ready to enter production and to achieve outcomes. After the ORR, CMS returns comments to the state, and the state addresses the observations and findings as the project goes into production in preparation for system certification (CMS 2022b).
- **System Certification**: To be eligible to receive the enhanced 75 percent FFP for IT operations, CMS must certify the state's system after the system has been in production for at least six months (CMS 2022a). CMS uses the certification process, now called streamlined modular certification, to ensure that the state's system meets the standards and conditions outlined in federal regulations and achieves planned outcomes (CMS 2022b). Once received, certification can be retroactive to the first day of the calendar quarter following the initial use by the state. Although not specified in guidance or regulation, certification must meet a timeline that ensures the state can request any retroactive funding in a timely manner (45 CFR 95.7).
- **Ongoing operational approval**: After initial approval for O&M enhanced 75 percent FFP, CMS periodically reviews and reapproves state systems. CMS has discretion regarding which modules to re-review, but at a minimum must validate that the system operates in alignment with federal requirements (42 CFR 433.119, CMS 2023b). CMS requires states to submit operational reports containing metric data and verification of compliance with applicable federal and state requirements. In 2025, CMS announced that states will need to submit monthly operational reports using an updated Operational Report Workbook (CMS 2025a). If CMS determines a state's MES module or solution is no longer compliant as a result of operational reporting or reapproval review, the state will be required to complete a corrective action plan. Ongoing system non-compliance can result in the reduction of the enhanced FFP (CMS 2023b, 2022a).
- **Medicaid IT Architecture (MITA) State Self-Assessment (SS-A)**: CMS has provided states with a structured methodology to assess their current business operations and supporting technology, as well as their planned future operations and technology. The state conducts a self-assessment that identifies the goals, plans, and objectives of their MITA and submits this self-assessment to CMS. CMS ensures MES investments align with the goals, plans, and objectives reported in the state's MITA self-assessment (CMS 2014). Generally, a state completes an SS-A for their entire Medicaid program, not for a specific MES module or IT investment. Therefore, SS-As are updated only as necessary and agreed to by CMS and the state.

## Cost Allocation of IT Investments

When a given investment in IT will benefit more than one program, federal policy and regulations require that states allocate the costs among the programs benefiting from the investment (45 CFR 95.501-95.519). For example, many state Medicaid eligibility systems are developed and operated by the state's human services agency. These systems are often used to determine eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP) Temporary Assistance for Needy Families (TANF), and other state-level assistance programs.

In a similar manner, costs for a health information exchange (HIE) in a state must be allocated across programs that benefit from the HIE.

The cost allocation plan must describe the procedures used to identify, measure, and allocate costs to each of the programs operated by the state agency, and must comply with accounting procedures described by the Office of Management and Budget (OMB) in their Circular A-87. The cost allocation plan must also contain enough information to allow the federal government to assess the soundness of the plan.

Because there are various ways costs can be allocated to Medicaid and other federal programs, states and their various federal partners may need to negotiate over the approved cost allocation methodology. For example, a state may propose a provider-based cost allocation methodology to allocate HIE expenses. In this scenario, any provider accepting Medicaid patients would be counted in the cost allocation plan, even a provider who has only one Medicaid member in their population. However, CMS may consider a beneficiary-based methodology, which would allocate expenses based upon Medicaid's proportion of the population served by the HIE, as more appropriate.

## Recent Policy Developments

In recent years, CMS has undertaken a number of activities designed to strengthen and improve their oversight processes of IT projects. These enhancements include:

- **Creating transparent approval processes**. Historically, states noted a lack of transparency in CMS's IT approval process, specifically the timeline and progress as well as confusion surrounding requests for additional information. In response, CMS created APD standard operating procedures, standardized budget templates, and provided more visibility to states regarding APD review status. CMS also created a single repository to store documentation that supports APD review decisions and allows CMS to more accurately track and report on approvals and MES spending.
- **Greater technical assistance on IT projects**. To improve CMS partnership with states and to better ensure consistency of decision making for a state, CMS started providing greater technical support on IT projects. Medicaid State Systems Officers were established in 2019 as part of a broader reorganization of the CMS Center for Medicaid and Children's Services. Typically, a state officer works with one to three states and has visibility into that state's overall program goals and business objectives, as well as the overall set of IT investments underway in the state.
- **Updating the standards and conditions for enhanced IT spending**. The 2015 final rule on Medicaid mechanized claims processing and information retrieval systems made eligibility systems permanently eligible for the enhanced MES match (CMS 2015). In addition, this regulation updated various standards and conditions for the enhanced federal match for all MES, created the process for modular certification, updated definitions to better align with modern software development principles, and clarified ownership of software developed with federal funding.
- **Transitioning to outcomes-based IT projects**. CMS moved to an outcomes-based approach called streamlined modular certification, which requires states to meet a set of outcomes that are based in federal statute and regulation (CMS 2022b). For example, state E&E systems must make eligibility determinations within 90 days. States may also add their own state-specific outcomes. CMS uses these outcomes and resulting metrics to assess project success and to make ongoing funding approvals for the investment.

# MES Challenges

## Complex systems are difficult to maintain and expensive to operate

Medicaid is a complex program to administer. In each state, Medicaid can cover a range of different populations, providing each with a distinct set of benefits. For each of these populations, states need to have IT systems that can support different eligibility policies, varying benefit plans, and multiple payment methods or delivery systems. For example, pregnant women may receive their benefits through managed care or have their maternity-related care paid for through a bundled payment. Individuals eligible on the basis of disability may receive benefits through a fee-for-service model where providers are paid for each specific service they provide. Each of these policy requirements must be reflected accurately in the systems used to administer, monitor, and oversee Medicaid. Any changes in Medicaid policy, either at the federal or state level, require corresponding changes within the MES.

Originally, states primarily used IT to process claims for payment to providers. As Medicaid has grown in complexity, IT systems have evolved to cover additional populations, administer contracts with managed care plans to deliver benefits, use data to analyze for fraud, waste and abuse, measure quality of care, and conduct many other functions. These new IT functions may be developed as new systems or built into existing systems, and sometimes these functions are developed and maintained through contracts with outside vendors. These varied systems do not necessarily communicate with each other directly and often can only exchange information through complex data exchanges, which may be prone to error. System changes in one system often requires corresponding changes in other systems, making the entire operation difficult and expensive to maintain.

In addition, states often require their vendors to have previous experience and knowledge of Medicaid systems, which can limit the pool of vendors who can win contracts. Limited competition can also lead to higher costs for maintaining and operating Medicaid systems.

## Prioritization and limited state capacity

Medicaid agencies have a number of federal mandates which require upgrades to IT systems. For example, recent federal legislation, regulation, and guidance have included requirements to implement:

- **Electronic Visit Verification for Home- and Community-Based Services (HCBS).** In an effort to combat fraud, the 21st Century Cures Act (Cures Act, P.L. 114-255) mandated that states implement systems so that caregivers providing HCBS care could electronically record information about their visit to a beneficiary.
- **Responses to the COVID-19 Public Health Emergency and subsequent return to normal operations.** States were required to take many actions in response to the COVID-19 public health emergency and were given many options they could elect to help in the response, such as expanded telehealth reimbursement and enhanced match for continuous eligibility (Libersky et al 2020; Families First Coronavirus Response Act, P.L. 116-127). Virtually all of these mandates and options required updates to systems, and many had to be changed back at the end of the PHE (CMS 2025b).
- **Mandatory submission of child and adult core set quality measures.** Although many states have been submitting core set health care quality measures to CMS, the data submission has been voluntary. Beginning in FY 2024, submission of clinical health care quality measures for both children and adults is mandatory for states (42 CFR 433, 437, and 457).
- **Mandatory coverage of adult vaccinations under the Inflation Reduction Act.** Congress required that states provide coverage for recommended vaccinations to all adults in their Medicaid programs (CMS 2023a).
- **New regulatory provisions to improve access to health information by beneficiaries and providers.** Through regulation, CMS required states to make certain patient health care data and provider network data

electronically available. The rule also requires that states be able to exchange data with other insurers when Medicaid members move to new health care plans (CMS 2020).

- **Changes to prior authorization interoperability standards.** The 2024 Advancing Interoperability and Improving Prior Authorization Processes final rule requires Medicaid fee-for-service and managed care organizations to implement and maintain four application programing interfaces – prior authorization, patient access, provider, and payer-to-payer – that follow a set of interoperability standards (i.e., Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®)) by January 1, 2027 (CMS 2024).
- **Requirements to improve monthly data submissions to CMS.** CMS specified data quality criteria that states must meet in their monthly data submissions to CMS. These criteria strengthened over time, meaning states had to devote resources to meeting the new criteria or face funding consequences (CMS 2019b).
- **Community engagement requirements.** Public Law No. 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act), enacted on July 4, 2025, requires states to establish processes to use the reliable information it has in its possession to confirm whether a beneficiary either meets or is exempt from the community engagement requirements. The information states may utilize includes individual case records or information obtained through other reliable data sources, such as payroll data, encounter data, or data sources regarding higher education enrollment. A state may not request additional information or documentation from a beneficiary unless it is unable to use available data to establish that the beneficiary either meets or is exempt from the community engagement requirements. As some of the information above has the potential to exist outside of states' current MES, states may need to upgrade or enhance current IT systems to obtain the necessary information to confirm a beneficiary's status as it relates to the community engagement requirements.

Nearly all of these mandates require substantial development and enhancement of existing systems, a Medicaid agency's time and resources, and budget for enhancing and improving systems. While states can ask for additional resources through the approval processes outlined above, those requests often require time, especially if a procurement is involved. States must also have the necessary state matching funds in their budgets.

In addition to the federal mandates and regulations, state governments often have system changes that they want to make based on state legislative requirements or their own initiatives, which can challenge a Medicaid agency's ability to balance priorities in a way that meets state and federal requirements. In this situation, states make their own prioritization decisions or seek guidance from CMS about how to balance priorities and resources.

## Use of Contractor Resources

In FY 2025, states spent just under 82 percent of MES spending, amounting to $7.4 billion, on MES contractor resources. As a result, a significant portion of both program and technical knowledge resides with personnel who are employed by contractors, not by the state. Use of external vendors can create different challenges and a need for different skills among the state staff. For example, in 2016, the Department of Health and Human Services Office of Inspector General released a case study of the failed implementation of HealthCare.gov (OIG 2016). The study named 10 key lessons from that implementation, including: ensuring that there is clear project leadership from the beginning of a major effort, aligning project strategies with the resources (including personnel) available, paying constant attention to the project to simplify design and operations, integrating technical and policy decisions, and ensuring effective oversight of large IT projects.

With such a heavy reliance on contracted resources in MES projects, these lessons are instructive to CMS and state leaders. Namely, the state should have the capacity to manage IT contractors, and operations and that technical design is kept simple, state Medicaid staff should make technical and policy decisions, not IT vendors, and state staff should assess the quality of the work provided by the contractor effectively. All of these capabilities are required to guide and monitor a contractor's performance successfully.

IT procurements can be resource intensive and time consuming. This includes multiple levels of approval, lengthy technical specifications, and the use of specific financial penalties in the event a vendor does not perform

successfully. These actions add time to the overall process and may ultimately limit the number of vendors who are able to accept the risk of the procurement and meet the requirements of the subsequent contract.

## Transitioning to an outcomes-based approach

CMS has been transitioning MES toward an outcome-based approach to provide greater flexibility to states and lower the burden on state and CMS resources in the certification process (CMS 2022b). Historically, CMS measured project success based on three criteria: whether the project was executed on time, on budget, and provided desired functionality. However, determining the schedule, budget, and desired functionality before the work started meant there was little opportunity for adapting to shifting state and federal priorities nor was there any measurement of improvements to work processes or user satisfaction once the IT system was implemented.

The outcomes-based approach provides more flexibility, requires objective assessment of the improvement resulting from the new technology, and compels CMS and states to identify the desired outcomes of the investment as a condition of receiving funding (CMS 2022a). In 2025, CMS announced forthcoming standardized templates to support states and reduce burden during the APD process. These templates are intended to expedite funding reviews, promote reuse, standardize operational reporting, and facilitate a unified certification process for all MES modules (CMS 2025a).

CMS has the flexibility to implement a corrective action plan and rescind the enhanced federal match if states do not accomplish state outcomes (CMS 2023b). However, for state-developed outcomes, CMS has not made clear whether funding might be at risk when outcomes are not achieved.

## Modularity and Reuse

Modularity and reuse are regulatory requirements for states to receive enhanced funding for IT projects. The goals for these two policies are to reduce costs and accelerate implementation timelines for states. Despite common business practices across state Medicaid programs, and years of experience operating under these requirements, there are little data available that show these goals have been achieved.

Modularity in Medicaid refers to a set of hardware and software that supports one business area of the Medicaid enterprise (CMS 2016).[4] For example, a module might support provider enrollment and screening. Another module might support eligibility and enrollment for a specific category of beneficiaries.

Reuse can be defined in many ways, but it generally refers to a state checking for options to re-use previous IT work in their current IT project. States may be able to re-use an analysis of a process done by another state agency, or reuse software developed by another state. For example, one state's eligibility and enrollment module could be purchased and replicated for a neighboring states' Medicaid eligibility system.[5] A few states currently are re-using technology developed by Virginia to process encounter data submitted to the states by their managed care plans. CMS provides examples of the MES components that states can reuse, as well as other expectations that CMS has of states to demonstrate compliance with reuse requirements.

While Medicaid policy varies by state, there are business functions that are common across states.[6] For example, all states enroll, screen and manage the health care providers who serve Medicaid beneficiaries. All states make payments to health care providers and/or health plans. All states conduct program integrity operations, deliver pharmacy benefits, and measure health care quality outcomes. All states send monthly data to CMS through the Transformed Medicaid Statistical Information System.

To date, modularity and reuse policies have achieved mixed results. In one example, 13 states collaborated on systems to implement the HITECH program, which paid incentives to Medicaid providers to adopt, implement or upgrade health information technology. In contrast, CMS abandoned efforts to build a provider enrollment and screening solution when states failed to adopt the technology. Multiple states have collaborated to create common contracting vehicles through the National Association of State Procurement Officers to meet reuse

requirements for various Medicaid business operations, such as provider enrollment and screening and claims processing.

# Conclusion

MES plays a significant role in a state's management of data and the overall management and oversight of its Medicaid program. States must consider federal mandates as well as state needs in implementing, enhancing, and maintaining MES. While total administrative spending has grown steadily from 2010–2025, the increases in MES spending have been relatively flat since 2015. However, MES spending is expected to increase as states make investments in IT systems needed to implement various provisions in the 2025 Budget Reconciliation Act, including the community engagement requirements.

**Endnotes**

[1] Congress has passed legislation that provides higher matching rates (e.g., 100 percent) for specific functions. For example, under the SUPPORT Act in 2018 (P.L. 115-271), funding for Prescription Drug Monitoring Programs (PMDPs) is matched at 100 percent. This matching rate includes associated systems. However, per CMS guidance, states must obtain advanced approval through the APD process for these systems-related expenditures (CMS 2019).

[2] This represents federal and state combined spending. This amount includes spending on eligibility and enrollment systems, but not the staff using those systems. Since this analysis focuses on mechanized claims processing and information retrieval systems, we exclude E&E staff spending. In FY 2025, total spending on E&E staff was $7.4B, with activities that can be matched at either 50 percent of 75 percent FFP.

[3] CMS-64 categories included in administrative and MES spending totals are displayed in Appendix B.

[4] CMS guidance defines modularity as "a packaged, functional business process or set of processes implemented through software, data, and interoperable interfaces that are enabled through design principles in which functions of a complex system are partitioned into discrete, scalable, reusable components."

[5] CMS states that "Reuse can be accomplished through sharing artifacts, documents, services or systems, code segments and business rules, such as advance planning documents, request for proposals (RFPs), CMS-approved milestone review documentation, artifacts developed to support operations and management, and other development artifacts." (https://www.medicaid.gov/medicaid/data-systems/medicaid-enterprise-reuse/index.html )

[6] Business functions that are relevant for Medicaid IT systems are described within the MITA framework.

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# APPENDIX A

**TABLE A-1.** IT System Spending as a Percentage of Total Medicaid Administrative Expenditures and Total Medicaid Expenditures, FY 2025 (Millions)

| State | MES Spend | Total Admin Spend | Percent of Admin Spend | Total Spend (Benefit + Admin) | Percent of Total Spend |
|---|---|---|---|---|---|
| Alaska | $58.2 | **$193.0** | 30.0% | **$3,243.9** | 1.8% |
| Alabama | 85.8 | **306.2** | 28.0 | **8,374.1** | 1.0 |
| Arizona | 105.7 | **605.8** | 17.5 | **22,057.2** | 0.5 |
| Arkansas | 196.5 | **530.5** | 37.0 | **8,916.5** | 2.2 |
| California | 672.1 | **9,328.1** | 7.2 | **173,402.7** | 0.4 |
| Colorado | 218.4 | **937.8** | 23.3 | **16,491.7** | 1.3 |
| Connecticut | 115.2 | **463.6** | 24.9 | **11,700.3** | 1.0 |
| Delaware | 73.2 | **155.4** | 47.1 | **3,400.6** | 2.2 |
| District of Columbia | 146.4 | **309.4** | 47.3 | **4,294.1** | 3.4 |
| Florida | 200.2 | **983.3** | 20.4 | **39,343.0** | 0.5 |
| Georgia | 236.5 | **791.7** | 29.9 | **19,692.3** | 1.2 |
| Hawaii | 111.5 | **218.9** | 50.9 | **3,179.2** | 3.5 |
| Idaho | 54.6 | **156.3** | 35.0 | **4,166.9** | 1.3 |
| Illinois | 246.7 | **1,364.7** | 18.1 | **36,162.7** | 0.7 |
| Indiana | 132.8 | **672.5** | 19.8 | **20,451.8** | 0.6 |
| Iowa | 65.1 | **208.2** | 31.3 | **8,730.8** | 0.7 |
| Kansas | 87.1 | **274.8** | 31.7 | **6,499.4** | 1.3 |
| Kentucky | 144.2 | **425.2** | 33.9 | **20,474.9** | 0.7 |
| Louisiana | 186.4 | **512.2** | 36.4 | **15,800.5** | 1.2 |
| Maine | 94.1 | **238.0** | 39.5 | **5,202.7** | 1.8 |
| Maryland | 316.8 | **734.0** | 43.2 | **18,707.4** | 1.7 |
| Massachusetts | 276.6 | **1,698.4** | 16.3 | **28,725.5** | 1.0 |
| Michigan | 275.1 | **946.9** | 29.1 | **27,306.7** | 1.0 |
| Minnesota | 145.0 | **966.4** | 15.0 | **21,425.3** | 0.7 |
| Mississippi | 70.7 | **186.0** | 38.0 | **7,708.7** | 0.9 |
| Missouri | 135.4 | **589.3** | 23.0 | **17,112.3** | 0.8 |
| Montana | 69.7 | **137.4** | 50.7 | **2,633.1** | 2.6 |
| Nebraska | 62.3 | **204.3** | 30.5 | **4,372.0** | 1.4 |
| Nevada | 78.5 | **259.6** | 30.2 | **7,313.1** | 1.1 |
| New Hampshire | 63.7 | **172.9** | 36.8 | **3,067.2** | 2.1 |
| New Jersey | 138.8 | **1,214.1** | 11.4 | **25,939.0** | 0.5 |
| New Mexico | 186.2 | **521.6** | 35.7 | **10,469.8** | 1.8 |

| State | MES Spend | Total Admin Spend | Percent of Admin Spend | Total Spend (Benefit + Admin) | Percent of Total Spend |
|---|---|---|---|---|---|
| New York | 499.0 | **5,089.9** | 9.8 | **102,699.3** | 0.5 |
| North Carolina | 214.5 | **1,267.8** | 16.9 | **34,499.3** | 0.6 |
| North Dakota | 55.2 | **120.5** | 45.8 | **1,779.9** | 3.1 |
| Ohio | 252.5 | **1,283.2** | 19.7 | **38,633.9** | 0.7 |
| Oklahoma | 61.4 | **302.6** | 20.3 | **10,764.5** | 0.6 |
| Oregon | 109.7 | **1,180.2** | 9.3 | **18,871.6** | 0.6 |
| Pennsylvania | 240.8 | **1,573.5** | 15.3 | **49,525.3** | 0.5 |
| Rhode Island | 87.6 | **224.9** | 39.0 | **4,293.8** | 2.0 |
| South Carolina | 233.8 | **543.6** | 43.0 | **10,266.0** | 2.3 |
| South Dakota | 27.4 | **106.7** | 25.7 | **1,863.9** | 1.5 |
| Tennessee | 731.7 | **1,221.2** | 59.9 | **17,783.0** | 4.1 |
| Texas | 591.4 | **2,166.9** | 27.3 | **54,954.7** | 1.1 |
| Utah | 61.6 | **212.7** | 29.0 | **5,320.2** | 1.2 |
| Vermont | 70.0 | **218.2** | 32.1 | **2,425.4** | 2.9 |
| Virginia | 94.2 | **566.5** | 16.6 | **23,020.1** | 0.4 |
| Washington | 151.6 | **1,449.0** | 10.5 | **23,122.6** | 0.7 |
| West Virginia | 130.8 | **263.7** | 49.6 | **5,872.0** | 2.2 |
| Wisconsin | 206.1 | **669.8** | 30.8 | **13,822.8** | 1.5 |
| Wyoming | 40.6 | **72.7** | 55.8 | **846.6** | 4.8 |
| **Subtotal (states)** | **$8,909.6** | **$44,840.4** | 19.9 | **$1,026,730.2** | 0.9 |
| American Samoa | 0.2 | **3.3** | 4.9 | **54.8** | 0.3 |
| Guam | 2.5 | **7.4** | 33.1 | **200.9** | 1.2 |
| N. Mariana Islands | 0.5 | **1.6** | 29.8 | **92.9** | 0.5 |
| Puerto Rico | 71.3 | **135.6** | 52.6 | **4,869.5** | 1.5 |
| Virgin Islands | 11.4 | **15.3** | 74.6 | **104.7** | 10.9 |
| **Subtotal (states and territories)** | **85.8** | **163.2** | 52.6 | **5,322.8** | 1.6 |
| **Total** | **$8,995.5** | **$45,003.6** | **20.0** | **$1,032,053.1** | **0.9** |

**Notes:** FY is fiscal year. Admin is administrative. MES is Medicaid Enterprise Systems. MES spending represents Medicaid Management Information Systems (MMIS), health information technology (HIT), and eligibility and enrollment (E&E) spending. Spending on administration is only for state programs; federal oversight spending is not included. Federal spending in the territories is capped; however, territories report their total spending regardless of whether they have reached their caps. As a result, federal spending shown here may exceed the amounts actually paid to the territories.

– Dash indicates zero; $0 indicates an amount less than $0.5 million that rounds to zero.

IT is Information Technology.

**Source:** MACPAC, 2026, analysis of CMS-64 expenditure data as of June 24, 2026.

**TABLE A-2.** Spending on MES by state, FY 2025 (Millions)

| State | Total MMIS | Total HIT | E&E Systems | Total MES |
|---|---|---|---|---|
| Alaska | **$49.6** | **–** | $8.6 | **$58.2** |
| Alabama | **75.4** | **–** | 10.3 | **85.8** |
| Arizona | **76.1** | **–** | 29.6 | **105.7** |
| Arkansas | **159.4** | **–** | 37.1 | **196.5** |
| California | **523.2** | **–** | 148.9 | **672.1** |
| Colorado | **166.1** | **–** | 52.4 | **218.4** |
| Connecticut | **56.5** | **–** | 58.7 | **115.2** |
| Delaware | **55.8** | **–** | 17.4 | **73.2** |
| District of Columbia | **88.6** | **–** | 57.8 | **146.4** |
| Florida | **167.2** | **–** | 33.0 | **200.2** |
| Georgia | **169.9** | **–** | 66.6 | **236.5** |
| Hawaii | **75.5** | **–** | 36.0 | **111.5** |
| Idaho | **49.8** | **–** | 4.8 | **54.6** |
| Illinois | **111.9** | **–** | 134.8 | **246.7** |
| Indiana | **113.9** | **–** | 18.9 | **132.8** |
| Iowa | **33.0** | **–** | 32.1 | **65.1** |
| Kansas | **66.5** | **–** | 20.6 | **87.1** |
| Kentucky | **76.9** | **–** | 67.3 | **144.2** |
| Louisiana | **82.6** | **–** | 103.8 | **186.4** |
| Maine | **71.9** | **–** | 22.2 | **94.1** |
| Maryland | **232.8** | **-0.0** | 84.0 | **316.8** |
| Massachusetts | **199.2** | **–** | 77.4 | **276.6** |
| Michigan | **167.3** | **–** | 107.8 | **275.1** |
| Minnesota | **89.7** | **–** | 55.3 | **145.0** |
| Mississippi | **48.6** | **–** | 22.1 | **70.7** |
| Missouri | **96.7** | **–** | 38.7 | **135.4** |
| Montana | **60.3** | **–** | 9.4 | **69.7** |
| Nebraska | **50.8** | **–** | 11.5 | **62.3** |
| Nevada | **52.5** | **–** | 26.0 | **78.5** |
| New Hampshire | **53.6** | **–** | 10.1 | **63.7** |
| New Jersey | **112.9** | **–** | 25.9 | **138.8** |
| New Mexico | **146.2** | **–** | 40.0 | **186.2** |
| New York | **354.4** | **-0.0** | 144.7 | **499.0** |
| North Carolina | **135.4** | **–** | 79.1 | **214.5** |
| North Dakota | **35.2** | **–** | 20.0 | **55.2** |
| Ohio | **148.7** | **–** | 103.7 | **252.5** |
| Oklahoma | **59.4** | **–** | 2.1 | **61.4** |
| Oregon | **68.1** | **–** | 41.6 | **109.7** |
| Pennsylvania | **133.9** | **–** | 107.0 | **240.8** |

| State | Total MMIS | Total HIT | E&E Systems | Total MES |
|---|---|---|---|---|
| Rhode Island | **65.6** | **–** | 22.1 | **87.6** |
| South Carolina | **102.3** | **–** | 131.5 | **233.8** |
| South Dakota | **21.9** | **–** | 5.5 | **27.4** |
| Tennessee | **474.1** | **–** | 257.6 | **731.7** |
| Texas | **431.3** | **–** | 160.1 | **591.4** |
| Utah | **42.6** | **–** | 18.9 | **61.6** |
| Vermont | **50.5** | **–** | 19.6 | **70.0** |
| Virginia | **79.2** | **–** | 15.0 | **94.2** |
| Washington | **104.0** | **–** | 47.6 | **151.6** |
| West Virginia | **72.9** | **–** | 57.9 | **130.8** |
| Wisconsin | **131.0** | **–** | 75.1 | **206.1** |
| Wyoming | **29.9** | **–** | 10.6 | **40.6** |
| **Subtotal (states)** | **$6,120.7** | **-$0.0** | **$2,788.9** | **$8,909.6** |
| American Samoa | **–** | **–** | 0.2 | **0.2** |
| Guam | **2.5** | **–** | – | **2.5** |
| Northern Mariana Islands | **0.4** | **–** | 0.1 | **0.5** |
| Puerto Rico | **53.3** | **–** | 18.1 | **71.3** |
| Virgin Islands | **8.2** | **–** | 3.3 | **11.4** |
| **Subtotal (states and territories)** | **$64.3** | **–** | **$21.6** | **$85.8** |
| **Total** | **$6,185.0** | **-$0.0** | **$2,810.5** | **$8,995.5** |

**Notes:** FY is fiscal year. MMIS is Medicaid Management Information Systems. HIT is health information technology. E&E is eligibility and enrollment. MES is Medicaid Enterprise Systems. Includes federal and state funds. Excludes administrative activities performed by Medicaid managed care plans (which are included in the capitation payments that states make to these plans) and activities that are exclusively federal, such as program oversight by CMS staff. For more information on specific items from the Medicaid and CHIP Budget Expenditure System (MBES CBES) noted in this exhibit, see CMS, 2014, MBES CBES category of service line definitions for the 64.10 base form, https://www.medicaid.gov/medicaid/downloads/cms-6410-admin-category-of-services-definition-2-14.pdf.

– Dash indicates zero; $0 indicates an amount less than $0.5 million that rounds to zero.

**Source:** MACPAC, 2026, analysis of CMS-64 expenditure data as of June 24, 2026.

# APPENDIX B

**TABLE B-1: CMS-64 Categories included in MES Spending**

| CMS-64 category | Category for issue brief |
|---|---|
| Approved MMIS: Inhouse | MMIS – O&M |
| Approved MMIS: Private | MMIS – O&M |
| Mechanized Systems - In-House | MMIS – Other MES |
| Mechanized Systems - Not Approved under MMIS Procedures: Interagency | MMIS – Other MES |
| Mechanized Systems: Private Sector | MMIS – Other MES |
| MMIS - Inhouse Activities | MMIS – DDI |
| MMIS - Private Sector | MMIS – DDI |
| HIT: Implementation and Operation: Cost of In-house Activities | HIT |
| HIT: Planning: Cost of In-house Activities | HIT |
| HIT: Planning: Cost of Private Contractors | HIT |
| Design Development/Installation of Medicaid Elig. Determ. Sys. – Cost of In-house Activities | E&E – DDI |
| Design Development/Installation of Medicaid Elig. Determ. Sys. – Cost of Private Sec. Contractors | E&E – DDI |
| Operation of an Approved Medicaid Eligibility Determination Sys. – Cost of Private Sec. Contractors | E&E – O&M |
| Operation of an Approved Medicaid Eligibility Determination Systems – Cost of In-house Activities | E&E – O&M |

**Notes:** MES is Medicaid enterprise systems. MMIS is Medicaid Management Information Systems. HIT is health information technology. E&E is eligibility and enrollment. DDI is design development and implementation spending. O&M is operations and maintenance. Spending on DDI receives a 90 percent federal match, while O&M receives a 75 percent federal match. Other MES spending includes DDI and O&M for systems that have not been approved by CMS for enhanced federal match and can include systems shared with other state agencies; these expenditures receive the administrative federal match of 50 percent.

The CMS-64 collects states' quarterly expenditure data.

**Source:** CMS, 2014, Medicaid and CHIP Budget Expenditure System (MBES CBES) category of service line definitions for the 64.10 base form, https://www.medicaid.gov/medicaid/downloads/cms-6410-admin-category-of-services-definition-2-14.pdf.