



PROJECT FOR REDUCING INEFFECTIVE MEDICAID EXPENDITURES

Expanded Respiratory Panel Testing and Unspecified Infection Panel Testing

Diagnostic testing for infectious diseases has increased rapidly, particularly since the COVID-19 pandemic. In an analysis of available evidence, clinical guidelines, payer policies, and Medicaid data from 2024, we found substantial use of expanded respiratory panel testing despite lack of robust, direct evidence of benefits and lack of clear guideline recommendations for the technology. Estimated expenditures totaled \$282.6 million nationally (state and federal share) with significant state-by-state variation. In addition, we identified \$186.5 million (state and federal share) in unspecified infection panel testing as a service potentially warranting ongoing monitoring for overuse. We found multiple state Medicaid programs working to address overuse of these tests through differing approaches. From this brief, state Medicaid program administrators can recognize if overuse of these tests may be an issue in their state and identify potential policy solutions.

BACKGROUND

Acute respiratory illness is one of the most common reasons people seek medical attention in the US.^{1,2} Incorrect diagnosis of respiratory infections can lead to inappropriate antibiotic treatment (i.e., prescribing antibiotics for a viral infection) or lack of effective antiviral treatment (i.e., for influenza or

COVID-19).³ In the past several decades, the development and adoption of laboratory diagnostic testing has expanded rapidly, with the aim of increasing accurate diagnosis of respiratory illnesses.³

Commonly used newer tests are typically divided into 2 categories: antigen tests and molecular tests.⁴ Antigen tests are designed to identify the presence of certain proteins found on the surface of viruses and bacteria, and can be performed in a clinical setting or at home.⁴ Molecular tests, such as nucleic acid amplification tests, involve more complex methods to identify specific genes or gene expression that indicate the presence of target viruses or bacteria.⁴ Further, molecular tests can be developed to examine several targets at one time; these are termed panel tests.⁴ Use of respiratory panel tests (i.e., molecular tests that include multiple respiratory viral and bacterial targets) has increased rapidly in recent years.⁵

Panel tests can be targeted, including only viruses with specific treatments such as influenza A and B and COVID-19.⁴ They can also have an expanded number of targets, defined for this brief as including more than 5 different viruses and bacteria, many of which do not have treatments other than management of symptoms (e.g., adenovirus and rhinovirus).³ Expanded tests can also include targets for “atypical” bacteria that do have specific antibiotic treatments (e.g., *Bordetella pertussis*, which causes whooping cough) but are relatively uncommon.³ Although these tests can identify a wide range of infections, concerns remain about their clinical value and appropriateness. For example, expanded respiratory panel tests represent “one-size-fits-all” testing not individualized to a patient, patients are unlikely to have symptoms potentially compatible with every single infection in the expanded panel test, and the results of expanded panel tests may not necessarily change clinical management.⁶ Further, expanded respiratory panel tests are typically more costly than targeted tests (Table 1).⁷

TABLE 1
Medicare Reimbursement for Respiratory Panel Tests, 2026

Procedure Code(s)	Brief Description	Fee
Examples of targeted respiratory panel tests		
87631	Respiratory viral panel, 3 to 5 targets	\$142.63
87636	SARS CoV-2 and influenza A and B	\$142.63
87637	SARS CoV-2, influenza A and B, and respiratory syncytial virus	\$142.63
Examples of expanded respiratory panel tests		
87632	Respiratory viral panel, 6 to 11 targets	\$218.06
87633	Respiratory viral panel, 12 to 25 targets	\$416.78

Procedure Code(s)	Brief Description	Fee
0115U	Proprietary Lab Analyses code for a respiratory viral panel with 26 targets	\$275.35
0202U, 0223U, 0225U, 0563U, and 0564U	Proprietary Lab Analyses code for a respiratory viral panel with 14 to 22 targets	\$416.78
0528U	Proprietary Lab Analyses code for a lower respiratory viral panel with 26 targets and 7 antimicrobial-resistance genes for 15 bacteria	\$634.84

Source. Adapted from the January 2026 Medicare Clinical Laboratory Fee Schedule.⁷

Beyond respiratory illnesses, the use of panel tests for other types of infections has also been increasing. Broadly, Medicare spending on molecular infectious disease testing increased by 250%, from approximately \$400 million in 2019 to \$1.4 billion in 2024.⁸ A 2024 study identified significant use of panels testing for urinary tract infections in Medicare⁹ while a recent expert workgroup raised concerns about such testing potentially leading to overdiagnosis and overtreatment.¹⁰ Because many infection panel tests do not have a specific Common Procedural Terminology (CPT) code for the entire panel, the individual component tests are billed, which can include testing for “unspecified” targets (hereafter termed “unspecified infection panel tests”).⁹ Therefore, for many panels, from procedure codes alone, it can be challenging to identify the specific purpose of the test, which is a barrier to managing appropriate use through coverage and reimbursement policies.

Because of the potential for overuse, we selected these services for the Project for Reducing Ineffective Medicaid Expenditures (PRIME). The purpose of PRIME is to identify Medicaid-covered services that may warrant coverage limitation due to limited or no demonstrated benefit relative to harms. For expanded respiratory panel tests, we reviewed available evidence, guidelines, and payer policies, and estimated potential savings in Medicaid on a state-by-state basis. For unspecified infection panel testing, we conducted an analysis of Medicaid data, for the purpose of highlighting an area of possible increasing concern.

EVIDENCE, GUIDELINE, AND PAYER POLICY LANDSCAPE

Evidence for Expanded Respiratory Panel Tests

We did not identify any systematic reviews evaluating the use of expanded panels versus targeted panels using our definitions, which were guided by CPT code definitions. We did identify 6 recent systematic reviews of respiratory panel testing in the general population.¹¹⁻¹⁶ However, the focus of the reviews was typically on rapid versus non-rapid methods.¹¹⁻¹⁶ In other words, both intervention and comparison tests could include both expanded or targeted respiratory panel tests.¹¹⁻¹⁶ Based on

these reviews, we did not find any robust evidence demonstrating clinical superiority of expanded versus limited respiratory panel tests.

Guidelines for Expanded Respiratory Panel Tests

Through targeted searches, we identified 3 relevant guidelines for the general population from 4 organizations:

- Academy of Diagnostics and Laboratory Medicine (2024)⁴
- American Thoracic Society (2021)¹⁷
- Infectious Diseases Society of America and the American Society for Microbiology (2024)¹⁸

Two guidelines contained specific recommendations related to expanded respiratory panel testing but limited those recommendations to hospitalized or immunocompromised patients.^{4,17} Of these, one guideline was based on authors' expert opinions⁴ and the other guideline's recommendations were described as "conditional" and based on "very-low-quality evidence."¹⁷

The Academy of Diagnostics and Laboratory Medicine document describes itself as a guidance document based on authors' expert opinions.⁴ The guidance document proposes an algorithm to identify an appropriate test.⁴ For example, for symptomatic immunocompetent individuals in the outpatient setting, the document recommends testing using a targeted panel when results would change clinical management.⁴ The guidance document recommends that testing of pediatric patients "should be limited to hospitalized children or children with underlying conditions. Depending on the season, small, targeted panels (e.g., influenza/RSV) might be sufficient."^{4(p617)} The recommendation to use expanded respiratory panel testing is limited to immunocompromised patients (outpatient or hospitalized), or non-immunocompromised hospitalized patients who first test negative on a targeted panel.⁴

The American Thoracic Society guideline focuses on the diagnosis and management of community-acquired pneumonia.¹⁷ The guideline evaluates the use of respiratory panel testing and broadly identifies "little direct evidence" that such testing improves "critical outcomes such as overall survival or antibiotic use patterns."^{17(p1070)} For outpatients with suspected community-acquired pneumonia, the guideline suggests "not performing routine nucleic acid-based testing of respiratory samples for viral pathogens other than influenza (conditional recommendation, very-low-quality evidence)."^{17(p1072)} For hospitalized people with suspected community-acquired pneumonia, the guideline suggests testing for viruses other than influenza only in patients who have severe community-acquired pneumonia (based on their criteria) and immunocompromised patients (conditional recommendation, very-low-quality evidence).¹⁷

The joint guide by the Infectious Diseases Society of America (IDSA) and the American Society of Microbiology describes itself as "not an official guideline of the IDSA but rather an authoritative guide

with recommendations for utilizing the microbiology laboratory in infectious disease diagnosis.”^{18(p6)} The document is divided by anatomical site, and contains information on a wide variety of infections, not just respiratory tract infections.¹⁸ It does not offer any recommendations specific to respiratory panels for upper respiratory tract infections.¹⁸ For lower respiratory tract infections, the guide states, “[m]ultiplex molecular pneumonia syndromic panels, when used judiciously, may provide earlier opportunity for therapeutic optimization than traditional cultures.”^{18(p40)}

Payer Policies for Expanded Respiratory Panel Tests

We reviewed 5 payer policies, including 4 commercial payers¹⁹⁻²² and 1 Medicare Administrative Contractor.²³ For commercial insurers, not all payers cover expanded respiratory panel tests and those that did covered them with limitations.¹⁹⁻²² Anthem and UnitedHealthcare do not cover expanded respiratory panel tests.^{20,22} Cigna covers expanded respiratory panel tests for only up to 11 targets and up to 12 per year.²¹ Aetna covers expanded respiratory viral panels if the patient is symptomatic, immunocompromised or at high-risk for complications and the test will be used to guide therapy.¹⁹

For Medicare, the MolDx program had specific coverage criteria for expanded respiratory viral panel tests.²³ For patients without immunocompromise, testing must be ordered by a “clinician specialist in Infectious Diseases or Pulmonology” for a “patient with severe and established underlying respiratory pathology” or the patient must be “seriously or critically ill or at imminent risk of becoming seriously or critically ill” and “treated in an appropriate critical care facility.”²³ For immunocompromised patients, the testing must be ordered by a clinician specialist in infectious diseases, pulmonology, oncology, or transplant, unless the patient is “being managed in an appropriate critical care facility.”²³ Coverage policies are described in more detail in Appendix Table A1.

MEDICAID DATA ANALYSIS

We analyzed data from Transformed Medicaid Statistical Information System Analytical Files for 50 states and the District of Columbia for 2024, the most recent year available from the Centers for Medicare & Medicaid Services (CMS). For each state, we identified fully adjudicated paid fee-for-service (FFS) claims and managed care encounters for relevant tests. Because guidelines and payer policies sometimes separately considered use of expanded respiratory panel tests in the general population versus immunocompromised patients and in emergency department settings, we separately identified the use of tests in those circumstances.²⁴ We were unable to identify tests performed in the inpatient setting, as those are typically included under the payment for inpatient hospital services (e.g., Diagnosis-Related Group or per diem payment). We identified unspecified infection panel tests using an algorithm described in a recent publication.⁹ The algorithm describes how to identify unspecified panels and classify their intended clinical use based on diagnosis codes.⁹

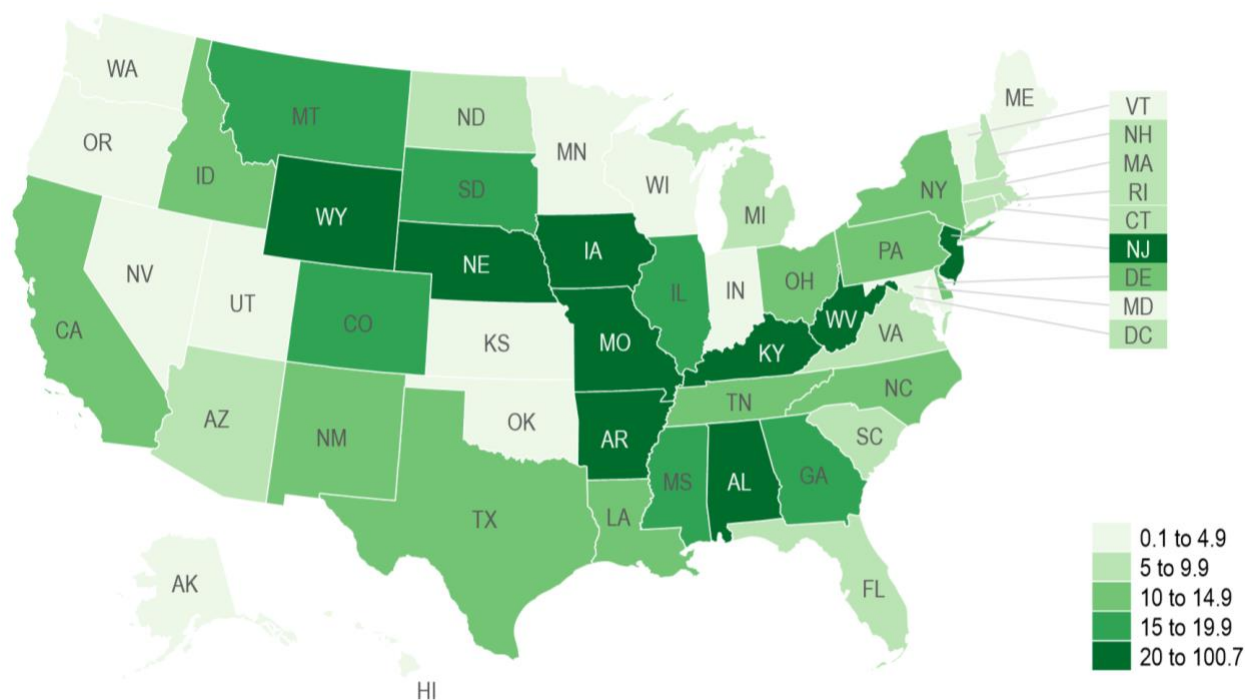
We also estimated total expenditures on expanded respiratory panel tests, unspecified infection tests, and potential savings if expanded respiratory panel tests were replaced by targeted respiratory panel tests. Because CMS suppresses paid amounts for managed care encounters, we estimated payments based on FFS claims. The full data tables for all results are available in Appendix Tables A2 and A3.

Expanded Respiratory Panel Tests

Nationally, we identified the use of 1.1 million expanded respiratory panel tests with an estimated \$282.6 million in expenditures. There was significant state-by-state variation, ranging from 0.1 to 100.8 tests per 10,000 member months of enrollment (Figure 1). Nationally, we estimated that approximately half (50.1%) of the tests were performed on the same day as an emergency department visit, and 4.8% were performed in immunocompromised patients. We estimated the potential savings associated with a targeted respiratory panel being used instead of an expanded respiratory panel at \$212.8 million (state and federal share).

FIGURE 1

Use of Expanded Respiratory Panel Tests, per 10,000 Member Months, by State, 2024



Unspecified Infection Panel Tests

Nationally, we identified the use of 809,831 unspecified infection panel tests associated with an estimated \$186.5 million in expenditures. There was also significant state-by-state variation, ranging from too few claims to report to 32.0 tests per 10,000 member months (Figure 2). Nationally, we

estimated that the majority of expenditures (56%) were for urogenital or anogenital infection tests (e.g., sexually transmitted infections) followed by 18% for urinary tract infection tests (Figure 3).

FIGURE 2

Use of Unspecified Infection Panel Tests, per 10,000 Member Months, by State, 2024

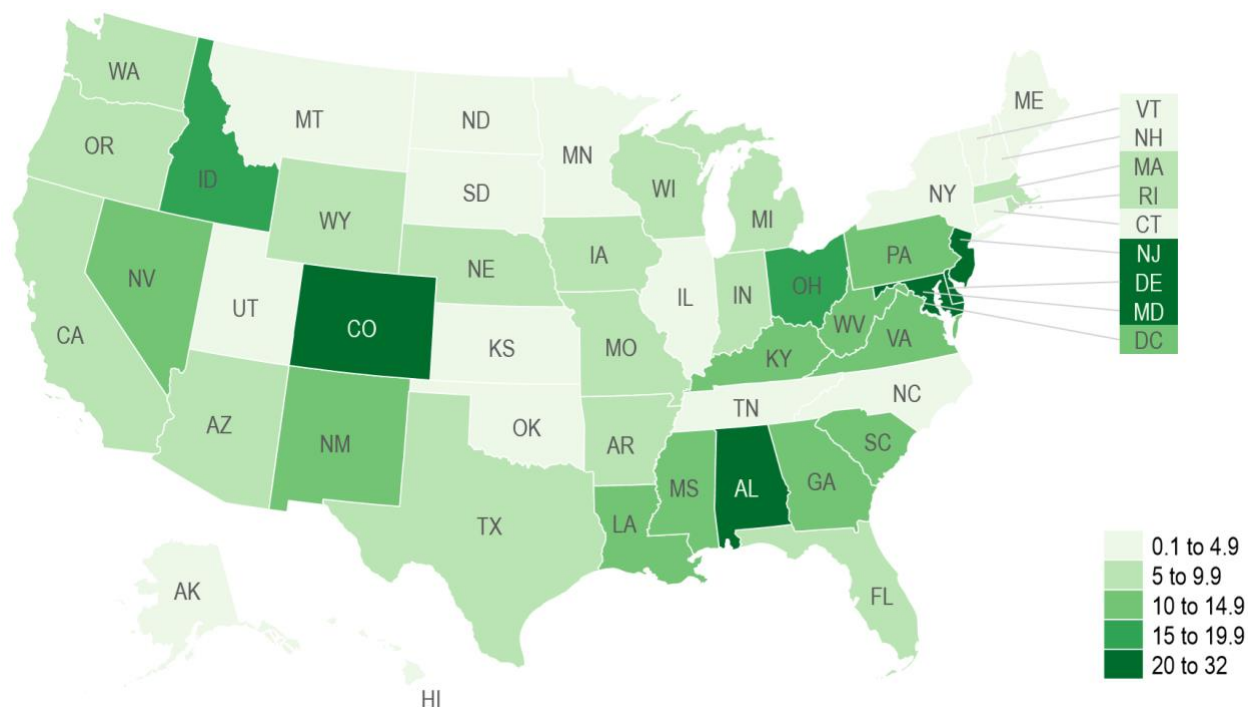
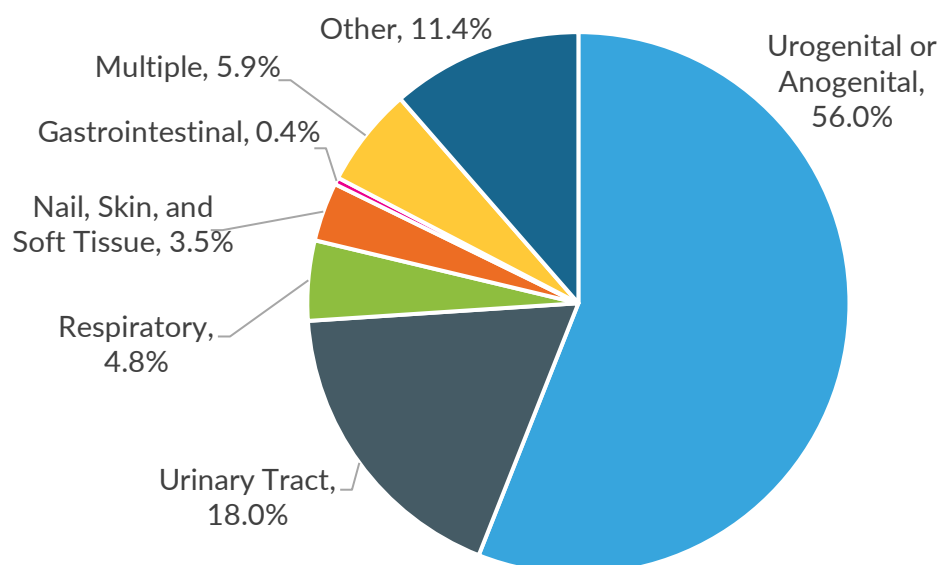


FIGURE 3

Estimated Expenditures on Unspecified Infection Panel Tests, by Category, 2024



STATE POLICY ACTIONS

Several state Medicaid programs have enacted coverage policies to limit the use of expanded respiratory panel tests:

- **Alabama** limited coverage of all respiratory panel tests to the outpatient hospital, inpatient hospital, and emergency department setting, effective July 11, 2025.²⁵
- **Louisiana** added coverage of both expanded and targeted respiratory panel tests, effective September 1, 2024.²⁶ Expanded respiratory panel tests were covered with a similar policy as MolDx (Medicare Administrative Contractor).^{23,26} Targeted respiratory panel tests were only covered for infants receiving prophylaxis for respiratory syncytial virus infection and people returning to congregate settings.²⁶
- **New York** does not include expanded respiratory panel tests (i.e., 87632 and 87633) on its FFS laboratory fee schedule.²⁷
- **Nevada** does not cover expanded respiratory panel tests (i.e., 87632 and 87633).²⁸
- **Oklahoma** considers expanded respiratory panel tests (i.e., 87632 and 87633) to be not medically necessary in the outpatient setting.²⁹
- Several **Medicaid managed care organizations** instituted coverage limitations on expanded respiratory panel tests.³⁰⁻³²

We did not identify any recent state Medicaid agency policies around unspecified infection panel testing.

STATE CONSIDERATIONS

For expanded respiratory panel tests, state Medicaid program administrators can consider evaluating whether coverage limitation may be warranted, including:

- Analyzing whether expanded respiratory panel testing meets the state's definition of medical necessity in the outpatient setting, given:
 - » Viruses other than influenza and COVID-19 do not currently have any specific treatments and therefore results may not change management
 - » Expanded panels can represent "one-size-fits-all" care, are not tailored to the patient and, because various infections have different symptoms, it would be clinically unusual for a patient to have symptoms compatible with all of them⁶
 - » Lack of robust direct evidence of benefit and guideline recommendations that are based on very-low-quality evidence and expert opinion
 - » Costs that are typically significantly higher relative to targeted respiratory panel testing

- If expanded respiratory panel testing meets the state's definition of medical necessity, consider establishing a coverage policy for expanded respiratory panel tests in the outpatient setting, such as:
 - » Limiting testing to patients who are immunocompromised, critically ill, or at risk of critical illness
 - » Limiting testing to certain specialties of ordering clinicians, as in the MoDx Medicare Administrative Contractor policy²³
 - » Other limitations, such as requiring that a panel test be billed using only a single procedure code (i.e., as opposed to billing separate codes for the components of the test), requiring the patient to be symptomatic, specifying that the test is only covered when results will change clinical management, or limiting testing to one panel test per day
- Examining reimbursed claims for expanded respiratory panel tests with consideration of referring claims that may not meet coverage criteria for post-payment review

For unspecified infection panels, state Medicaid administrators can consider:

- Monitoring claims to understand any trends in utilization and spending growth
- Examining the types of panels billed to determine if they are medically necessary under the state's definition, for example:
 - » Urogenital and anogenital panels may include sexually transmitted infection testing, which is an important service; however, there may be more cost-effective testing strategies in some cases
 - » Other panels, for example urinary tract infection panels, may raise potential concerns around overdiagnosis, overtreatment, and use when not medically necessary⁹
 - » Other uses of the unspecified testing codes may be an attempt to circumvent existing coverage policies or maximize reimbursement (e.g., for respiratory panel tests)
- Creating coverage policies for unspecified infection panels (with periodic ongoing monitoring given their rapid, ongoing development)

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APPENDIX A: RESULTS

TABLE A1

Coverage Policies for Commercial Payers and Medicare

Payer (Year)	Coverage Criteria
Commercial Aetna (2026) ¹⁹	“B. Qualitative Multiplex PCR Tests Aetna considers the following qualitative multiplex PCR tests medically necessary (unless otherwise stated): 5. Respiratory panel (up to 5 respiratory pathogens) when member has signs and symptoms of a respiratory illness (e.g., COVID-19) and test will be used to guide therapy; 6. Respiratory virus and/or bacteria panel (e.g., BioFire FilmArray Respiratory Panel [EZ, RP, or RP2], BioFire SpotFire Respiratory/Sore Throat [R/ST] Panel, ePlex RP Panel, HealthTrackRx Bronchitis Panel, Respiratory Pathogen with ABR [RPX] Panel) or Pneumonia panel (e.g., BioFire FilmArray Pneumonia Panel) when all of the following criteria are met: a. Member has signs and symptoms of a respiratory infection, and b. Member is immunocompromised and/or considered high-risk for complications (e.g., infants up to 1 to 2 months of age, receiving cancer treatment, organ transplant recipient); and c. Test will be used to guide therapy;”
Anthem (2026) ²⁰	“Medically Necessary: Respiratory viral panel testing in the outpatient setting is considered medically necessary when all of the following criteria have been met: 1. Use of limited panels involving 5 targets or less; and 2. Testing is for individuals who are at high risk for complications of respiratory viral infection including, but not limited to, individuals who are immunocompromised (for example, lung transplant recipients); and 3. The results of testing will be used to guide or alter management. Not Medically Necessary: Respiratory viral panel testing in the outpatient setting is considered not medically necessary when the criteria above have not been met and for all other indications, including but not limited to: 1. Testing average risk individuals; 2. Use of large panels involving 6 or more targets.””
Cigna (2026) ²¹	“Medically Necessary Infectious pathogen detection by nucleic acid panel is considered medically necessary for the following:

Payer (Year)	Coverage Criteria
	• respiratory pathogens, not to exceed one test per date of service, up to 12 tests per 12 rolling months (i.e., up to 11 targets) • gastrointestinal pathogens (i.e., up to 11 targets) • central nervous system pathogens (i.e., 12-25 targets) • herpes simplex (HSV) (Types 1 & 2) and varicella-zoster virus panel <u>Not Covered or Reimbursable</u> Nucleic acid pathogen testing of single pathogen or by panel is not covered or reimbursable if performed in an outpatient level of care setting and the criteria described above are not met. Metagenomic next-generation sequencing (mNGS) is not covered or reimbursable. Use of Not Otherwise Specified (NOS) CPT codes: 87797, 87798, 87799, for molecular microbe testing is not covered or reimbursable when a more specific CPT/HCPCS code is available for use.”
UnitedHealthcare (2026) ²²	“Coverage Rationale Respiratory pathogen panel testing of six or more targets in an outpatient setting is unproven and not medically necessary due to insufficient evidence of efficacy for all indications.”
Medicare MoIDx, Palmetto GBA (2026) ²³	“LIMITED COVERAGE FOR EXPANDED (>5 Pathogens) PANEL TESTING Respiratory (RP) and Pneumonia (PNP) Panels will only be covered when targeted testing is not appropriate AND according to the following additional criteria: • For immune-competent patients, at least 1 of the following must apply: ◦ Testing is ordered by a clinician specialist in Infectious Diseases or Pulmonology for a patient with severe and established underlying respiratory pathology (i.e., severe asthma, chronic obstructive pulmonary disease (COPD), cystic fibrosis, pulmonary fibrosis, radiation therapy to the lung) AND treatment with antibiotics may be indicated according to established guidelines.^{1,2} Specific examples that do NOT meet coverage criteria according to established guidelines include the following: ◦ Asthma exacerbations without the additional presence of either fever and purulent sputum or radiographic evidence of pneumonia ◦ Uncomplicated community acquired pneumonia (CAP)¹ ◦ The patient is seriously or critically ill or at imminent risk of becoming seriously or critically ill (as defined by the American Hospital Association’s “General Guide for the Release of Information on the Condition of

Payer (Year)	Coverage Criteria
	Patients”)³ as a result of a presumed respiratory infection AND the patient is being treated in an appropriate critical care facility. • For immune-suppressed patients: Testing is ordered by a clinician specialist in 1 of the following: Infectious Diseases, Pulmonology, Oncology, Transplant OR the patient is being managed in an appropriate critical care facility. • For ALL patients: Only 1 of the following panels - RP OR PNP- will be covered for a given patient for the same clinical indication. The PNP should be prioritized in the evaluation of pneumonia from lower respiratory tract specimens (i.e., bronchoalveolar lavage samples [BALs]). For the purposes of repeat panel testing for the same clinical indication, RP and PNP will be considered as equivalent tests, such that if criteria for repeat testing are met (as defined above), a clinician may choose to perform the repeat test using the PNP, even if the original test was performed using the RP. • For ALL patients, exceptions to the limitation on medical specialists who can order expanded panel tests are provided in the accompanying Billing and Coding Article, such that patient geography and access to care do not preclude the receipt of appropriate diagnostic testing when indicated.”

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Abbreviations. PNP: pneumonia panel; RP: respiratory panel.

TABLE A2

Utilization of Expanded Respiratory Panel Testing in 50 State Medicaid Programs and the District of Columbia, 2024

State	Number of Tests	Number of Tests, Per 10,000 Member Months	Estimated Expenditures, \$	Expenditure on Tests Performed on the Same Day as an Emergency Department Visit, %	Expenditure on Tests Performed on Immuno-compromised Patients, %	Estimated Savings if a Targeted Panel was Performed Instead, \$
US	1,161,953	13.1	\$282,611,404	50.1%	4.8%	\$212,751,696
AK	847	3.3	\$370,963	33.6%	1.8%	\$198,411
AL	119,128	100.8	\$25,421,622	10.7%	1.0%	\$17,369,500
AR	21,150	23.7	\$5,068,397	72.4%	1.8%	\$2,342,243
AZ	11,805	5.3	\$246,584	63.8%	3.1%	\$244,918
CA	219,830	13.8	\$60,930,641	46.1%	5.0%	\$52,453,312
CO	21,280	15.3	\$3,054,298	56.1%	5.3%	\$632,027
CT	5,699	5.5	\$1,454,922	21.8%	4.2%	\$1,301,177
DC	2,106	7.7	\$761,682	68.2%	3.1%	\$592,749
DE	3,767	13.7	\$1,533,217	59.6%	2.3%	\$1,228,690
FL	28,570	6.8	\$6,735,395	72.7%	13.7%	\$4,565,846
GA	35,947	16.0	\$10,831,764	79.0%	3.1%	\$8,503,182
HI	326	0.7	\$91,612	25.6%	0.8%	\$65,176
IA	16,718	22.7	\$4,026,833	77.9%	2.9%	\$3,727,126
ID	4,047	11.5	\$1,418,839	72.7%	3.9%	\$948,256
IL	58,542	17.2	\$11,667,229	13.8%	5.5%	\$8,195,812
IN	5,572	2.8	\$2,182,852	44.0%	5.1%	\$1,551,408
KS	1,643	3.8	\$451,753	50.0%	5.1%	\$402,430
KY	56,356	35.0	\$22,752,171	56.6%	2.9%	\$17,672,131
LA	22,200	13.2	\$4,803,079	44.3%	10.6%	\$3,714,282
MA	10,388	5.3	\$3,424,689	58.1%	5.6%	\$2,418,737
MD	3,025	1.8	\$1,165,734	3.1%	1.0%	\$810,589
ME	1,661	4.5	\$28,333	13.0%	1.8%	\$27,270
MI	17,459	6.3	\$202,103	41.1%	19.0%	\$163,353
MN	6,296	4.9	\$1,324,075	65.4%	4.3%	\$1,115,352
MO	36,018	26.0	\$13,281,625	67.6%	5.3%	\$9,167,946
MS	10,535	16.2	\$3,931,205	27.9%	1.1%	\$2,907,748
MT	3,794	15.4	\$17,001	13.3%	7.4%	\$16,774

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State	Number of Tests	Number of Tests, Per 10,000 Member Months	Estimated Expenditures, \$	Expenditure on Tests Performed on the Same Day as an Emergency Department Visit, %	Expenditure on Tests Performed on Immuno-compromised Patients, %	Estimated Savings if a Targeted Panel was Performed Instead, \$
NC	35,386	11.8	\$6,594,066	57.9%	26.7%	\$3,749,010
ND	769	7.1	\$208,860	73.5%	5.9%	\$123,856
NE	7,619	21.3	\$2,541,218	75.6%	4.5%	\$1,923,732
NH	1,160	5.9	\$450,996	79.2%	4.9%	\$363,099
NJ	57,385	27.8	\$22,822,617	58.4%	2.1%	\$16,446,294
NM	13,263	14.7	\$5,423,231	35.1%	2.3%	\$3,472,368
NV	171	0.2	\$32,925	54.7%	4.4%	\$19,451
NY	95,643	14.7	\$2,574,064	71.6%	19.4%	\$2,137,072
OH	37,161	12.1	\$4,394,497	61.8%	5.2%	\$2,633,556
OK	119	0.1	\$24,634	72.3%	7.6%	\$12,016
OR	6,057	4.1	\$1,856,388	50.0%	3.0%	\$1,533,650
PA	45,284	14.2	\$16,394,149	63.5%	3.2%	\$11,101,004
RI	1,829	5.5	\$954,030	34.1%	9.6%	\$812,311
SC	12,833	9.7	\$403,658	49.1%	12.8%	\$298,968
SD	2,808	19.6	\$1,046,600	56.5%	2.1%	\$771,198
TN	21,887	13.5	\$6,347,617	70.5%	2.2%	\$5,676,793
TX	46,031	9.0	\$14,050,193	46.2%	7.5%	\$11,934,707
UT	1,168	3.2	\$425,894	81.2%	6.6%	\$283,971
VA	20,577	9.9	\$88,200	63.0%	5.5%	\$66,013
VT	23	0.1	\$6,860	8.9%	6.1%	\$6,520
WA	9,871	4.9	\$1,495,387	62.7%	4.3%	\$1,331,625
WI	3,103	2.5	\$1,236,731	65.7%	2.8%	\$939,276
WV	15,686	28.4	\$5,802,191	55.2%	4.1%	\$4,562,835
WY	1,411	20.8	\$257,777	0.8%	1.0%	\$215,933

Source. Center analysis of Medicaid claims and encounter data from the Transformed Medicaid Statistical Information System maintained by the Centers for Medicare & Medicaid Services for calendar year 2024

Note. “—” indicates that there were either no claims identified or fewer claims identified than are allowed to be reported according to the Centers for Medicare & Medicaid Services’ privacy policy—the value is therefore suppressed.

TABLE A3

Utilization of Unspecified Infection Panel Testing in 50 State Medicaid Programs and the District of Columbia, 2024

State	Number of Tests	Number of Tests, per 10,000 Member Months	Estimated Expenditures, \$
US	809,831	9.1	\$186,476,816
AK	142	0.6	\$22,235
AL	26,532	22.4	\$8,425,813
AR	6,656	7.5	\$1,006,897
AZ	15,875	7.1	\$1,121,284
CA	146,195	9.2	\$23,434,333
CO	28,924	20.7	\$9,344,160
CT	1,735	1.7	\$194,990
DC	4,428	16.3	\$697,736
DE	7,850	28.5	\$1,423,963
FL	21,904	5.2	\$1,868,002
GA	27,953	12.5	\$10,460,880
HI	174	0.4	\$23,405
IA	6,204	8.4	\$805,711
ID	6,733	19.2	\$1,956,015
IL	1,432	0.4	\$494,145
IN	18,104	9.1	\$4,449,390
KS	1,850	4.3	\$435,872
KY	23,099	14.3	\$22,673,400
LA	24,957	14.8	\$3,786,444
MA	17,839	9.1	\$1,753,244
MD	54,528	32.0	\$17,047,538
ME	551	1.5	\$56,135
MI	19,493	7.0	\$2,939,222
MN	3,551	2.8	\$416,923
MO	9,545	6.9	\$5,373,194
MS	6,773	10.4	\$4,527,013
MT	668	2.7	\$165,011
NC	5,574	1.9	\$1,126,592
ND	265	2.5	\$132,083
NE	2,536	7.1	\$1,481,346

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State	Number of Tests	Number of Tests, per 10,000 Member Months	Estimated Expenditures, \$
NH	704	3.6	\$83,781
NJ	58,744	28.5	\$7,377,162
NM	10,598	11.8	\$2,329,666
NV	10,067	11.6	\$5,474,565
NY	15,558	2.4	\$904,995
OH	48,977	16.0	\$8,858,234
OK	2,523	2.4	\$155,528
OR	12,884	8.7	\$1,424,740
PA	40,077	12.6	\$5,873,909
RI	1,788	5.4	\$167,960
SC	14,320	10.9	\$7,007,700
SD	100	0.7	\$43,588
TN	771	0.5	\$130,490
TX	35,537	7.0	\$5,064,745
UT	30	0.1	\$7,765
VA	30,972	14.9	\$9,069,907
VT	—	—	\$841
WA	18,884	9.5	\$1,377,584
WI	8,369	6.7	\$1,532,636
WV	6,202	11.2	\$1,584,309
WY	651	9.6	\$363,739

Source. Center analysis of Medicaid claims and encounter data from the Transformed Medicaid Statistical Information System maintained by the Centers for Medicare & Medicaid Services for calendar year 2024.

Note. “—” indicates that there were either no claims identified or fewer claims identified than are allowed to be reported according to the Centers for Medicare & Medicaid Services’ privacy policy and the value is therefore suppressed.

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