HEALTH POLICY

Exploring Artificial Intelligence and Automation in Medicaid

Findings from Text Analysis of State Medicaid Documents and Stakeholder Interviews

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Contents

Acknowledgments iv

Executive Summary v

What We Found v

Key Recommendations for State Medicaid Agencies vi

Exploring Artificial Intelligence and Automation in Medicaid 1

Introduction 1

Background 4

Methods 5

Text Analysis 5

Stakeholder Interviews 7

Limitations 7

Results 8

Presence of Key Topics in Public Medicaid Agency Documentation 8

How AI and Automation Are Used across Medicaid Programs 10

Policy Recommendations 15

State Agencies Can Require MCOs to Publish Standardized Information About Current AI and Automated System Usage 15

State Agencies Can Require Monitoring and Evaluations of All Patient-Involved AI and Automated Systems Used in Medicaid 16

State Agencies Can Use AI Ethics Committees and Frameworks 17

Extensions and Next Steps 17

Replicate over Time as New Developments Occur 17

Additional Engagement with State and National Medicaid and MCO Stakeholders 18

Engage Directly with Patients Who Interact with AI and Automated Systems 18

Appendix A. Protocol for National and State Medicaid Stakeholders 19

Appendix B: Structure of Search Term Hit Tracker 21

Appendix C: Number of Documents Collected by State and Type 22

Appendix D: Hits for Automated Systems in Specific Medicaid Functions by State 23

Notes 24

References 26

About the Authors 27

Statement of Independence 28

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Executive Summary

As the use of artificial intelligence (AI) expands in health care, its adoption in Medicaid, one of the largest health care payers in the United States, is still poorly understood. Medicaid operates as a federal-state partnership, with each state designing and running its program subject to federal rules and requirements. Most states contract with multiple managed care organizations (MCOs) to deliver covered health services to Medicaid members. With numerous distinct processes and parties, as well as the length and complexity of public documentation, it is challenging to systematically study the use of AI across agencies and providers for core Medicaid processes, such as risk stratification, prior authorization, and care management.

To examine AI and automation usage across the state Medicaid landscape, as well as how agencies consider equity when developing and deploying these systems, we analyzed nearly 900 publicly available Medicaid documents. These include state agency materials (e.g., annual reports, quality strategy reports, equity plans) and contracts with MCOs across 45 states. We built a dictionary of relevant AI-, automation-, and equity-related terms to assess how often and in what contexts state agencies and MCOs publicly document and discuss these use cases. We also conducted six Medicaid stakeholder interviews to complement our text analysis. Based on preliminary findings from text analysis and stakeholder interviews, we selected seven states for a deeper qualitative review.

What We Found

We find that Medicaid agency documents, such as annual and quality strategy reports, do not frequently describe AI and automation usage, with many not mentioning these topics at all. The contracts that states make with MCOs are more likely to include descriptions of AI and automation, especially for functions like risk stratification and utilization management. Their language largely focuses on efficiency in service delivery or intervention targeting, with little detail on specific methods, equitable implementation, evaluation, or oversight. We found minimal evidence of generative AI use in state documents, with the lone exception of an AI nurse assistant employed by UnitedHealthcare in Nebraska. Nebraska and Washington stand out for their detailed public documentation of AI usage; Nebraska's contracts with MCOs are particularly detailed in their discussion, while Washington's state agency has published a comprehensive ethical framework and created an AI ethics committee.

Key Recommendations for State Medicaid Agencies

Based on our findings, we recommend the following policy actions for state Medicaid agencies:

- To support transparency, state Medicaid agencies can require MCOs to publish standardized information on their uses of AI and automated systems, including the tools they use, their specific functions, and how members might interact with them.
- State Medicaid agencies can require evaluations of all AI and automated systems that involve patients, including a complete set of performance metrics, equity analysis for effects of implementation on demographic subgroups, and monitoring over time.
- State Medicaid agencies can establish AI ethics committees and governance frameworks to guide responsible decisionmaking and deployment of AI and automated systems.

Exploring Artificial Intelligence and Automation in Medicaid

Introduction

Since OpenAI launched ChatGPT as a consumer-facing product in late 2022, over 43 percent of Americans are estimated to be using large language models (LLMs) in their work as of March and April 2025, and usage forecasts only point upward (Hartley et al. 2024). This uptake is part of a broader acceleration in artificial intelligence (AI) development, including particular applications in health care. AI tools like chatbots have been designed for a range of health communication uses, such as scheduling appointments, monitoring patient vital signs remotely, and providing real-time mental health support (Grassini et al. 2024). The integration of these tools into health care settings can help reduce staff burden and improve operational efficiency while enabling a greater number of touchpoints between patients and the health care system (Kocakoç 2022). In the realm of predictive AI, machine learning models are used to predict patient health outcomes, like pregnancy complications (Bertini et al. 2022), and to target proactive health interventions (Triantafyllidis and Tsanas 2019).

However, these potential benefits of AI applications are tempered by concerns. For health care administrators, physicians, and patients to feel confident in the safety and effectiveness of new technologies, transparency is needed to minimize the "black box" nature of AI algorithms (Xu and Shuttleworth 2024). Moreover, biases in training data produce or exacerbate current disparities in patient care. For example, models using prior health care spending as a proxy for need may deprioritize marginalized communities with less historic access to and use of health care services (Obermeyer et al. 2019). Concerns regarding privacy and security are also present, with the risk that AI models have access to health data that patients may not have given explicit consent for the models to use. Even data regulation policies, such as General Data Protection Regulation in Europe, which allow patients to opt out of their confidential data being used for purposes beyond direct care, do not apply to deidentified data. As a result, patients in the United Kingdom could not prevent their data from being used to train a large AI model that took in 57 million records.[1] These issues raise important questions about whether AI can be responsibly, ethically, and equitably integrated into our country's health care system.

Medicaid is one of the largest health care payers in the United States, providing health coverage to over 71 million low-income people as of January 2025.[2] How leaders of this key public coverage source manage the tradeoffs between the promises and concerns of AI as they consider its role in Medicaid will have a widespread impact on the nation's overall health. Further, Medicaid is managed at a state level and most state Medicaid agencies contract with multiple managed care organizations (MCOs) to deliver health services to beneficiaries, leaving room for variation in deployment policies between and even within states (among MCOs).

Although the focus of recent legislation and public discourse has been on generative AI and more complex automated systems for health care-related decisions, even simpler automated systems can have a significant impact on Medicaid patients, providers, and insurers. Many of these automated systems predate the wider societal uptake in AI by years or even decades, but they still raise meaningful questions about transparency, efficiency, and impact on patients. To fully understand the role of AI in Medicaid today, examining both emerging generative AI tools capturing widespread attention and long-standing tools for automation is important. In our work, we use the umbrella term *automated systems* to encompass this entire set of relevant tools, and we define key terminology in box 1 below.

Our exploratory study aims to characterize the landscape of the current usage and evaluation of AI and automated systems in state Medicaid agencies across the United States. Our design involves computational text analysis of state Medicaid agency documents and exploratory stakeholder interviews. Many states have public-facing Medicaid documents that describe where the state may lie along the adoption spectrum and list particular examples of use cases and tools being implemented today; however, this information is often highly decentralized. To our knowledge, ours is the first scan of the nationwide Medicaid landscape that analyzes agency documents directly for usage and uptake of AI and automated systems. We began with a particular focus on the use of AI in maternal health, but expanded the scope of our scan when it became clear that maternal health was rarely mentioned alongside automation and AI in agency documents and contracts. This signaled to us that the adoption of AI and automation in specific maternal health care contexts may still be under development, may be restricted to internal MCO documents whose content is not captured in public contracts with state agencies, or both. As a result, our research poses the following three questions:

1. What are the current policies and practices of state Medicaid agencies in terms of their use of AI and automated systems?
2. How, if at all, are state Medicaid agencies evaluating the efficacy and equity of AI and automated systems they are implementing?

3. Which states provide the most detailed public documentation of their use of AI and automated systems in Medicaid?

BOX 1

Definitions of Key Terms Related to AI and Automation

Algorithm: A sequence of computational rules or instructions to follow that transforms an input into an output. Algorithms are the building blocks of automated systems. For example, a Medicaid managed care plan might employ an algorithm as a part of a broader strategy to target enrollees who are overdue for cancer screenings based on age, sex, and past claims.

Artificial Intelligence: Computational systems that can perform complex tasks normally requiring human skills, such as reasoning, learning, decision-making, problem-solving, autonomous action, and understanding natural language.[a]

Automated System: Any system or process that uses computation to make or inform decisions, collect data, determine outcomes, and/or interact with individuals. This is an umbrella term that includes complex techniques like artificial intelligence and machine learning, as well as simpler rule- or heuristic-based methods.[b] For example, automated prior authorization that approves routine procedures without human review would be an automated system, whether it uses AI.

Generative Artificial Intelligence (GenAI): A category of AI systems that *generates* new content such as text, images, audio, and video in response to a user request, rather than just recognizing patterns from and analyzing existing data.[c]

Machine Learning: A subfield of artificial intelligence that trains computers to learn patterns from data without being explicitly programmed.[d]

Predictive Analytics: The use of statistical or computational techniques to extract information from data in order to predict trends and behavior patterns.[e]

Notes: [a] Stryker, Cole. "What Is Artificial Intelligence (AI)?" IBM, August 9, 2024, https://www.ibm.com/think/topics/artificial-intelligence.
[b] The White House Office of Science and Technology Policy, "Definitions," Blueprint for an AI Bill of Rights, accessed June 13, 2025, https://bidenwhitehouse.archives.gov/ostp/ai-bill-of-rights/definitions/.
c The White House Office of Science and Technology Policy, "Definitions," Blueprint for an AI Bill of Rights, accessed June 13, 2025, https://bidenwhitehouse.archives.gov/ostp/ai-bill-of-rights/definitions/.
[d] Sara Brown, "Machine Learning, Explained," MIT Sloan, April 21, 2021, https://mitsloan.mit.edu/ideas-made-to-matter/machine-learning-explained.
[e] Anamaria Berea, "Predictive Analytics," In: Schintler, L., McNeely, C. (eds) Encyclopedia of Big Data, Springer, April 19, 2017, https://doi.org/10.1007/978-3-319-32001-4_170-1.

Background

The federal and state AI policy landscapes have evolved rapidly over the past few years. "The Blueprint for an AI Bill of Rights," published by the Biden White House in 2022, intended to "guide the design, use, and deployment of automated systems to protect the rights of the American public in the age of artificial intelligence (White House 2022)." Building on this, in October 2023, the Biden administration issued EO 14110 on artificial intelligence to promote a national approach to "safe, secure, and trustworthy development and use of artificial intelligence."[3] The order emphasized responsible AI development and deployment and set quality data privacy and security standards for government AI initiatives. However, in January 2025, the Trump administration passed an executive order on "Removing Barriers to American Leadership in Artificial Intelligence," which revoked EO 14110 and similar directives that "act as barriers to American AI innovation."[4] The Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services both released AI playbooks intended to review best practices and provide step-by-step instructions for responsible AI development that have since been removed from government websites (CMS 2024).[5]

At the state level, numerous states have introduced or enacted AI-related legislation impacting health care.[6] For example, California passed S.B. 1120, "The Physicians Make Decisions Act," which regulates how health care plans and disability insurers use AI in utilization review, the process of determining medical necessity for health care services, treatment, and equipment.[7] Proposed legislation in Massachusetts,[8] Nebraska,[9] and multiple other states requires experts to review AI decisions around benefits eligibility and medical necessity; similar legislation in Minnesota bans AI use altogether in prior authorization decisions.[10] Washington State has also taken action: its Health Care Authority published an AI ethics framework, which sets guiding principles and evaluative questions to govern the use of AI in Medicaid and health care services (Washington State Health Care Authority 2023). Several states introduced legislation in 2025 to govern the use of AI chatbots, particularly in a mental health context, requiring the provision of accurate information, preventing the waiving of liability, and treating user data sensitively. Finally, in a broader effort affecting AI usage across sectors, the Colorado legislature passed S.B. 205 in May 2024, known as the "Consumer Protections for Artificial Intelligence," to protect against algorithmic discrimination and enforce consumer transparency and risk management.[11] S.B. 205 has served as a model for legislation introduced by many other states. Notably, these state examples apply broadly to health care plans and services regulated by the states, and are not limited to Medicaid.

Methods

Text Analysis

Data Collection

To select Medicaid agency documents, we began by consulting subject matter experts and web-based research to identify illustrative examples of AI use in Medicaid and where they were documented. We then selected Medicaid agency documents that would be both publicly available and likely to contain language related to AI, automation, or algorithmic systems. These documents included annual reports, quality strategy reports, and equity plans. We also identified Medicaid agency contracts with MCOs (both generic and specific). We relied on a mixture of web scraping and manual downloads, depending on the state-specific websites, which we collected from the National Association of Medicaid Directors website. The code to replicate documents is included in our accompanying GitHub repository. In total, our team collected and analyzed 895 documents across 45 state agencies between June and September 2024.

To extract text from PDFs, the team used the Python package PyPDF for documents containing searchable text, and Amazon Web Services' Textract tool to apply Optical Character Recognition software to PDFs consisting of unsearchable scans or images. Notably, 786 (88 percent) of these documents are generic or specific contracts between agencies and MCOs, while most of the remainder are quality strategy reports or annual reports. Exemplifying the usefulness of a quantitative text analysis at scale, the mean number of pages is 157, and the mean number of tokens (loosely equivalent to words) is nearly 40,000.[12] A full table of document types collected by state is shown in appendix C.

Dictionary Search across All Documents

To analyze extracted text, we built a dictionary of relevant terms and topics based on subject matter expertise. Table 1 lists each topic and the specific search terms that we applied within that topic. For example, we hypothesized that risk might be a concept that occurred in the context of AI applications, but risk also appeared in thousands of less relevant instances as well (e.g., "financial risk" or "comprehensive risk"). To focus on just the most relevant search terms, we applied an n-gram analysis to view the most commonly occurring two- and three-word phrases that include "risk," and then manually added only the relevant such phrases to our dictionary. To ensure relevance to the context of AI and automation, we also searched for instances where topics like equity, disparities, or maternal morbidity

and mortality appeared within the same window of text as topics more explicitly linked to our research questions (e.g., "artificial intelligence," "machine learning," etc.).

TABLE 1

Dictionary of Search Terms for Text Analysis

Topic	Search term(s)
AI and automated systems concepts	
Risk	risk scor*, risk level, risk screening, risk pregnancy, rates risk
Artificial intelligence	artificial intelligence, ai
Machine learning	machine learning, ml
Predictive analytics	predictive analy*
Algorithm	algorithm
Automation	automate*, automation
Evaluation and impact concepts	
Bias	bias
Equity	equity, equitable
Ethics	ethic*
Fairness	fairness
Disparities	disparat*, disparit*
Enhanced care	enhanced care
Severe maternal morbidity and mortality	maternal mortal*, maternal morbid*

Source: Author's analysis.

Notes: AI = artificial intelligence. * denotes a "wild-card" character that allows for any number of characters to follow, in order to capture different suffixes.

Deeper Review for Sample States

We applied our dictionary across each document to construct summary statistics for commonly occurring terms and the top states and documents for each search term. Then, we identified states for deeper review by using preliminary keyword match results to assess the frequency and context of relevant terms across states. We prioritized states with high match counts for a mixture of AI- and equity-related terms (e.g., Nebraska, Georgia) and included others (e.g., Alabama, Colorado) based on recommendations from national stakeholders who noted agency activity on AI in health care programs that may not yet be reflected in public documentation. The seven selected states for closer analysis were: Alabama, Colorado, Georgia, Illinois, Nebraska, Tennessee, and Washington.

For these seven states, the team used the R packages *quanteda* and *corpustools* to create a **Browser Tool** to efficiently identify and place priority search terms in the context of their original documents. We make a similar version of this tool publicly available here: https://urbn.is/4m0Mau8. Using the browser tool, the team systematically encoded a subset of dictionary topics in table 1 that we found most frequently indicated relevant practices and policies related to the usage of AI and automated systems.

To document these trends, the team created a **Search Term Hit Tracker**, specific columns of which are described in appendix B. This enabled us to easily count and track instances of text that represent relevant, affirmative mentions of specific applications of AI and automated systems in Medicaid.[13] Below, we discuss key findings from our detailed review of these seven states in our sample.

Stakeholder Interviews

In parallel, we conducted six semistructured interviews with national and state stakeholders between December 2024 and March 2025. Interviewees included individuals responsible for policy strategy, program implementation, and ethical oversight of AI and automated systems, such as Medicaid agency staff, policy advisors, and members of state-level AI governance bodies. We prioritized speaking with stakeholders from states showing clear public documentation of AI activity, as well as representatives from national organizations representing Medicaid programs and state policymakers.

We conducted interviews using videoconferencing software, and each lasted approximately 30 to 45 minutes. Interviewees were not compensated for participation. The interviews explored how states are developing and deploying AI in Medicaid programs, including how they are considering potential advances and risks of AI technology and how equity factors into these considerations. Findings from these interviews are incorporated below alongside findings from our text analysis. Our interview protocol is included as appendix A.

Limitations

Although we analyzed a large number of public agency reports and MCO contracts, our review is not comprehensive of all possible mentions of AI and automated systems. These tools may be described in other documents created by agencies or their contractors, which were not included in our review. Moreover, given the lack of standardized reporting requirements, the absence of keyword mentions in certain states does not indicate that AI and automation themselves are absent from Medicaid altogether in those states, but rather that these technologies are simply not mentioned in public documents. For example, while eligibility determination was not a frequently mentioned theme in reviewed documents, the Affordable Care Act required all Medicaid agencies to modernize eligibility determination by providing automated, streamlined, and paperless enrollment processes.[14] Similarly, MCOs implementing AI and automated systems may have internal oversight, evaluation, and ethical guidelines that are not required to be made public. Therefore, results should be interpreted in the

context of these limitations, and our landscape scan should be understood as a review of *public* discussion and reporting by agencies about their practices within the documents included in this study.

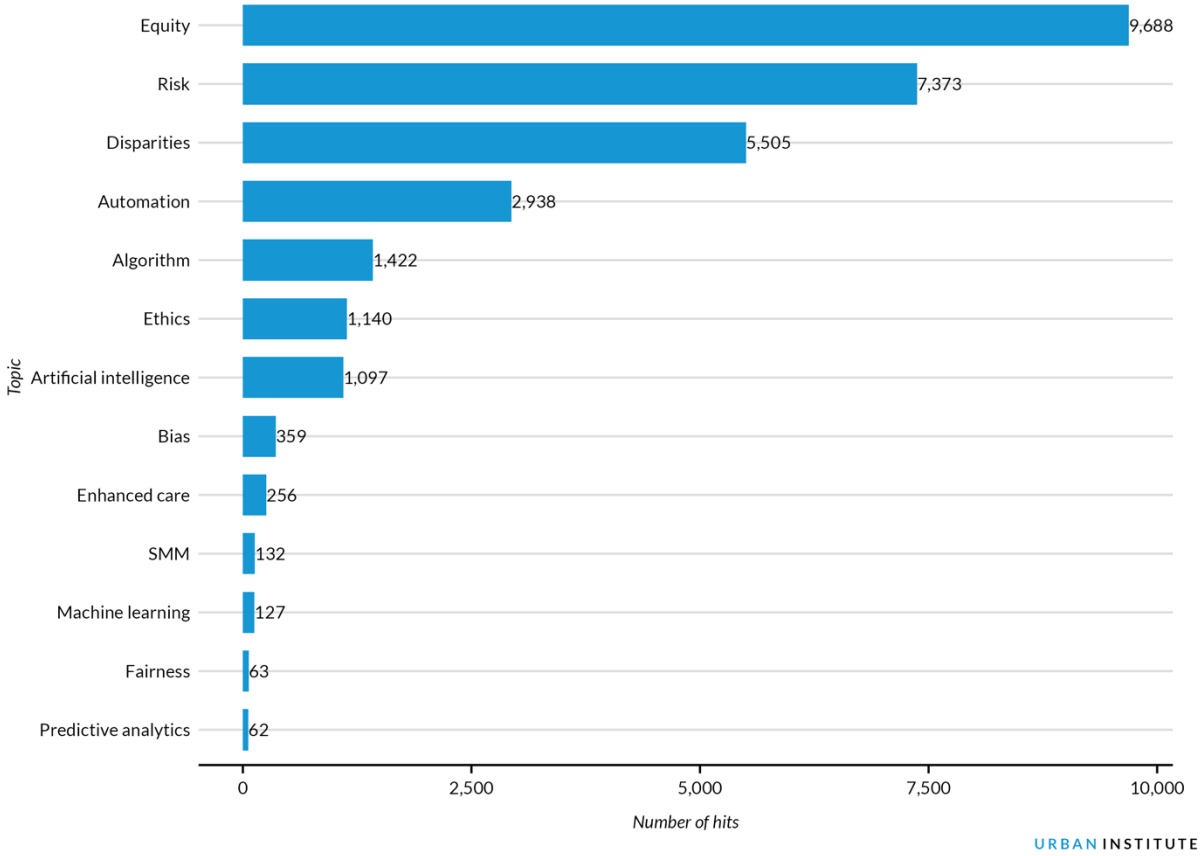
Results

Presence of Key Topics in Public Medicaid Agency Documentation

Figures 1 and 2 summarize the prevalence of keyword topics across all 895 documents. Figure 1 shows the number of times different search terms were mentioned in the documents we reviewed. Broad terms like *equity* and *risk* occur several thousand times, and key overarching topics like *AI*, *automation system*, and *algorithm* also number in the thousands. More specific terms like *machine learning* and *predictive analytics* are less frequent. Figure 2 identifies the five states that have the highest concentration of mentions for each keyword. Nebraska appears at or near the top for most keywords, even for terms like *predictive analytics* and *machine learning* that are comparatively rare in all other states' documents. Some other states appear in the top five for only one keyword related to AI and automated systems (e.g., Texas and Washington for *artificial intelligence*, Missouri for *algorithm*), highlighting how much specific terminology can differ across states. The same is true for topics like *disparities*, *fairness*, *ethics*, and *equity*, whose overall prevalence also varies widely by state. Further below, we discuss the co-occurrence of AI- and equity-related keywords.

FIGURE 1

Topic Occurrences across Analyzed Documents

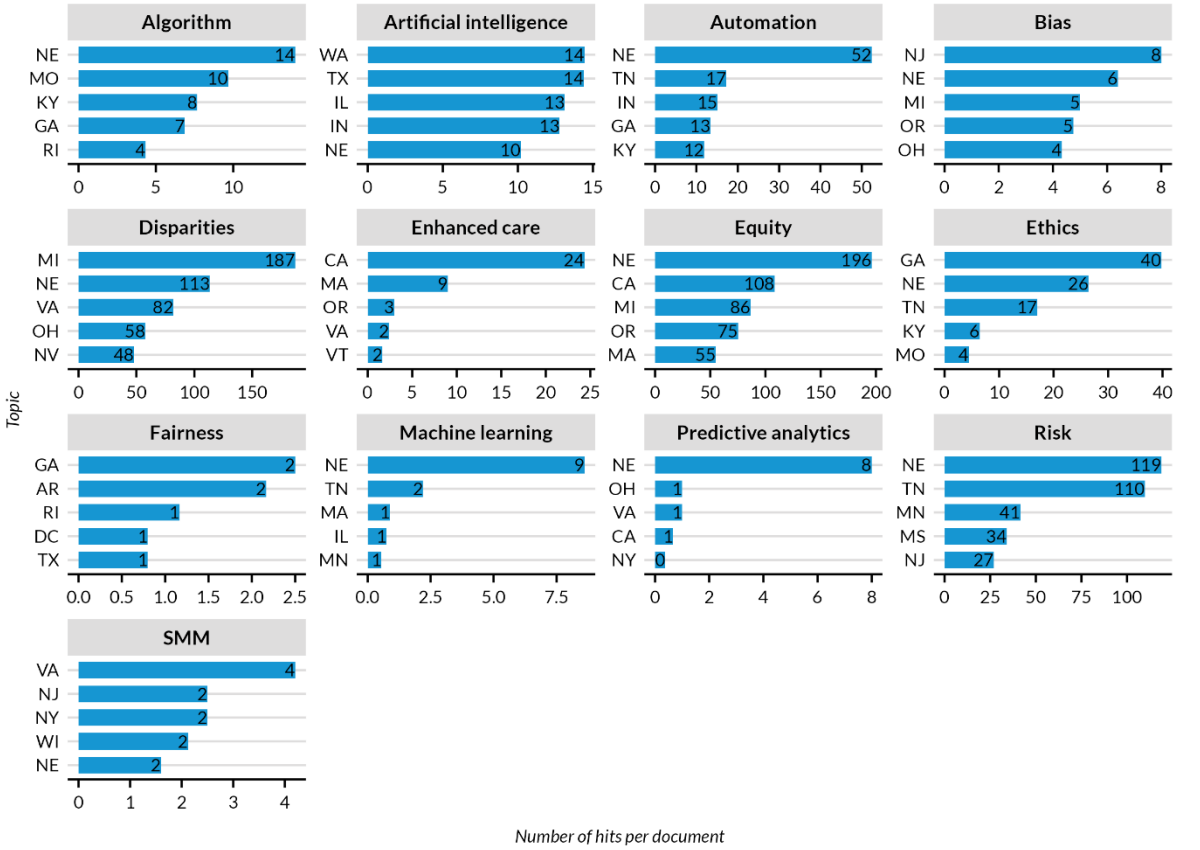


Source: Author's calculations based on documents collected from state Medicaid agencies.
Notes: SMM = severe maternal morbidity or mortality. Not all collected documents were processed and analyzed due to text extraction costs and the specific states we selected as most relevant.

FIGURE 2

Top Five States by Topic Occurrence

Number of Keyword Matches Divided by Number of State Documents



Source: Author's calculations based on documents collected from state Medicaid agencies.
Notes: SMM = severe maternal morbidity or mortality. Not all collected documents were processed and analyzed due to text extraction costs and the specific states we selected as most relevant.

How AI and Automation Are Used across Medicaid Programs

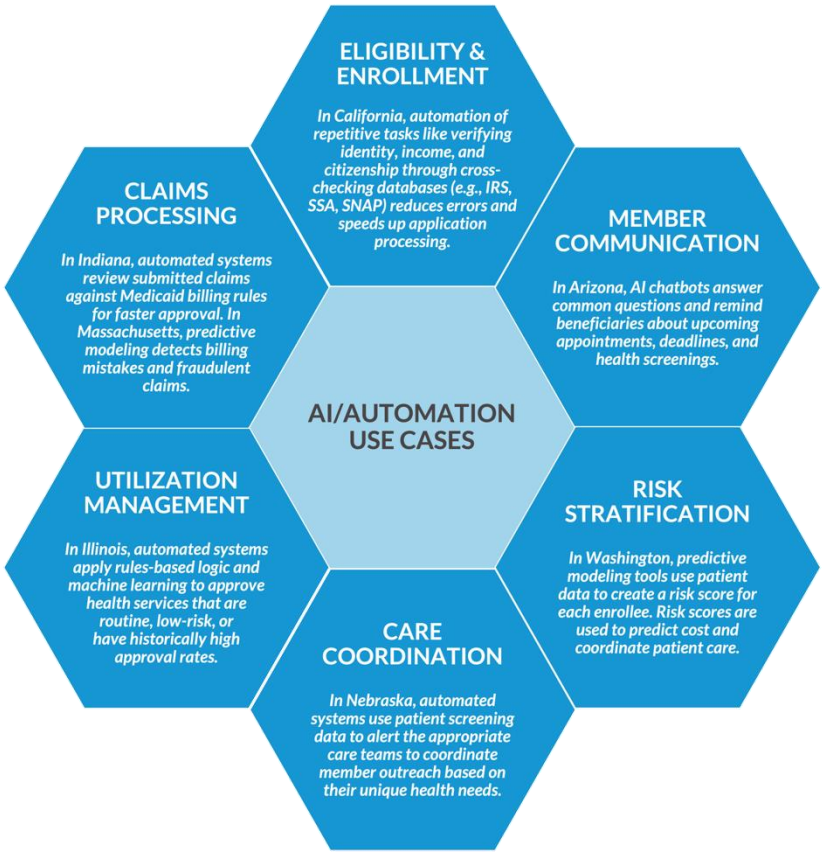
Examples of AI and Automation across Medicaid Functions

Moving from keyword hits to specific examples that address our key research questions, figure 3 shows how state Medicaid agencies, MCOs, and other contractors may use AI and automation across key functions of Medicaid. We identified the figure's illustrative examples using our **Browser Tool** and **Search Term Hit Tracker,** supplemented by interview data and web-based research for functions that did not appear in the study's text analysis (e.g., automated enrollment and eligibility functions, given that all states are required to automate eligibility determination per the Affordable Care Act). These

examples are not exhaustive; for some of these functions, similar approaches may exist across multiple states and MCOs. This figure is meant to illustrate the breadth of AI and automation across different Medicaid functions. In the sections below, we will more closely examine two of the functions that we found to be particularly active areas for AI and automated systems in our seven sample states: risk stratification and utilization management.

FIGURE 3

Representative AI/Automation Use Cases across Medicaid Functions



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Source: Authors' analysis of public documents and state websites.
Notes: AI = artificial intelligence.

Risk Stratification and Utilization Management

Using our **Browser Tool** and **Search Term Hit Tracker,** we find examples of AI and automation in many of the major Medicaid functions—most often in MCO contracts with state agencies, rather than from the agencies themselves. We summarize mentions of AI and automated systems in risk stratification and care authorization for all seven states in tables 2 and 3 below. All the information referenced in these tables was identified in MCO contract language and reflects activity by contracted health plans,

rather than by state agencies, with the exception of the Georgia Medicaid portal for automated prior authorization that MCOs must use. Most of the documented uses below relate to operational efficiency, including targeting specialized interventions for patients based on algorithmic assessments of risk, identifying potential overutilization, and streamlining prior authorization processes. Public documents offer little detail about the specific systems, methodologies, evaluation practices, or oversight. Although some MCO contracts reference patient equity and health disparities, they are typically framed in terms of more efficient service delivery or intervention targeting, rather than as reflections of the design and impact of AI and automated systems themselves on these groups.

Although language in documents around evaluation, oversight, and equity was limited, study interviewees frequently emphasized that these concerns are central to how Medicaid officials consider adoption of AI and automated systems in their agencies. One national stakeholder described Medicaid leaders as skeptical of AI-enabled service delivery applications, citing direct concerns that AI could perpetuate health disparities because of its reliance on "data and information that is inherently biased in many ways." Several interviewees elevated the importance of evaluating AI applications for critical components such as fairness, responsibility, and transparency. Both national- and state-level Medicaid stakeholders underscored the importance of "having a human in the loop" to vet and correct for mistakes, biases, or blind spots that might have damaging impacts for patients. As one stakeholder put it directly, they see a "huge risk" in automating tasks without understanding how a system operates or ensuring that there are "eyes monitoring it" or having "people at the table to call it out" when not performing as intended. Another state Medicaid stakeholder reported that, for now, their agency currently prohibits the use of AI to make substantive decisions about its Medicaid members or providers altogether, citing potential harms to individual health or continuity of care, as well as the risk of deteriorating patient and provider trust if decisions cannot be clearly explained.

Of the states we analyzed in depth, Nebraska and Washington offer the clearest indications that they are leading the way in publicly documenting current AI adoption. In Nebraska, this documentation appears primarily in MCO contracts, with all three of the contracts we reviewed—for UnitedHealthcare, Molina, and TotalCare—detailing many examples of AI and automated systems in core Medicaid functions. By contrast, Washington's state agency has taken a proactive and prescriptive approach: staff published an AI ethics framework and created an ethics committee to guide decisionmaking about the proper use of these systems.[15]

TABLE 2

Uses of AI and Automation by Medicaid MCOs for Risk Stratification

Question	Key dimension	Frequency across documents in sample states (n=7)
What are automated risk stratification systems used for?	Classifying members into risk tiers to determine level of case or care management	Mentioned in NE, TN, IL, WA, CO, AL
	Identifying members for targeted outreach based on specific risk profiles	Mentioned in TN, WA, NE (maternity risk) and NE (social isolation and loneliness)
	Determining program eligibility or disenrollment from targeted interventions	Mentioned only in Apple Health contract in WA
Is automation of risk stratification a requirement?	Required by state	WA, NE, TN, IL
	Not required	Did not find requirements in AL, CO, GA
Which data are used for inputs to AI/automated systems?	Health risk assessments and screenings	Common across most states, both as complements and as direct inputs to risk models
	Medical and pharmacy claims, utilization patterns, lab results, and referral data	One or more mentioned in NE, TN, IL, WA, CO
	Social determinants of health, demographic characteristics, and external public data sources (e.g., Census, Immunization Registry)	Mentioned only in TotalCare contract in NE
How are AI/automated systems evaluated?	Performance or accuracy metrics of system	Several mentions, but lacking methodological detail
	Oversight of model development and implementation	Not discussed in reviewed documents
	Explicit mentions of fairness and ethics of AI/automated system	Not discussed in reviewed documents
To what extent are the equity implications of systems discussed?	Equity or disparity reduction mentioned as explicit goal	Mentioned only in UnitedHealthcare contract in NE
	Subgroup auditing of system by race, ethnicity, etc.	Mentioned only in TotalCare contract in NE

Source: Authors' analysis of publicly available Medicaid MCO contracts.

Notes: AI = artificial intelligence; MCO = managed care organization.

TABLE 3

Uses of AI and Automation by Medicaid MCOs for Utilization Management

Question	Emerging theme or practice	Frequency across documents in sample states (n=7)
How are AI/automated systems used within utilization management?	Automating approval of common procedures or medications	Mentioned across many MCO contracts in NE, WA, CO, GA, IL
	Streamline provider portals and tools	Mentioned across many MCO contracts in NE, WA, CO, IL
	Enable quicker decision-making for urgent or emergency care	Mentioned across MCO contracts in NE, WA
	Identifying overutilization by members and integration with risk stratification	One or both mentioned across many MCO contracts in NE, TN
Is automation of prior authorization a state requirement?	Required by state	Mentioned in WA, GA; GA runs own automated portal that MCOs must use
	Not required	Did not find requirements in TN, AL, CO, NE, IL
How are AI/automated systems evaluated?	Performance or accuracy metrics of system	Not found in reviewed documents
	Oversight of model development and implementation	Not found in reviewed documents
	Explicit mentions of fairness and ethics of AI/automated system	Not found in reviewed documents
To what extent are the equity implications of systems discussed?	Equity or disparity reduction mentioned as explicit goal	Not found in reviewed documents
	Subgroup auditing of system by race, ethnicity, etc.	Not found in reviewed documents

Source: Authors' analysis of publicly available Medicaid MCO contracts.
Notes: AI = artificial intelligence; MCO = managed care organization.

From Automated Systems to Generative AI

Both our text analysis and interview findings elevated a variety of other AI use cases and stages of adoption. Discussions about AI in publicly available documents were overwhelmingly related to general automation and to *predictive* AI models, suggesting that *generative* AI (genAI) use cases had not yet permeated agency documentation at the time of data collection in 2024.

Our interview findings suggest that the use of any type of AI varies widely by state. Some agencies are in the "early consideration phase," internally testing options and observing other states. Echoing the theme of operational efficiency that appeared in our text analysis, we heard interest in agency-led pilots of genAI tools to streamline eligibility determination, support call center staff with chatbots, polish writing, build better website interfaces, and sort through claims more quickly. The theme of easing staff burden and providing more accessible and timelier beneficiary support surfaced frequently, both in streamlining the labor-intensive process of reviewing large policy manuals to determine eligibility and in answering member questions to improve customer support bandwidth. However, staff reiterated that they continue to approach any public-facing services cautiously.

One of the few genAI implementations identified in this study's text analysis and interviews that could foreshadow coming trends is an AI nursing assistant created by UnitedHealthcare, one of Nebraska's contracted MCOs. Described as a voice-enabled AI nurse assistant, CareAngel aims to reach pregnant members with complex, chronic conditions to "address social determinants of health, care coordination, and medication adherence."[16] Although high infant mortality rates among African American infants are the stated impetus for CareAngel, we did not find language discussing efficacy, usage, or oversight of the tool. For now, UnitedHealthcare describes interactions with CareAngel as an administrative expense, rather than encounter data, suggesting that it is not considered a formal component of patient care.

Policy Recommendations

State Agencies Can Require MCOs to Publish Standardized Information About Current AI and Automated System Usage

Although our deeper dive into the seven sample states revealed concrete examples of AI and automated system usage, our broader text analysis highlighted how little information many state agencies include in key public documents, and how much variance there was among states that did publish information. In most of the 45 states we reviewed, the MCO contracts contain few, if any, mentions of these topics. This may reflect limited adoption in some states and limited documentation in others, and we currently cannot make this determination based on the publicly available information. In either case, MCOs and other contractors should report a minimal set of information about AI, including a broader set of automated systems that may not be as technically complex but may still have the same impact on patients or participating providers.

For MCOs actively deploying automated systems for functions like risk stratification, utilization management, customer service, and any other patient-centric, sensitive topic areas, individuals who can expect to interact with these systems should readily be able to access information about model training data, variables used for prediction, model performance (both overall and for key demographic subgroups), and the specific settings and decisionmaking systems in which models are deployed. One promising format for reporting this information in a standardized, digestible way is through "model cards," which describe how models are developed and tested (Mitchell et al. 2019). The Google researchers who developed model cards describe them as "nutrition labels" for AI that typically include information such as intended use and users, demographic factors, model performance, evaluation

processes, training data descriptions, ethical considerations, and any important caveats. Standardized approaches like these are especially important in systems interacting with vulnerable populations, fostering trust and accountability for both individuals and their advocates.

At the federal level, the Centers for Medicare & Medicaid Services published proposed reforms on the use of AI and automated systems in prior authorization for the Medicare Advantage program. The proposal called for Medicare Advantage organizations to audit AI tools for input bias, regular review to ensure nondiscriminatory application of outputs, and increased public disclosure.[17] However, the Centers for Medicare & Medicaid Services recently finalized the rule (applicable as of January 2026) and declined to implement these AI-specific provisions, though it signaled openness to consider rule-making in the future.[18] This development signals that even in adjacent programs, federal oversight has yet to lead to clear, codified standards around AI transparency. State agencies have the opportunity to fill this gap and lead by example in requiring MCOs and other organizations they contract with to document their usage of AI and automated systems.

State Agencies Can Require Monitoring and Evaluations of All Patient-Involved AI and Automated Systems Used in Medicaid

Even among the seven sample states, we found little information on how MCOs, if at all, are evaluating the impact of their systems. Contracts rarely describe how systems are assessed beyond occasional mentions of overall predictive accuracy, devoid of crucial context or disaggregation by key patient subgroups. Evaluation does not need to be limited to identifying risks or negative impacts; agencies, MCOs, and other Medicaid contractors can and should surface success stories where AI tools may streamline previously inefficient, error-prone processes.

However, effective oversight is more holistic than a single performance metric. Agencies partnering with organizations that implement AI or automated systems should require impact assessments across the full lifecycle. The National Institute of Standards and Technology's "AI Risk Management Framework 1.0" outlines several distinct stages relevant to agencies, including planning and design, data collection (or processing of existing resources), verification and validation, operation and monitoring, and impact assessment.[19] Agencies should consider ways to both compile and formally report this information to the public, not only to assess the types of tools we found in our text analysis, but to establish governance structures before genAI adoption grows from its current early stages.

State Agencies Can Use AI Ethics Committees and Frameworks

To promote more holistic evaluation, all state Medicaid agencies should have a governing body, such as an AI ethics committee, tasked with ethically implementing AI systems. These committees can be responsible for explicitly assessing the risks, concerns, limitations, and potential biases of AI and automated systems before approving new use cases, particularly those involving sensitive member data.

Washington State can serve as a leading example here. In March 2024, the state's Health Care Authority published an AI ethics framework to assist its AI ethics committee in evaluating proposed use cases involving Medicaid data. The committee's evaluation process includes screening questions focused on bias and fairness, equity, transparency, accountability, compliance, and trustworthiness. The agency has identified these criteria as essential to a balanced approach that protects individuals served by Medicaid while also considering the benefits, risks, and costs of AI systems.

A key tool in the arsenal of ethics committees should be the development of an AI framework to thoughtfully guide decisionmaking. In the local government context, Stern, Ramos, and Prinvil (2025) provide practical support on developing such frameworks, including curated resources to help build AI expertise, guidance for vetting vendor products, and templates for defining appropriate use and policy (Stern, Ramos, and Prinvil 2025). These materials can help orient Medicaid agencies that are earlier in their AI journeys, grounding sensitive decisions in core agency principles.

Extensions and Next Steps

Replicate over Time as New Developments Occur

This work reflects the publicly available data collected in 2024 on the current state of AI uptake by state agencies and the MCOs with which they contract. In this analysis, we reviewed 895 documents across 45 states, and genAI usage in particular appeared infrequently in our collected dataset. However, our interviews with agency staff who are actively thinking about genAI tools and their uptake in fields outside of health care suggest Medicaid is a space that could experience high technological volatility in the coming years. Efforts building on this exploratory study could attempt to align with key evolutions in the landscape (e.g., state-level regulatory changes, introduction of new genAI capabilities such as "reasoning"[20] or "agentic"[21] models). Notably, AI tools themselves may help to directly support this research, aiding in the large-scale location, extraction, and interpretation of large bodies of text.

Additional Engagement with State and National Medicaid and MCO Stakeholders

We were unable to secure interviews with stakeholders from all seven sample states. Future work should engage a wider range of stakeholders, including those at the vanguard of AI and automation in Medicaid and those in slower-moving agencies, to paint a more robust picture of the landscape as it unfolds. Our interviews suggest several methodological questions that could be further refined with more stakeholder engagement: which data to collect, what questions to seek answers to in collected documents, and which AI use cases are top of mind for staff. We are confident that we identified a strong set of sample states that showcase the current state of AI implementation, but for state-level studies of this breadth, more engagement with agency and MCO staff is crucial to prioritize research strategically.

Engage Directly with Patients Who Interact with AI and Automated Systems

More work is also needed to document the experiences of patients who already or may soon interact with AI and automated systems in their Medicaid journeys. This could include users of member support chatbots, members identified for specific interventions via risk stratification tools, and members whose eligibility for health care services may be determined, in part, by AI and automated systems. Patient perceptions of transparency, trust, efficiency, and equity are essential components to understanding the risk/reward tradeoffs of these technological advancements. This is true for all beneficiaries, but especially for those in communities of color who have historically faced egregious mistreatment and unethical experimentation, resulting in lower levels of trust in health care systems, patient understanding, and more successful tools. Future research designs should incorporate participatory methods such as community advisory boards, community-engaged surveys, and data walks (Murray, Falkenburger, and Saxena 2015; Sankofa, Daly, and Falkenburger 2024).

Appendix A. Protocol for National and State Medicaid Stakeholders

BOX 1

Protocol for National and State Medicaid Stakeholders: Interview Questions

- Could you tell us more about your role in your organization?
- Probe: Do you have responsibilities associated with AI automation?
- How are state health agencies, including but not limited to Medicaid, using AI automation as they operate health programs?
- Probe: You haven't mentioned uses in maternal health programs; what, if anything, can you share regarding this health service area?
- What are the areas of highest potential for use of AI in the Medicaid space specifically?
- How about areas of highest risk [for use of AI in the Medicaid space]?
- One area we've observed that states are using AI in Medicaid is to determine who receives enhanced services to combat severe maternal morbidity and mortality risk.
- National Stakeholders Only: What do you know about state approaches for doing this? How do they vary by state?
- State Stakeholders Only: What methods, if any, are currently in place within your state Medicaid program to do this? [If not already indicated] Has your state considered using AI for this?
- How, if at all, are state Medicaid programs explicitly discussing equity considerations (e.g., algorithmic bias) in how they approach identifying beneficiaries at risk of poor health outcomes?
- Probe: Are any of these discussions specific to maternal health outcomes?
- [For national interviewee] Are there any state Medicaid programs that you see as especially ahead of the curve on AI policy or usage?
- Probe: For maternal health care specifically?
- State Stakeholders Only: Which agencies, health and hospital systems, or other entities in your state, if any, are especially ahead of the curve on AI policy or usage?

- As we mentioned in our introduction to this interview, the data scientists on our team are conducting text analysis across a large set of public documents and state agencies. Are there any other places where you think AI usage, strategy, or development might be published?
- As you think about the documents we just discussed [repeat if needed], are there certain topics, keywords, or phrases that you've seen associated with AI in Medicaid?
- What are your "unknowns" about AI in health care right now? In other words, what are the things you wish you knew?
- Which other stakeholders would you recommend we speak to about this topic?

Appendix B: Structure of Search Term Hit Tracker

TABLE 1.B

Structure of Search Term Hit Tracker

Selected columns	Description
Metadata	
Term	[text] List of all search terms present in the given page
State	[text] The state the document comes from
Document ID	[text] Unique ID for each search term occurrence/hit
Reader-filled	
Automated systems	[binary] Marked 1 if text snippet discusses AI, algorithms or automated systems
Risk stratification	[binary] Marked 1 if text snippet discusses the use of AI/automated systems to construct patient risk categories.
Care authorization	[binary] Marked 1 if text snippet discusses the use of AI/automated systems in the care authorization or utilization management process
Maternal mortality—General	[binary] Marked 1 if text snippet discusses maternal mortality
Maternal mortality—Race	[binary] Marked 1 if text snippet discusses racial disparities in maternal mortality
Health equity	[binary] Marked 1 if text snippet discusses health equity
Mishit	[binary] Marked 1 if the search term flagged in the text snippet does not refer to our actual term of interest (e.g., an alternative meaning of the term)
Vendors	[text] Names of the creators of the AI/automated tool mentioned in the text snippet

Source: Authors' analysis.

Notes: AI = artificial intelligence.

Appendix C: Number of Documents Collected by State and Type

TABLE 1.C

Number of Documents Collected by State and Type

State	Annual report	Equity plan	MCO document	Quality strategy report	Total
AL	1	-	7	3	11
AR	2	-	3	1	6
AZ	-	-	355	2	357
CA	-	-	1	2	3
CO	2	1	8	2	13
DC	1	-	2	2	5
FL	1	-	10	1	12
GA	1	-	4	3	8
IA	1	-	26	2	29
ID	-	-	10	1	11
IL	1	-	6	1	8
IN	1	-	35	1	37
KS	1	-	3	2	6
KY	1	1	36	2	40
LA	1	-	42	1	44
MA	-	-	7	2	9
MD	1	1	2	1	5
MI	1	2	-	1	4
MN	1	-	27	1	29
MO	-	-	8	1	9
MS	1	-	3	1	5
MT	-	-	-	1	1
NC	1	-	-	1	2
ND	1	-	1	1	3
NE	1	-	3	1	5
NH	1	-	-	1	2
NJ	1	-	2	1	4
NM	1	-	8	1	10
NV	1	-	-	1	2
NY	1	-	5	2	8
OH	1	-	1	1	3
OK	-	-	-	1	1
OR	1	-	2	1	4
PA	2	-	-	2	4
RI	1	-	4	1	6
SC	-	-	1	1	2
TN	1	-	3	1	5
TX	2	-	6	2	10
UT	1	-	28	1	30
VA	2	-	2	1	5
VT	1	-	-	2	3
WA	1	-	5	1	7
WI	1	1	6	-	8
WV	1	-	1	1	3
WY	2	-	-	1	3

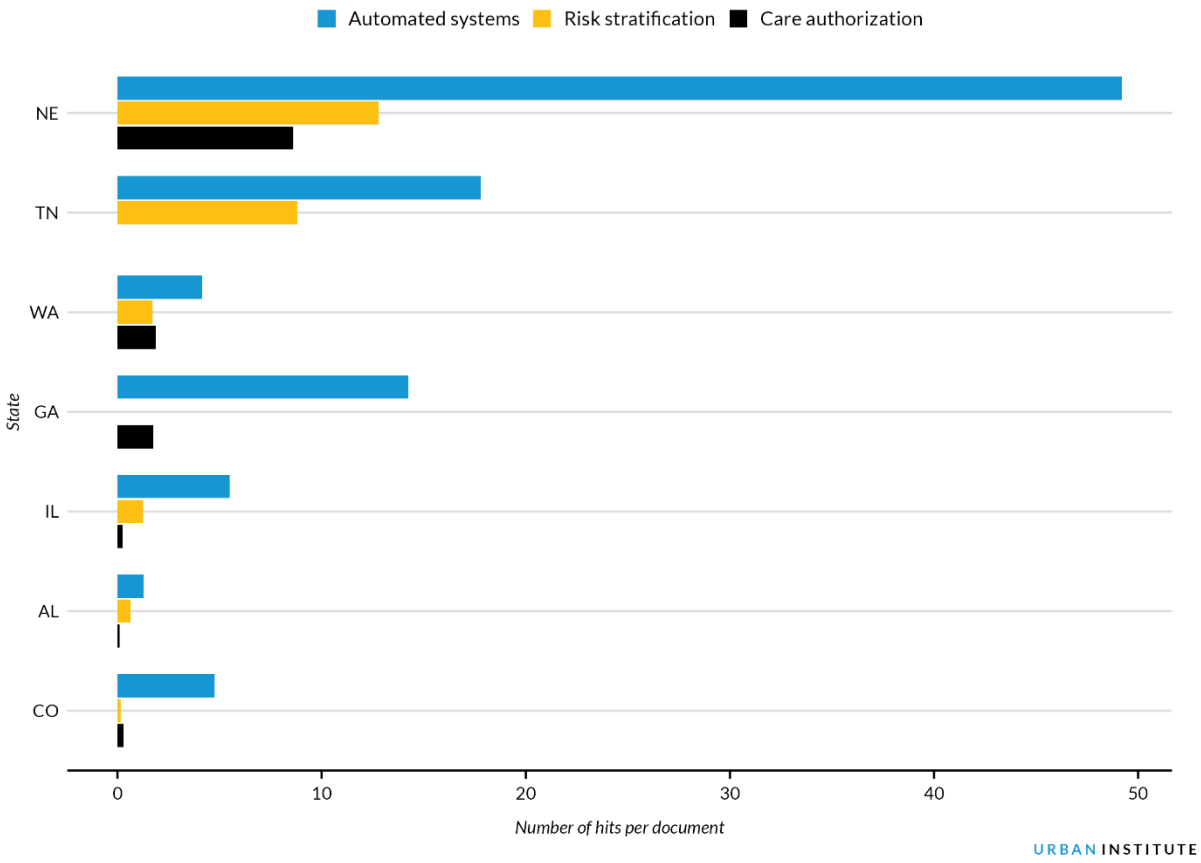
Source: Authors' calculations based on documents collected from state Medicaid agency websites.

Notes: MCO = managed care organization.

Appendix D: Hits for Automated Systems in Specific Medicaid Functions by State

FIGURE 1.D

Hits for Automated Systems in Specific Medicaid Functions by State



Source: Authors' calculations based on documents collected from state Medicaid agency websites.

Notes: Calculations based on total number of reader-reviewed documents and Search Term Hit Tracker.

Notes

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[11] S.B. 205, *Concerning Consumer Protections in Interactions with Artificial Intelligence Systems*, 2024 Reg. Sess. (Co. 2024), https://legiscan.com/CO/text/SB205/id/2996839.

[12] A token is technically defined as a sequence of characters in text that is segmented as useful for analysis, typically corresponding to a word, sub-word, or punctuation mark. See Manning, Raghavan, and Schütze (2009), Chapter 2.

[13] We found many false positives (e.g., "AI" as "American Indian" rather than "artificial intelligence") and several mentions that did not indicate affirmative usage of a particular tool or technology.

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