Partnering for Progress: Advancing Medicaid Through Evidence and State Collaboration

2025 Annual Report

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Contents

Message From the Director 3

60 YEARS OF MEDICAID
History and Evolution of Medicaid: Population, Benefits, and System Impact (1965-2025) 4

PREPARING FOR THE NEXT 60 YEARS
Ongoing Support for State Medicaid Programs 6

PREPARING FOR THE NEXT 60 YEARS
New Support for State Medicaid Programs 12

2025 IN REVIEW
Evidence Reports 18

2025 IN REVIEW
Center Staff 22

Message From the Director

In 2025, Medicaid celebrated its 60th anniversary—6 decades as one of the nation's most essential health care pillars. Since its inception, Medicaid has expanded access to care for millions of children, families, older adults, and people with disabilities. For states, Medicaid has also served as a platform for innovation, partnership, and problem-solving, continually adapting to meet evolving needs and circumstances.

Today, Medicaid stands at a pivotal moment. New policy activity is reshaping financing, coverage design, delivery systems, participation requirements, and accountability expectations. At the same time, states are confronting rising costs, workforce shortages, shifting population needs, and growing demands for measurable results. In this environment, high-quality evidence and strong state collaboration aren't just helpful—they're indispensable.

Our 2025 annual report, **Partnering for Progress: Advancing Medicaid Through Evidence and State Collaboration**, highlights how the Center for Evidence-based Policy is helping states meet this moment. Over the past year, the Center has strengthened its role as a trusted evidence partner and neutral convener, bringing states together to analyze emerging research, exchange insights, and accelerate learning. Our work spans critical areas including coverage policy, payment innovation, pharmacy, maternal and child health, and care for individuals with complex needs. Across all of it, our mission remains the same: equip state leaders with the evidence and tools they need to make informed, forward-looking decisions.

Looking ahead, we are deepening our commitment to helping states navigate a rapidly evolving Medicaid landscape. We are expanding analytic capabilities, strengthening collaborative networks, and developing practical resources that turn evidence into action. Priority areas include strategic financing to sustain coverage under budget pressure; workforce solutions across clinical, administrative, and community-based roles; data that can strengthen oversight and improvement; strategies to address social determinants of health; and planning that builds resilience amid fiscal and policy uncertainty.

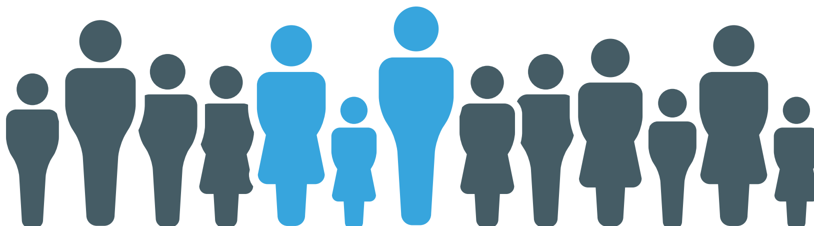
Medicaid's first 60 years show what is possible when federal and state partners work together to drive progress. At the Center for Evidence-based Policy, we are honored to support our state partners as they shape the next chapter of Medicaid, providing trusted support as they prepare for the future.

60 YEARS OF MEDICAID

History and Evolution of Medicaid: Population, Benefits, and System Impact (1965-2025)

Medicaid has evolved from a small, welfare-linked program into a central pillar of US health coverage, serving more than 80 million people annually and accounting for a significant share of national health spending. Its layered eligibility rules, diverse delivery systems, and intricate financing structure make it one of the most operationally complex programs in American public policy.

Nearly 1 in 4 of all Americans have health insurance through Medicaid



MEDICAID FACTS

Look for more **MEDICAID FACTS** for spotlights on specific populations served by Medicaid.

1965–1970s
Origins and Early Expansion

Created in 1965 as a means-tested program tied to Aid to Families with Dependent Children and state disability programs, Medicaid initially focused on institutional long-term care and required coverage of core medical services. Early Periodic Screening, Diagnostic and Treatment (EPSDT) was added in 1967, and states gained broad discretion over eligibility and benefits. By the 1970s, medically needy options expanded, supplemental security income was automatically linked to Medicaid, and the program became the dominant payer for nursing home care.

1980s–Mid 1990s
Coverage Growth and Delinkage

Congress steadily expanded eligibility (especially for children and pregnant women) through a series of omnibus budget reconciliation acts and the Medicare Catastrophic Coverage Act. Transitional medical assistance and the Qualified Medicare Beneficiary program were created. Welfare reform in 1996 formally separated Medicaid from cash assistance, established Section 1931 eligibility, and imposed a 5-year ban on most new legal immigrants.

Late 1990s–2000s
Managed Care and HCBS Shift

Waiver authority under Sections 1915(b), 1915(c), and 1115 fueled rapid growth of managed care and community-based long-term services and supports (LTSS). The Balanced Budget Act eased managed care enrollment rules, and the US Supreme Court's Olmstead decision accelerated deinstitutionalization of people with disabilities. By 2010, Medicaid had become the nation's core national health infrastructure, with over 50 million enrollees.

2010s
ACA Transformation

The Affordable Care Act introduced the largest eligibility expansion in Medicaid program history, created alternative benefit plans, and strengthened preventive and behavioral health coverage. Medicaid became the nation's largest behavioral health payer and efforts to coordinate care for dually eligible beneficiaries were expanded.

2020–2025
Pandemic Response and Rising Complexity

Continuous enrollment during the COVID-19 pandemic drove enrollment to nearly 94 million. The unwinding that began in 2023 required massive administrative processing. At the same time, new initiatives (e.g., mobile crisis services, HCBS funding boosts, postpartum coverage extensions, and IMD waivers) further broadened program scope. Medicaid now finances over half of LTSS nationally and remains a high-complex federal-state partnership program, with wide variation across 56 jurisdictions.

PREPARING FOR THE NEXT 60 YEARS

Ongoing Support for State Medicaid Programs

As Medicaid continues to evolve amid a changing landscape, states will face both new challenges and new opportunities. The Center helps states with practical, nonpartisan, evidence-based support that strengthens the credibility of state decisions and addresses critical knowledge gaps—not just for the year ahead, but for decades to come. We will continue to provide resources and strategic guidance that helps state decision makers navigate Medicaid complexity and design member-centered policies that drive measurable outcomes.

Multi-State Collaboration

When states pool their expertise, Medicaid gets stronger. For over 20 years, the Center has hosted 2 multistate collaborations: the Drug Effectiveness Review Project (DERP) and the Medicaid Evidence-based Decisions Project (MED). DERP and MED turn collaboration into a force multiplier, helping states tackle their toughest coverage and policy challenges with evidence they can trust, and experience they can count on.

These member-driven collaboratives give states full control over their research agendas. Members choose

States Served in 2025

topics, shape priorities, and apply the findings to drive meaningful change. With meetings and research closed to industry and vendors, states gain a rare space for candid discussion, peer learning, and shared problem solving. The collaboratives are designed to be complementary, and most states participate in both DERP and MED to maximize the value of collective intelligence.

- DERP delivers clear, actionable evidence to support drug coverage decisions. Its research helps states evaluate management strategies, anticipate shifts in the pharmacy landscape, and stay ahead of the drug pipeline.
- MED expands that impact across the broader Medicaid program. Members receive approximately $2.6 million in pooled research each year, including access to a proprietary evidence library. MED's work spans emerging technologies, genetic testing, artificial intelligence, complex utilization management, and new payment models, giving states the insight they need to navigate rapid change.

Together, DERP and MED will continue to equip Medicaid leaders with the tools to build cost-effective, evidence-based policies at a time when new policy changes may tighten budgets. By working together and grounding decisions in objective evidence, states will shape a stronger, more sustainable Medicaid program for the decades ahead.

> We consider MED and DERP an essential resource for non-biased clinical information.
>
> *- Mark Roaseau, Clinical Pharmacist/ Physician, Missouri HealthNet*

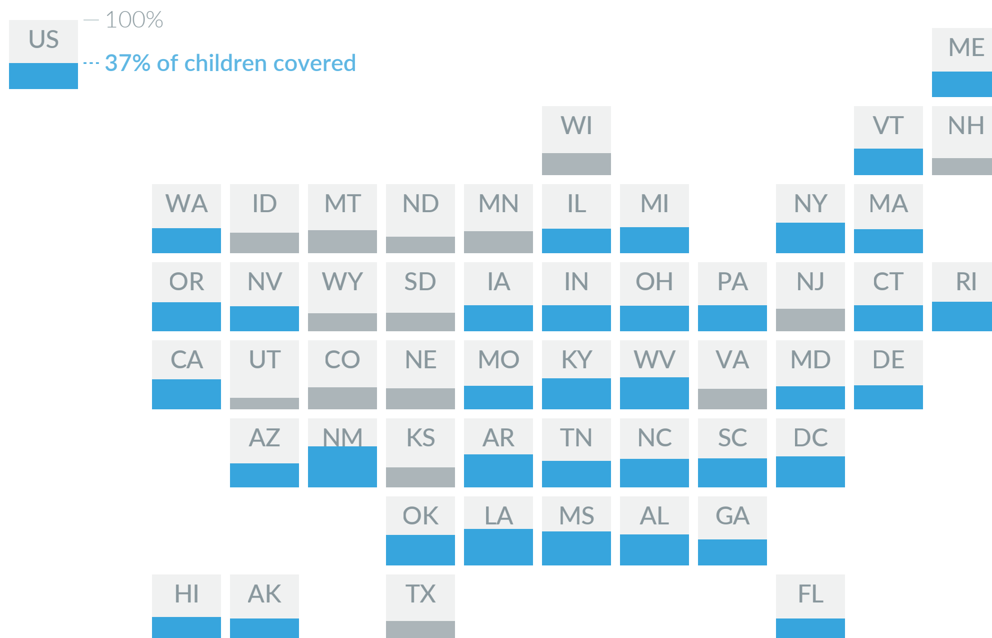
Conferences

When state Medicaid leaders meet face-to-face, they accelerate evidence-driven decisions that directly influence real-world health outcomes. Each year the Center hosts 4 collaborative conferences, creating a trusted, collaborative space where Medicaid officials connect with peers, deepen their expertise, and exchange insights free from industry or association influence. Each of our multistate collaboratives (DERP and MED) hosts 2 annual conferences designed to strengthen state capacity and catalyze meaningful innovation.

In 2025 a special joint conference focused on practitioner-administered drugs, a fast-growing and increasingly complex policy area. The conference brought together state teams from different program areas to strengthen coordination between Medicaid medical and pharmacy programs. Participants also worked hands-on with the Center's drug review and documentation tools to address real-world coverage questions. Discussions highlighted key differences in how medical and pharmacy benefits are structured and financed, helping states identify practical ways to support more consistent, evidence-based coverage decisions.

Medicaid or CHIP provides health insurance coverage for at least 1 in 3 children in most states

MEDICAID FACTS



Source: 2024 American Community Survey Public Use Microdata Sample Data

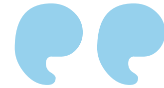
Health Technology Assessment Programs

Health care is advancing at remarkable speed, with new drugs, devices, and surgical innovations transforming patient care. As these technologies proliferate, the need for clear, evidence-based guidance has never been greater. Health technology assessment (HTA), as defined by the International Network of Agencies for Health Technology Assessment (INHTA), provides clarity by delivering trusted insights on the value that emerging technologies bring to patients, health systems, and society.

The Center partners with 3 leading state HTA programs: New York's Evidence Based Benefit Review Advisory Committee (EBBRAC), Oregon's Health Evidence Review Commission (HERC), and Washington State's HTA program. We evaluate the effectiveness, safety, and value of new technologies and provide policy analysis and methodological expertise that helps strengthen decision making. Independent committees determine whether technologies should be covered by Medicaid and other insurers. We support these committees with clear, comprehensive evidence reviews and provide training on evidence synthesis and related topics.

In 2025, we completed reviews on topics ranging from continuous glucose monitoring and contingency management for substance use disorder to surgical options for obstructive sleep apnea. We also introduced an expedited approach for evaluating biomarkers and diagnostic tests—an area of growing interest for Medicaid programs as testing options rapidly expand.

As HTA methods evolve, we work closely with program teams and committees to deliver the right information in formats that are accessible and actionable. Our goal is simple: equip state partners with the evidence and insight they need to make informed, equitable decisions for the populations they serve.



New York State Medicaid relies on the Center's consistent, high-quality expertise and reports to advance the EBBRAC's goals, functions, and purpose. Their dedication to evidence-based science affords the EBBRAC the opportunity to advise and assist our program in providing access to the highest quality care for millions of New Yorkers.

- Kate Bliss, Director, Bureau of Health Access, Policy, & Innovation, NY Department of Health

Technical Assistance Offerings

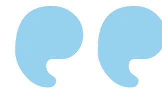
States have leveraged the Center's technical assistance services to strengthen Medicaid operations, including drafting state plan amendments and waivers; analyzing federal authority, state legislation, and CMS guidance; examining data and developing budget tools; evaluating financing strategies and payment methodologies; facilitating collaboration with state officials and partner agencies; engaging key stakeholders; and supporting public decision committees.

Examples of 2025 technical assistance include:

State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D)

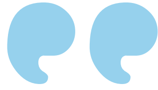
The Center launched the SMART-D initiative to help states innovate in the areas of drug purchasing and reimbursement. With grant funding from Arnold Ventures, the SMART-D program has engaged 14 states in technical assistance projects to help them develop and implement a wide range of policy solutions to address pharmacy costs and innovations, including:

- Helping 3 states launch multiagency purchasing of hepatitis C drugs, saving millions and improving the health of state residents
- Designing a high-cost drug carve-out from inpatient and outpatient bundled reimbursement
- Developing a prior authorization workflow and new payment model for physician-administered drugs
- Implementing sharing of costs saved between the pharmacy benefit, administered by the state's pharmacy benefit manager, and the medical benefit, administered by managed care



The SMART-D team exceeded my expectations in mapping our Physician Administered Drug process and identifying holes. Their flow chart and recommendations made the case for senior leadership to approve the project for implementation. I am looking forward to my next project with the team.

- Brian Mabie R.Ph, Pharmacy Director, DE Division of Medicaid and Medical Assistance



The Center has provided invaluable support in the development of Washington's Multi-payer Primary Care (MPC) initiative, a collaborative effort of private and public insurers working to transform primary care delivery and payment. The support Center staff provided through facilitation, policy analysis, and program development has been critical inputs for state decision making.

- Judy Zerzan-Thul, MD, MPH, Chief Medical Officer, Washington State Health Care Authority

Washington Multi-payer Collaborative (MPC)

Since 2019, the Center has supported the Washington Multi-payer Collaborative (MPC), a collaborative of the state's private and public insurers working to transform primary care, delivery and payment.

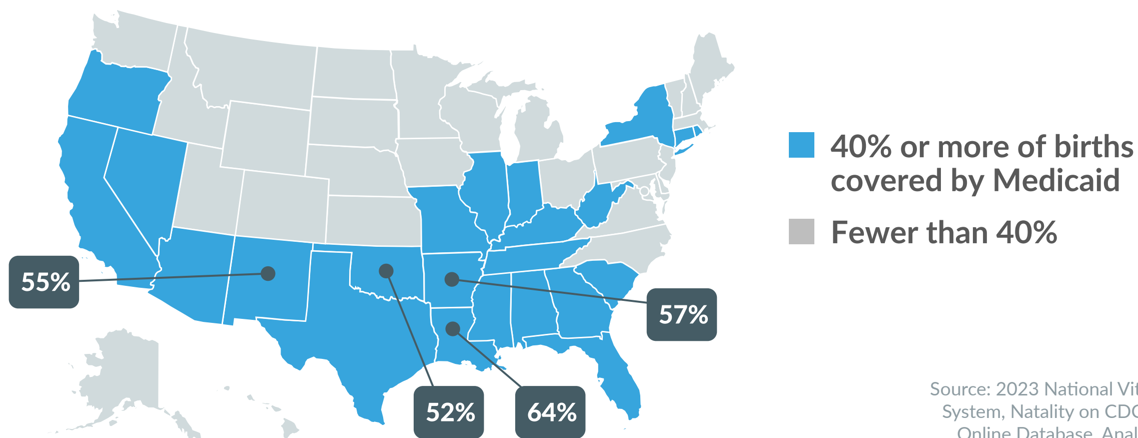
Through the MPC's Primary Care Transformation Initiative (PCTI), the Center helped insurers and primary care providers collaborate to:

- Create a primary care measure set shared across health plans and practices
- Hold learning collaboratives for primary care providers
- Launch a primary care practice recognition program

Through our unique capacity to integrate evidence-based research, data and policy analysis, strategic planning, and multi-stakeholder facilitation, the Center provided critical technical assistance to the MPC, Washington's leaders, and their primary care improvement agenda.

Medicaid finances 4 out of every 10 births on average, and more than half of births in 4 states

MEDICAID FACTS



Source: 2023 National Vital Statistics System, Natality on CDC WONDER Online Database. Analysis by KFF.

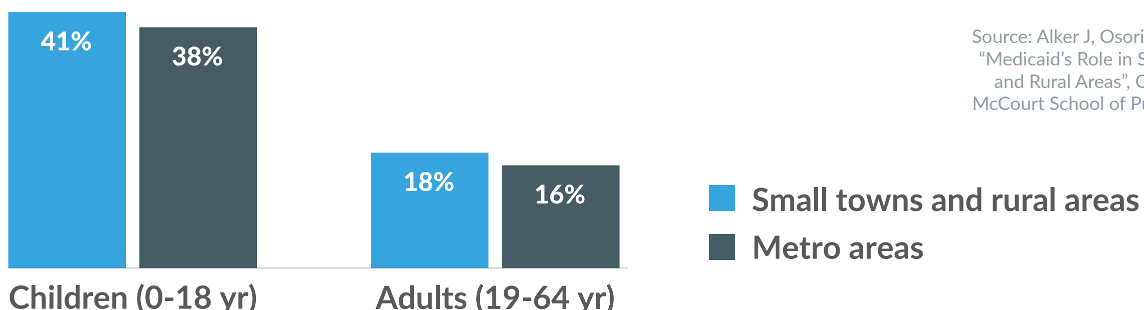
PREPARING FOR THE NEXT 60 YEARS

New Support for State Medicaid Programs

As Medicaid continues to evolve, states will need to move from managing short-term changes to leading long-term transformation. The Center remains a steady partner in that work, expanding our delivery of forward-looking, data-driven analysis to help states anticipate and shape policy. Over the next year, we will continue to expand our offerings to include tools and programs designed to help states think about the long-term.

MEDICAID FACTS

Medicaid is a critical source of coverage for people who live in rural areas and small towns



Source: Alker J, Osorio A, Park E. “Medicaid’s Role in Small Towns and Rural Areas”, Georgetown McCourt School of Public Policy,

Cost Calculators

The Center has begun to build powerful cost calculator tools to help Medicaid agencies quickly understand the potential budget impacts of covering new treatments and services. These tools give states a clear view of potential costs, savings, and management strategies that are grounded in evidence, not guesswork.

Each tool captures the full cost picture, from utilization and pricing to offsets from alternative treatments and required auxiliary services. Evidence-informed default values, such as uptake estimates, disease prevalence, and projected savings give states a strong starting point, while fully customizable inputs let them tailor calculations to their own data, prices, and FMAP rates. Most tools model short-term costs, while the Center's most advanced version uses a Markov framework to project longer-term financial impacts. All tools include transparent formulas and detailed documentation.

An example includes a cost estimator for Zolgensma, a gene therapy for spinal muscular atrophy, which provides cost estimates over a 3-year time horizon and accounts for potential cost savings associated with treatment. Other examples include cost calculators for coverage expansions for continuous glucose monitors and biomarker testing.

Medicaid Policy Matters Quarterly Webinar

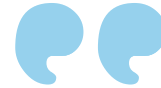
In 2025, we introduced Medicaid Policy Matters, a dynamic quarterly webinar series designed to share key insights from our proprietary research with a broader audience. Each session is led by our expert research and policy analysts, who break down emerging trends and complex issues shaping Medicaid. Recent topics have included practitioner-administered drugs, integrated care systems for children with special health care needs, and evolving biomarker testing legislation.

Register for future Medicaid Policy Matters webinars and find links to previous recordings on our LinkedIn page!

linkedin.com/company/center-for-evidence-based-policy

Low-Value Care

As state officials look for tools to get more value for dollars spent in state Medicaid programs, a major focus is on eliminating coverage of services with poor evidence of clinical value and those that are not medically necessary. In early 2026, we received funding from Arnold Ventures to conduct a tactical assessment of selected Medicaid-covered services, tests, drugs, and devices to identify those that may warrant either removal from coverage or designation as a preferred option over other more costly alternatives.



I appreciate so much all that you do to help us get the information needed in making some tough decisions and ensuring these decisions are based on evidence-based information and criteria.

- Melinda Rowe, Assistant Medical Director, Alabama Medicaid

Genetic Testing and Genomics

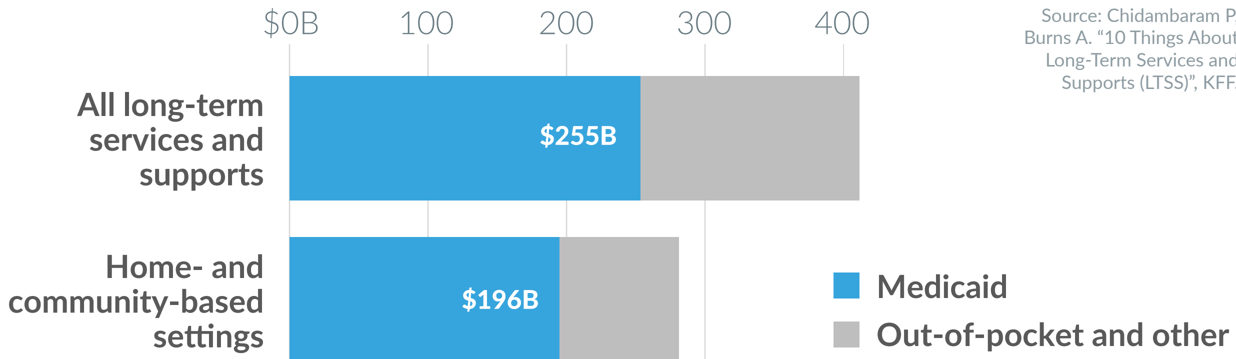
The genetics landscape is evolving at a pace few could have imagined. Breakthrough scientific and technological advances are fueling an explosion of new (and increasingly costly) genetic tests. These innovations promise to pair rich clinical data with advanced analytics to better match patients with the treatments most likely to help them, bringing the vision of precision medicine to life at scale. At the same time, transformative gene therapies for conditions such as spinal muscular atrophy and sickle cell disease are entering the market with multimillion-dollar price tags, offering unprecedented hope for patients with severe genetic disorders. Even more individualized, patient-specific therapies are on the horizon.

For state Medicaid agencies, this rapid acceleration brings both extraordinary opportunity and significant operational complexity. Agencies must navigate a genetics ecosystem that is expanding daily, requiring new capabilities and informed decision making across several fronts:

- Keeping pace with a fast-moving testing market—from expansive oncology panels analyzing thousands of genes, to emerging blood-based screening and monitoring tools for cancer, Alzheimer's disease, and more
- Interpreting evolving evidence and clinical guidelines to understand the true value of new tests and therapies, and how they improve care and outcomes
- Monitoring shifting federal and state policy landscapes, including new biomarker testing mandates that directly affect Medicaid coverage obligations
- Developing forward-looking coverage frameworks that can evaluate today's technologies while preparing for the wave of innovations expected in the next decade

Medicaid is the dominant payer for long-term care, especially home- and community-based services

MEDICAID FACTS

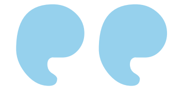


Source: Chidambaram P, Burns A. "10 Things About Long-Term Services and Supports (LTSS)", KFF.

The Center is uniquely positioned to help states meet this moment. Led by experts including genetic counselor and former payer specialist Lindsay Zetzsche, our agile team brings deep clinical genetics knowledge and hands-on Medicaid experience. Through our MED collaborative, dedicated genetics workgroup, and tailored technical assistance, we support states with:

- Comprehensive reports on emerging gene and cell therapies, plus strategic guidance on biomarker testing legislation
- Cost projections and planning tools for both genetic tests and gene therapies
- Rapid evidence, coverage, and guideline reviews to inform timely decision making
- Clear, actionable coverage policy development
- Ongoing monitoring of industry, regulatory, and scientific developments that impact Medicaid programs

Reach out to the Center to explore how we can partner with your state to navigate this fast-changing field and strengthen your genetics strategy.



As a state with limited expertise in the exploding work of genetics, the MED workgroup and consultations have been invaluable as we address specific coverage questions, while starting to think about a more proactive development of clinical policy for the future.

- Jeffrey Huebner, Lead Medical Officer, Division of Medicaid Services, Wisconsin Department of Health

Data Support

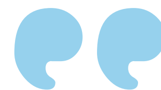
2025 marked a major leap forward in the Center for Evidence-based Policy's data-driven capabilities, expanding the analytic tools, insights, and infrastructure that will support stronger Medicaid decision making for years to come.

Throughout the year, our analytic work focused on transforming complex data into clear, actionable intelligence for state Medicaid leaders. Across projects, we advanced not only answers to today's policy questions, but also the analytic foundation states need to make evidence-based decisions in a rapidly evolving environment. By integrating publicly available datasets, commissioned evidence reviews, and real-world Medicaid claims analysis, we are able to deliver more timely, relevant insights to guide program design and implementation.

A standout achievement was the launch of *State Medicaid by the Numbers* in 2025, a first-of-its-kind, publicly available tool that brings together key data on coverage, financing, enrollment, and delivery system design for every state. Instead of navigating scattered federal and state sources, policymakers can now access a single, consistent, policy-focused profile that supports cross-state comparison and strategic analysis. The tool has already become a go-to resource for both internal and external partners seeking a clearer understanding of how Medicaid programs differ nationwide.

We also broadened our analytic offerings by introducing a new class of reports that pair traditional evidence reviews with real-world Medicaid claims data. These reports ground published research in current program experience, helping states understand how evidence translates into practice and how outcomes vary across populations and geographies. One example is our analysis of early uptake of GLP-1 therapies among Medicaid members. By examining utilization patterns, discontinuation rates, and select adverse reactions across states, we uncovered meaningful variation tied to coverage policies, clinical practices, and member characteristics. When combined with commissioned evidence reviews, this work gave states a more complete, actionable picture of how emerging therapies are being used, and where implementation challenges may arise.

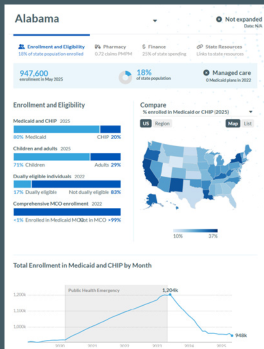
Together, these advancements underscore the Center's commitment to delivering rigorous, policy-relevant analytics. By building new tools, expanding real-world evidence, and integrating diverse data sources, we strengthened our ability to support Medicaid policymakers with timely, credible insights they can use to lead with confidence.



The Center is one of the best organizations our agency team has the opportunity to partner with on data projects that support state policy making.

- Mark Greenwald, Research Manager, Oregon Youth Authority

State Medicaid Profiles



No 2 states run their Medicaid programs the same way and that is exactly why we built the State Medicaid by the Numbers tool. Find the **bolded stats** and more for every state!

centerforevidencebasedpolicy.org/medicaid-by-the-numbers

Michigan

Michigan's Medicaid program covered an estimated **2.4 million residents**—about **23% of the state's population** as of May 2025. In 2025, **children accounted for about 39%** of Medicaid and CHIP enrollment in Michigan, while **adults accounted for 61%**. Enrollment is supported through the MI Bridges platform, which integrates eligibility, enrollment, and access to additional state resources, including food assistance, child development and care, and supports for Women, Infants and Children (WIC).

Michigan is an **expansion state**, having expanded coverage eligibility under the Affordable Care Act in 2014. Michigan uses a **managed care** model to provide comprehensive benefits to its enrollees, and contracted with **9 managed care plans** to provide those services.

Michigan Medicaid's pharmacy benefit uses a **uniform PDL** that is administered by each of the state's contracting managed care organizations.

The program provides a broad array of services including acute care, behavioral health, long-term care, and preventive care for low-income children, adults, seniors, and individuals with disabilities. Together, these services amount to approximately **$7,100 in spending per enrollee**, with total Medicaid spending (state and federal shares combined) in 2023 accounting for about **31% of total state spending**. As in other states that use a managed care model to administer covered benefits, managed care costs account for the largest portion of state Medicaid spending—**66% in 2023**—equating to about **$422 per member per month**. Fee-for-service acute care and long-term care were the next largest service types, each accounting for about **14% of state Medicaid spending**.

Alabama

Alabama's Medicaid program covered an estimated **950,000 residents**—about **18% of the state's population** as of May 2025. In 2025, **children accounted for about 71%** of Medicaid and CHIP enrollment in Alabama, while **adults accounted for 29%**. Eligibility and enrollment are managed through the Insure Alabama website, which streamlines application submission and documentation intake for applicants to the ALL Kids and Alabama Medicaid programs. Alabama **did not expand coverage** eligibility under the Affordable Care Act.

Alabama Medicaid uses a **fee-for-service** model to provide benefits to its enrollees and manages its pharmacy benefit using a **single preferred drug list (PDL)**.

The program provides coverage for low-income children, pregnant women, seniors, and people with disabilities, delivering a range of services from preventive care to long-term supports. Together, these services amount to approximately **$5,900 in spending per enrollee**, with total Medicaid spending (state and federal shares combined) in 2023 accounting for about **25% of total state spending**. Acute care fee-for-service costs accounted for the largest portion of state Medicaid spending—**65% in 2023**—equating to about **$365 per member per month**. Long-term care accounted for the 2nd-largest share of spending at **25%, or $140 per member per month**.

2025 IN REVIEW

Evidence Reports

Baumgartner J, Burbank C, Evans A, King V. *MED policy brief: building an integrated system of care for children and youth with special health care needs (CYSHCN)*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Connor S, Baumgartner J, Pavlech L, King V, Brown E. *Hospital at home for admission avoidance or early discharge in adult and pediatric patients*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Connor S, Leof A, Pavlech L, King V, Brown, E. *Applied behavior analysis provided via telehealth*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Connor S, Leof A, Pavlech L, Lazur B, Brown E, King V. *Contingency management for stimulant use disorder.* Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Cooper C, Bachhuber M, Ryan J, Durbin S, Schellinger J, King V. *Coverage guidance: surgical treatments for obstructive sleep apnea*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Curtis, P. *Applying evidence to make the most of population health*. Lecture presented at: Milbank Memorial Fund Fellows Program, Cohort 5; December 2025; New Orleans, LA

De Carolis H, Clary A, King V. *Supporting youth aging out of state custody*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Dickson V, Anderson R, Shaw B. *Management strategies for value-based purchasing agreements and payment approaches for high-cost drugs in Medicaid*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Dickson V, Clary A, King V. *Telehealth options for pediatric preventive screenings and assessments*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Dickson V, King, V. *MED policy brief: enhancing global billing practices for pregnancy services under Medicaid*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Durbin S, Vintro A, Jasmin H, et al. *Glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP)/GLP-1 receptor agonists: adherence and safety from real-world evidence studies*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Harju A, Clary A, King V. *General anesthesia for pediatric patients in the dental office setting*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Keating C, Miller M, Bachhuber M, Shaw B, Clary A, Anderson R. *Oncology: preferred drug management strategies*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Leof A, Clary A, King V. *Medical necessity criteria for orthodontia services for pediatric patients*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

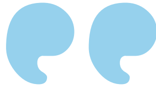
Leof A, Lazur B, Miller M, Clary A, King V. *Strategies for creating meaningful community engagement with Medicaid members*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Leof A, Miller M, Clary A, King V. *Utilization management of applied behavior analysis for autism spectrum disorders and other conditions*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

Lindsey W, Hartsell F, Bricken L, et al. *Pharmaceutical treatments for hereditary angioedema: prevention and acute treatment of attacks*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

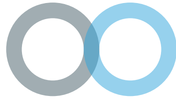
The Medicaid Evidence-based Decisions Project exemplifies what thoughtful public policy should look like—grounded in the best available evidence, shaped through collaboration, and focused on improving outcomes for the people we serve. I deeply appreciate MED's commitment to rigorous analysis and its role in bringing states together to learn, share, and make informed decisions that strengthen Medicaid programs nationwide.

- *Kevin McCann MD, West Virginia Medicaid*



MED gives us support on sticky issues even when there is not a clear path or evidence is evolving.

- MED member, Colorado



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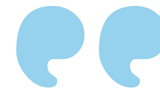

As legislators, we need better data to inform how and where to invest our limited resources to get the best results and to understand how the state's children and families are faring in their multifaceted lives. OCID is a nonpartisan resource that integrates information from across state programs and services to support policymakers like us!

- Oregon State Senators Dick Anderson and Lisa Reynolds

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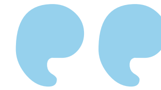


The DERP Collaborative provides MO HealthNet with excellent, and timely, in-depth research to guide evidence based clinical policy. Along with insight into the pipeline, DERP helps ensure MO HealthNet makes policy that data supports.

- *Josh Moore, Medicaid Director, MO HealthNet Department of Social Service*

2025 IN REVIEW

Center Staff

Rhonda Anderson, Director of Pharmacy

Marcus Bachhuber, Clinical Epidemiologist

Jesse Baumgartner, Policy Analyst

Mike Bonetto, Consultant

Elizabeth Brown, Clinical Epidemiologist

Caitlin Burbank, Research Associate

Beth Church, Administrative Program Manager

Gülcan Çil, Senior Statistician

Sharon Civil, Project Coordinator

Amy Clary, MED Director

Susan Connor, Senior Systematic Reviewer

Courtney Cooper, Research Associate

Pam Curtis, Director

Firozeh Darabi, Project Coordinator

Hayley De Carolis, Policy Analyst

Amanda Delzer Hill, Editor

Virgil Dickson, Policy Analyst

Landon Donsbach, Administrative Systems Manager

Shauna Durbin, Research Associate

Galen Gamble, Project Coordinator

Amelia Harju, Policy Analyst

Scott Harvey, Department Administrator

Jami Hoffman, Project Coordinator

Hilary Jasmin, Research Associate

Chelsea Keating, Policy Analyst

Emma Kenagy, Research Administrator

Valerie King, Research Director

Jacqui Krawetz, Graphic Artist/Editor

Brittany Lazur, Policy Analyst

Allison Leof, Senior Policy Analyst

Kate Lonborg, Policy Analyst

Jennifer Lyon, Research Associate

Rachel McCausland, Research Associate

Heather McConnell, Editor

Dylan Miksicek, Research Associate

Michelle Miller, Consultant

Shane Mofford, Finance, Payment and Analytics Specialist

Gretchen Morley, OCID Project Director

Laura Pavlech, Research Associate

Kelsey Platt, Project Coordinator

David Radley, Research Director Data Analytics

Morgan Reeder, Data Visualization Analyst

Shannon Robalino, Senior Information Specialist

Shreya Roy, Research Associate

Jennifer Ryan, Research Associate

Erin Sanborn, Project Coordinator

Jana Schellinger, Research Associate

Beth Shaw, Research Director, Evidence Synthesis and Methods

Susan Stuard, State TA Director

Nicole Thompson, Project Coordinator

Nanda Vallamkondu, Research Data Analyst

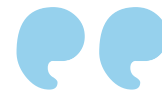
Andrea Vintro, Research Associate

Dan Vizzini, Senior Policy Analyst

Al Yang, Financial Analyst

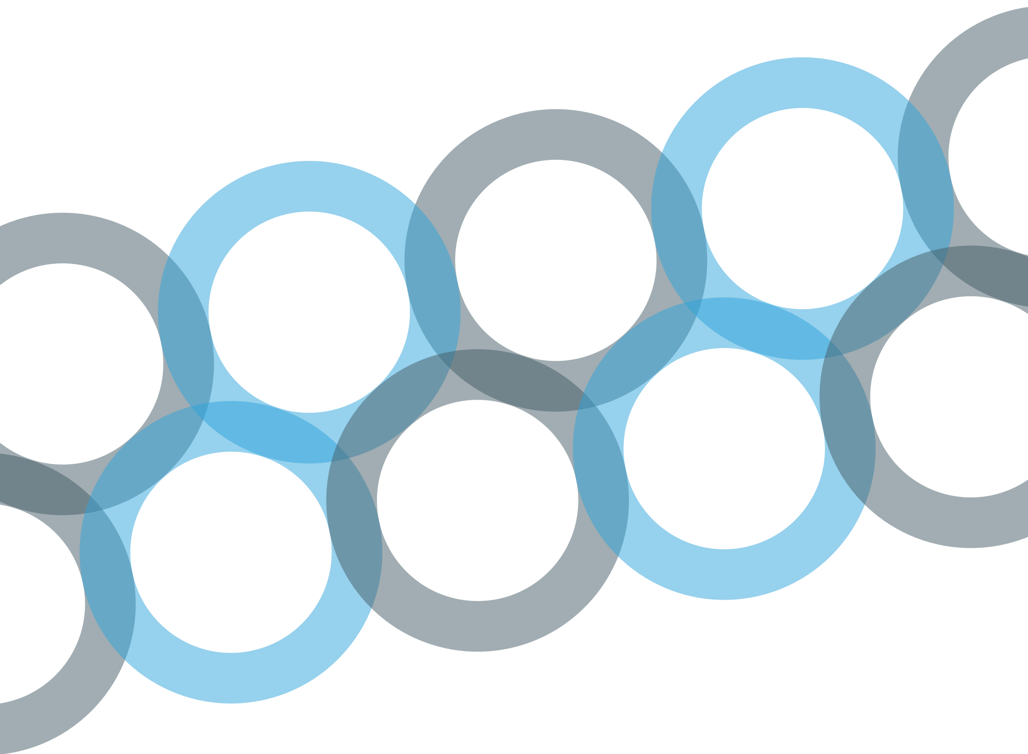
Sneha Yeddala, Research Associate

Erin Young, Research Associate



I really am struggling to identify an area for improvement. The team responded to our needs and questions appropriately and always delivered the level of expertise necessary to accomplish the end product.

- DERP member, North Carolina



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Center for Evidence-based Policy

3030 S Moody Ave,
Suite 250
Portland, OR 97201