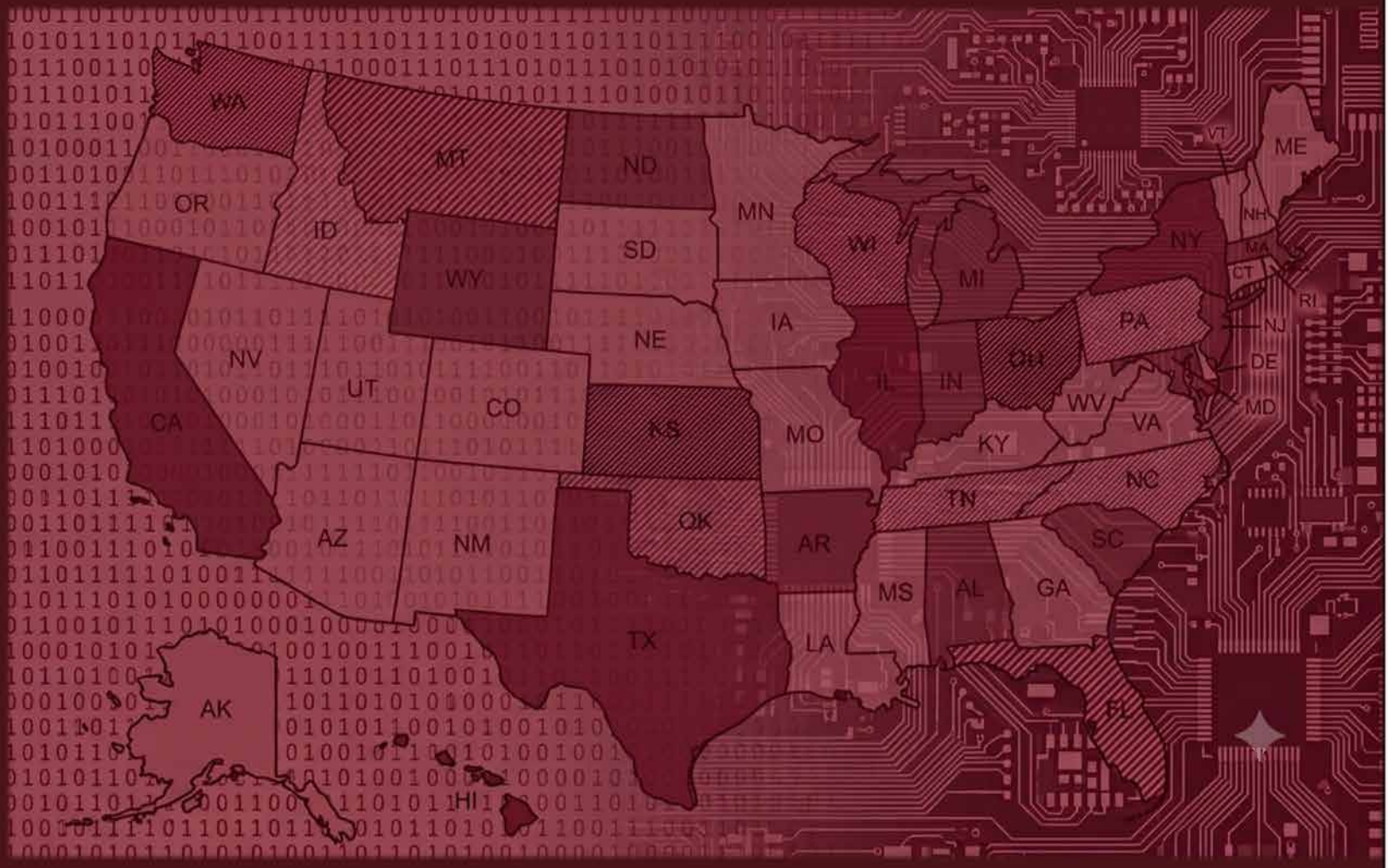
Legal Landscape of Data Sharing Between Medicaid and Public Health Agencies



A White Paper

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I. EXECUTIVE SUMMARY

A. BACKGROUND

Data sharing between state Medicaid and public health agencies offers significant opportunities to enhance health care delivery and population health. Medicaid claims data provide rich insights into health care utilization and disease trends, offering public health agencies a granular view of health status and care patterns, particularly in vulnerable populations. On the other hand, public health data—defined in this study as data collected and/or maintained by public health agencies—could inform Medicaid program planning, resource allocation, and quality improvement, enabling Medicaid agencies to reduce program costs by supporting prevention for beneficiaries. By linking diverse data types across sectors, both agencies can enhance their capabilities to monitor health trends and develop targeted interventions, improving health outcomes in the communities they serve. One potential opportunity is joint-agency partnership to develop and improve prevention programs, particularly those in the chronic disease prevention and management space.

However, the ability for Medicaid and public health agencies to share data is constrained by a fragmented and complex legal landscape, consisting of multiple layers of federal and state law. Medicaid programs are subject to specific federal confidentiality requirements under 42 U.S.C. § 1396a and 42 C.F.R. Part 431, Subpart F. These rules provide limited flexibility to share state Medicaid data with public health agencies. State laws can take different approaches to implement these federal Medicaid standards. For example, they can impose more stringent requirements that further constrain data sharing or offer expansive interpretations of federal requirements that enable greater sharing. Additionally, states often have laws that provide specific rules for using or disclosing different types of public health data. For example, states' immunization information systems and vital statistics systems are often governed by different rules established in state statutes or regulations. Collectively, these federal and state laws create a layered patchwork system where variability creates uncertainty and limits coordinated action to share data.

B. APPROACH

Using scientific legal mapping, an established method in legal epidemiology, we collected and analyzed state laws authorizing or restricting data sharing between state Medicaid and public health agencies in all 50 US states in effect as of May 28, 2025. First, we analyzed state laws related to sharing Medicaid data with public health agencies. Then, we analyzed state laws related to sharing state public health data with Medicaid agencies.

The legal analysis of each data flow was tailored to account for their unique challenges. The analysis and coding of state laws regulating Medicaid data was tailored to identify where states have created pathways for public health data sharing within these federal restrictions. The analysis of state laws regulating public health data was tailored to account for the varied legal frameworks that might be specific to different public health data systems (i.e., immunization information, vital statistics, syndromic surveillance).

C. PURPOSE OF WHITE PAPER

The goal of this white paper is to examine state laws governing bidirectional data sharing between Medicaid and public health agencies. By identifying legal enablers, barriers, and policy implications, this paper aims to guide states seeking to strengthen their intergovernmental data-sharing partnerships.

D. HIGH-LEVEL TAKEAWAYS AND POLICY IMPLICATIONS

1. A COMPLEX, FRAGMENTED LEGAL ENVIRONMENT

The laws governing data sharing between state Medicaid and public health agencies form a layered, patchwork system of state and federal regulations. The legal landscape differs fundamentally depending on the direction of the data flow and the specific type of data involved, limiting coordinated action across agencies.

2. MEDICAID→PUBLIC HEALTH: UNCERTAIN BOUNDARIES

State Medicaid data sharing laws are heavily influenced by strict federal confidentiality requirements. A minority of states have provisions that expressly permit sharing with public health authorities, but most must rely on indirect sharing pathways. Federal law generally restricts Medicaid data use to purposes directly connected to the "administration of the state plan", a constraint that is echoed in most state laws.[1]

The strictness of federal Medicaid confidentiality rules may be perceived as a barrier to data sharing, but our findings suggest these requirements may not act as an absolute prohibition. Because states are afforded flexibility to administer their programs within these federal guidelines, agencies may legally justify cross-sector sharing by actively connecting public health use cases to Medicaid plan administration—this is especially relevant in the 14 states that do not explicitly limit "plan administration" to enumerated activities in the law. For instance, a Medicaid agency might successfully argue that disclosing a list of client names to the state public health agency is directly related to the administration of the Medicaid state plan because it facilitates coverage of preventative services, improves care coordination and case management, and supports program integrity and cost efficiency. Furthermore, where explicit public health pathways do not exist in state law, agencies can leverage other legal allowances—such as authorized disclosures to other state welfare programs (present in 20 states)—to achieve cross-agency insights.

3. PUBLIC HEALTH→MEDICAID: SILOED SYSTEMS AND OVER-CAUTION

The sharing of public health data with Medicaid agencies requires a complex legal analysis because it is rarely governed by a specific and clear rule. Public health data protection laws are widely variable, and often tied to a specified data type or source, reinforcing data silos within separate legal frameworks even when data are collected and managed by a common organization such as a state department of health. Given that public health data often contains sensitive or identifiable information, this complex legal landscape might cause relevant authorities to become overly cautious when faced with data sharing opportunities, regardless of the actual legality of the activity.

Our analysis points to meaningful sharing opportunities tempered by variability and ambiguity that require state-specific interpretation. Across all three datasets, we identified a mix of explicit statutory

authority, broader public health purpose provisions, and (where needed) alternative pathways and operational agreements to facilitate disclosure. (See Tables 3, 5, and 7).

Explicit provisions authorizing data sharing with state Medicaid agencies remain the most straightforward route, but the variation in these provisions across distinct data types reflects the siloed data landscape; while 49 states explicitly authorize vital record sharing, that number drops to 39 for immunization data, and only 6 for syndromic surveillance data. Legal provisions that permit data sharing for research pathways and/or after de-identification, while often more restrictive and resource intensive, can serve as interim access routes when other legal data sharing options lack clarity or are overly narrow.

II. BACKGROUND AND CONTEXT

A. VALUE OF MEDICAID-PUBLIC HEALTH DATA SHARING

Data sharing between state Medicaid and public health agencies offers significant opportunities to enhance health care delivery and population health.

Medicaid claims data provide rich insights into health care utilization and disease trends, offering a granular view of health status and care patterns, particularly in vulnerable populations. Because Medicaid agencies have continuous access to these data, it can be leveraged by public health agencies to monitor disease prevalence, identify emerging health threats, and develop evidence-based prevention strategies.[2,3]

In the course of performing their duties, public health departments collect a wealth of population health information from a variety of sources, including providers. These data could be hugely informative for Medicaid program planning, resource allocation, and quality improvement. In theory, access to public health data could enable Medicaid agencies to reduce program costs by supporting prevention for beneficiaries.

By linking diverse data types across sectors, both agencies can enhance their capabilities to monitor health trends and develop targeted interventions, improving health outcomes in the communities they serve.

B. FRAGMENTED LEGAL LANDSCAPE

Despite the rich potential in data sharing, the ability for Medicaid and public health agencies to share data is constrained by a fragmented and complex legal landscape, consisting of multiple layers of federal and state law.

Acting as the federal floor for data protection, the federal Health Insurance Portability and Accountability Act and its accompanying regulations (hereinafter collectively referred to as HIPAA). HIPAA applies to covered entities, which include state Medicaid agencies (i.e., as health payors) and some public health departments (those that have declared themselves to be covered or hybrid entities). HIPAA contains broad exceptions that generally permit public health disclosure of protected information by covered entities.[4]

However, more stringent federal or state laws often restrict the use of the broad HIPAA legal exceptions. Medicaid programs are subject to specific federal confidentiality requirements under 42 U.S.C. § 1396a and 42 C.F.R. Part 431, Subpart F. These rules can act as a barrier to sharing, whether that barrier is a result of perception of a legal restriction or a true legal restriction. State laws implementing these federal Medicaid standards introduce additional complexity, imposing more stringent requirements or unique confidentiality protections, and sometimes challenging traditional interpretations of federal restrictions. Additionally, states often have laws that provide specific rules for using or disclosing different types of public health data. For example, states' immunization information system and vital statistics system are often governed by different rules established in state statutes or regulations. Collectively, these federal and state laws create a layered patchwork system where variability creates uncertainty and limits coordinated action to share data.

C. NECESSITY OF NATIONAL LEGAL SCAN

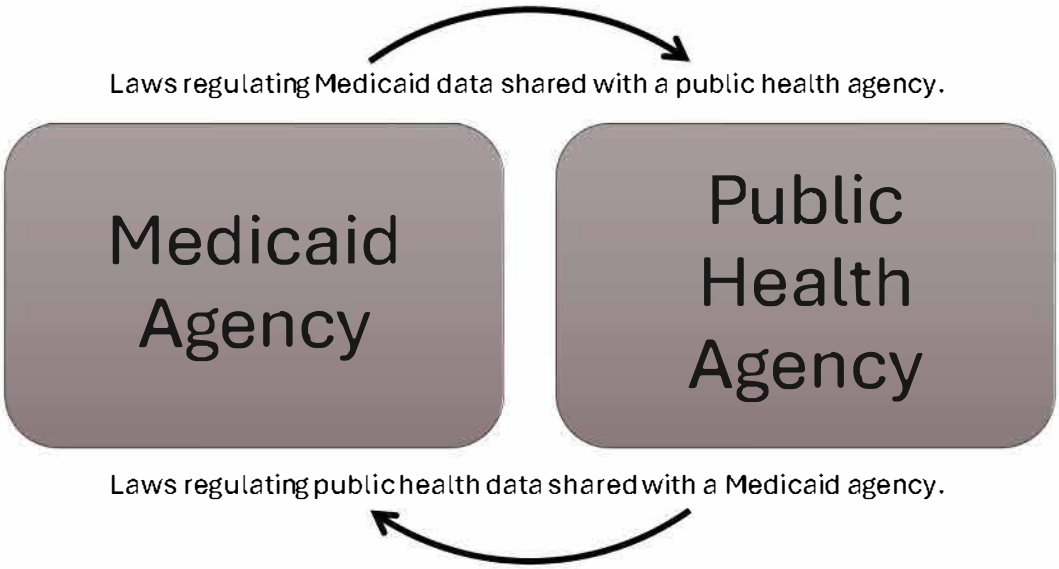
A comprehensive national scan is necessary to identify the legal enablers and barriers to interagency data flows. A systematic legal scan aids state policymakers to better understand the variability of state laws both within and across jurisdictions, potentially illuminating models for the implementation of laws that enable beneficial data use while mitigating risks.

III. APPROACH

Using a scientific legal mapping approach, we collected and analyzed state laws authorizing or restricting data sharing between state Medicaid and public health agencies.

This analysis has two components because state laws can differ depending on whether state Medicaid data are shared with the state public health agency or if state public health data are shared with the state Medicaid agency. See Figure 1.

Figure 1: Laws governing data sharing can be different depending on whether Medicaid data are shared with a public health agency or if public health data are shared with a Medicaid agency.



A. SCOPE

This study examines laws governing data sharing between Medicaid agencies and public health authorities in all 50 US states in effect as of May 28, 2025.

B. LEGAL RESEARCH (COLLECTING RELEVANT LAWS)

In collaboration with our Pew Research partners and state-level stakeholders, we identified three primary data types of interest: vital statistics, immunization, and syndromic surveillance data. Additionally, we collected laws relating to public health data generally, to capture authority where our data types of interest are not governed individually.

We took similar approaches for collecting the relevant laws for the analyses of state laws relating to sharing Medicaid data with public health agencies and laws relating to sharing public health data with Medicaid agencies.

To begin identifying and collecting relevant legal texts, the project team utilized a three-pronged search strategy designed to maximize coverage and minimize gaps:

1. Search Strings: We developed Westlaw search strings through exploratory research and pilot testing for each data type. For states where this search returned no results, we created a broader secondary search string to identify additional relevant provisions. Table 1 includes our final search strings all data types.
2. Federal Authority: Using Westlaw, we systematically located state laws that referenced applicable federal authority, giving us known examples to cross-check against search results.
3. Table of Contents Scan: We reviewed tables of contents in relevant state code sections to confirm that no pertinent laws were missed by the search instruments.

Once collected, all laws were reviewed for relevance and uploaded into the coding platform, the Public Health Law Information Portal (PHLIP), for abstraction. See **Appendices** below for detailed research protocol information.

Table 1: Westlaw search strings to identify state laws pertaining to sharing data between state Medicaid and public health agencies.

Data Type	Search Strings Used
State Medicaid Data	Adv: SD("Medicaid" or "Medic! assistance program" or "medic! Assistance" and "safe-guard!" or "protect" or "release" or "discles!" and "information" or "confident!" or "health inform!" % "benefits" % "prescription!" or "drug" or "bureau!" or "licens!" or "hipaa" or "HIV" or "tax" or "victim" or "registry") Adv: SD("Medicaid" or "Medic! assistance program" or "medic! Assistance" or "assistance" and "safe-guard!" or "protect" or "release" or "discles!" and "information" or "confident!" or "health inform!" and "connected" or "related" and "administration of")
Vital Records Data	Adv: (PR("vital" AND (record! ●R Stat!)) AND SD(Information ●R Record! ●R Data) AND SD(discles! ●R Shar! ●R Trans! ●R Disseminat!)) Adv: (PR("vital" AND (record! Stat!)) AND SD(Information ●R Record! ●R Data) AND SD(discles! ●R Shar! ●R Trans! ●R Disseminat! ●R Access))
Immunization Data	Adv: SD((immuniz! Vaccin!) /3 (Information ●R Records ●R Data))
Syndromic Surveillance Data	Adv: Syndromic % Syndrome

General Public Health Data	Adv: (SD((confidential ●R protected ●R priva! ●R sensitive ●R identifiable) /3 (Information ●R Records ●R Data) /p (disclos! ●R Shar! ●R Trans! ●R Disseminat!)) AND PR(Health % (Medicaid ●R "medical assistance" ●R "health maintenance organizations" ●R "Insurance" ●R "Licensure" ●R "facilities" ●R "drugs" ●R "health Care")))

C. DEVELOPING ABSTRACTION INSTRUMENT AND CODING

The abstraction instrument—or coding scheme—was developed through an iterative process that began with questions drawn from the approved research plan and insights from the legal research stage. The instrument was designed to capture elements across jurisdictions, such as express permissions or prohibitions on sharing data with government agencies, conditions placed on disclosure (if any), and provisions that could serve as potential pathways for sharing. Different considerations for Medicaid data and public health data influenced the creation of different abstraction instruments.

Federal laws—i.e., 42 CFRPart 431, Subpart F and 42 U.S.C. § 1396a—have central importance to understanding how state Medicaid data can be used because states must operate their Medicaid programs within federal guidelines. Specifically, because federal laws shape what states can and cannot permit under state law, they were central to law collection and abstraction instrument development. By using federal requirements as a reference point, this analysis seeks to identify where states have created pathways for public health data sharing within these federal restrictions.

Sharing public health data has different considerations because the existence of different siloed data systems creates a more complicated legal analysis. Each data system could be governed by different laws within the state or a state could elect to have broadly worded laws that govern all public health data under the same rules. Consequently, our abstraction instrument for public health data sharing was designed to capture differences between the legal authorities that apply to different public health data types.

Regular engagement with our Pew collaborators further helped ensure the abstraction instruments aligned with project objectives. The project team then conducted multiple rounds of pilot testing with coders who had not participated in creating the instrument to assess clarity and usability. Both abstraction instruments can be found in Appendix B.

D. SECONDARY ANALYSIS OF PUBLIC HEALTH DATA LAWS

We conducted two secondary analyses of the laws pertaining to sharing public health data with state Medicaid agencies. First, general public health data laws were interpreted to understand their applicability to vital records, immunization, and syndromic surveillance data in those states where we did not identify specific laws for those data types. For example, if a state had a law applying broadly to public health data but it did not have a law specific to syndromic surveillance data, we interpreted the provisions applying broadly to public health data generally as also applying to syndromic surveillance data.

Second, we conducted a grouping analysis to simplify the interpretation of restrictions on sharing legal data. This grouping analysis was informed by standard data sharing practices within public health and

governmental sectors. For example, most data sharing between or within governments or governmental units are connected with some sort of legal agreement (e.g., a **data use agreement [DUA]**) and governmental systems for sensitive data are typically protected with technical safeguards. As such, legal requirements for a DUA or technical safeguards do not differ substantially from existing standard practices. Our grouping analysis also recognized that some data sharing requirements might substantially affect the volume or nature of the data that can be shared in ways that might impact future analyses. For example, a law that authorizes only aggregated data to be shared will effectively restrict any secondary analyses involving individual records. These insights informed our grouping categories.

Jurisdictions were categorized and grouped based on the restrictiveness of their data sharing requirements. States were categorized for each public health data type by whether their laws had 1) no restrictions, 2) low-burden requirements, or 3) restrictions affecting data utility. The low-burden category includes jurisdictions with restrictions such as technical safeguards and mandatory legal agreements (e.g., a DUA), which are standard practices among governmental data sharing. While these restrictions might demand some additional time or resources to navigate, they do not fundamentally interfere with the ability of Medicaid agencies to receive quality data. In contrast, restrictions affecting data utility include requirements for de-identification, aggregation, and narrow purpose limitations, which may ultimately undermine the purpose for which the data was shared.

Jurisdictions with restrictions that were coded as "Other" (see Tables 3, 5, and 7) were evaluated by trained legal researchers on a case-by-case basis for the purposes of the grouping analysis.

E. QUALITY ASSURANCE

We incorporated quality assurance measures throughout the project to help ensure that the resulting legal dataset is complete, reliable, and accurate. First, the multi-pronged legal research approach provided redundancy, allowing the team to cross-check results during pilot testing against known laws and confirm that no relevant provisions were missed. Second, extensive piloting of the coding instrument served as an important quality control step. These tests ensured that the instrument was not only theoretically sound but also practical, leading to refinements that improved clarity and usability. Finally, the laws were coded by two researchers acting as blind, redundant coders. All coded data underwent validation by a trained legal researcher, and any discrepancies were resolved through coding meetings.

IV. LEGAL SCAN FINDINGS

A. SHARING STATE MEDICAID DATA WITH STATE PUBLIC HEALTH AGENCIES

State Medicaid data are highly regulated under federal and state laws.[5] These laws establish general rules for the use of Medicaid applicant and beneficiary data, as well as exceptions to those general rules. Generally, when interpreting overlapping data protection laws (i.e., those pertaining to privacy, confidentiality, and security), the most restrictive provision is the one that applies. This makes compliance with data protection laws complex and challenging.

In the context of state Medicaid agencies sharing data with public health agencies, HIPAA is among the more permissive laws.[5] HIPAA regulates Medicaid agencies use and disclosure of Medicaid beneficiary

information (i.e., as HIPAA Protected Health Information or PHI). However, HIPAA contains broad exceptions permitting uses and disclosures for public health and research purposes that would generally permit Medicaid agencies to share their data with public health agencies.[6] Nonetheless, HIPAA is considered a floor protection, meaning that states can enact more stringent rules without contradicting HIPAA.

In addition to HIPAA, other federal laws provide more restrictive requirements for safeguarding information about Medicaid applicants and beneficiaries. Since Medicaid programs are administered by states but are subject to federal requirements, federal rules exist for how states can and cannot use their Medicaid data. Federal laws 42 CFR Part 431, Subpart F and 42 U.S.C. § 1396a require state Medicaid plans to protect confidentiality and limit disclosure to specific circumstances. In general, the federal framework restricts disclosing Medicaid data to purposes directly related to the administration of the Medicaid state plan, with few other exceptions, such as disclosures for school lunch programs.[7]

The apparent restrictiveness of the federal Medicaid rules likely acts as a barrier to sharing Medicaid data with public health agencies, even when such sharing could improve population health. However, states are often afforded flexibility to administer their programs that gives states some freedom to creatively implement their Medicaid program within the federal guidelines, including how to leverage available Medicaid data to promote population health objectives. For example, the federal Medicaid data protections allow data sharing for "purposes directly connected with the administration of the [state Medicaid] plan," but the regulations do not provide an exhaustive definition of what constitutes as "administration of the plan." Consequently, a state could make an argument that a data sharing activity

"STATE PLAN ADMINISTRATION"

Federal regulations provide limited flexibility for states to define what "State plan administration" means. CMS regulations state:

"Purposes directly related to plan administration include—

a. Establishing eligibility;
b. Determining the amount of medical assistance;
c. Providing services for beneficiaries; and
d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan." 42 CFR § 431.302.

The word "include" implies that other purposes for data use might also be permitted as being related to plan administration. Some states have provided greater specificity, indicating that uses for research and public health are purposes related to state plan administration.

Other states have chosen not to clarify what "State Plan Administration" entails. For example, Alabama regulations state: "Confidential information relating to applicants and recipients may be used or disclosed only for purposes directly connected with the administration of the State Plan and in accordance with the Agency HIPAA Privacy Compliance Manual or other appropriate authority." Ala. Admin. Code r. 560-X-27-.01.

with a state public health agency is part of the administration of the plan. Whether the apparent restrictiveness of the federal Medicaid data protections is an actual or perceived barrier is an important and complex question that we will explore through our analysis.[8]

By systematically analyzing laws across all 50 states, this scan aims to identify where states have successfully created pathways for sharing within federal restrictions. Providing clarity on this complex legal landscape can guide state-level decision-makers in navigating legal complexities to foster more equitable and effective public health strategies.

1. PRESENCE AND SCOPE OF DATA-SHARING LAWS

We found laws in 49 states pertaining to sharing Medicaid data; Arkansas was the only state where we could not identify a relevant law.[i] Table 2 provides our analysis of these state laws.

Twenty-eight states have laws that specifically address sharing data on Medicaid applicants and beneficiaries, and 21 states have laws that broadly address sharing public assistance or medical assistance data (Figure 2). Over 70% do not have laws that mention sharing data for public health agencies or public health purposes, but eleven states have laws that either explicitly name state public health agencies as data recipients (9 states) or broadly permit sharing data for public health purposes (2 states).

Consistent with federal law, 44 states have laws that expressly permit sharing Medicaid data for purposes directly related to the administration of the program, but 14 states do not further elaborate on what the administration of the program means in their statutes or regulations. Of those states that enumerate activities that qualify as administration of the program, most include those present in federal law, and 22 include additional administrative examples. Twenty-five states list at least one exception or allowance that could overlap with public health agencies' missions or activities, including sharing for public health purposes (8 states), sharing for research purposes (10 states), and sharing with other state welfare programs (20 states) (Figure 3).

[i] Ark. Code Ann. §20-77-907 and Ark. Code Ann. § 5-55-104 govern access to Medicaid data by relevant authorities for program fraud and abuse enforcement, but those laws lack the direct relevance to data sharing for inclusion in this study.

Figure 2: States with laws on sharing Medicaid data.

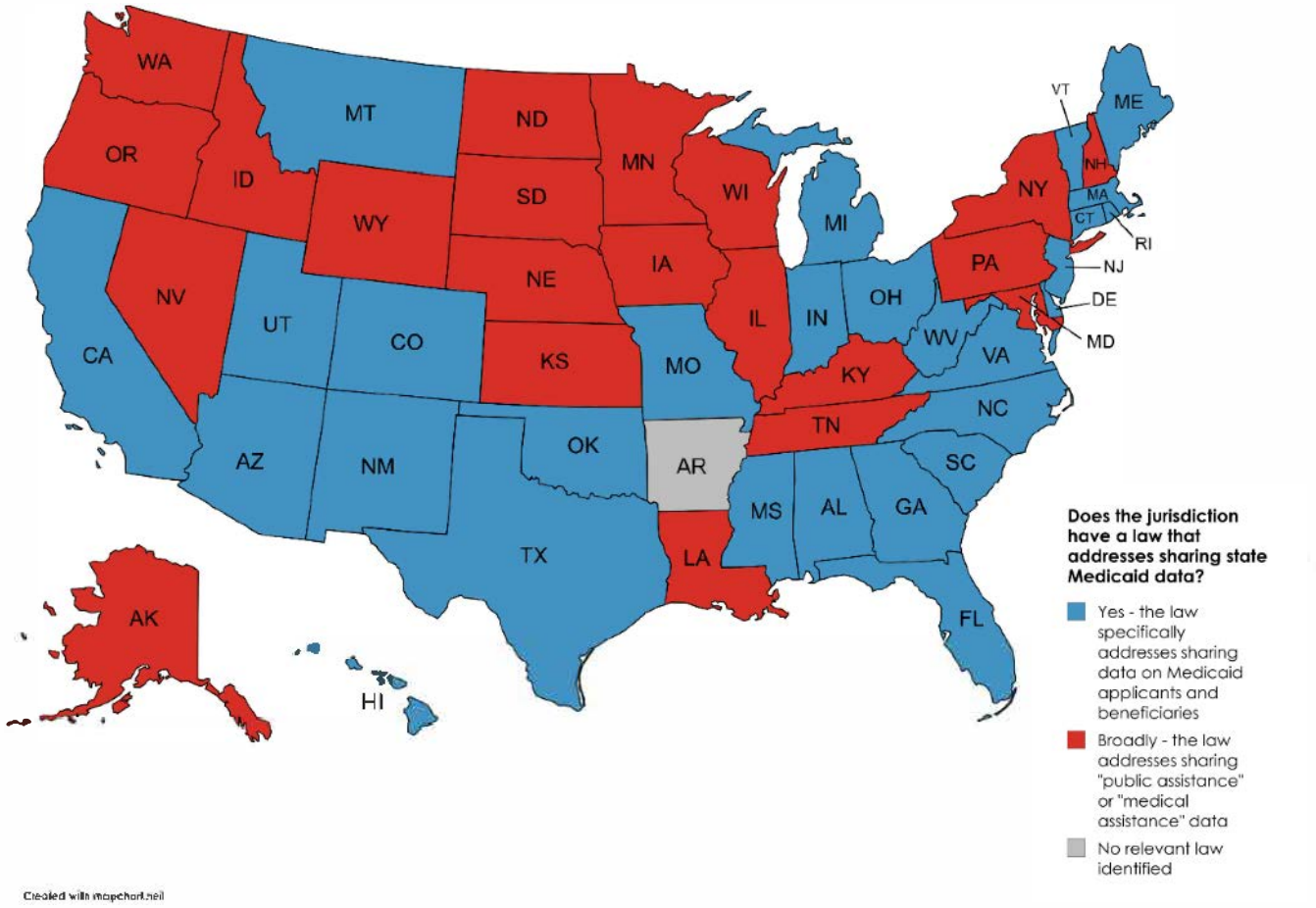


Figure 3: Exceptions or Allowances for Sharing Medicaid Data.

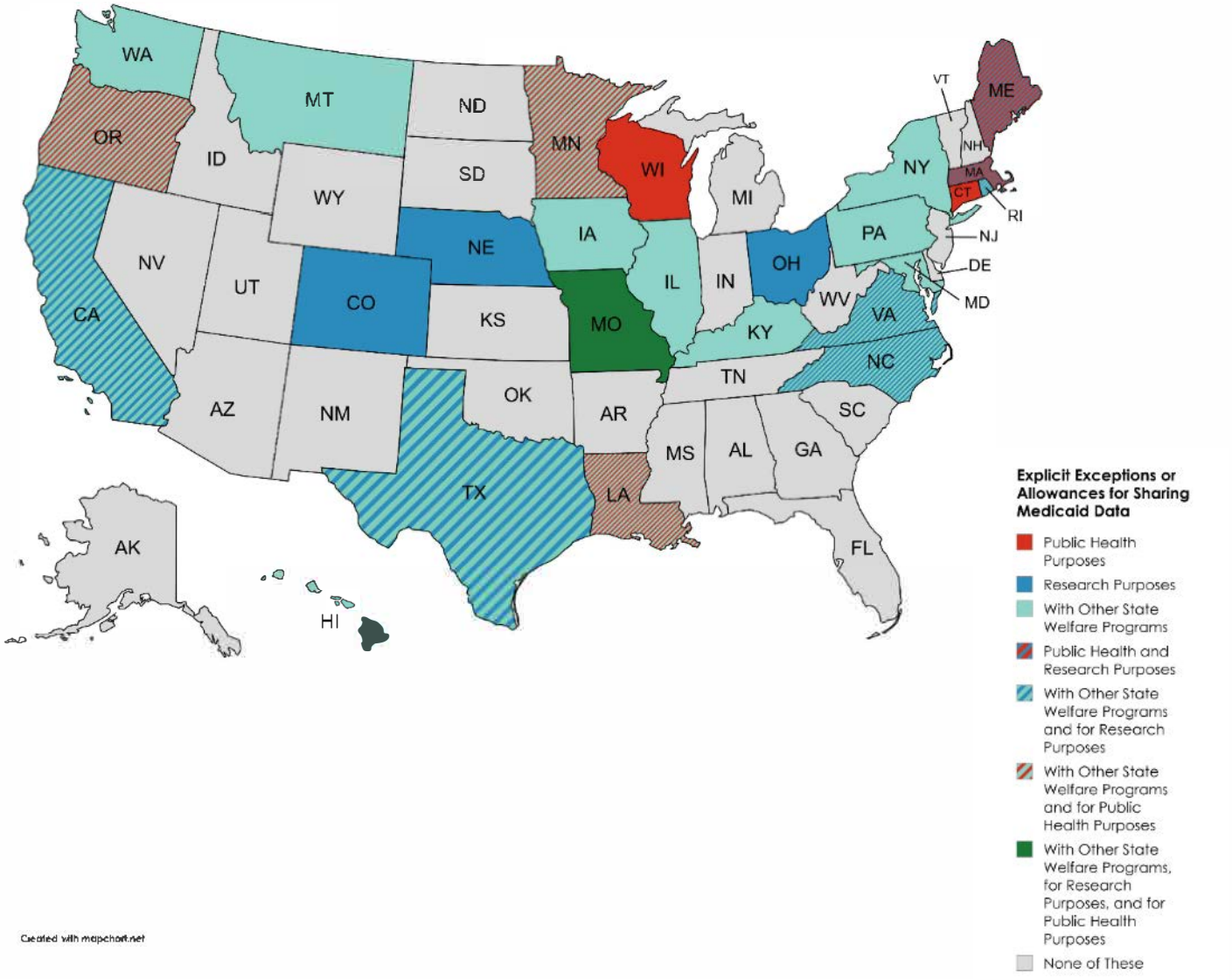


Table 2: States with laws pertaining to sharing Medicaid data with public health agencies.

Question text	Answer Options	States	#
Does the jurisdiction have a law that addresses sharing state Medicaid data?	Yes - the law specifically addresses sharing data on Medicaid applicants and beneficiaries	AL, AZ, CA, CO, CT, DE, FL, GA, HI, IN, ME, MA, MI, MS, MO, MT, NJ, NM, NC, OH, OK, RI, SC, TX, UT, VT, VA, WV	28
	Broadly - the law addresses sharing "public assistance" or "medical assistance" data	AK, ID, IL, IA, KS, KY, LA, MD, MN, NE, NV, NH, NY, ND, OR, PA, SD, TN, WA, WI, WY	21
	No relevant law	AR	1
Does the law address sharing state Medicaid data with state public health agencies?	Yes - the law explicitly names state public health agencies as recipients	CT, LA, ME, MN, MS, MO, MT, VA, WI	9
	Indirectly - the law permits sharing for public health purposes but does not name public health agencies	MA, OR	2
	No - the law does not mention public health agencies or public health purposes	AL, AK, AZ, CA, DE, FL, GA, HI, ID, IN, IA, KS, KY, MD, MI, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VT, WA, WV, WY	36
Does the law cite or incorporate relevant federal law governing Medicaid data?	Yes	AL, AK, AZ, CA, CO, CT, DE, FL, IL, IN, KS, LA, ME, MA, MI, MS, MO, MT, NE, NV, NJ, NM, NC, OH, RI, SC, TX, UT, VA, WA	30
	No	GA, HI, ID, IA, KY, MD, MN, NH, NY, ND, OK, OR, PA, SD, TN, VT, WV, WI, WY	19
Does the law expressly permit sharing Medicaid (or medical/public assistance) data for purposes directly related to the administration of the state Medicaid plan or assistance program?	Yes	AL, AK, AZ, CA, CO, CT, DE, GA, HI, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WY	44
	No	FL, ID, KY, MS, WV	5
Does the law list permitted uses of protected data for purposes related to the administration of the state Medicaid plan or assistance program? Select all that apply:	No examples listed / NA	AL, CT, FL, ID, MA, MS, NE, NV, NH, NM, SC, TN, UT, WV	14
	Eligibility determinations or redeterminations	AK, AZ, CA, CO, DE, GA, HI, IL, KY, ME, MD, MN, MO, MT, NJ, NC, ND, OK, PA, RI, SD, TX, VT, VA, WI	25
	Enrollment or disenrollment	CO, MN	2
	Coordination of benefits	AK, AZ, CO, IL, ME, MD, MN, MO, NJ, ND, OH, OK, OR, PA, RI, SD, VT, VA, WI, WY	20
	Program integrity/fraud prevention	CA, DE, GA, HI, IN, IA, KY, ME, MI, MN, MT, NY, PA	13
	Providing or coordinating services for members	AK, AZ, CA, CO, DE, GA, HI, KY, LA, ME, MD, MN, MO, NJ, NY, NC, ND, OH, OK, OR, PA, RI, SD, TX, VT, VA, WI	27
	Protecting the health or safety of members	CO, IL, IA, MN, OR	5
	Other administrative function explicitly listed (comment below)	AK, AZ, IN, IA, KS, ME, MD, MO, NJ, NC, ND, OH, OK, OR, PA, RI, SD, TX, VT, VA, WA, WI	22
Are any of the following exceptions or allowances for sharing Medicaid data explicitly stated in the law? Check all that apply.	Sharing permitted with school lunch programs	CA	1
	Sharing permitted with other state welfare programs	CA, DE, HI, IL, IA, KY, LA, ME, MD, MN, MO, MT, NY, NC, OR, PA, RI, TX, VA, WA	20
	Sharing permitted for research purposes	CA, CO, MA, MO, NE, NC, OH, RI, TX, VA	10
	Sharing permitted for public health purposes	CT, LA, ME, MA, MN, MO, OR, WI	8
	None of the above	AL, AK, AZ, FL, GA, ID, IN, KS, MI, MS, NV, NH, NJ, NM, ND, OK, SC, SD, TN, UT, VT, WV, WY	23
Does the law explicitly permit sharing of de-identified, statistical, or aggregated Medicaid data?	Yes	AZ, CA, CO, IN, IA, KS, NE, NJ, NY, NC, PA, RI	12
	No	AL, AK, CT, DE, FL, GA, HI, ID, IL, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NV, NH, NM, ND, OH, OK, OR, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	37
Does the law require a Data Use Agreement (DUA) or another written agreement prior to sharing Medicaid data?	Yes	CT, GA, IA, ME, MA, MS, SD, VA, WV	9
	No	AL, AK, AZ, CA, CO, DE, FL, HI, ID, IL, IN, KS, KY, LA, MD, MI, MN, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, WA, WI, WY	40

Public Health Agencies Named as Authorized Recipients of State Medicaid Data

State Law Example: Maine

10-144 CMR Ch. 332, Pt. 1, § 2

V. "Information necessary for other Offices within the Department to administer their programs may be given. These Offices include (…) the Preventive Health Program (PHP)*. Information may also be provided to other Offices within DHHS if there is a written Memorandum of Understanding between OFI and that Office."

*The Preventative Health Program was the predecessor to the Maine Centers for Disease Control and Prevention.

Sharing Permitted with Welfare Programs

State Example: Pennsylvania

55 Pa. Codes§ 105.3

"The use of information in the possession of the Department concerning applicants and recipients is restricted to purposes directly connected with the following:

(3) The administration of another Federal or Federally-assisted program which provides assistance, in case or in-kind, or services directly to individuals on the basis of need."

2. PUBLIC HEALTH AGENCIES NAMED AS AUTHORIZED RECIPIENTS

Despite the narrow federal restrictions, eleven states have established clear legal bases for sharing with public health authorities. Within this group, nine states explicitly name state public health agencies as authorized data recipients, while eight explicitly permit sharing Medicaid data for public health purposes.

3. POTENTIAL DATA SHARING PATHWAYS

In the absence of explicit permissions, we sought to identify legal routes to facilitate public health data sharing within the existing federal framework.

A) EXPANDING "PLAN ADMINISTRATION"

Since federal regulations do not provide an exhaustive definition of "administration of the plan," states without enumerated examples have the flexibility to argue that certain public health activities—such as monitoring disease prevalence or care coordination—further the administration of the state Medicaid program.

B) UTILIZING OVERLAPPING EXCEPTIONS

Public health agencies may qualify for data under other explicitly stated exceptions.

a. Service Coordination: Federal Medicaid law and 27 states permit sharing to provide or coordinate services for members, which often aligns with public health missions.

b. Welfare Programs: 20 states permit sharing with other state welfare programs; public health agencies may oversee some of these programs, facilitating access.

c. Research: 10 states permit sharing for research purposes, provided the data use is structured appropriately. This pathway to data access tends to be a more burdensome one with rigid protocols, but the granularity of data available may be worth the effort in absence of alternative means.

d. De-identified or Aggregated Data: While de-identification can substantially limit the utility of public health data, any data is better than none for public health planning and activities. Twelve states explicitly permit the sharing of de-identified, statistical, or aggregated Medicaid data. **Even in the absence of explicit permission, agencies may still find success requesting data in this form.**

B. SHARING PUBLIC HEALTH DATA WITH STATE MEDICAID AGENCIES

1. VITAL RECORDS

Vital records are official documents that establish identity, legal status, and major life events with legal relevance—like birth, marriage, and death. Data falling under this category includes any information derived from these documents, from the individual record-level to aggregated, anonymized lists. Medicaid agencies could leverage data from vital records to potentially improve eligibility accuracy, strengthen maternal and infant health programs, support value-based care and equity initiatives, and reduce fraud and administrative inefficiencies.[9,10]

It is important to note that vital records are commonly controlled by a state registrar, a role that is often, but not always, housed within the state public health department. Although this study did not analyze the organizational location of registrars within the state government, the legal scan included all laws governing vital records to accurately reflect the real-world legal pathways through which Medicaid agencies might gain access to these data.

Nearly all states explicitly authorize the sharing of vital records data with state Medicaid agencies or state public health authorities. Forty-nine states permit such disclosures, with New Jersey being the only state where we could not identify an express provision authorizing the disclosure of vital statistics data to the Medicaid agency. This statutory landscape suggests that, in principle, Medicaid programs can access vital records data in almost every state. However, state laws differ meaningfully in whether and how they condition such sharing (Table 3).

Grouped by restrictiveness, twenty-nine states present no apparent restrictions, while eighteen states impose low-burden conditions such as a DUA, technical safeguards, or similar process requirements. Two states include provisions categorized as restrictions that can affect data utility. Taken together, the grouped vital records landscape signals substantial opportunity for lawful exchange of at least some vital records data, while also highlighting the need for state-specific implementation planning. The full results of the grouping analysis can be found in Table 4 and Figure 4.

States also vary in additional protections applied to particular data elements, diseases, or conditions. Twenty-two states provide no such added protections, while others include targeted provisions that limit identifiable elements or require special handling of specific categories of information. Vital records have comparatively unique protections in this area; to illustrate this, consider the case of Alaska, which restricts the "disclosure of any information indicating that a birth occurred out of wedlock".[11] This explicit protection was coded "additional data protection for specific diseases/conditions" because they operate as a categorical, status-based confidentiality rule that functions similarly to condition-specific privacy protections (e.g., for HIV status, substance use disorder treatment, or mental health records). In total, we found related provisions in 8 states. These rules can influence the granularity of the data available to Medicaid programs even when disclosure is authorized.

Table 3: States with Laws Pertaining to Sharing Vital Records Data with State Medicaid Agencies

Question Text	Answer Options	States	#
Does the jurisdiction permit sharing jurisdictional public health information to state Medicaid agencies or state public health authorities?	Yes	AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	49
	No	NJ	1
Does the jurisdiction have general requirements/restrictions for the disclosure of public health information? If yes, what are the requirements for disclosure?	No requirements	AK, AZ, AR, CA, CT, DE, FL, GA, HI, IA, MD, MN, MO, MT, NH, NM, NY, OH, PA, RI, SD, TN, TX, UT, VT, VA, WV, WI, WY	29
	DUA or other legal agreement	AL, ID, IL, IN, KS, ME, NV, OK, OR, WA	10
	Technical safeguards	ME, NE, NC, OR, SC	5
	Dataminimization, (e.g., only disclose minimum necessary)	CO, IL, OR, WA	4
	Privacypreserving record linkage	NONE	0
	Partial identification, (e.g., coded data, pseudonymization, limited dataset)	ND	1
	Deidentification, (record-level) or aggregation	NONE	0
	Consent, (e.g., from the patient or data subject)	NONE	0
	Other, (comment below)*	KY, LA, MA, MI, MS, NC	6
Does jurisdiction provide additional protections to specific populations, diseases/conditions, or specific data elements? If yes, to what do the additional protections apply?	No additional protections	AL, FL, HI, ID, IL, IN, ME, MD, MA, MI, MN, MS, NE, NY, NC, OK, OR, PA, TN, UT, WV, WI	22
	Specific populations, (e.g., minors)	NONE	0
	Specific diseases/conditions, (e.g., HIV, mental health)	AK, AR, CA, CO, IA, OH, RI, SC	8
	Specific data elements, (e.g., race and ethnicity, birthdate, ZIP code)	AZ, AR, CT, DE, GA, KS, LA, MO, MT, NV, NH, NM, ND, SD, TX, VT, VA, WA, WY	19
	Other, (comment below)	KY	1
Does the jurisdiction have a law that specifically PERMITS sharing public health data for public health purposes?	Yes	AR, CO, CT, HI, ID, KS, LA, MA, MI, MN, MO, NE, NV, NH, NY, OH, OK, OR, SC, TX, UT, VT, WA, WI	24
	No	AL, AK, AZ, CA, DE, FL, GA, IL, IN, IA, KY, ME, MD, MS, MT, NJ, NM, NC, ND, PA, RI, SD, TN, VA, WV, WY	26
Does the jurisdiction have a law that specifically PERMITS sharing public health data for research purposes?	Yes	AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NV, NH, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	48
	No	NJ, MS	2

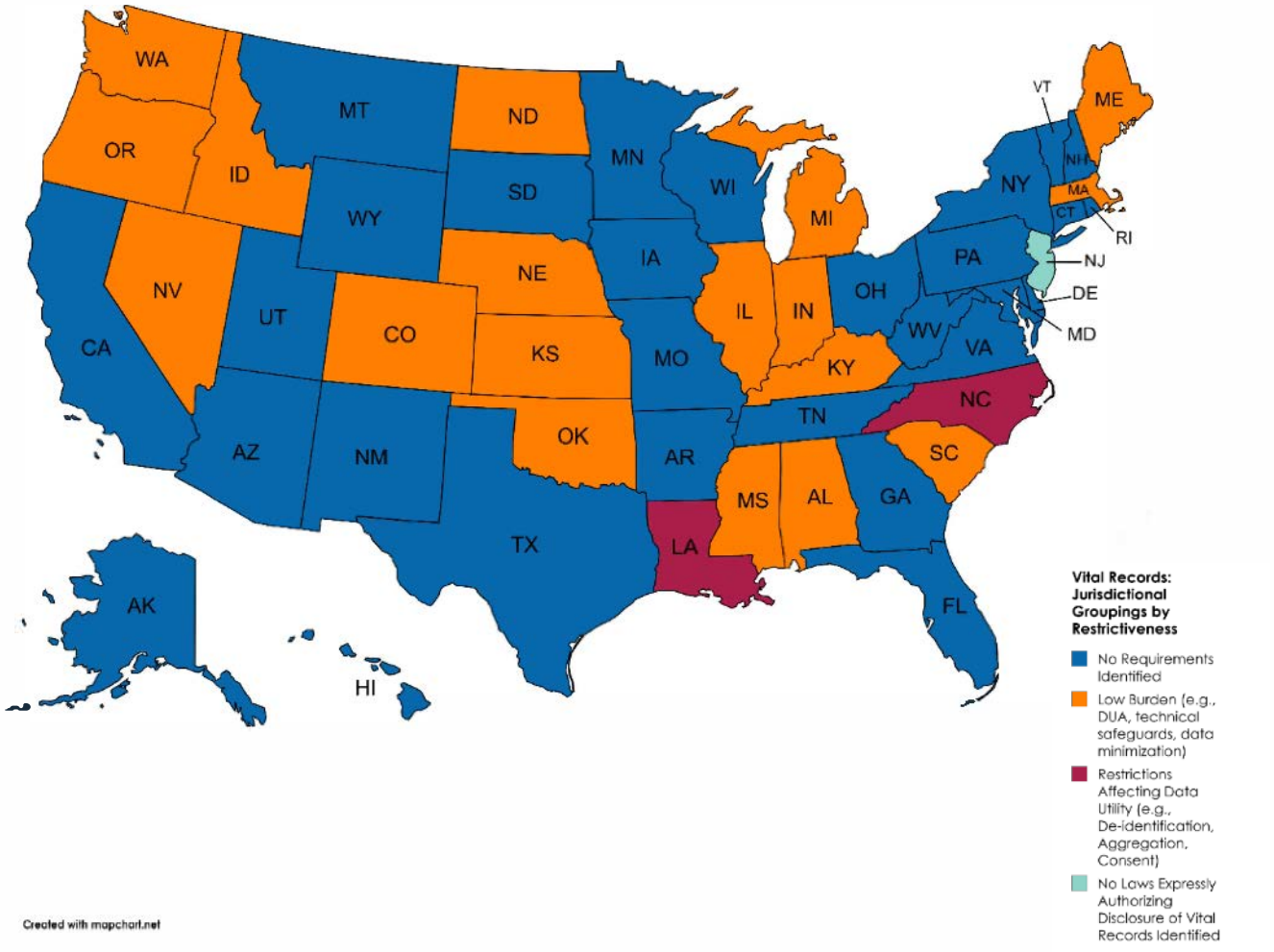
* Jurisdictions with restrictions that were coded as "Other" were evaluated by trained legal researchers on a case-by-case basis for the purposes of the grouping analysis. Coder comments are available in the raw validated dataset in Appendix D.

Table 4: Jurisdictional Groupings Based on Laws, Vital Records Data

No Laws Authorizing Specific Data Type Disclosure to Medicaid Agencies Identified (1)	No Requirements (29)	Low Burden (e.g., DUA, technical safeguards, data minimization) (18)	Restrictions Affecting Data Utility (e.g., de-identification, aggregation) (2)
New Jersey	Alaska†	Alabama	Louisiana†
	Arizona†	Colorado†	North Carolina
	Arkansas†	Idaho	
	California†	Illinois	
	Connecticut†	Indiana	
	Delaware†	Kansas†	
	Florida	Kentucky†	
	Georgia†	Maine	
	Hawaii	Massachusetts	
	Iowa†	Michigan	
	Maryland	Mississippi	
	Minnesota	Nebraska	
	Missouri†	Nevada†	
	Montana†	North Dakota†	
	New Hampshire†	Oklahoma	
	New,Mexico†	Oregon	
	New York	South Carolina†	
	Ohio†	Washington†	
	Pennsylvania		
	Rhode Island†		
	South Dakota†		
	Tennessee		
	Texas†		
	Utah		
	Vermont†		
	Virginia†		
	West Virginia		
	Wisconsin		
	Wyoming†		

† Denotes laws with protections for specified data content. Such protections do not necessarily impact restrictiveness groupings; identified laws can be found in the relevant appendices.

Figure 4: Jurisdictional Groupings by Restrictiveness, Vital Records.



2. IMMUNIZATION LAWS

The statutory landscape governing disclosure of immunization data to state Medicaid agencies is considerably less uniform than the landscape for vital records (Table 5). Thirty-nine states expressly authorize sharing of immunization information with Medicaid agencies or state public health authorities, while immunization-specific provisions permitting disclosure were not identified in eleven states. In these jurisdictions—indicated by asterisks in the tables—general public health data laws may apply and create potential, but less explicit, pathways for disclosure.

Among the 39 states that allow disclosure, the conditions placed on immunization data sharing vary meaningfully. Twenty-nine states impose no general requirements on disclosure. Others require additional steps, such as formal DUAs, technical safeguard provisions, or data-minimization obligations. These conditions affect the process of data sharing, but may permit data quality and impact to remain intact. In states where general public health law is the source of authority, these requirements reflect the broader statutory framework that applies to identifiable public health information more generally.

Clarifying Public Health Authority Inclusion in Abstraction Instrument

In some jurisdictions, there are no disclosure provisions that govern sharing specifically with Medicaid agencies, but there are permissions for sharing with "public health authorities". We intentionally captured this nuance in our abstraction instrument. Because of legal ambiguity regarding Medicaid agencies' potential designation as such, these states were categorized at the most restrictive level, reflecting the uncertainty and contingent nature of this sharing pathway.

Additional protections for specific diseases, populations, or data elements are relatively uncommon for immunization data. Thirty-eight states have no such protections beyond the baseline confidentiality standards in state public health law. In the remaining jurisdictions, protections most often apply to particular diseases or sensitive categories of information. These protections may arise either from immunization-specific provisions or from general confidentiality rules that apply across public health data types.

The grouping analysis highlights the unevenness of this legal environment (Table 6 and Figure 6). Eleven states do not explicitly authorize disclosure, while many others present no apparent restrictions on sharing. Seventeen states impose low-burden requirements, such as DUAs or technical safeguards, that increase process steps without substantially interfering with data utility. Four jurisdictions include restrictions that could limit the usefulness or granularity of Medicaid-facing immunization data, but notably, all are states where general public health laws have been interpreted to apply. This is relevant because it shows that when immunization data sharing is explicitly supported in law, these laws are non- or minimally restrictive without exception.

The immunization data landscape offers considerable opportunity for interagency immunization data sharing. Most states provide clear avenues for sharing, and only a minority of those impose statutory restrictions at all. Even in the absence of immunization data-specific laws, sharing may be permitted under broader general public health data sharing laws. As with vital records, these findings are encouraging but underscore the importance of state-specific analysis when planning and implementing immunization data exchange.

Table 5: States with Laws Pertaining to Sharing Immunization Data with State Medicaid Agencies

Question Text	Answer Options	States	#
Does the jurisdiction permit sharing jurisdictional public health information to state Medicaid agencies or state public health authorities?	Yes	AL, AK, AZ, AR, CA, CO, CT, DE, GA, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MS, MO, NE, NV, NH, NJ, NM, NY, ND, OR, RI, SC, SD, TX, UT, VT, VA, WV, WY	39
	No	FL, ID, KS, MT, NC, OH, OK, PA, TN, WA, WI	11
Does the jurisdiction have general requirements/restrictions for the disclosure of public health information? If yes, what are the requirements for disclosure?	No requirements	AK, AZ, CO, CT, DE, GA, ID*, IA, KY, LA, MN, MS, MO, NE, NV, NH, NM, NC*, OK*, OR, PA*, RI, SD, TN*, TX, UT, VT, VA, WV	29
	DUA or other legal agreement	AL, AR, IL, IN, MD, NJ, NY, OH*, SC, WY	10
	Technical safeguards	HI, ME, NY, SC	4
	Data minimization, (e.g., only disclose minimum necessary)	KS*, NY	2
	Privacy-preserving record linkage	NONE	0
	Partial identification, (e.g., coded data, pseudonymization, limited dataset)	ND	1
	Deidentification, (record-level) or aggregation	NONE	0
	Consent, (e.g., from the patient or data subject)	NONE	0
	Other**	CA, FL*, HI, MA, MI, MT*, NJ, WA*, WI*	9
Does jurisdiction provide additional protections to specific populations, diseases/conditions, or specific data elements? If yes, to what do the additional protections apply?	No additional protections	AZ, AR, CA, CO, CT, FL*, GA, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MS, MO, NE, NV, NH, NJ, NM, NY, NC*, ND, OR, RI, SC, SD, TX, UT, VT, WV, WI*, WY	38
	Specific populations, (e.g., minors)	NONE	0
	Specific diseases/conditions, (e.g., HIV, mental health)	ID*, KS*, MT*, OH*, OK*, PA*, TN*, WA*	8
	Specific data elements, (e.g., race and ethnicity, birthdate, ZIP code)	AL, AK, DE, VA	4
	Other	NONE	0
Does the jurisdiction have a law that specifically PERMITS sharing public health data for public health purposes?	Yes	AL, AK, AZ, AR, CA, CO, CT, DE, GA, HI, ID*, IL, IN, IA, KS*, KY, LA, MD, MA, MI, MO, MT*, NE, NH, NJ, NM, NY, NC*, OH*, OK*, OR, PA*, SC, TN*, TX, UT, VT, VA, WA*, WV	40
	No	FL, ME, MN, MS, NV, ND, RI, SD, WI, WY	10
Does the jurisdiction have a law that specifically PERMITS sharing public health data for research purposes?	Yes	AL, AK, AZ, CT, DE, GA, ID*, IL, IN, KS*, LA, ME, MA, MI, NH, NY, NC*, OH*, OK*, PA*, SC, VT, VA, WI*	24
	No	AR, CA, CO, FL, HI, IA, KY, MD, MN, MS, MO, MT, NE, NV, NJ, NM, ND, OR, RI, SD, TN, TX, UT, WA, WV, WY	26

* Indicates interpretation of general public health data law as applied to the immunization data

** Jurisdictions with restrictions that were coded as "Other" were evaluated by trained legal researchers on a case-by-case basis for the purposes of the grouping analysis. Coder comments are available in the raw validated dataset in Appendix D.

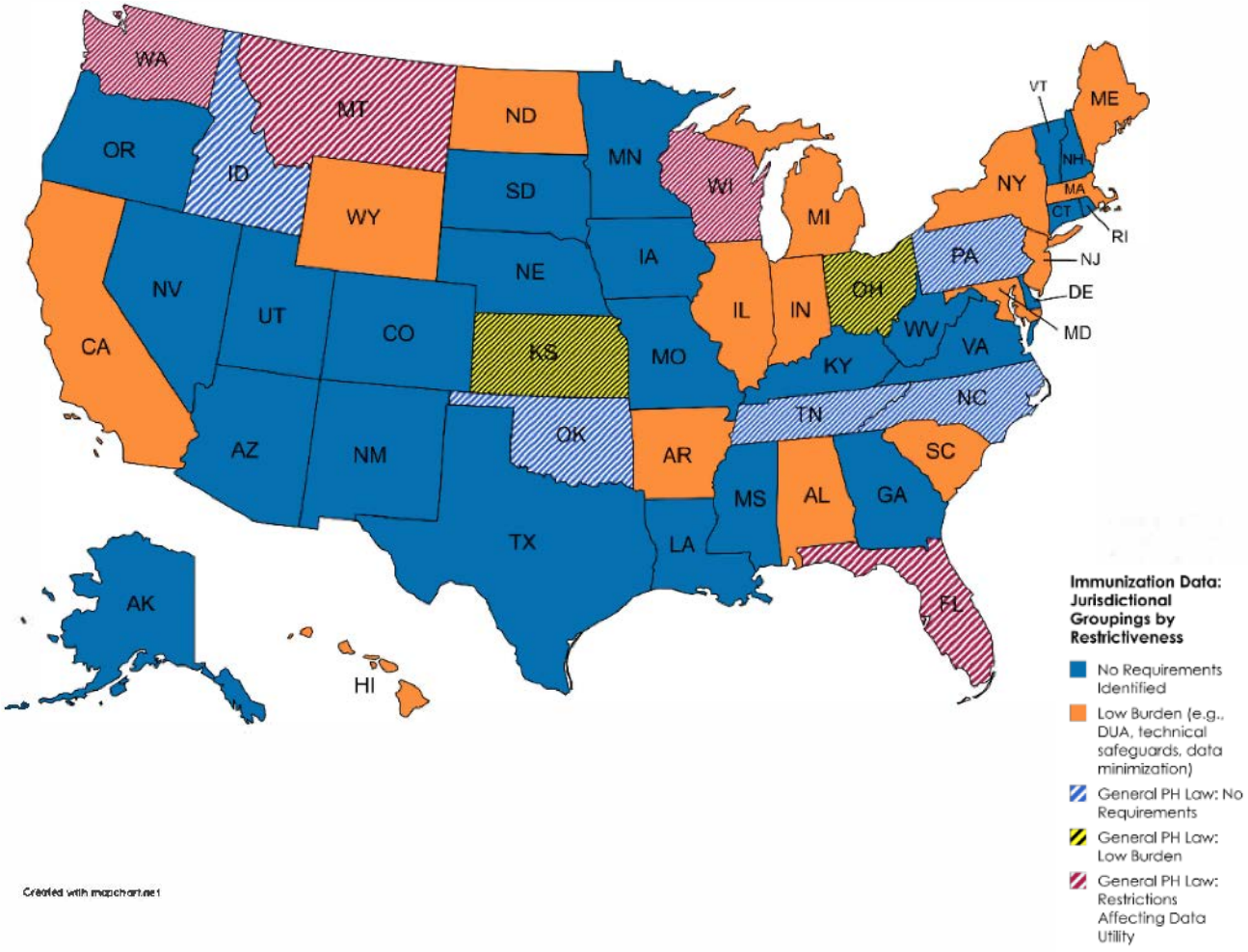
Table 6: Jurisdictional Groupings Based on Laws, Immunization Data

No Laws Authorizing Specific Data Type Disclosure to Medicaid Agencies or State Public Health Authorities Identified (11)	No Requirements (29)	Low Burden (e.g., DUA, technical safeguards, data minimization) (17)	Restrictions Affecting Data Utility (e.g., de-identification, aggregation) (4)
Florida	Alaska†	Alabama†	Florida*
Idaho	Arizona	Arkansas	Montana*†
Kansas	Colorado	California	Washington*†
Montana	Connecticut	Hawaii	Wisconsin*
North Carolina	Delaware†	Illinois	
Ohio	Georgia	Indiana	
Oklahoma	Idaho*†	Kansas*†	
Pennsylvania	Iowa	Maine	
Tennessee	Kentucky	Maryland	
Washington	Louisiana	Massachusetts	
Wisconsin	Minnesota	Michigan	
	Mississippi	New Jersey	
	Missouri	New York	
	Nebraska	North Dakota	
	Nevada	Ohio*†	
	New Hampshire	South Carolina	
	New Mexico	Wyoming	
	North Carolina*		
	Oklahoma*†		
	Oregon		
	Pennsylvania*†		
	Rhode Island		
	South Dakota		
	Tennessee*†		
	Texas		
	Utah		
	Vermont		
	Virginia†		
	West Virginia		

* Indicates interpretation of general public health data law as applied to the immunization data

† Denotes laws with protections for specified data content. Such protections do not necessarily impact restrictiveness groupings; identified laws can be found in the relevant appendices.

Figure 5: Jurisdictional Groupings by Restrictiveness, Immunization Data.



3. SYNDROMIC SURVEILLANCE LAWS

Syndromic surveillance data present a unique legal and operational landscape because, compared to vital records or immunization information, there is less uniformity surrounding what constitutes syndromic surveillance data across states. In some jurisdictions, syndromic surveillance systems primarily draw from emergency department intake records, urgent care encounters, and other clinical presentations that contain substantial amounts of identifiable health information. In others, syndromic surveillance programs also incorporate non-clinical indicators—such as over-the-counter medication sales, school absenteeism reports, or environmental data—that contain little or no personal information. Because these data elements differ so widely in sensitivity and identifiability, they may fall under different statutory structures within the same state. As a result, certain syndromic surveillance data types may be more readily shareable under general public health authority or other legal pathways, even when more sensitive syndromic surveillance components face stricter limits. This variability in data composition adds an additional layer of nuance to the already complex legal environment surrounding syndromic surveillance data exchange with Medicaid agencies. Furthermore, it is possible that our search methodology might have missed laws that are relevant to subsets of syndromic surveillance data given this significant heterogeneity.

Only a small handful of states have enacted data-type-specific laws that expressly authorize the sharing of syndromic surveillance data with Medicaid agencies (Table 7). Among the six states with such laws, restrictiveness varies substantially. Two states—North Carolina and West Virginia—have particularly narrow permissions that strictly limit the circumstances under which syndromic surveillance data may be disclosed. These states condition sharing on both the nature of the requestor and the purpose for which the data will be used. For example, WV ADC§ 64-7-12(12.5) requires Medicaid agencies to justify their inclusion as a "local health department" and limit use to public health purposes.

These examples illustrate that even when states do explicitly authorize sharing, the statutory language may be too narrow to clearly encompass Medicaid agencies or the full range of Medicaid-related operational purposes.

Because data-type-specific syndromic surveillance laws are so rare, the vast majority of the legal analysis relies on interpretation of laws that apply to public health data generally. These broader provisions—which appear as asterisks in the tables—often govern the confidentiality and permissible disclosure of any identifiable information collected by public health authorities. In many states, such laws may allow disclosure of syndromic surveillance data to Medicaid agencies, especially when the data are used for public health, epidemiology, or healthcare coordination purposes. However, because these laws are not written with syndromic surveillance specifically in mind, the scope and certainty of the permissible sharing pathway vary. This reliance on general authority is particularly salient given the diversity of syndromic surveillance data types: less sensitive data elements, such as over-the-counter medication sales, may more comfortably fall within the general framework, while more sensitive clinical encounter data may raise additional statutory or interpretive questions.

States also differ in the restrictions placed on syndromic surveillance data sharing. Sixteen states impose no restrictions; others require steps such as DUAs, technical safeguards, or data-minimization provisions.

These conditions generally affect the process of sharing rather than whether data can be shared at all. Additional protections tied to certain diseases, populations, or data elements appear in several states, though these often arise from more general communicable disease or public health confidentiality laws rather than syndromic surveillance-specific frameworks. These protections may affect the granularity or identifiability of the syndromic surveillance data that can ultimately be disclosed, especially when clinical elements are included.

The grouping analysis reflects this diversity. Many states lack explicit statutory authorization for sharing syndromic surveillance data with Medicaid agencies, while others permit sharing with no apparent restrictions. Thirteen states fall into low-burden categories, where sharing is possible but subject to procedural requirements. Fifteen have restrictions that can materially affect the utility of the data—most notably where de-identification, aggregation, or narrow purpose limitations apply. Across these categories, it is notable the extent to which general public health law—as opposed to laws specific to syndromic surveillance—structures the legal environment for these data (see Table 8 and Figure 7).

Taken together, these findings reveal a landscape shaped by both substantive legal gaps and considerable variation in how states conceptualize and collect syndromic surveillance data. The scarcity of explicit syndromic surveillance laws, the narrowness of the few that exist, the reliance on general public health law, and the heterogeneous nature of syndromic surveillance data itself all contribute to a highly nuanced legal environment. As with other data types in this study, effective syndromic surveillance data exchange will require careful, state-specific interpretation that accounts not only for statutory authority but also for the composition and sensitivity of the underlying data.

Table 7: States with Laws Pertaining to Sharing Syndromic Surveillance Data with State Medicaid Agencies

Question Text	Answer Options	States	#
Does the jurisdiction permit sharing jurisdictional public health information to state Medicaid agencies or state public health authorities?	Yes	CA, IL, MO, NE, NC, WV	6
	No	AL, AK, AZ, AR, CO, CT, DE, FL, GA, HI, ID, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MT, NV, NH, NJ, NM, NY, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WY	44
Does the jurisdiction have general requirements/restrictions for the disclosure of public health information? If yes, what are the requirements for disclosure?	No requirements	AL*, AZ*, ID*, IL, MI*, MO, NE, NV*, OK*, OR*, PA*, RI*, SD*, TN*, TX*, VA*	16
	DUA or other legal agreement	CA, LA*, MS*, NM*, OH*, UT*, WY*	7
	Technical safeguards	MS*	1
	Data minimization, (e.g., only disclose minimum necessary)	AK*, CA, CO*, CT*, DE*, HI*, KS*, LA*, MA*, NH*	10
	Privacy-preserving record linkage	NONE	0
	Partial identification, (e.g., coded data, pseudonymization, limited dataset)	NONE	0
	Deidentification, (record-level) or aggregation	AR*, DE*, MD*, ND*	4
	Consent, (e.g., from the patient or data subject)	NH*	1
	Other, (comment below)**	FL*, HI*, ME*, MN*, MT*, NJ*, NY*, NC, WA*, WV, WI*, WY*	12
Does jurisdiction provide additional protections to specific populations, diseases/conditions, or specific data elements? If yes, to what do the additional protections apply?	No additional protections	AL*, AK*, AR*, CA, CT*, DE*, FL*, MO, NE, NV*, NJ*, NM*, ND*, OR*, RI*, SD*, VA*, WI*, WY*	19
	Specific populations, (e.g., minors)	NY*, TX*	2
	Specific diseases/conditions, (e.g., HIV, mental health)	AZ*, CO*, HI*, ID*, KS*, LA*, ME*, MD*, MA*, MN*, MT*, NH*, NY*, OH*, OK*, PA*, TN*, TX*, UT*, WA*	20
	Specific data elements, (e.g., race and ethnicity, birthdate, ZIP code)	IL, ME*, MS*, NC, WV	5
	Other, (comment below)	MI*	1
Does the jurisdiction have a law that specifically PERMITS sharing public health data for public health purposes?	Yes	AL*, AK*, CO*, CT*, DE*, HI*, ID*, IL, KS*, LA*, ME*, MA*, MN*, MS*, MO, MT*, NE, NH*, NJ*, NC, ND*, OH*, OK*, PA*, RI*, SD*, TN*, TX*, UT*, VA*, WA*, WV	32
	No	AZ, AR, CA, FL, GA, IA, IN, KY, MD, MI, NV, NM, NY, OR, SC, VT, WI, WY	18
Does the jurisdiction have a law that specifically PERMITS sharing public health data for research purposes? Syndromic Surveillance	Yes	AK*, AZ*, AR*, CA, CO*, CT*, DE*, ID*, IL, KS*, LA*, MA*, MI*, MS*, NH*, NM*, NY*, ND*, OH*, OK*, PA*, RI*, VA*, WI*, WY*	25
	No	AL, FL, GA, HI, IN, IA, KY, ME, MD, MN, MO, MT, NE, NV, NJ, NC, OR, SC, SD, TN, TX, UT, VT, WA, WV	25

* Indicates interpretation of general public health data law as applied to the syndromic surveillance data

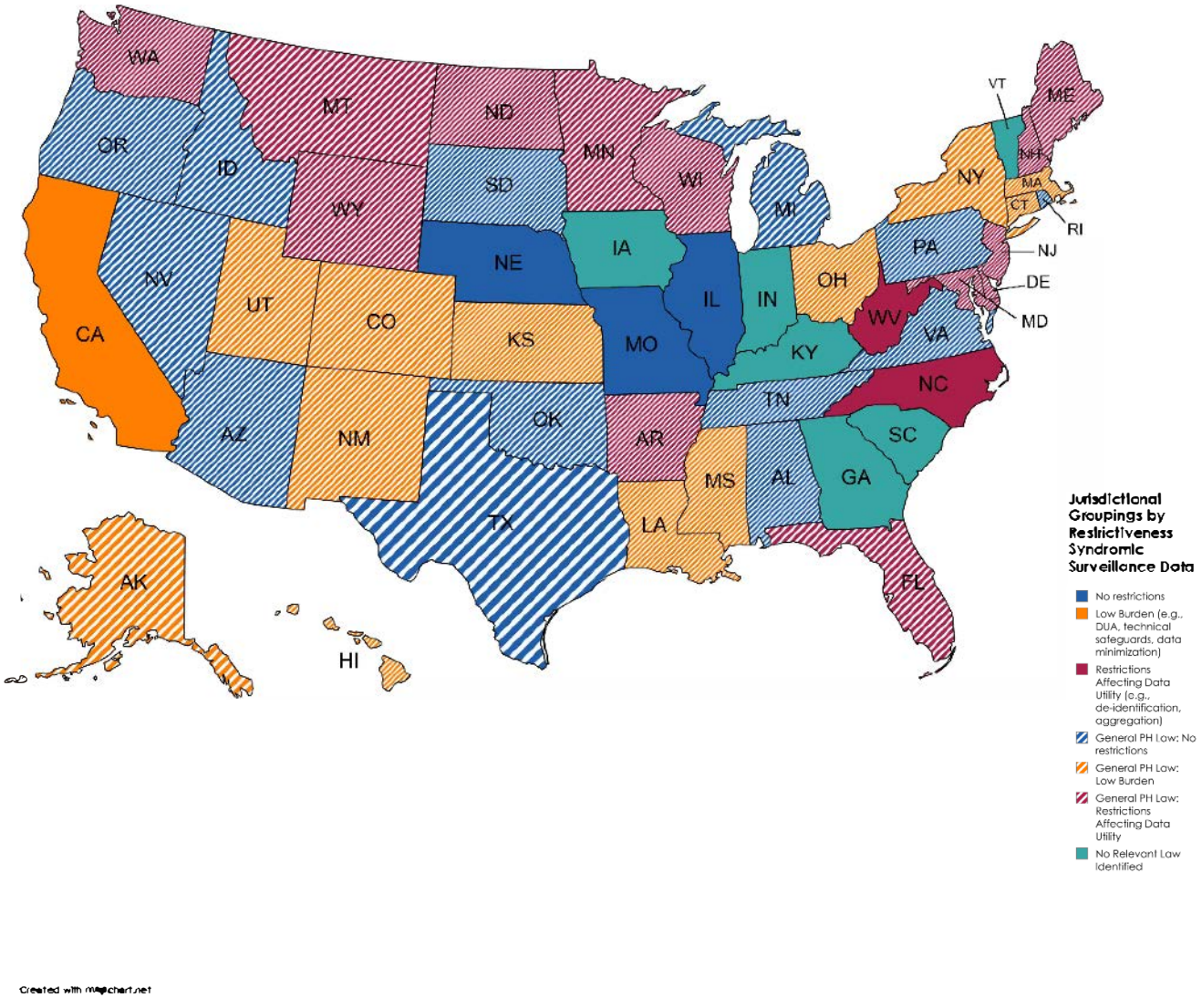
** Jurisdictions with restrictions that were coded as "Other" were evaluated by trained legal researchers on a case-by-case basis for the purposes of the grouping analysis. Coder comments are available in the raw validated dataset in Appendix D.

Table 8: Jurisdictional Groupings Based on Laws, Syndromic Surveillance Data

No Laws Authorizing Specific Data Type Disclosure to Medicaid Agencies Identified (44)		No Requirements (16)	Low Burden (e.g., iDUA, technical safeguards, data minimization) (13)	Restrictions Affecting Data Utility (e.g., de-identification, aggregation) (15)
Alabama	Nevada	Alabama*	Alaska*	Arkansas*
Alaska	New Hampshire	Arizona*†	California	Delaware*
Arizona	New Jersey	Idaho*†	Colorado*†	Florida*
Arkansas	New Mexico	Illinois†	Connecticut*	Maine*†
Colorado	New York	Michigan*†	Hawaii*†	Maryland*†
Connecticut	North Dakota	Missouri	Kansas*†	Minnesota*†
Delaware	Ohio	Nebraska	Louisiana*†	Montana*†
Florida	Oklahoma	Nevada*	Massachusetts*†	New Hampshire*†
Georgia	Oregon	Oklahoma*†	Mississippi*†	New Jersey*
Hawaii	Pennsylvania	Oregon*	New Mexico*	North Carolina†
Idaho	Rhode Island	Pennsylvania*†	New York*†	North Dakota*
Indiana	South Carolina	Rhode Island*	Ohio*†	Washington*†
Iowa	South Dakota	South Dakota*	Utah*†	Wisconsin*
Kansas	Tennessee	Tennessee*†		West Virginia†
Kentucky	Texas	Texas*†		Wyoming*
Louisiana	Utah	Virginia*		
Maine	Vermont			
Maryland	Virginia			
Massachusetts	Washington			
Michigan	Wisconsin			
Minnesota	Wyoming			
Mississippi				
Montana				

* Indicates interpretation of general public health data law as applied to the syndromic surveillance data
† Denotes laws with protections for specified data content. Such protections do not necessarily impact restrictiveness groupings; identified laws can be found in the relevant appendices.

Figure 6: Jurisdictional Groupings by Restrictiveness, Syndromic Surveillance Data



C. ALTERNATIVE PATHWAY: INTRA-DEPARTMENTAL DATA SHARING

Many of the laws within the scope of this project relate to data sharing between government agencies (i.e., interdepartmental sharing). For example, the law might authorize disclosures to specified government agencies or for specified purposes. These laws are highly relevant to this project when the state Medicaid and public health agencies are organizationally separate. However, some states have a "**super agency**"; in other words, the Medicaid agency and the public health authorities are located within the same agency or department. See Table 9.

Laws that restrict disclosures could apply differently to data sharing between the state public health and Medicaid personnel when they are within a super agency or if they are located within organizationally separate agencies. Depending on the specific language of the law, data shared within a super agency might not be legally "disclosed" or "released." Consequently, the otherwise applicable legal requirements for disclosure or release of data might not be required for data sharing within some super agencies. Nevertheless, HIPAA Privacy restrictions also apply to data uses, meaning that even if data is not legally disclosed or released within a superagency the specific use of data must still satisfy a HIPAA data use exception. Moreover, if a superagency is a HIPAA hybrid-covered entity, meaning some components perform HIPAA covered functions and others do not, then there will likely be administrative and technical divisions that need to be navigated before data sharing can occur, potentially reducing the organizational benefit for the data sharing within the superagency.

Table 9: States with "super agencies," where the Medicaid and public health agencies are housed in the same state department/agency

State	Super Agency Name
Alaska	Alaska Department of Health
Delaware	Department of Health and Social Services
Idaho	Idaho Department of Health and Welfare
Iowa	Iowa Health and Human Services
Kansas	Kansas Department of Health and Environment
Kentucky	Cabinet for Health and Family Services
Louisiana	Louisiana Department of Health
Maine	Department of Health and Human Services
Maryland	Maryland Department of Health
Massachusetts	Department of Health and Human Services
Michigan	Michigan Department of Health and Human Services
Montana	Montana Department of Public Health and Human Services
Nebraska	Nebraska Department of Health and Human Services
Nevada	Nevada Department of Health and Human Services
New Hampshire	New Hampshire Department of Health and Human
New York	New York State Department of Health
North Carolina	North Carolina Department of Health and Hum
North Dakota	North Dakota Department of Health and Human
Oregon	Oregon Health Authority
Utah	Utah Department of Health and Human Services
Vermont	Agency of Human Services
Wisconsin	Wisconsin Department of Health Services
Wyoming	Wyoming Department of Health

The existence of a super agency is especially significant with states that have highly restrictive data sharing laws or where the state laws lack specific data sharing authority. In these cases, states might perceive data sharing between state Medicaid and public health agencies to carry less legal risk when they are within the same super agency than if they were organizationally separate. Table 10 shows those states with super agencies and for which our analysis revealed the absence of a specific authority to share data between state Medicaid and public health agencies or that had legal restrictions on data sharing that likely would affect the utility of shared data.

Table 10: States with No Laws Authorizing Disclosure to Medicaid Agencies or Restrictions Affecting Data Utility

Jurisdiction	Relevant Data Type(s)	Super Agency
Alaska	Syndromic Surveillance (N)	Alaska Department of Health
Delaware	General Public Health (U); Syndromic Surveillance (N)	Department of Health and Social Services
Idaho	Immunization (N); Syndromic Surveillance (N)	Idaho Department of Health and Welfare
Iowa	General Public Health (N); Syndromic Surveillance (N)	Iowa Health and Human Services
Kansas	Immunization (N); Syndromic Surveillance (N)	Kansas Department of Health and Environment
Kentucky	General Public Health (N); Syndromic Surveillance (N)	Cabinet for Health and Family Services
Louisiana	Vital Records (U); Syndromic Surveillance (N)	Louisiana Department of Health
Maine	General Public Health (U); Syndromic Surveillance (N)	Department of Health and Human Services
Maryland	General Public Health (U); Syndromic Surveillance (N)	Maryland Department of Health
Massachusetts	Syndromic Surveillance (N)	Department of Health and Human Services
Michigan	Syndromic Surveillance (N)	Michigan Department of Health and Human Services
Montana	General Public Health (U); Immunization (N); Syndromic Surveillance (N)	Montana Department of Public Health and Human Services
Nevada	Syndromic Surveillance (N)	Nevada Department of Health and Human Services
New Hampshire	General Public Health (U); Syndromic Surveillance (N)	New Hampshire Department of Health and Human Services
New York	Syndromic Surveillance (N)	New York State Department of Health
North Carolina	Vital Records (U); Immunization (N); Syndromic Surveillance (N)	North Carolina Department of Health and Human Services
North Dakota	General Public Health (U); Syndromic Surveillance (N)	North Dakota Department of Health and Human Services
Oregon	Syndromic Surveillance (N)	Oregon Health Authority
Utah	Syndromic Surveillance (N)	Utah Department of Health and Human Services
Vermont	General Public Health (N); Syndromic Surveillance (N)	Agency of Human Services
Wisconsin	General Public Health (U); Immunization (N); Syndromic Surveillance (N)	Wisconsin Department of Health Services
Wyoming	General Public Health (U); Syndromic Surveillance (N)	Wyoming Department of Health

*N = No relevant law identified; U=Restrictions affecting data utility.

V. POLICY IMPLICATIONS AND ACTIONABLE CONSIDERATIONS FOR STATES

A. IMPLICATIONS OF STATE MEDICAID DATA LAWS

Federal regulations on permitted uses and disclosures of state Medicaid data provide a narrow window for states to authorize sharing Medicaid applicant and beneficiary data with public health agencies. State Medicaid data is regulated by HIPAA, 42 CFR Part431, Subpart F, 42 U.S.C. § 1396a, and state law. Consequently, custodians of state Medicaid data must determine whether a restriction in any of these laws might prohibit a given data use or disclosure. The federal regulations authorize sharing Medicaid data for purposes related to plan administration, but they do not provide an exhaustive definition of what plan administration entails.[12] Our analysis shows that some states are taking advantage of this limited flexibility to authorize the disclosure of Medicaid data for public health purposes or related activities in laws (e.g., research and welfare programs). Specifically, addressing disclosures for public health activities or to public health agencies provides substantial clarity for custodians trying to determine if a given data use or disclosure is permitted by law.

Below we discuss different legal routes that could be available to states identified from our analysis.

1. PUBLIC HEALTH AGENCIES NAMED AS MEDICAID DATA RECIPIENTS

Across state laws governing Medicaid data sharing, 9 jurisdictions explicitly authorize the exchange of Medicaid data with public health agencies. These provisions establish a clear legal basis for interagency collaboration, offering stronger guidance than general data-sharing clauses. The scope of authorization varies: some states, such as Virginia, frame permissions broadly by allowing disclosure to "governmental authorities"—which necessarily includes public health agencies—while others, like Missouri, narrowly specify public health agencies as the intended recipients.

2. SHARING PERMITTED FOR PUBLIC HEALTH PURPOSES

Eight states (Connecticut, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Oregon, and Wisconsin) have laws that explicitly permit sharing Medicaid data for public health purposes. All 8 of these are included in the category of states that either directly or indirectly authorize sharing for public health agencies, with 6 explicitly naming these agencies as recipients, and 2 implying authorization through their public health purpose permissions. These permissions vary from purpose-specific exceptions like contact tracing to broader frameworks that accommodate varying public health needs. Some laws use stronger language permitting—or in the case of Missouri, arguably mandating—the sharing of Medicaid data for public health purposes, signaling strong support for interagency collaboration. Most of these states still explicitly restrict sharing to purposes related to plan administration while also specifying permissions for public health purposes. Taken together, these state laws reflect a willingness to interpret federal Medicaid parameters in ways that support interagency data sharing, and they could be persuasive in states with less explicit permissions.

3. ACTIVITIES AND RECIPIENTS RELATED TO PUBLIC HEALTH

We found a substantial number of states with laws that permit sharing Medicaid data in ways that could be relevant to public health agencies. Here are some examples:

- 20 states have exceptions for sharing Medicaid data with welfare programs; therefore, a public health agency could be a legal recipient of Medicaid data to the extent that a public health

program meets the legal definition for one of these exceptions. However, some of these welfare exceptions are narrowly tied to specific welfare programs (e.g., school lunch programs) that might have only a narrow overlap to public health missions.

- 10 states permit sharing Medicaid data for research purposes, so a public health agency in those states could structure a proposed data use—for example, by designing it to be generalizable in some way—to receive Medicaid data under the research exception.
- 27 states permit sharing Medicaid data to provide or coordinate services for members, so public health agencies that have programs that provide services (e.g., vaccinations, preventative treatments, screenings) or coordinate care (e.g., Community Health Worker services, care navigators), could conceivably rely on these exceptions to receive Medicaid data for purposes related to these exceptions.

4. AUTHORITY FROM OMISSION

While some state laws contain express language that give the authority to share data, this is not the only approach that states could take. Instead, states could rely on interpretations of existing language to justify sharing Medicaid data for public health purposes. For example, we found that 14 states do not elaborate on "plan administration" in their laws, but that does not foreclose the ability of states to expansively interpret their legal authority either publicly (e.g., via published attorney general opinion) or internally (e.g., an internal agency memorandum, DUA). While explicit statutory or regulatory language provides the clearest authority for sharing Medicaid data, the absence of a specific prohibition against sharing Medicaid data still allows for state agencies to interpret their authority within legal limits.

B. IMPLICATIONS OF STATE PUBLIC HEALTH DATA LAWS

The legal landscape governing disclosure of public health data to Medicaid agencies is characterized by wide variability, incomplete legal coverage, and meaningful differences in both the specificity and restrictiveness of state laws. Across vital records, immunization data, and syndromic surveillance data, state laws are comprised of a mix of data-type-specific laws and broader authorities that do not clearly address interagency data sharing. This patchwork creates both opportunities and substantial ambiguity for Medicaid programs seeking timely, actionable public health data to support population health management and care coordination. The findings of this legal mapping project illuminate several cross-cutting themes that have significant implications for policy, implementation, and state practice.

1. LAWS SPECIFIC TO DATA TYPES PROVIDE CLARITY, BUT ALSO INCONSISTENCY

Laws that apply to specific public health data or systems play a clarifying role in the leading landscape, but their distribution is uneven. Nearly all states have explicit provisions governing vital records disclosures, and most authorize sharing with Medicaid agencies. Immunization laws are somewhat less consistent, but still present in a majority of states. Syndromic surveillance laws, by contrast, are both rare and, when present, highly variable in restrictiveness.

The lack of specific legal authority to share data is especially pronounced when different laws potentially overlap in the application to the same data type or data system. This problem is especially relevant to syndromic surveillance data as these systems include heterogeneous data from different sources—from

nonclinical indicators such as over-the-counter (OTC) medication sales or school attendance to not readily identifiable clinical encounter information. Consequently, different components of syndromic surveillance systems may fall under different legal frameworks even within the same state. In states with narrow syndromic surveillance laws, such as North Carolina and West Virginia, broad categories of clinical syndromic surveillance data may be harder to share with Medicaid agencies than nonclinical indicators that are governed only by general confidentiality law. This creates operational challenges where agencies might have authority to share some syndromic surveillance data streams but not others. Having a law that provides specific authority to use or disclose syndromic surveillance data can provide much greater clarity to data custodians about whether a given use or disclosure is legally permissible.

However, laws that are specific to data types can be a source of confusion if different public health data systems are protected differently within the same state. The confusion resulting from this legal complexity could result in the perception of legal barriers to data sharing or use (e.g., suppose a data custodian wrongly believes that a legal restriction for immunization data also applies to vital records).

2. IDENTIFIED BARRIERS TO SHARING PUBLIC HEALTH DATA

We identified several categories of potential barriers to data sharing and use:

A) AMBIGUOUS LEGAL AUTHORITY:

Ambiguous legal language complicates decisions on data use or sharing. Medicaid and public health agencies in states without specific legal authority for using or sharing Medicaid or public health data will likely be uncertain about the boundaries of permissible data use or sharing. Uncertainty often results in conservative and risk-adverse legal interpretations or restrictive organizational policies that can delay or prevent data exchange or use even when legal pathways exists.

B) NARROW PURPOSE LIMITATIONS

Several states restrict disclosure to highly specific, enumerated purposes. For example, a law could restrict disclosures of public health data to specific purposes or activities—such as communicable disease control or epidemiologic surveillance—that could exclude Medicaid objective functions. In comparison, state laws that more broadly authorize data uses for public health activities or programs could enable the use of the same data to meaningfully advance public health goals like maternal health monitoring or childhood vaccination efforts.

C) DE-IDENTIFICATION REQUIREMENTS

Laws that require data de-identification or aggregation can undermine the utility of public health data for Medicaid agencies. Indeed, since many laws that protect public health data apply only to identifiable data, provisions that authorize the disclosure of de-identified or aggregated data do not offer additional benefits beyond legal clarity. While these requirements offer some individual privacy benefits, they have the effect of prohibiting or severely limiting the public benefit of interagency health data sharing.

D) PROCEDURAL BURDENS

Some state laws authorize data use or sharing, but require following specified procedures. Some procedures could be routine or standard practice. For example, our analysis of public health data sharing

laws classified requirements for DUAs or technical safeguards as "low burden" because these are typical requirements for sharing or using government data. However, not all requirements for DUAs or technical safeguards are equal. Some might be highly specific or detailed in ways that makes compliance difficult or burdensome. Mandatory data use agreements, technical safeguard provisions, and multi-layered approval processes may slow the exchange of data even where legal authority is clear. While these safeguards can be reasonable and appropriate, inconsistent requirements across data types or within the same state create complexities.

A notable procedural barrier is the existence of 'cyclical' data sharing requirements for bidirectional exchange. Because this analysis captures the legal landscape according to the direction of data flow, the study may not fully reflect the procedural nuance where authority to receive data is contingent upon separate authority to share data first. For example, Vermont has a law permitting the sharing of vital records for individuals upon the request of their health insurer, meaning there are no additional requirements for sharing client data with Medicaid agencies under the law. However, the Medicaid agency must have legal authority to provide a list of relevant clients in order to request such information. This bidirectional dependency creates a complex procedural hurdle that can stifle interagency collaboration if pathways for both directions are not simultaneously clear.

3. POSSIBLE PATHWAYS FOR SHARING PUBLIC HEALTH DATA

A) SPECIFIC LEGAL PERMISSIONS:

A law that expressly authorizes disclosure of data to a state Medicaid agency provides the clearest pathway to share public health data with a state Medicaid agency. These express permissions are nearly universal for vital records (49 states authorize), common for immunization data (39 authorize), and rare for syndromic surveillance data (6 authorize). Where such authority exists, state Medicaid data requestors can demonstrate their legal basis by citing the specific provision and, where relevant, the agency's acknowledgement of and compliance with sharing requirements—to overcome institutional caution.

B) BROAD POPULATION HEALTH PURPOSE PERMISSIONS:

State laws that include a broadly worded authorization to use or disclose protected data for public health activities can enable sharing public health data with state Medicaid agencies. These laws typically authorize public health agencies to disclose identifiable data for general public health purposes or specified activities. Since state Medicaid agencies have a significant role in managing population health by providing access to health care services to low-income and vulnerable populations, many of the intended uses of public health data within the Medicaid program could fall within these public health purpose provisions. Public health purpose authorizations exist in state laws regulating specific public health data as well as those laws that regulate public health data broadly.

These public health purpose authorizations offer meaningful and flexible mechanisms for disclosure, particularly in states lacking narrowly tailored data-type-specific authority. However, their applicability often requires interpretation or explanation justifying how the Medicaid agency's use of public health data furthers a public health objective. The absence of specific language authorizing a disclosure to a state Medicaid agency can make public health agencies risk-averse—especially when data contain sensitive elements.

C) RESEARCH PERMISSIONS:

Nearly all states authorize disclosure of public health data for research purposes, but these pathways are typically restrictive. Research disclosures often require formal approval by an institutional review board, stringent data-use limitations, and documentation of a bona fide research purpose. In many states, these pathways explicitly prohibit the use of data for administrative functions or program operations—which would constrain Medicaid agencies aiming to use data for eligibility assessment, care management, and quality improvement.

Despite these constraints, research pathways may serve as a practical means in states with especially restrictive or unclear rules. In states where vital records or immunization laws prohibit identifiable disclosure to non-public-health entities, a well-designed research protocol may allow Medicaid agencies to access aggregated or partially identifiable data that can still provide value. These pathways are far from ideal—they are often slow, resource-intensive, and may limit the timeliness or granularity of the resulting data. Additionally, data disclosed under a research exception likely could not be use for non-research activities. However, these narrow pathways can provide access in settings where no other sharing opportunity is clearly available. For syndromic surveillance data, where explicit authority is rare and protections are often designed around disease-specific confidentiality, research pathways may be one of few viable options for cross-agency insight into emerging trends.

D) DE-IDENTIFIED OR AGGREGATED DATA

In states with restrictive laws, sharing public health data with state Medicaid agencies might still be possible if the data are de-identified or aggregated even in the absence of explicit statutory authority. Many state laws protect only identifiable information, so de-identification effectively removes data from the scope of legal protections.

However, de-identification comes with costs. De-identification severely limits the utility of shared data because it often means that useful data elements are suppressed or removed, and it is not an ideal requirement for data sharing. Nonetheless, sharing de-identified data or aggregated data can still provide greater insights and actionable information than if no data is available. De-identification preserves trend analysis, limited hotspot identification and program design insights. It can be an interim measure while longer-term solutions are pursued.

VI. LIMITATIONS

Even when legal mapping follows established best practices, certain limitations are inherent to this type of work. These constraints provide essential context for interpreting the findings and for understanding how statutory environments interact with real-world practice.

A. METHODOLOGICAL LIMITATIONS

This project relies on publicly available statutes and regulations, which means some data-sharing mechanisms fall outside the scope of analysis. States frequently use unpublished policies, standing agreements, or administrative practices—such as memoranda of understanding or agency-specific confidentiality rules—that are not codified in law. Because these instruments are often not systematically

accessible, they could not be included, even though they may meaningfully shape actual data-flow patterns.

State codes differ widely in structure, terminology, and internal cross-referencing. Despite a comprehensive search strategy and multiple layers of quality assurance, some relevant provisions may not be captured due to unconventional placement, outdated indexing, or ambiguous phrasing. Additionally, some states embed public health disclosure authority in broader administrative, privacy, or communicable-disease statutes that are not always clearly labeled as pertaining to data-sharing.

Temporally, this project captures the legal environment as of May 28, 2025. State laws governing data collection, privacy, and sharing are dynamic, with numerous jurisdictions considering reforms to public health authority, privacy protections, and cross-agency data sharing in the wake of the COVID-19 pandemic. Subsequent amendments, repeals, or enacted privacy frameworks may meaningfully alter the pathways for disclosure identified in this report.

In addition, the methodological process—while supported by redundancy, adjudication procedures, and quality assurance checks—is inherently limited by the precision of the abstraction instrument and the complexity of state statutory schemes. Some statutes serve multiple functions, combine confidentiality and operational requirements, or use terminology that differs from state to state. While coders were trained for consistency, complex or multi-layered provisions may not map neatly onto standardized categories.

B. MULTIPLE LEGAL MECHANISMS FOR DATA DISCLOSURE

Many jurisdictions provide more than one legal pathway that could independently authorize data sharing between state Medicaid and public health agencies. A single state may, for example, simultaneously permit (i) release of de-identified data without additional conditions, (ii) identifiable disclosure with data-subject consent, and (iii) identifiable disclosure to governmental entities for defined public health purposes subject to a data use agreement (DUA). Our instrument was designed to determine whether a lawful pathway exists and to capture salient features that affect utility, rather than to code each alternative mechanism as a separate, mutually exclusive route.

To preserve clarity and comparability across jurisdictions, we consistently coded the least restrictive pathway that was strongly supported in law as the primary pathway. For instance, if a state broadly permitted de identified data sharing but also contained an explicit provision authorizing identifiable disclosure to governmental entities pursuant to a DUA, we coded the DUA based identifiable pathway—because, from a utility standpoint, it enables fuller data use with fewer inherent constraints.

This approach means the dataset does not always disaggregate every co existing legal route within a jurisdiction. A focused secondary analysis could unpack these independent mechanisms—showing, for example, how consent based, de identified, public health purpose, and research pathways overlap or diverge in scope, timeliness, security requirements, and resulting data utility. Accordingly, the findings should be read as identifying the presence of a legally viable and policy salient route for disclosure in each jurisdiction, while acknowledging that multiple parallel mechanisms may exist and can be pursued strategically depending on the use case.

VII. APPENDICES

A. APPENDIX A: COMPREHENSIVE LIST OF STATE LAWS REVIEWED

B. APPENDIX B: CODING INSTRUMENT (FULL CODEBOOK)

C. APPENDIX C: SEARCH STRINGS, PROTOCOLS, AND DATA SOURCES

D. APPENDIX D: RAW VALIDATED DATA

VIII. REFERENCES

1. 42 C.F.R. § 431.301
2. Bright RA, Avorn J, Everitt DE. Medicaid data as a resource for epidemiologic studies: Strengths and limitations. *J Clin Epidemiol*. 1989;42:937–45. doi: 10.1016/0895-4356(89)90158-3
3. Daw JR, Auty SG, Admon LK, *et al*. Using Modernized Medicaid Data to Advance Evidence-Based Improvements in Maternal Health. *Am J Public Health*. 2023;113:805–10. doi: 10.2105/AJPH.2023.307287
4. 45 C.F.R. § 164.512
5. Hulkower R, Penn M, Schmit C. Privacy and Confidentiality of Public Health Information. In: Magnuson JA, Dixon BE, eds. *Public Health Informatics and Information Systems, 3rd Edition*. London: Springer London 2020:147–66
6. 45 C.F.R. Parts 160 and 164
7. 42 C.F.R. § 431.301
8. 42 C.F.R. § 431.302; Schmit C, Kelly K, Bernstein J. Cross Sector Data Sharing: Necessity, Challenge, and Hope. *J. of L., Med. & Ethics*. 2019;47:83–6. doi: 10.1177/1073110519857325
9. Predmore Z et al. State Experiences Linking Medicaid Data With Birth Certificates and Other Data Sources. *Med. Care*. 2023;61(6):353-359. doi: 10.1097/MLR.0000000000001853
10. Office of Inspector General. *Medicaid Fraud Control Units Annual Report: Fiscal Year 2024* (Report no. OEI-09-25-00090). U.S. Department of Health and Human Services.
11. 7 AAC 05.935
12. 42 C.F.R. § 431.302