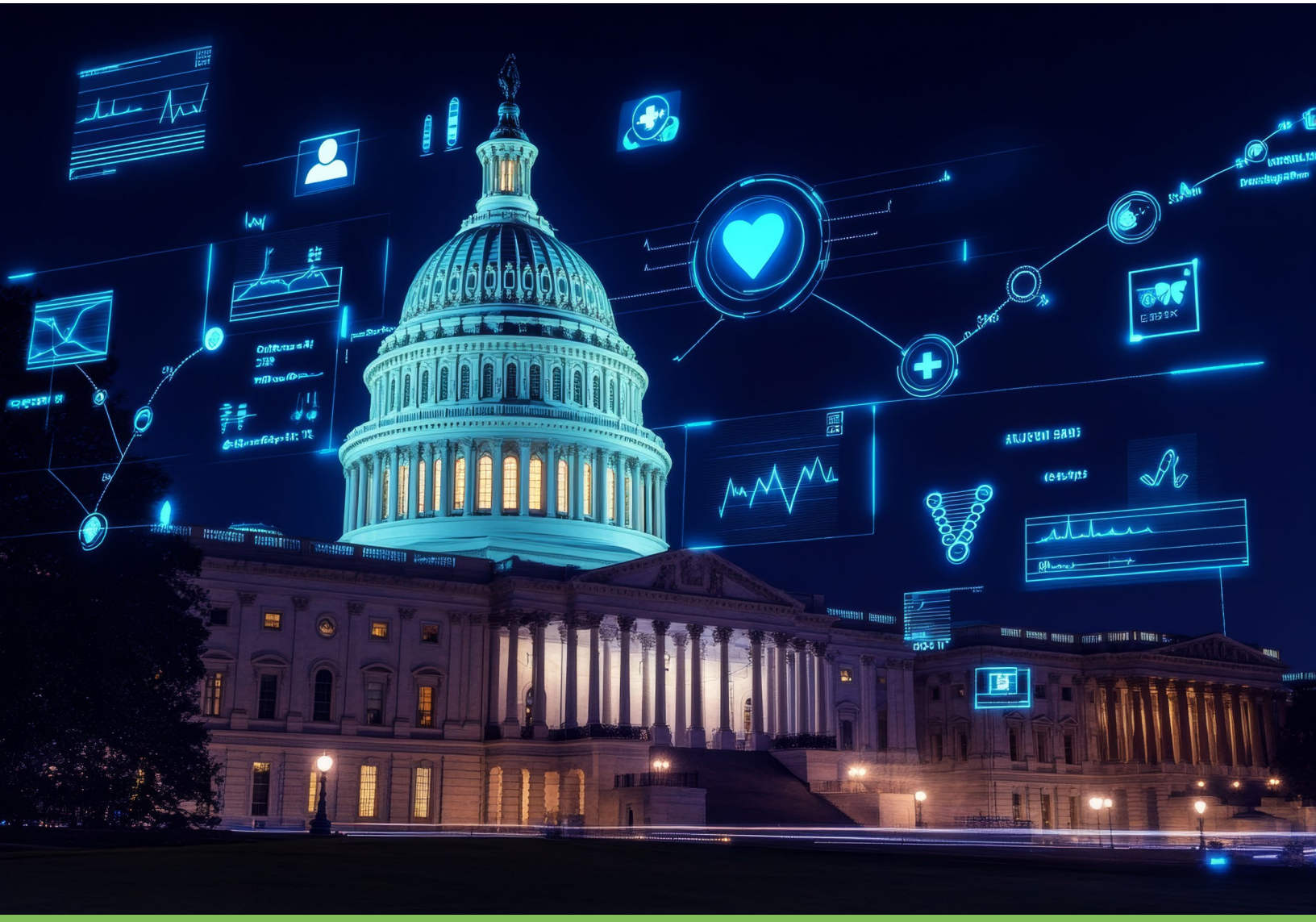
WHITE PAPER

How Medicaid Payers can Prepare for New Work Requirements Coming in Early 2027



PRESENTED BY:

GROUNDGAME. HEALTH®

HMA

PUBLISHED BY:

FIERCE Healthcare

OCTOBER 2025

PRESENTED BY: GROUNDGAME. HEALTH® HMA

PUBLISHED BY: FIERCE Healthcare

How Medicaid Payers can Prepare for New Work Requirements Coming in Early 2027

CONTENTS:

Overview 3

Introduction 4

Reaching the Medicaid community – an uphill challenge 6

Lessons learned from COVID-19 redetermination, state efforts 8

Payers: Follow five-phased solution beginning with communicating early and often 11

Healthcare and tech collaboration: seven best practices 12

Payers need to act now 14

About 16

References 17

Overview

The Reconciliation Act of 2025, signed on July 4th, introduces new Medicaid work requirements. States must verify at application and renewal that Affordable Care Act (ACA) expansion group members meet these requirements. Adults under 65 who do not qualify for exemptions must show they complete at least 80 hours per month in work, education, or volunteer activities.[1]

Going into effect in January 2027, the law poses significant challenges for states, the Medicaid payer community and for the members who may find themselves without insurance if they aren't compliant with the new work requirements.

That's concerning given that Medicaid covers one in five Americans,[2] accounting for one in $6 spent on healthcare in the United States. The Congressional Budget Office (CBO) projects that as a result of the new requirements, the number of uninsured people will increase to 10 million by 2034.[3] Michigan alone expects 150,000 people to lose coverage, predict experts, while Arkansas disenrolled 18,000 without increasing employment the last time they implemented work requirements.[4]

This white paper will assess the historical challenges of reaching lower income adults across 41 states and the District of Columbia who receive expanded Medicaid ACA coverage, which includes nearly all adults with incomes up to 138% of the federal poverty level.[5]

The paper also will share lessons learned from both the redetermination process after COVID-19 and recent efforts by state Medicaid programs to simplify and streamline their beneficiaries' work and community service reporting. Experts share best practices and what states and payer organizations need to do to prepare for this new federal law as it goes into effect in early 2027.

Adults **under 65** who do not qualify for exemptions must show they complete at least **80 hours per month** in work, education, or volunteer activities.[1]

Introduction

Medicaid payers have long struggled to build lasting relationships with their members. Abner Mason, Chief Strategy and Transformation Officer at GroundGame.Health, knows this challenge well: the healthcare technology leader has devoted his career to creating a more just and equitable healthcare system.

“Payers really struggle with building relationships with their members, and this is true across all lines of business, but particularly in the Medicaid space,” says Mason, who previously served as founder and CEO of SameSky Health, a company focused on increasing member engagement across multicultural populations.

Payers, he notes, too often take “a one-size-fits-all approach” with their members. “What we found is if you treat everyone the same, it sends a signal that the person really isn’t that important— that they’re just a number. When you treat people like who they are doesn’t matter, they don’t engage.”

As the clock ticks down for new work reporting requirements under the Reconciliation Act to go into effect, the payer community is racing to bridge those historic communication divides that could hinder people from taking the necessary steps to protect their Medicaid benefits.

An alarming percentage of the United States’ 16.6 million Medicaid-covered adults (age 19 to 64) who worked either full time or part time could face lost health coverage for not complying with reporting requirements under the Reconciliation Act. The responsibility of helping Medicaid members understand and comply with work requirements will be shared among payers, community navigators, and state Medicaid programs. KFF, an independent health policy newsroom, finds that implementing the work requirements on a national scale requires states to verify individuals’ work status (at least every 6 months)

and implement exemptions.[6] The exemptions generally include individuals who are physically or mentally unfit for work, care for a dependent child or incapacitated person, work at least 30 hours per week, are pregnant, are students half-time or more, or participate in a drug or alcohol treatment program.

In Arkansas, requirements were in effect from June 2018 through March 2019. During that period, 18,000 people lost coverage, "primarily due to failure to regularly report work status or document eligibility for an exemption," reports KFF.[7] Evidence points to both a lack of awareness and confusion about requirements. Also, despite significant outreach efforts, many enrollees were not successfully contacted.

Georgia's work requirements program, Pathways to Coverage, in effect since 2023, saw only a small percentage of eligible residents enrolled (9,175 as of August 31, 2025)[8], despite an estimated 300,000 Georgians eligible for Medicaid expansion under the ACA. Residents already face some of the worst health outcomes, with the state ranking #45 in Commonwealth Fund's 2025 Scorecard on State Health System Performance.[9]

Reasons for the low enrollment in the first year include a complicated enrollment process and restrictive eligibility criteria. Applicants had to complete a lengthy online or paper application and compile documents to verify qualifying activities and hours. Only about half of individuals who showed initial interest in applying to the program submitted a complete application, found the Georgia Budget & Policy Institute.[10] Preliminary data also indicate that at least one in every five denials for those who submitted a complete application was because they failed to meet the qualifying hours and activities requirement.

Pathways costs Georgia five times more on a per-capita basis than a full Medicaid expansion. Why? Implementing Pathways precluded Georgia from fully expanding federal Medicaid programs, which resulted in the state losing $1.1 billion in federal funding, according to a report by the Georgetown University Center for Children and Families.[11] This decision, along with lower Medicaid matching in Georgia, means the state "will pay more to cover fewer people," the report found.

Reasons for the **low enrollment in the first year** include a complicated enrollment process and **restrictive eligibility criteria.** Applicants had to complete a lengthy online or paper application and compile documents to verify qualifying activities and hours.

Further analysis finds that most Medicaid adults under age 65 are working already without a requirement or face barriers to work. This segment of the population frequently works low-wage jobs or is employed by small firms and in industries with low employer-sponsored insurance offer rates.

Reaching the Medicaid community – an uphill challenge

There are several obstacles to reaching the Medicaid community, among them communications hurdles as a result of the Telephone Consumer Protection Act, enacted in 1991, which restricted managed care plans from texting members.[12] That outmoded policy doesn't align with how people live and communicate today.

"It was crazy even 10 years ago when our plan partners said to us…this is the way our members want to communicate, but we can't because of this law," recalls Mason.

A Pew Research Center study finds while most U.S. adults (95%) use the internet and 90% have a smartphone, households earning $100,000 are more likely to use smartphones than those earning less than $30,000 (98% vs. 79%).[13] A similar pattern emerges by level of formal education.

Key findings from GroundGame.Health's own learnings, however, point to the effectiveness of texting, which substantially increases the likelihood of members being helped across all lines of business, gender, age groups. In particular, GroundGame.Health found increased response rates from texting across all age groups (25% for 18-39 year olds, 27% among 40-64 year olds and 29% for 65+ year-olds). The results underscored that members are significantly more likely to act on a call to action across all adult age groups when contacted through text.

But texting in and of itself is not effective, warns Syam Adusumilli, Chief Evangelist and Head of Strategic Partnerships at GroundGame.Health. “It has to be bi-directional,” he says, meaning that the Medicaid member must engage, too.

Fortunately, the reconciliation law will allow providers to text members about work requirements. The government’s decision came after significant outreach by industry partners, including GroundGame.Health, which now encourages payers to work with state Medicaid agencies to see what is permissible.

Besides communication barriers, the Medicaid population also experiences intersectional challenges—such as disability, race, gender and geography—that make compliance with work requirements difficult.

Summarizing these challenges, Adusumilli says, “There is a compliance cost, there is a psychological cost and there’re is an understanding cost” to the Medicaid community.

Medicaid members also can feel disconnected from the process because of unclear documentation requirements or poor communication. For example, eligible applicants for Medicaid in both Arkansas and Georgia lacked clarity on what documentation or action is needed, leading to confusion and low enrollment, finds KFF.[16] Recognizing these pitfalls, states are embracing different approaches, with some moving ahead of federal deadlines and others facing political and operational challenges. Past efforts in states such as Arkansas and Georgia illuminate the need for better implementation.

Who Is Exempted from Work Requirement Reporting?

Medicaid’s new work requirements do not apply to over 3 in 10 Medicaid-covered adults, or 9.5 million people.[14] Those exempted include parents and caretakers with children ages 13 and under, individuals who are “medically frail,” and individuals who are pregnant or postpartum, among others, while the “medically frail” designation includes individuals who are blind or disabled, have physical, intellectual, or developmental disabilities, who suffer from a substance use disorder or a “disabling” mental disorder, or who have “serious or complex” medical conditions.[15]

States also may allow short-term hardship exceptions from work requirements for enrollees or applicants experiencing certain extenuating circumstances.

KFF further reports that state implementation choices can result in more stringent requirements than the minimum federal requirements highlighted in the law. For example, requiring more frequent verification or imposing longer "look-back" periods when verifying coverage. In addition, states have struggled to use existing data to automate verification processes, which could affect the number of individuals at risk of losing coverage.

Lessons learned from COVID-19 redetermination, state efforts

The aftermath of U.S. handling of Medicaid coverage and redetermination following COVID-19 and how a set of states sought to roll out new workforce requirements within their Medicaid community both offer lessons to payers facing the challenge of engaging their members as the new regulation goes live.

The first lesson occurred during and after the COVID-19 epidemic, when the federal government relaxed this eligibility review members normally go through to determine if they are still eligible for Medicaid benefits. Enrollment in Medicaid and CHIP grew by an estimated 23.3 million people from February 2020 to the end of March 2023 when the U.S. government allowed continuous enrollment into both programs because of the pandemic[17].

"Given the state of emergency, people were told they were just covered," recalls Mason, who was leading a company at the time tasked with helping health plan partners manage the process.

When the crisis ended, redetermination went back into effect, putting a major burden on state Medicaid infrastructure to process all their Medicaid members, Mason says. "It was a huge lift."

The U.S. Government Accountability Office found that many states didn't do redeterminations properly when they resumed in April 2023. In fact, over 400,000 people lost coverage because states assessed household, not individual eligibility.[18] States cited challenges such as workload and insufficient staffing and training to handle the volume of redeterminations, as well as a lack of enrollee response to renewal messages.

The U.S. Government Accountability Office found that **many states didn't do redeterminations** properly when they resumed in April 2023. In fact, **over 400,000 people** lost coverage because states assessed household, not individual eligibility.[18]

Now, states will need to implement a similar verification effort but more frequently under the new requirements, where Medicaid recipients must document that they are working, volunteering, caregiving or going to school, Mason said.

"The administrative burden is going to be enormous," he predicts. "We're facing a big challenge for states, for payers and for the healthcare and technology communities who need to come together and build solutions that they haven't done in the past."

A handful of states, including Arkansas, Georgia, New Hampshire and Michigan, attempted to implement more effective Medicaid work requirements programs. Georgia's program, the only Medicaid work verification program still operating, has been in place since 2023. In the two years since launching its program, Georgia has spent more than $91 million in state and federal funds, with more than $50 million of that amount covering building and operating the eligibility reporting system.[19]

In the first seven months of Arkansas implementing its Medicaid work-reporting environment, 18,000, or 1 in 4 Arkansas residents subject to the requirement, lost coverage, with only a small number regaining coverage the next year.[20] The low participation was blamed on the complexity of the portal, which would shut down overnight, and confusion over the new rules.

"The Arkansas experience should be the poster child for how stewardship reporting requirements can cause mass coverage loss without achieving the stated goal of greater workforce participation," says Farah Hanley, Managing Principal of the Michigan office of

Health Management Associates (HMA), a leading independent healthcare research and consulting firm.

Prior to joining HMA, Hanley spent a decade at Michigan's Department of Health and Human Services, where she most recently served as chief deputy for Health, where she oversaw Medicaid and the state's psychiatric hospitals and centers. "Key challenges were a lack of member awareness, low participation and disenrollment."

Michigan's Medicaid work determination program took effect in January 2020 but was halted by a federal court ruling in March 2020.[21] Several HMA officials who previously worked for the state of Michigan remember the time well, noting that they studied the Arkansas model and held focus groups to determine how to better message the process, recalls Jackie Prokop, Associate Principal with HMA, who at the time served as Policy Director for Michigan's Medicaid program, where she oversaw covered services and eligibility.

"With Medicaid eligibility there's a number of things that people need to provide in order to have their eligibility determined. That in itself is a process, but when you add the community engagement or work requirements on top of that that's something that's quite foreign to a lot of people," she says, adding that the burden is on the state to help educate people.

That education burden extends not only to beneficiaries but also to the providers, the policy leader explains. "This is something that's so new. We found that messaging and using certain words would resonate better with different populations."

Hanley agrees, noting, "When we look at work requirements, it's not what health plans need to do; it's also what states need to do, it's also what states need to do, what members need to do, what providers need to do and what community-based organizations need to do."

"With Medicaid eligibility there's a number of things that people need to provide in order to have their eligibility determined. That in itself is a process, but when you add the community engagement or work requirements on top of that that's something that's quite foreign to a lot of people.

JACKIE PROKOP
Associate Principal
HMA

What's at stake nationally is a large number of people becoming uninsured, which in 2027 could be 2.2 million, peaking in 2034 at 5.3 million people, according to CBO estimates.[22]

"It's about 30 percent of people eligible for this would be disenrolled, going by the CBO figures," explains David Fosdick, Associate Principal at HMA, who previously spent 10 years at the state of Michigan budget office, including as Director of the Office of Health and Human Services.

Looking at these states' experience, Prokop says messaging plays a key role. "How well do people understand what's expected of them?"

"Also, how frequently will you have to demonstrate your compliance with this and what process will states establish to support that?" asks Fosdick.

According to Adusumilli, "the big disconnect is there is no clarity on documentation. There is not understanding of what to do, and little communication with members."

Payers: Follow five-phased solution beginning with communicating early and often

GroundGame.Health and HMA advocate for a five-phase approach to preparing for work requirements:

1. Identify high-risk members and develop intervention strategies to manage this group.
2. Provide clear communication about requirements and begin communicating early (danger of payer paralysis, where payers delay action waiting for clarity or direction).
3. Automate form submissions, especially for exemptions.
4. Enable data sharing (e.g., from Electronic Health Records) with consent to reduce paperwork.

5. Help those people doing part-time or seasonal work meet requirements, possibly through micro-volunteering.

Adusumilli notes that those who work part time may not have enough hours accrued, so these individuals may need access to community-based organizations that can help them shore up the required hours for compliance.

Throughout the process, maintaining regular contact with Medicaid members is critical to foster trust and ensure compliance.

Healthcare and tech collaboration: seven best practices

According to Mason, meeting the diverse needs of the Medicaid population under this new regulation requires healthcare and technology communities to collaborate in the new ways, which he summarized in the following seven best practices:

1. **Design compassionate, comprehensive and compliant solutions**
   Solutions must be compassionate (addressing the real-life challenges and diversity of the Medicaid population), comprehensive (able to handle various scenarios such as work, school, caregiving and volunteering), and compliant (meeting federal and state requirements).
2. **Personalize communication and engagement**
   Companies must tailor engagement to individual preferences, including language, and communications preference (e.g., text, phone, in-person, etc.). They must design technology for the "cheapest phone," not just the latest devices, to ensure accessibility.
3. **Integrate human and technological elements**
   While technology is essential for scale and efficiency, human touchpoints (such as care coordinators and community-based organizations) are critical for building trust and reaching those with limited tech access or higher needs.

Throughout the process, **maintaining** regular **contact with Medicaid members** is critical to foster trust and **ensure compliance.**

4. **Collaborate across sectors and states**
   Healthcare and technology organizations should work together to develop best practices, share data and avoid duplicating efforts across 50 states. Regional models or templates can help states adopt proven approaches while allowing for local adaptation.

5. **Prioritize early and culturally appropriate communication**
   Payers should start communication campaigns early, using linguistically and culturally diverse messaging, and providing clear guidance on requirements and exemptions. The campaigns should educate both enrollees and providers.

6. **Leverage community resources and peer support**
   Providers must partner with local organizations and employ care coordinators or peer supporters who understand the Medicaid community's unique needs.

7. **Foster innovation and industry engagement**
   Companies should use industry conferences, contests and collaborative forums to surface new ideas and technologies, and to encourage broad participation in solution development.

On the technology front, there are tools such as Artificial Intelligence (AI) that weren't available even 10 years ago, says Mason.

"The challenge is how do we deploy them in a way that is effective, but meets the needs of this population? This is an unusual population – they're hard to design for because of the complexity of their lives," he says.

GroundGame.Health is at the forefront of bringing together leaders in healthcare and IT to shape impactful strategies, drawing on its proven expertise in breaking down barriers to care through personalized, culturally sensitive, human-centered connections that improve outcomes for Medicaid members. According to HMA, health plans and states also must work closely together to forecast enrollment and risk, including eligibility losses, since Medicaid work requirements on health plans will change the risk pools. They also must navigate policy changes to ensure compliance and ensure health plans are adequately funded to support these efforts.

At the state level, the former Michigan Medicaid leaders underscore the importance of IT keeping up with changes with eligibility systems and ensuring that the state's Information Systems are aligned with policy.

"That critical component cannot be underscored enough when it comes to barriers with people getting people enrolled," says Hanley. "Remember states are operating now in budget shortfalls because of H.R. 1 (also known as the budget reconciliation bill) that will reduce federal healthcare spending by approximately $1.15 trillion over the next decade. This is massive, so it's going to put significant administrative and financial pressure on the states. The risks and stakes are huge. Just getting IT to align with policy intent is one of the biggest hurdles."

Payers need to act now

In conclusion, experts agree that it's important for payers to communicate early and often with their Medicaid members to avoid confusion and ensure compliance, so members won't experience unnecessary coverage loss.

"With this audience, you have to be active; you can't text them once every six or nine months," explains Adusumilli. "If you're talking to them regularly, then they start believing you."

HMA leaders says trust is built through consistency and transparency. The communication imperative includes not only outreach, to beneficiaries but also for payers to start communicating their needs to state agencies and policy developers.

At the state level, the former Michigan Medicaid leaders **underscore the importance of IT** keeping up with changes with eligibility systems and **ensuring that the state's Information Systems** are aligned with policy.

“Communication is so central to this on multiple levels — communicating to plans, communicating to members, and getting the details out there. That’s where health plans can work with their providers and their safety net providers,” says Prokop, noting that when Michigan launched its work requirements program, the state had regular contact with health departments and health plans to get the word out.

According to Adusumilli, the biggest issue with payers is they wait too long to engage with their members.

“It’s not that they don’t have intent, they are waiting for more guidance,” says Adusumilli, urging payers, whether they serve single state plans or a national group, to engage early.

About GroundGame.Health

GroundGame.Health manages the complex connections between health plans, providers, employers, community-based organizations (CBOs), and other stakeholders to remove the barriers that prevent people from getting the care they need. By facilitating personalized, culturally tailored, human-to-human connections and experiences, we make the biggest difference in people's lives. GroundGame.Health has engaged more than 2.3 million people, solved more than 374,000 social needs, and flowed $43+ million back to communities. For more information, visit groundgame.health.

About HMA

Health Management Associates (HMA) is a leading independent national research and consulting firm in the healthcare industry. Founded in 1985, HMA has grown exponentially over the past four decades. Today, we have one of the most skilled teams, offering deep expertise in multiple disciplines and knowledge of both national and regional issues. As our diverse set of clients face an ever-widening array of policy and business challenges, we help them thrive by providing technical assistance, resources, decision support and expertise.

REFERENCES

1. Hinton, Elizabeth, Amaya, Diana, Rudowitz, Robin (2025, July 30). A closer look at the work requirement provisions in the 2025 federal budget reconciliation law. KFF, https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

2. Gifford, Kathleen, Ellis, Eileen, Coulter Edwards, Barbara, Lashbrook, Aimee, Hinton, Elizabeth, Antonisse, Larissa, Rudowitz, Robin (2018, Oct. 25). States focus on quality and outcomes amid waiver changes: results from a 50-state Medicaid budget survey for state fiscal years 2018 and 2019. KFF, States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019 | KFF

3. Burns, Alice, Ortaliza, Jared, Lo, Justin, Rae, Matthew, Cox, Cynthia. (2025, Aug. 20). How will the 2025 Reconciliation law affect the uninsured rate in each state? KFF, https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/

4. Karpman, Michael, Gangopadhyaya, Anuj (2025, April 23), New evidence confirms Arkansas's Medicaid work requirement did not boost employment. Urban Institute, https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment

5. KFF (2025, September 12). Status of state Medicaid expansion decisions. https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/#:~:text=Published:%20Sep%2012%2C%202025,NH*%20MA%20MA%20NJ%20NJ

6. Hinton, Elizabeth, Amaya, Diana, Rudowitz, Robin (2025, July 30). A closer look at the work requirement provisions in the 2025 federal budget reconciliation law. KFF, https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

7. Hinton, Elizabeth. Rudowitz, Robin (2025, February 18). 5 key facts about Medicaid work requirements. KFF, https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/

8. Georgia Pathways (2025). Current enrollment. https://www.georgiapathways.org/data-tracker

9. Commonwealth Fund (2025). 2025 Scorecard on State Health System Performance (Georgia). https://www.commonwealthfund.org/datacenter/georgia

10. Georgia Budget & Policy Institute (2024, October 29). Georgia's Pathways to Coverage program: the first year in review. https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/#:~:text=Enrollment%20in%20the%20Pathways%20to,qualifying%20hours%20and%20activities%20requirement

11. Georgetown University McCourt School of Public Policy Center for Children and Families (2023, June 30). Georgetown CCF analysis finds Georgia's Pathways to Coverage program would cost more to cover fewer people. https://ccf.georgetown.edu/2023/06/30/georgetown-ccf-analysis-finds-georgias-pathways-to-coverage-program-would-cost-more-to-cover-fewer-people/

12. Twilio.com (2025). What is the Telephone Consumer Protection Act (TCPA)? https://www.twilio.com/docs/glossary/what-is-telephone-consumer-protection-act-tcpa

13. Gelles-Watnick, Risa (2024, January 31). Americans' use of mobile technology and home broadband, Pew Research Center, https://www.pewresearch.org/internet/2024/01/31/americans-use-of-mobile-technology-and-home-broadband/

14. Tolbert, Jennifer, Cervantes, Sammy, Rudowitz, Robin, Burns, Alice (2025, May 30). Understanding the intersection of Medicaid and work: an update, KFF, https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/#:~:text=Courts%20struck%20down%20many%20of,tape%20related%20to%20reporting%20requirements

15. Hinton, Elizabeth, Amaya, Diana, Rudowitz, Robin (2025, July 30). A closer look at the work requirement provisions in the 2025 federal budget reconciliation law. KFF, https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

16. Corallo, Bradley, Amaya, Diana, Tolbert, Jennifer, Mudumala, Anna, Rudowitz, Robin (2024, Jan. 10). Unwinding of Medicaid

continuous enrollment: key themes from the field. KFF, https://www.kff.org/medicaid/unwinding-of-medicaid-continuous-enrollment-key-themes-from-the-field/#:~:text=number%20of%20states.-,Coverage%20Transitions,completing%20their%20renewal%20or%20reapplying

17. Tolbert, Jennifer, Ammula, Meghana (2023, June 9). 10 things to know about the unwinding of the Medicaid continuous enrollment provision. KFF, https://www.kff.org/medicaid/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/#one

18. U.S. Government Accountability Office (2024, July 18). Medicaid: federal oversight of state eligibility redeterminations should reflect lessons learned after COVID-19 (GAO-24-106883, Q&A Report to Congressional Committees). https://www.gao.gov/assets/gao-24-106883.pdf

19. Mador, Jess (2025, July 28). Do 'work requirements' in Medicaid work? Georgia's been trying it for two years. NPR, https://www.npr.org/sections/shots-health-news/2025/07/28/nx-s1-5466338/georgia-work-requirements-medicaid-pathways

20... Harker, Laura (2023, August 8). Pain but no gain: Arkansas' failed Medicaid work-reporting requirements should not be a model. Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

21. Wells, Kate (2025, August 8). He built Michigan's Medicaid work requirement system. Now he's warning other states. NPR, https://www.npr.org/sections/shots-health-news/2025/08/08/nx-s1-5493417/michigan-robert-gordon-medicaid-work-requirements

22. Center on Budget and Policy Priorities (2025, June 6), By the numbers: harmful Republican megabill will take health coverage away from millions of people and raise families' costs. https://www.cbpp.org/research/health/by-the-numbers-harmful-republican-megabill-will-take-health-coverage-away-from