Navigation Infrastructure ROI Analysis: Comparing Investment Models for Work Requirement Support

The MCO's chief financial officer reviews three proposals from her care coordination team. The first recommends hiring 40 professional navigators at $78,000 annually plus benefits, creating dedicated work requirement support for their 180,000 expansion adult members. The second proposes contracting with community-based microenterprises that would receive $45 per successfully retained member, shifting risk to organizations with deep community ties. The third suggests building a volunteer network through faith organizations and community colleges, requiring only $2.2 million annually for coordination, training, and technology.

Each proposal promises the same outcome: members who would otherwise lose coverage for documentation failures will maintain enrollment. Each claims positive ROI. But the math differs dramatically. Professional navigators cost $4.2 million annually and require 18 months to reach full productivity. Microenterprise contracts could cost anywhere from $1 million to $8 million depending on how many members need intensive support. Volunteer networks cost least upfront but create quality and liability concerns her legal team has flagged.

She needs to recommend one approach by Friday. Her actuaries project 12-15% of expansion members will face compliance challenges requiring navigation support. At current margins, each retained member generates roughly $840 annually in contribution to overhead. Losing 20,000 members to preventable documentation failures would cost $16.8 million in margin while creating downstream costs in risk adjustment degradation and care management disruption that her models cannot fully quantify.

The numbers suggest navigation investment pays for itself. The question is which investment model delivers results at acceptable cost and risk.

The Navigation Cost Spectrum

Work requirement navigation encompasses a range of activities: explaining requirements to members, identifying qualifying activities, gathering documentation, submitting verification, pursuing exemptions for those who qualify, and managing appeals when initial submissions fail. The intensity of support varies enormously across the expansion population. Some members need only a text message reminder and a link to the verification portal. Others need months of hands-on assistance navigating housing instability, mental health treatment, and employment simultaneously.

This variation in need creates the fundamental challenge of navigation infrastructure design. Building capacity for the hardest cases means over-investing in the easy ones. Building only for easy cases means failing the members most likely to lose coverage. The cost models differ based on how they handle this variation.

Professional Navigators

Professional navigation staff bring credentials, training, and organizational accountability. They typically hold degrees in social work, public health, or related fields. They operate within institutional frameworks that include supervision, documentation requirements, and quality

oversight. They can handle complex cases involving multiple barriers, clinical needs, and system coordination.

The cost structure reflects this capacity. Salary ranges from $55,000 to $85,000 depending on credentials and geography. Benefits add 25-35% to base compensation. Supervision requires approximately one supervisor per eight navigators, adding another layer of cost. Office space, technology, and administrative support contribute further overhead.

Caseload limitations constrain productivity. Professional navigators handling complex cases typically manage 80-120 active members. Those focused on less intensive outreach might reach 200-250. At $95,000 fully loaded cost per navigator serving 100 members, the per-member cost reaches $950 annually for intensive support or $380 for lighter-touch outreach.

Professional navigators excel at complex cases requiring clinical coordination, benefits expertise, and sustained engagement. They struggle with scale. An MCO with 180,000 expansion adults cannot afford professional navigators for everyone. The model works for the 5-10% requiring intensive support, not for population-wide coverage.

CISE Microenterprises

Community Inclusive Social Enterprises represent an alternative model emerging from disability services and peer support traditions. These microenterprises employ community members with lived experience navigating the systems their clients face. They operate with lower overhead than traditional nonprofits, often working from homes or shared community spaces. They bring cultural competence and trust that credentialed professionals may lack.

The CISE model emerged from recognition that the people best positioned to help someone navigate Medicaid bureaucracy are often those who have recently navigated it themselves. A formerly homeless person who maintained coverage through housing instability understands the documentation challenges in ways a social worker with stable housing cannot. A recovery coach who kept Medicaid while completing substance use treatment knows which exemptions apply and how to document them.

The cost structure differs fundamentally from professional models. CISE navigators typically earn $18-28 per hour without traditional benefits, though some models include health coverage stipends. Supervision is lighter, often peer-based rather than hierarchical. Administrative overhead is minimal. The per-member cost for completed navigation episodes runs $35-65 depending on complexity.

Outcome-based contracting shifts risk from payers to providers. An MCO might pay $45 per member who successfully completes verification with CISE assistance, nothing for members who fail despite assistance. This creates strong incentives for effectiveness but also incentives to cherry-pick easy cases and avoid members with complex needs.

The CISE model also creates economic opportunity in the communities it serves. Rather than extracting navigation work to professional classes, it keeps the economic benefit within low-income communities. A CISE navigator earning $24 per hour while helping neighbors maintain coverage is building their own economic stability while contributing to community health. This multiplier effect does not appear in narrow ROI calculations but matters for community development goals.

Quality variation is the primary concern. Some CISE enterprises deliver excellent results through deep community relationships and genuine expertise. Others lack the training and capacity to

handle anything beyond routine cases. Payers must invest in vetting, monitoring, and performance management that partially offsets the lower per-unit cost. Credentialing systems that validate CISE navigator competency without replicating professional licensure barriers are still emerging.

Volunteer Networks

Faith organizations, community colleges, libraries, and civic groups represent potential navigation capacity that requires coordination rather than direct employment. Volunteers bring community presence, trusted relationships, and willingness to help neighbors that paid staff cannot replicate. They also bring limitations: variable availability, inconsistent training, and liability exposure that organizations must manage.

The volunteer model draws on deep traditions of mutual aid and community support. Faith communities have long helped members navigate bureaucratic systems, from immigration paperwork to benefits applications. Libraries serve as de facto social service access points in many communities. Community colleges connect with populations seeking to improve their economic circumstances. These institutions already have relationships with the people who will need navigation support.

The cost structure focuses on coordination infrastructure rather than direct service delivery. A volunteer coordinator managing 50 active volunteers might cost $65,000 fully loaded. Training programs require curriculum development, materials, and instructor time. Technology platforms enabling volunteers to access verification systems require licensing and support. Liability insurance adds ongoing expense.

Volunteer recruitment and retention present ongoing challenges. Unlike paid staff who have contractual obligations, volunteers participate based on personal motivation that may wane. Turnover rates in volunteer programs often exceed 40% annually. Continuous recruitment and training must replace volunteers who depart. The coordination investment never ends.

Quality control is more difficult with volunteers than paid staff. Organizations cannot terminate volunteers as readily as employees. Performance feedback must be delivered carefully to avoid discouraging participation. Some volunteers will prove ineffective despite training but remain difficult to remove. These quality challenges create risk that members receive inadequate support from well-meaning but unprepared helpers.

At scale, volunteer networks can achieve per-member costs of $8-15 annually for light-touch support. A network of 200 trained volunteers each helping 20 members annually reaches 4,000 members at roughly $12 per member. But volunteer capacity is inherently limited. Complex cases exceed volunteer capability. Turnover requires continuous recruitment and training. Quality control depends on supervision infrastructure that increases costs.

Volunteer networks work best as the broad base of a layered system, handling routine outreach and simple verification support while escalating complex cases to professional staff. They extend reach without proportional cost increase and maintain community presence that builds trust. But they cannot replace professional capacity for the hardest cases.

Coverage Retention Economics

Navigation investment makes economic sense only if the value of retained coverage exceeds the cost of navigation support. This calculation differs by stakeholder, each of whom captures different value from maintained enrollment.

MCO Value Calculation

Managed care organizations receive per-member-per-month capitation that typically ranges from $350 to $550 for expansion adults. After medical costs, administrative expense, and taxes, margins run 2-4% of revenue. A member generating $450 PMPM produces roughly $54-108 annually in margin contribution.

But margin understates the value of retention. Members who lose and later regain coverage create administrative costs for re-enrollment processing. Risk adjustment suffers when coverage gaps interrupt the documentation that drives accurate risk scores. Care management investments lose value when the member being managed disappears mid-intervention.

A more complete accounting values retained membership at $600-900 annually for members without significant health conditions, higher for members with documented chronic conditions whose risk adjustment generates premium above the population average. For a member with diabetes, heart failure, and depression generating $800 PMPM in risk-adjusted capitation, the margin contribution might reach $200 annually, and the risk adjustment continuity value adds hundreds more.

The MCO break-even calculation divides navigation cost by per-member value. At $45 per successful retention and $700 annual value per retained member, the investment returns 15:1. Even at $400 per member for intensive professional navigation, the return exceeds 1.5:1 for members with meaningful risk scores.

State Value Calculation

States capture different value from coverage retention. Federal matching funds cover 90% of expansion adult costs, meaning states pay only 10% of coverage expense. When members lose coverage, states lose federal dollars that were flowing into their healthcare economies.

The calculus becomes more complex when considering what happens to members who lose coverage. Some find employer insurance, removing themselves from state responsibility entirely. Some qualify for marketplace coverage, shifting costs to federal premium subsidies. But research from Arkansas and Georgia suggests most become uninsured, eventually presenting for care that generates uncompensated costs flowing back to state budgets through safety net funding.

States also bear administrative costs of enrollment churn. Processing terminations, managing appeals, handling re-enrollments, and updating eligibility systems all consume state resources. The GAO estimated Arkansas spent $26 million implementing work requirements that disenrolled 18,000 people, a cost exceeding $1,400 per disenrollment before accounting for downstream healthcare costs.

State break-even analysis must account for federal match on administrative spending. Navigation infrastructure costs that qualify as Medicaid administrative expense receive 50% federal match, effectively halving state investment. If navigation prevents disenrollment that would generate $1,400 in administrative cost plus downstream uncompensated care, the break-even threshold for state investment is quite low.

Provider Value Calculation

Healthcare providers capture value from coverage retention through multiple channels. Hospitals avoid uncompensated care when patients maintain insurance. Primary care practices retain

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

patients in their panels rather than losing them to coverage gaps. ACOs preserve attribution that drives shared savings calculations.

The value varies by provider type and payment model. Fee-for-service providers lose the revenue stream a patient represents when coverage lapses. Value-based providers lose both current revenue and the care management investments they made expecting to capture savings over time. An ACO that spent $500 on diabetes management for a patient who then loses coverage and returns a year later with diabetic complications has lost both the investment and the savings it was generating.

Provider break-even calculations are harder to generalize because provider circumstances vary so widely. A safety-net hospital might value coverage retention at $2,000 or more per member annually given their high rates of uncompensated care. A specialty practice with few Medicaid patients might place minimal value on navigation investment.

Cost Modeling by Approach

Translating the conceptual cost spectrum into operational budgets requires assumptions about population need, service intensity, and infrastructure requirements. The following models assume an MCO with 180,000 expansion adult members, of whom 15% (27,000) will require some navigation support and 5% (9,000) will require intensive assistance.

Professional Navigator Model

Intensive support at 1:100 ratio for 9,000 members requires 90 navigators. At $78,000 salary plus 32% benefits and overhead, fully loaded cost per navigator reaches $103,000. Ninety navigators cost $9.27 million annually.

Light-touch outreach for the remaining 18,000 members at 1:300 ratio requires 60 additional staff at lower compensation (outreach specialists rather than licensed social workers). At $52,000 salary plus benefits, these positions cost $68,000 fully loaded, totaling $4.08 million for 60 staff.

Supervision requires 19 supervisors at $95,000 salary ($125,000 loaded), adding $2.38 million.

Administrative infrastructure including space, technology, and support staff adds approximately $1.5 million.

Total professional model cost: $17.23 million annually, or $639 per member requiring support, $96 per expansion adult overall.

CISE Microenterprise Model

Outcome-based contracts at $45 per successful retention for 27,000 members would cost $1.215 million if all members succeed. Realistic success rates of 75% mean paying for 20,250 successes while 6,750 members still lose coverage.

But outcome-based payment alone does not cover the full cost. MCOs must invest in vendor management, quality monitoring, and escalation pathways for cases exceeding CISE capacity. This infrastructure costs approximately $800,000 annually.

Complex cases requiring professional backup create additional cost. If 20% of the 9,000 intensive-need members (1,800 people) exceed CISE capability, providing professional navigation for these members at $400 each adds $720,000.

Total CISE model cost: $2.735 million annually, or $101 per member requiring support, $15 per expansion adult overall.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

The dramatically lower cost comes with risk. CISE quality varies. Success rates may fall below projections. Complex cases may be underserved. The model requires robust performance management that adds hidden costs.

Volunteer Network Model

Volunteer coordination for 200 active volunteers requires 4 full-time coordinators at $65,000 loaded cost ($260,000) plus a program manager at $95,000 ($95,000).

Training infrastructure including curriculum, materials, and ongoing education costs approximately $150,000 annually.

Technology platform for volunteer access to verification systems runs $180,000 annually including licensing and support.

Liability insurance and legal compliance adds $75,000.

The 200 volunteers each supporting 25 members annually reach 5,000 members with light-touch navigation. This leaves 22,000 members requiring support beyond volunteer capacity.

Filling this gap requires professional staff for intensive cases (45 navigators at $103,000 = $4.635 million) and CISE contracts for moderate cases (12,000 members at $45 = $540,000).

Total hybrid model with volunteer base: $5.935 million annually, or $220 per member requiring support, $33 per expansion adult overall.

The hybrid approach costs more than pure CISE but provides more consistent quality for complex cases while leveraging volunteer capacity for routine support.

Break-Even Analysis

Each model's viability depends on whether retained members generate value exceeding navigation cost. The break-even point identifies how many members must be retained for the investment to pay for itself.

MCO Break-Even

Using $700 average annual value per retained member (combining margin contribution and risk adjustment continuity), the professional model at $17.23 million breaks even at 24,614 retained members. With 27,000 members at risk, this requires 91% success rate.

The CISE model at $2.735 million breaks even at 3,907 retained members, requiring only 14% success rate among the 27,000 at-risk population.

The hybrid model at $5.935 million breaks even at 8,479 retained members, requiring 31% success rate.

These calculations suggest CISE and hybrid models are nearly certain to generate positive returns while professional models require high effectiveness to justify their cost. But the calculations assume equal member value. If professional navigators are more effective at retaining high-value members with complex conditions, their higher cost may be justified by higher per-member returns.

The time dimension also matters. Professional navigators require 12-18 months to recruit, train, and reach full productivity. CISE networks can scale more quickly by contracting with existing community organizations. Volunteer networks require significant lead time to recruit, vet, and train volunteers before they can contribute. MCOs facing the December 2026 deadline may find that implementation timeline constraints favor CISE models regardless of long-term cost comparisons.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

Risk tolerance shapes model choice. Professional models offer predictable costs but require upfront investment before results materialize. Outcome-based CISE contracts limit downside risk but create uncertainty about total spending. Volunteer models offer low costs but uncertain quality and capacity. Conservative MCOs may prefer the predictability of professional models despite higher costs. Risk-tolerant MCOs may embrace CISE contracts that pay only for results.

State Break-Even

States face different economics because federal match covers most coverage costs. A state paying 10% of $5,400 annual coverage cost ($540 per member) might question whether navigation investment to retain that member makes sense when the member's coverage costs the state money.

The counterargument focuses on what happens when members lose coverage. Uncompensated care costs ultimately flow to states through safety net funding. Administrative churn consumes state resources. And 50% federal match on administrative costs including navigation infrastructure effectively halves the state investment.

A state investing $5 million in navigation infrastructure (net $2.5 million after federal match) that retains 10,000 members who would otherwise lose coverage avoids perhaps $3 million in administrative churn costs and $5-10 million in eventual uncompensated care. The investment is budget-positive even before accounting for economic activity from federal matching funds flowing into the state.

Provider Break-Even

Provider break-even depends heavily on payer mix and payment model. A safety-net hospital with 40% Medicaid revenue values coverage retention highly. A suburban specialty practice with 5% Medicaid patients may not find navigation investment worthwhile.

For providers in value-based arrangements, the calculation includes care management investments that lose value when patients lose coverage. An ACO investing $400 per attributed member in care coordination loses that investment when members disenroll. If 10% of attributed members face coverage risk, the ACO is effectively writing off 10% of care management spending. Navigation investment that reduces this loss rate can generate substantial returns.

State Budget-Neutral Pathways

States concerned about navigation costs can structure investments to achieve budget neutrality through several mechanisms.

Federal Administrative Match

Medicaid administrative costs receive 50% federal matching funds. Navigation infrastructure that qualifies as administrative activity effectively costs states half the nominal investment. Careful categorization of navigation spending as eligibility support, outreach, or care coordination can maximize federal participation.

States can also claim enhanced federal match for health information technology investments. Navigation platforms with robust data infrastructure may qualify for 90% federal match during implementation and 75% ongoing, dramatically reducing state cost.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

MCO Contract Requirements

Rather than funding navigation directly, states can require MCOs to provide navigation support as a condition of their Medicaid managed care contracts. This shifts cost to MCO administrative budgets, which are funded through capitation rates that already include federal match.

States can structure performance incentives that reward MCOs for coverage retention, effectively paying for navigation through bonus payments only when navigation succeeds. This outcome-based approach limits state exposure while creating strong MCO incentives for effective navigation.

Hospital Community Benefit

Non-profit hospitals must demonstrate community benefit to maintain tax-exempt status. Navigation support for Medicaid beneficiaries clearly qualifies as community benefit. States can encourage hospitals to fund navigation infrastructure as part of their community benefit obligations, shifting costs to hospital budgets while generating coverage retention that benefits hospital finances through reduced uncompensated care.

Workforce Development Integration

Work requirement navigation overlaps substantially with workforce development services that receive dedicated federal funding through the Workforce Innovation and Opportunity Act. States can braid Medicaid administrative funding with WIOA resources to support navigation infrastructure that serves both coverage retention and employment goals. This multi-source funding approach reduces the burden on any single budget.

The Counterargument: Navigation as Coverage Subsidy

Critics of navigation investment argue that helping people maintain Medicaid coverage may work against the policy's underlying goals. If work requirements exist to encourage employment and transition to self-sufficiency, navigation that helps people stay on Medicaid without transitioning to employment represents a coverage subsidy rather than a pathway to independence.

This critique has particular force when navigation costs approach or exceed coverage costs. If an MCO spends $600 per member on navigation to retain a member whose coverage costs $5,400 annually, the system is spending $6,000 to provide $5,400 in coverage. The navigation investment might be better spent on employment services that actually move people toward self-sufficiency.

The counter-response distinguishes between members who lose coverage for compliance failures versus those who lose coverage for documentation failures. Evidence from Arkansas found that most coverage losses occurred among members who were working, exempt, or both. They failed to document compliance, not to achieve it. Navigation investment for this population does not subsidize non-compliance; it corrects administrative dysfunction.

For members genuinely struggling to meet work requirements, navigation investment might still make sense if the alternative is coverage loss followed by health deterioration followed by more expensive care needs. A member who loses coverage, stops taking diabetes medication, and returns months later with diabetic ketoacidosis generates costs far exceeding navigation investment. Even from a pure cost perspective, maintaining coverage may be cheaper than managing the consequences of coverage loss.

The honest assessment is that navigation ROI depends on what members do with maintained coverage. Navigation that supports compliance documentation generates clear positive returns. Navigation that enables continued non-compliance without consequence generates returns only if the alternative (coverage loss) creates costs exceeding navigation investment. For most populations, this condition is met. For some, it may not be.

Investment Allocation Framework

Given limited resources, how should stakeholders allocate navigation investment across the professional-CISE-volunteer spectrum? The answer depends on population characteristics, existing infrastructure, and risk tolerance.

Populations with high proportions of complex cases requiring clinical coordination benefit from professional navigator investment despite higher costs. The return on complex case navigation exceeds the return on routine support because complex cases generate higher per-member value through risk adjustment and have higher stakes when coverage is lost.

Populations with strong community organization infrastructure benefit from CISE investment that leverages existing relationships and trust. The lower per-unit cost of CISE navigation allows broader reach, and community credibility may generate better engagement than professional approaches for some populations.

Populations with active faith communities and civic organizations benefit from volunteer network investment that extends reach without proportional cost increase. The coordination investment is worthwhile where volunteer capacity exists and can be mobilized.

Most populations will benefit from layered approaches combining all three. Volunteers handle routine outreach and simple verification support. CISE microenterprises manage moderate complexity cases requiring cultural competence and sustained engagement. Professional navigators address the most complex situations requiring clinical coordination, benefits expertise, and intensive case management.

The allocation across layers should reflect population assessment. A population that is 60% routine, 30% moderate, and 10% complex might invest 20% of navigation resources in volunteer coordination, 40% in CISE contracts, and 40% in professional staff. A population with higher complexity concentration would shift investment toward professional capacity.

Conclusion

The MCO CFO makes her recommendation: a hybrid model with volunteer network base, CISE contracts for moderate cases, and professional navigators for complex situations. Total investment of $5.9 million annually, projected to retain 22,000 members who would otherwise lose coverage, generating $15.4 million in value for a return exceeding 2.5:1.

She includes sensitivity analysis showing the investment remains positive across plausible ranges of success rates, member values, and cost assumptions. Even pessimistic scenarios generate returns above break-even. The risk is not that navigation investment loses money; the risk is that alternative investments might generate higher returns.

Her recommendation acknowledges uncertainty about the optimal allocation across navigation modalities. She proposes building measurement infrastructure that will enable rebalancing as evidence accumulates about which approaches work best for which member segments. The first-year allocation is a starting point, not a final answer.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

She also notes what the numbers cannot capture. Navigation infrastructure builds relationships with community organizations that will prove valuable beyond work requirement compliance. The CISE enterprises her MCO contracts with today will become partners in addressing social determinants of health tomorrow. The volunteer network coordination creates community health worker pipelines. The professional navigators develop expertise applicable to redetermination support, care transitions, and benefits coordination.

The investment decision is not simply about work requirement navigation. It is about building infrastructure for member engagement that will serve multiple purposes over time. The work requirement deadline forces a decision that might otherwise be deferred. But the infrastructure created will outlast the immediate compliance challenge.

The broader insight extends beyond her MCO's decision. Navigation infrastructure represents a new category of healthcare investment that did not exist before work requirements created the need. The economics are favorable across stakeholder perspectives. MCOs, states, and providers all benefit from coverage retention in ways that exceed navigation costs for most populations.

The policy choice embedded in work requirements is whether to invest in navigation infrastructure that makes compliance achievable or to allow coverage losses that could have been prevented. The ROI analysis demonstrates that navigation investment typically pays for itself. The remaining question is whether stakeholders will make the investments that the economics support.

States that build robust navigation infrastructure will retain coverage for expansion adults who face documentation challenges but not genuine compliance failures. States that decline this investment will see coverage losses concentrated among populations least equipped to navigate administrative complexity. The fiscal impact may be similar in the long run as costs shift from coverage to uncompensated care. But the human impact differs dramatically, and the economics favor investment over neglect.

The CFO's spreadsheets tell a clear story: navigation pays. The question for every MCO, every state, and every provider organization is whether they will act on what the numbers show. December 2026 approaches. The infrastructure that exists by then will determine how many people keep coverage and how many lose it to preventable documentation failures. The time for investment decisions is now.

References

1. Kaiser Family Foundation. "Medicaid Work Requirements: Implementation Challenges." February 2019.
2. Sommers BD, et al. "Changes in Utilization and Health Among Low-Income Adults After Medicaid Work Requirements." JAMA Internal Medicine. 2019.
3. Government Accountability Office. "Medicaid: State Implementation of Work Requirements." GAO-19-573. September 2019.
4. Urban Institute. "Costs of Medicaid Work Requirements." March 2018.
5. MACPAC. "Medicaid Risk-Based Managed Care: Analysis of State Program Characteristics." March 2022.
6. Hinton E, Rudowitz R. "Medicaid Enrollment Churn and Implications." Kaiser Family Foundation. June 2019.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

7. Brooks T, et al. "Medicaid and CHIP Eligibility and Enrollment Policies." Kaiser Family Foundation. January 2023.
8. Cross-Call J, Solomon J. "Medicaid Work Requirements Cannot Be Fixed." Center on Budget and Policy Priorities. November 2018.
9. Gangopadhyaya A, Karpman M. "The Impact of Arkansas Medicaid Work Requirements." Health Services Research. April 2025.
10. Commonwealth Fund. "Work Requirements for Medicaid Enrollees." September 2025.
11. National Academy for State Health Policy. "State Approaches to Medicaid Work Requirements." August 2019.
12. Herd P, Moynihan D. Administrative Burden: Policymaking by Other Means. Russell Sage Foundation. 2018.
13. Rosenbaum S. "Medicaid Work Requirements: Lessons from the Supplemental Nutrition Assistance Program." Commonwealth Fund. April 2018.
14. Center on Budget and Policy Priorities. "Commentary: Taking Medicaid Work Requirements at Face Value." June 2018.
15. Mathematica. "Evaluation of Medicaid Demonstration Programs." CMS Contract Reports. 2020.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*