



## Recommendations for State Reporting of Work Requirement Outcomes: Do's and Don'ts

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Millions of people eligible for or enrolled in the adult Medicaid expansion program are at risk of losing access to health coverage when new federal work requirements go into effect January 1, 2027. We may never know exactly how many individuals lose coverage due to this policy unless states take action to prioritize data generation as they change their systems to meet OBBBA requirements. This brief offers concrete recommendations derived from NHeLP's previous work recommending [key data metrics for California](#). We focus on how states should prioritize the most important data to clearly document key work requirement outcomes. Targeted data collection will support interventions or eligibility system changes that might lessen the worst harms. Included with these recommendations is an appendix of key metrics that we recommend prioritizing while advocates track implementation in their state.

### Background on CMS Performance Indicators and Published Data

Since 2014, states must report specific eligibility and enrollment processing data to CMS. This data is known as the [Medicaid performance indicators](#), and the data sets were [expanded](#) to track renewal data during the COVID-19 Medicaid continuous coverage unwinding. CMS tracks and reports out this data on a monthly basis with a time lag.<sup>1</sup>

The current metrics states report to CMS are not detailed enough to isolate the effects that work requirements will have on enrollment and health outcomes for Medicaid expansion adults. For example, states report to CMS the total number of submitted applications for

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<sup>1</sup> Recent data has been released by CMS with an approximately 3-month data lag, with November 2025 eligibility data released in February 2026. Metrics include Total Medicaid renewals initiated in the prior month; Total Medicaid enrollees due for renewal during the prior month [including total renewed, total renewed automatically (ex-parte) using data the state had available, total renewed using a renewal form, total found ineligible through the renewal process, total not renewed for "procedural reasons," and total with pending renewals at the end of the reporting period]; and Call Center Volume, Wait Time, and Abandonment Rate.

Medicaid and CHIP, but they may not collect or report this data specifically for applications processed for enrollment in Medicaid expansion.

To track outcomes more specific to Medicaid work requirements, states may have to adapt their performance indicators to specifically track the adult Medicaid expansion population. While several recent analyses provide useful lists of potential metrics for states to track, most of them will require tweaks or overhauls to state reporting systems.<sup>2</sup> Even if a state separately reports total enrollment in Medicaid expansion, its system may not have the capacity to report eligibility processing data specifically for the Medicaid expansion eligibility group.

States may be reluctant to build in these types of reporting enhancements given the costs and time limits of the required changes. The new statute includes almost no specific requirements for states to report data metrics related to work requirement implementation, such as exemption rates, approval rates for processed applications, and renewals subject to work requirements. CMS should detail some reporting requirements in forthcoming guidance and rulemaking, but the extent of those requirements is still uncertain.

If CMS does not require states to create specific, publicly available reports, it may be impossible to directly measure the extent of coverage losses that work requirements have on low-income adults across the country. We know from past experience that many people will lose Medicaid coverage due to administrative barriers associated with reporting work requirements even if they are working or should meet an exemption.

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<sup>2</sup> See, Tricia Brooks, *Let's Start a Conversation about Data to Monitor the Impact of H.R. 1's Work Reporting Requirements*, Say Ahhh! (Feb. 4, 2026), <https://ccf.georgetown.edu/2026/02/04/lets-start-a-conversation-about-data-to-monitor-the-impact-of-h-r-1s-work-reporting-requirements/>; Janice Llanos-Velazquez & Melinda Becker Roach, Medicaid and CHIP Payment and Access Commission (MACPAC), *Considerations for Implementing Community Engagement Requirements*, 11 (Jan. 29, 2026), [https://www.macpac.gov/wp-content/uploads/2026/01/03\\_January-Slides\\_Considerations-for-Implementing-Community-Engagement-Requirements-Principals-and-Policy-Options.pdf](https://www.macpac.gov/wp-content/uploads/2026/01/03_January-Slides_Considerations-for-Implementing-Community-Engagement-Requirements-Principals-and-Policy-Options.pdf).

### The Challenge of Tracking Application Failures

The new Medicaid work requirement necessitates that individuals prove compliance in the month (or months) prior to enrollment. This feature, unprecedented in federal work requirements for public benefit programs, has proven to be a major barrier to enrollment at the state-level. Georgia implemented a pre-enrollment work requirement in July 2023, and its anemic enrollment rate persists today. Enrollment has yet to reach 15,000 adults in February 2026, meaning the state has not yet reached 60% of its own enrollment projection for Year 1.<sup>3</sup> A few years ago, Indiana required applicants with incomes above the poverty level to make at least a \$10 fast track payment to initiate coverage in its Medicaid expansion. A state-sponsored evaluation found that 23% of the otherwise eligible applicants did not enroll due to nonpayment, a far higher failure rate than the 6% of individuals who enrolled but later lost coverage due to nonpayment of monthly premiums.<sup>4</sup>

These state examples indicate the value in tracking application failures for this new federal work requirement, but doing so may require creative solutions. People apply for Medicaid, not for a specific eligibility group, and a single application may cover various eligibility pathways. Finding a way to separately describe a denominator of adults eligible only for Medicaid expansion and then flagging out those who would be eligible but for the new work requirement provisions may prove challenging. Processing work requirement compliance as the final step in review of Medicaid expansion eligibility may help isolate this group, but there may be applicants who abandon the application when they suspect they would not meet the work requirement, or who are found eligible for a different category only *after* they are found ineligible for Medicaid expansion.

More broadly, recognizing that a metric is valuable does not mean that actually reporting that data will be easy without careful planning. States need to be thinking now about how to report these metrics publicly and in a timely manner.

## General Recommendations for Effective Reporting

To get reporting right, states need to make important contracting decisions now. State advocates should press officials to consider their reporting strategy before the state

<sup>3</sup> Georgia Pathways Current Enrollment, <https://www.georgiapathways.org/data-tracker> (Last visited Mar. 31, 2026).

<sup>4</sup> In all, 57,189 of roughly 195,000 who ever faced a required premium were disenrolled or not enrolled due to nonpayment at least once. Lewin Group, *Indiana HIP 2.0: POWER Account Contribution Assessment*, ii (Mar. 31, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

procurement process has advanced too far to make meaningful changes. Below are steps that can help advocates and states work through the process of developing an effective, transparent, and timely work requirement monitoring system.

**Learn how the state’s eligibility system works** – Understanding a state agency’s enrollment pathways and the systems that operationalize them will help determine realistic data metrics and assess those that are infeasible. Learning the “roadmap” of how your Medicaid agency’s systems collect, exchange, and process information will help prioritize which metrics to advocate for in the short term and the long term, as well as identify systems’ limitations on what data cannot be reported without changes, and what changes will be made for work requirements that can be programmed to create data.<sup>5</sup> Relevant questions include:

- How does the state track application data? States that use a state-based Marketplace will have to adapt their Marketplace applications to include new screening questions, while the 30 states that use [healthcare.gov](https://www.healthcare.gov) will have to collect additional information from applicants received through that pathway.<sup>6</sup>
- Does your state use a multi-program combined application? Is the state’s eligibility data integrated with SNAP and/or TANF? If there is an integrated system, what data is already generated regarding SNAP applications and work?

**Consult with IT experts familiar with your state’s eligibility system data infrastructure.** Each state has its own eligibility hierarchies and data architecture. Many states integrate their systems across public benefits programs. IT and eligibility experts who know your state’s system could help sort easy fixes from quagmires, which helps you prioritize your reporting “asks.”<sup>7</sup> They can also help contextualize statements government officials may make about the capabilities of the system to justify their implementation decisions.

**Where feasible, states should structure their eligibility hierarchies so work requirement compliance is the last element reviewed in the Medicaid expansion work flow.** This is one way to show which renewals and applications failed solely due to the new work requirements, and why.

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<sup>5</sup> Some questions to consider: Does your state use [healthcare.gov](https://www.healthcare.gov) or a state-based marketplace? What data is already published by the state that can indicate the types of data that may be easily added? Some data characteristics, such as reporting key outcomes by county, could be very instructive.

<sup>6</sup> Thirty states use [healthcare.gov](https://www.healthcare.gov) for Marketplace enrollment. The federal government has made no indication it plans to update the application questions for [healthcare.gov](https://www.healthcare.gov).

<sup>7</sup> See, e.g., Benefits Tech Advocacy Hub, *Reducing Procedural Terminations from Medicaid Work Requirements* (2026), <https://www.btah.org/resources/reducing-procedural-terminations-from-medicaid-work-requirements.html> (discussing technical systems issues and suggesting some publicly reported data elements on systems outcomes).

**Carefully prioritize key data reporting points.** States with tight budgets may try to limit system redesign for the purpose of reporting data. Prioritize your “asks” and consider how reported data can be used to address and target eligibility fixes. It may also help to identify data that your state also finds useful. Identify short-term and long-term goals based on which metrics are the right balance of valuable for tracking harm and realistic for your state to report. States have to change their systems to incorporate the requirements regarding work activities and exclusions, so building data elements and reports should accompany those changes. Later additions or change orders are far more difficult and expensive.

**Work with other researchers in the state to investigate outcomes for groups that the state is unable or unwilling to investigate.** Some of the most important research that evaluated the effect of Arkansas’ failed Medicaid work requirement program came from outside research entities. These researchers helped track outcomes the state was not willing or able to follow up on. For example, outside researchers showed that the Arkansas program had no effect on employment rates.<sup>8</sup> Other studies tracked what happened to individuals after they were disenrolled, or estimated the share of people with disabilities who were disenrolled.<sup>9</sup> Advocates should consult with the research community about what kinds of data they might need from the state in order to conduct these types of studies effectively.

**Emphasize timeliness and transparency** – Emphasize the importance of making data reports publicly available without substantial data lags, even if the data is later updated after the state has verified accuracy or has additional reports come in. Enrollment failures due to work requirements may happen quickly, particularly for new applicants trying to enroll in Medicaid. Having access to timely reporting will be essential to address early system failures. You can also submit public records requests for Medicaid expenditure reports, enrollment data, and other reporting metrics.<sup>10</sup> Some advocates have also obtained information from the state through their Medicaid Advisory Committees or Beneficiary Advisory Councils.

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<sup>8</sup> Sommers et al., *Medicaid Work Requirements — Results from the First Year in Arkansas*, 381 *New Eng. J. Med.* 1073 (2019), <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

<sup>9</sup> MaryBeth Musumeci, KFF, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018* (June 11, 2019), <https://www.kff.org/report-section/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018-issue-brief/>.

<sup>10</sup> See Katy DeBriere & Elizabeth Edwards, National Health Law Program, *State Implementation of Medicaid Work Requirements: Guidelines for Public Records Requests* (Feb. 2026), <https://healthlaw.org/resource/state-implementation-of-medicaid-work-requirements-guidelines-for-public-records-requests/>.

**Seek stratified data reporting where possible** – Actionable data often requires specificity. Breaking down enrollment denials by specific components, pathways, or population type can help reveal problems that an aggregated figure may not show. As noted above, states already track and report applications and renewals that fail due to administrative reasons (procedural denials), as well as renewals that are denied for not meeting eligibility requirements. Unfortunately, most states do not publicly report specific reasons for procedural denials (e.g. paperwork not returned, incomplete paperwork) or for ineligibility (e.g. income too high; moved out of state). CMS’s public reports do not stratify renewals outcomes by eligibility category. If states track disenrollments (and failed enrollments) only by aggregated metrics, without at least reason codes specific to the Medicaid expansion category, the data cannot separately capture Medicaid expansion adults who were disenrolled (or who failed to enroll) due solely to work requirements. This would prevent an accurate assessment of coverage losses and enrollment barriers due to work requirements.

**Evaluate enrollee/applicant assistance** – A lot of ink has already spilled discussing the high administrative burden that work requirements will cause for low-income people. States have a responsibility to help individuals who need assistance, particularly people with disabilities who require accommodations and people with limited English proficiency (LEP). States already report on some call center statistics, though tracking additional elements like accommodations and language assistance provided could be valuable additional information due to the common barriers people with disabilities and people with LEP encounter.

**Develop metrics to track outreach** – Measuring the impact of outreach by mode can help evaluate which communication channels are most effective and among which populations and communities.<sup>11</sup> For example, if a significant portion of enrollees clicked on links sent via text messaging to prepare for work requirements, then investing in tools to complete applications or renewals via text message may be the best way to expand a state agency’s reach.

## Conclusion

We already know that Medicaid work requirements are going to harm low-income families and communities. Stories will quickly surface of people who lose coverage or who are unable to enroll.<sup>12</sup> Adults with diabetes or some other serious chronic condition who do not meet an

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<sup>11</sup> State Health & Value Strategies, *Communications Workplan: Preparing for the Implementation of Medicaid Work Reporting Requirements*, 14 (Feb. 2026), <https://shvs.org/wp-content/uploads/2026/02/Medicaid-Communications-Workplan-02.11.2026.pdf>.

<sup>12</sup> David Machledt et al., National Health Law Program, *Conditional Care: The Real Cost of Medicaid Work Requirements* (June 2025), <https://healthlaw.org/resource/conditional-care-the-real-cost-of-medicaid-work-requirements/>.

overly narrow medical exemption. An applicant with an undiagnosed mental health condition the state fails to flag in the application. Mothers and fathers caring for their own aging parents whose caregiving is invisible to eligibility databases. A self-employed lawn care worker whose regular income is not reported in the employment database used by the state. These are the kinds of people who will fall through the cracks and lose coverage, and ultimately these stories about coverage loss will show how much harm and wasteful loss this policy causes.

The full story of how work requirements affect low-income families requires more than just individual stories. Those stories also need accurate data that links the anecdotes to broader trends, to show how “big” these problems are. Work state advocates do now to demand meaningful, transparent reporting of work requirement outcome metrics will enable those connections to be made, so the fuller story of work requirements effects on low-income families can be told.

## Appendix – Key Metrics for State Reporting on Work Requirements

(**Bolded text** are already reported by states in aggregate)

### Enrollment

- 1) **Total enrollment in Medicaid Expansion**
- 2) Percentage of applications who previously applied/enrolled in prior 12 months
- 3) **Total and percentage of successful redeterminations at renewal** (specific to Medicaid expansion)
- 4) **Total procedural disenrollments or denials**, stratified to separately report reason codes related to work requirements
- 5) **Total and percentage of automatic, i.e., ex parte, redeterminations** by type (e.g., total who meet the automatic income threshold or verified exempt automatically)
- 6) **Total found compliant with work requirements via active reporting** of hours
- 7) **Total excepted and excluded individuals**, by type
- 8) **Total enrollees who transition to other eligibility categories**, by category

### Enrollee/Applicant Support

- 1) **Call center wait times** (for an individual to reach a person who can address their question, not just for call triage) and **abandonment rates**, and dropped call rates;
- 2) **Fair hearing requests and outcomes** related to work requirement compliance.<sup>13</sup>

### Administrative Costs

- 1) **Total design and set-up costs for work requirement-related system updates**
- 2) Total change in cost of ongoing administration after work requirement implementation
- 3) Breaking out the specific administrative costs unique to work requirements may be difficult, but states can track easily identifiable line items, such as payments to third party tech vendors for employment or other verifications

### Outcomes

- 1) **Change in total uncompensated care costs**
- 2) Qualitative follow-up with representative groups of disenrolled individuals to identify people disenrolled despite likely eligible for medical exemptions
- 3) **Average employment rate for low-income adult population**<sup>14</sup>
- 4) Survey a representative sample of low-income adults about their awareness of Medicaid work requirement provisions
- 5) Audit representative samples of procedural and of compliance denials (separately for applications and renewals). Use audit to identify system errors or weaknesses.

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<sup>13</sup> These data are already collected and reported to some extent, though the current data may not specifically relate to Medicaid expansion or to work requirements specifically. Fair hearing metrics should include, at least, total appeals, total number and rate at which denials are upheld, including the number of appeals withdrawn.

<sup>14</sup> Past efforts have tracked only the share of Medicaid enrollees who are working, but this leads to skewed interpretations. After work requirements implementation, that share would naturally rise as people not already working or exempt will either lose Medicaid coverage or not be able to enroll.