Robinson Ventures, LLC

OBBBA Medicaid Changes and Community Based Care: *Implications for behavioral health, social care, and Medicaid models based on CHI codes*

Executive perspective

Community based organizations should continue building reimbursable behavioral health and social care services, while redesigning their financial assumptions for a less stable Medicaid environment. The central risk is a widening gap between community need and collectible revenue. Coverage disruptions can reduce paid service volume while clients require more help maintaining treatment, housing, food access, and benefits.

The One Big Beautiful Bill Act, commonly called OBBBA and referred to by CMS as the Working Families Tax Cut legislation, was enacted on July 4, 2025, as Public Law *119-21*. The "2026 Medicaid cuts" are therefore a multiyear implementation issue. Certain financing and noncitizen coverage changes take effect in 2026; major eligibility provisions generally begin in 2027, with additional financing changes phased in later. [1–7]

CBOs implementing Community Health Integration (CHI) services face an additional execution risk. *G0019* and *G0022* are Medicare HCPCS codes. A Medicaid program may adopt them, use different codes for comparable work, or purchase services through an authorized contract. A Medicare code, a clinician's license, and a clinically sound service model do not alone establish Medicaid payment. [10–12]

Our recommendation is to protect continuity of care and verify every revenue pathway before expanding on fixed costs. CBOs should secure payment for the infrastructure required to deliver the service, including supervision, eligibility assistance, documentation, and coordination. Grants and philanthropy can fund transition costs and care during coverage gaps; recurring covered services require a durable purchasing commitment.

What leadership should take from this paper

Prioritize members at risk of losing coverage; distinguish payable services from unfunded navigation; stress test collected revenue and cash; and negotiate contracts that pay for community capacity. Shared savings can supplement this foundation after credible outcomes data are available, but should not be the financing source on which payroll depends.

Scope and evidence cutoff: U.S. Medicaid policy and research available through September 23, 2026. This paper distinguishes enacted law, current federal guidance, peer-reviewed findings, and Robinson Ventures analysis. It does not estimate losses for an individual state or organization.

1 The policy changes and their timing

The law does not impose a single nationwide percentage reduction on every CBO claim. It affects community-based organizations through eligibility, state financing, and purchasing decisions. The Congressional Budget Office estimates that the Medicaid chapter reduces federal direct spending by approximately $914.6 billion over fiscal years 2025–2034, and increases the number of uninsured people by 7.5 million in 2034. These are national projections related to the Congressional Budget Office's baseline, not observed 2026 losses or a Congressional Budget Office reimbursement forecast. [2]

Provision	Timing and scope	CBO operating implication
Noncitizen coverage Section *71109*	October 1, 2026. Federal funding narrows for certain lawfully present groups, including many refugees and asylees, subject to status and statutory exceptions. [3]	Identify affected clients individually; determine whether state funded coverage or another authorized source can support ongoing care.
Provider tax limits Section *71115*	October 1, 2026, limits generally use July 4, 2025, tax levels. Most affected expansion state thresholds begin declining October 1, 2027. [6]	Monitor state budgets and payer negotiations; do not assume a uniform cut to community provider rates.
Community engagement Section *71119*	Generally, January 1, 2027, or earlier. Certain adults ages 19–64 in expansion or specified *1115* groups must meet 80 hours of qualifying activity monthly or alternative criteria, unless excluded. [4]	Prepare work or activity verification support and exemption documentation as a pre-emptive measure before clients face termination.
Six-month renewals Section *71107*	Beginning in 2027 for the adult expansion group; CMS permits transition approaches for existing renewal schedules. [5]	Track each member's renewal date and procedural risk; a work requirement exclusion does not itself remove renewal obligations.
Shorter retroactive coverage Section *71112*	Applications on or after January 1, 2027: one prior month for the expansion adult group; two for other Medicaid groups. [1,7]	Reduce reliance on later enrollment to recover payment for previously delivered services.
Section *1115* budget neutrality Section *71118*	Chief Actuary certification applies to approvals, amendments, and renewals on or after January 1, 2027. [8]	Require authority and renewal plan for demonstration supported services.
State directed payments Section 71116	New limits affect specified hospital, nursing facility, and academic medical center services; grandfathered payments phase down for rating periods beginning on or after January 1, 2028. [9]	Assess referral partner and sponsor exposure. This provision is not a blanket reduction to all behavioral health payments.
New cost sharing Section *71120*	October 1, 2028, for certain expansion adults above 100% poverty; capped at $35 per service with exclusions. [1,7]	Behavioral health, primary care, FQHC, rural health clinic, and CCBHC services are excluded from this new requirement.

The provider tax rule published in July 2026 remains a proposed implementation rule in the source reviewed. The statutory dates are distinct from proposed regulatory details. Approved state relief, litigation, and later guidance can affect implementation. [4,6,23]

2. How the changes reach community organizations

Coverage loss becomes a continuity and revenue problem

A patient's loss of coverage does not remove the need for counseling, medication support, recovery services, or social care; but does change who can pay. For a CBO, the immediate exposure is fewer payable encounters or covered member months, additional eligibility checks, and more time resolving denials. If the organization continues essential services through a coverage gap, the cost must move to a separately identified source. This is our operating assessment of the policy changes, rather than a measured post-OBBBA effect.

Peer-reviewed research from Arkansas found that over 18 months, work requirements produced coverage losses without an increase in employment. Among surveyed adults ages 30–49 who had lost Medicaid in the prior year, 56% reported a delay in care and 64% reported a delay in receiving medications because of cost. The study supports planning for access disruption, although its population and implementation differ from the 2026 federal framework. [15]

Behavioral health exclusions require operational follow through

The statute includes protections for specified populations. CMS's September 2026 medical frailty guidance interprets the exclusion to require that a qualifying condition significantly impair the ability to comply with community engagement. A behavioral health diagnosis alone should not be treated as proof that the state has recognized an exclusion, but separately addresses substance use disorder and recovery status. Participation in a drug or alcohol treatment program is another exclusion described by CMS. [4,13]
Clinical teams should document functional limitations, treatment participation, and other relevant facts accurately, help clients transmit appropriate evidence, and track the state's responses. CMS's interpretation is currently being challenged via litigation filed in June 2026. Organizations should maintain current workflows and an update process rather than assuming either automatic exemption or an eventual court outcome. [13,23]

Social care demand and payable demand can diverge

Food, housing, transportation, and benefits organizations may receive more requests even as covered referrals decline. Referral volume is consequently an incomplete growth measure. Leadership should distinguish requests received, eligible referrals, completed authorized services, accepted claims, and cash received.

Restrictions on state financing may also reach a CBO indirectly. A health system may reduce community subsidies, a managed care plan may tighten purchasing terms,or a state may reprioritize optional programs. These are plausible responses, not uniform statutory mandates. Expansion status, existing financing arrangements, benefit authority, and state appropriations determine the local exposure. Nonexpansion states are not insulated from all provisions, even when the adult expansion rules do not apply to their traditional eligibility groups. [2,6,9]

Small organizations have less capacity to absorb the transition

Research on CBO participation in Medicaid redesign identified problems with the level, timing, and flow of funds, along with weak participation in partnership governance. These existing constraints can magnify the effect of new administrative work. Community care hubs and shared billing arrangements can spread fixed costs, if the fees, cash distribution, accountability, and decision rights are transparent. [18]

3. CHI is a service model and a payment decision

A useful Medicaid model starts with the patient's clinical and social needs, and then establishes the authority and payment terms for each service. "Matched and modeled" should mean that the workflow is deliberately mapped to the state's benefit and payer requirements.

What the Medicare framework establishes

Medicare CHI uses *G0019* for the initial 60 minutes per calendar month and *G0022* for an additional 30 minutes each. The framework connects upstream barriers to diagnosis or treatment through an initiating visit, documented services, consent, and qualified personnel. Eligible physicians and practitioners may use auxiliary personnel under applicable general supervision requirements. [10,12]

CMS also permits clinical social workers, marriage and family therapists, and mental health counselors to bill Medicare for CHI they personally perform for diagnosis or treatment of mental illness. CMS explicitly distinguishes this from billing for auxiliary personnel incident to their services, which those practitioner types are not authorized to do. This distinction matters when a CBO designs an LCSW led model. Medicaid has its own provider and supervision requirements. [10]

Choose the actual Medicaid payment route

Route	Evidence needed before launch	Financial consequence
State adoption of CHI G-codes	Current state benefit, provider manual, fee schedule, enrollment rules, and plan implementation.	Use the Medicaid rate and unit rules; validate payment with the applicable payer.
Comparable covered service	Approved CHW, preventive, rehabilitation, peer, or case management service that covers the proposed activities.	Use the authorized code and service definition. Similar purpose does not make services interchangeable.
Delegated care management	Executed payer agreement identifying purchased activities, funding basis, reporting, member attribution, and payment.	Price the contract as a service arrangement; don't assume every activity produces a medical claim.
Approved demonstration or other authority	Current approval, covered population and services, funding limits, expiration dates, and implementing contracts.	Distinguish startup funds from recurring service revenue; address renewal and termination risk.

The crosswalk is a Robinson Ventures due diligence framework. It describes possible routes, not coverage determinations. A contract cannot create federal Medicaid matching authority for an otherwise unauthorized expenditure.

A concrete example of state specific adoption

California's CHW billing decision tree explicitly addresses *G0019* and *G0022*. CMS approved California SPA *25-0016* in July 2026 with an April 1, 2025, effective date for a CHW HCPCS reimbursement methodology. This illustrates why the approved authority, operational guidance, and effective dates must be read together. It does not establish coverage in another state or guarantee a particular CBO's enrollment or payment. [11,12]

Keep clinical work and administrative assistance distinct

Benefits navigation may support care, but routine paperwork is not automatically a billable CHI service. Separately budget enrollment assistance and uninsured bridge services unless the applicable benefit or contract expressly pays for the work. Count staff time once and reconcile overlapping care management, behavioral health, and social care arrangements before invoicing. [10]

4. What the research supports

The best research available informs us of the mechanisms of risk and the design of a response. It does not yet establish the full national effect of OBBBA on CBO finances. The studies below evaluate earlier Medicaid policies, social care interventions, or financing models. Their results should inform local planning without being converted into a universal loss rate or savings guarantee.

Peer reviewed evidence	Finding	Application and limitation
Sommers et al. 2019 New England Journal of Medicine [14]	The first year Arkansas study documented coverage disruption after work requirements.	Supports concern about administrative coverage loss. One state and an earlier design do not forecast every state's 2027 results.
Sommers et al. 2020 Health Affairs [15]	No employment increase over 18 months; loss of coverage was associated with substantial affordability problems.	Budget for interrupted treatment and uninsured demand. Survey findings are not direct estimates of OBBBA effects.
Landis et al. 2026 Journal of Addiction Medicine [16]	Some coverage promoting policies during Medicaid unwinding were associated with smaller disruptions in buprenorphine treatment; effects varied.	Supports outreach and renewal assistance for continuity of substance use treatment. Retrospective associations do not prove causation.
Kangovi et al. 2020 Health Affairs [17]	An economic analysis using randomized trial data estimated $2.47 in avoided Medicaid spending for each $1 invested in the IMPaCT CHW program.	Supports targeted community investment. This was a modeled payer return from a specific intervention, not a guaranteed CBO margin.
Tsering et al. 2023 Health Affairs Scholar [18]	Analysis of CBO comments on Medicaid redesign found concerns about funding sufficiency, timing, payment flow, governance, and metrics.	Supports upfront infrastructure funding and clear contracting terms. Qualitative evidence does not quantify the national financial losses.
Basu et al. 2024 Journal of Community Health [19]	A microsimulation estimated sustainable CHW payment of $53.24 per 30-minute visit or $140.18 per member per month, with substantial variation.	Shows the importance of full cost pricing. These are study estimates using historical inputs, not 2026 rates or a proposed CHI fee schedule.

The investment case remains conditional

The evidence supports protecting interventions that improve care and reduce avoidable utilization. It also supports paying for the infrastructure required to deliver them. Savings depend on population, service intensity, execution, and the party that captures the benefit. A payer's avoided hospital spending does not automatically become revenue for the CBO that helped produce it. [17–19]

For new CHI modeled programs, Robinson Ventures recommends a paid operating base with performance incentives to be added after a credible baseline is established. Evaluate treatment continuity and resolve social barriers alongside spending. Lower claims after disenrollment may reflect loss of access and should not be labeled program savings.

5. Stress test collected revenue and cash

The financial exposure is multiplicative. Fewer covered months, less service completion, lower payment, and more unresolved claims can combine into a much larger decline in collections. The example below represents a hypothetical CBO's Medicaid social care program. It is not a CBO forecast, published reimbursement rate, or estimate derived from the national CBO score, but a planning exercise

Illustrative assumptions: 1,000 potentially served members; $100 allowed revenue for a completed qualifying member month; baseline 100% coverage retention, 80% payable service completion, and 95% ultimate collection of allowed revenue. Completion includes the required service, authorization, and documentation. Other revenue is excluded.

Monthly measure	Baseline	Moderate stress	Severe stress
Covered members retained	1,000	900	800
Payable service completion	80%	75%	70%
Allowed revenue per completed month	$100	$98	$95
Ultimate collection rate	95%	92%	88%
Net collectible revenue	$76,000	$60,858	$46,816
Change from baseline	—	−19.9%	−38.4%
Program expense	$70,000	$73,000	$76,000
Operating surplus or deficit	$6,000	−$12,142	−$29,184

Calculation: eligible members × completion share × allowed revenue × ultimate collection rate. Expense rises by an assumed $3,000 or $6,000 monthly for added assistance and rework, with the service platform being retained. Assumptions are independent planning inputs and should be replaced with actual experience.

A modest revenue change can consume a thin margin

The baseline margin is 7.9%. With expense unchanged, a 7.9% decline in collections eliminates that surplus. With 900 eligible members and moderate case assumptions, the allowed amount needed to cover $73,000 is approximately $117.55 per completed month, compared with the assumed $98. That gap requires a financing or operating decision.

Payment delay is a separate cash exposure

A 30-day increase in collection time would tie up approximately one additional month of collectible revenue; about $60,900 in the moderate case. That is incremental working capital, not a permanent revenue loss. Management should also model recoupments, restricted grant cash, payroll timing, and the cost of sustaining care during coverage gaps. They should avoid adding a claim delay to both lost revenue and receivables without identifying the distinction.

Underwrite each service line separately

Behavioral health encounters, CHI modeled social care, direct food or housing supports, and payer administrative contracts may have different eligibility and payment terms. Maintain separate contribution margins and consolidate them into a rolling 13-week cash forecast. Stage hiring against paid volume and committed funding. Require explicit board approval when unrestricted resources subsidize a recurring gap.

6. Build contracts that sustain community capacity

Robinson Ventures' recommended response is a disciplined purchasing model that recognizes what the CBO must maintain between billable encounters. A program can be clinically valuable and still financially unsustainable if payment omits travel, supervision, outreach, interpreter support, data work, or failed contact attempts. The sustainable price accounts for the full cost of the promised service and capacity, informed by expected utilization and collection experience. [18,19]

Establish a funded operating base

Where the benefit and contracting authority permit, combine payment for delivered services with a defined capacity payment or delegated care management fee. Identify which costs each payment covers and prohibit duplicate reimbursement. Specify the eligible population, attribution rules, service start and stop dates, which referrals the CBO can accept, and the treatment of members who lose coverage. A projected referral pipeline should not be used as a substitute for a minimum purchasing commitment.

Allocate risk to the party that can manage it

Payers and sponsoring providers should supply timely eligibility and attribution information, usable referrals, and access to the records needed for the purchased work. CBOs should be accountable for qualified staffing, service quality, accurate documentation, and timely reporting. Contract terms should address payment timing, rejected invoices, eligibility errors, retrospective recoupments, data access, termination notice, and who will pay for an orderly transition of active clients.

A CBO paid by a managed care organization should help members navigate requirements without assuming authority to decide community engagement compliance. Federal law restricts use of managed care entities and certain financially related contractors for those determinations. The state retains the relevant decision responsibility; and an assistance contract should clearly define the permitted role. [1,7]

Preserve the distinction between clinical and social services

Clinical leadership remains responsible for assessment, treatment planning, scope of practice, and supervision where required. CHWs and peers bring different qualifications and community expertise. A CBO's delivery of social care does not automatically make it a Medicaid enrolled clinical provider, and an LCSW or NP license does not establish organizational enrollment or eligibility to bill every service. Build the personnel and payment model together, using explicit written payer requirements.

Use performance incentives after the model can be measured

Start with outcomes the CBO can influence; successful contact, treatment follow through, service completion, and resolution or stabilization of documented needs. Shared savings requires agreed attribution, a comparison method, risk adjustment, complete claims data, treatment of coverage gaps, and a settlement schedule. Small panels can produce unstable cost results; use suitable aggregation and independent analytic review before accepting material financial risk.

Philanthropy and grants remain valuable for startup costs, technology, training, emergency assistance, and people who lack a covered payment path. Define those uses separately so that donors and boards can see what they are supporting. A grant should not conceal an underpriced recurring payer contract. This approach preserves the organization's mission while making the funding obligations of each partner visible.

7. A practical response for the next 90 days

CBOs should treat the remainder of 2026 as an implementation period. The chief executive should own the response, with clinical, finance, operations, and contracting leads accountable for specific deliverables. The objective is to enter 2027 with a verified payment model and a funded plan for continuity of care.

Period	Priority work	Decision or deliverable
Days 1–30	Map active clients by payer, eligibility category, renewal date, and known coverage risk. Inventory every service, code, authority, contract, and funding expiration.	An exposure register; a verified payment crosswalk; baseline denial, retention, and cash measures.

Period	Priority work	Decision or deliverable
Days 31–60	Implement multilingual outreach, exemption evidence support, renewal tracking, and a coverage gap protocol. Reprice contracts using full costs.	A documented client assistance workflow; proposed payer amendments; a costed bridge care plan.
Days 61–90	Run end to end claim and payment validation for the actual model. Stress test volume, rates, denials, and payment lag. Set capacity and reserve limits.	A board reviewed 2027 operating plan with owners, escalation triggers, and a funded launch or expansion decision.

Use a small operating dashboard

Measure	What it should show
Coverage continuity	Renewals due, assistance completion, confirmed exclusions, coverage gaps, and time to reinstatement.
Treatment continuity	Missed follow ups, interruptions in medication access, engagement after discharge, and crisis referrals.
Payment performance	Clean claim rate, denials by cause, net collections per eligible member month, receivable age, and recoupments.
Social care delivery	Referral acceptance, completed services, unresolved barriers, and available community capacity.
Organizational resilience	Contribution margin by service line, unrestricted cash, staff vacancies, and workload per active client.

Recommended management measures, not new federal reporting requirements. Review operational measures weekly during implementation and financial and access trends with the board at least monthly.

Set decisions before the organization reaches a cash crisis

Set thresholds based on reserves and contracts for declining covered member months, elevated denials, or cash below the board's minimum. Assign a response to each trigger; payer escalation, bridge funding, delayed expansion, staffing adjustments, or negotiated service transitions. Protect continuity for high-risk clients when changing capacity. A sound launch decision requires documented authority, a payable provider arrangement, operational claim acceptance, and a cash plan. Where one remains unresolved, preserve the clinical design and stage the investment until the payment uncertainty is addressed.

8. Policy and investment priorities

Preserve the community services that make care accessible

States and managed care purchasers should assess proposed savings against the cost of interrupted treatment and lost community capacity. We recommend paying explicitly for authorized enrollment assistance, maintaining adequate rates for covered community services, and giving CBOs a meaningful role in program design. Rate decisions should recognize supervision and infrastructure, along with direct service time. These are Robinson Ventures recommendations informed by the research, not requirements created by OBBBA. [16,18,19]

Use current authority for social care investments

CMS rescinded its 2023 and 2024 health related social needs guidance in March 2025 and stated that applications would be reviewed case by case. That administrative action is separate from OBBBA. The rescission should not be described as automatic cancellation of every existing social care approval; nor should older guidance be used as evidence that a new proposal will be approved. Read the current state plan, demonstration terms, managed care contract, and subsequent federal correspondence. [20]

The 2026 CMS budget neutrality guidance adds a more demanding approval and certification environment for section 1115 projects. CBOs dependent on demonstration funding should identify renewal dates, funding conditions, and a sustainable successor arrangement well before the current authorization ends. Existing approval and future renewal are different financing questions. [8]

Use rural transformation funds for a defined transition

The law established a $50 billion Rural Health Transformation Program over fiscal years 2026–2030, and CMS announced awards to all 50 states. CBOs should assess opportunities within their state's approved plan for rural behavioral health access, care coordination, workforce, and data infrastructure. Participation depends on state selection and award terms; the program does not guarantee a CBO award or replace ongoing Medicaid claims revenue. [21]

For funders, the most useful investment may be a time limited bridge tied to a credible payer contract, shared infrastructure that lowers administrative costs, or support for clients excluded from an available coverage pathway. Require a realistic plan for recurring expenses when the award ends. Avoid promising that new grants will fully offset the law's national spending reductions.

Robinson Ventures Conclusion

The strategic case for behavioral health and social care remains strong. Community organizations make treatment workable for people whose daily circumstances prevent a clinical plan from succeeding. The financial case now requires greater precision about coverage, authority, payment, and cost.

Our recommendation is to proceed with well-designed Medicaid CHI modeled services where the payment pathway is verified, protect treatment continuity as eligibility rules change, and secure contracts that fund the work the community is being asked to perform. The best organizations positioned to sustain their mission will be those that can connect a documented need to an authorized service, dependable payment, and a measurable result.

Method and limits

This is a targeted policy and evidence review, not a systematic review or actuarial forecast. Primary federal law and CMS publications establish policy; peer-reviewed studies support the impact mechanisms and operating recommendations. The financial scenarios are original illustrations. No client records, claims, contracts, or state specific financial data were analyzed. The June 2026 rule is subject to litigation; later court orders, CMS guidance, and state implementation decisions must be checked before operational reliance. References were reviewed through September 23, 2026.

Sources Cited

[1] U.S. Congress. (2025). Public Law 119-21, 139 Stat. 72. Title VII, subtitle B, especially sections 71107, 71109, 71112, 71115–71120, and 71401.
Enacted law. Read source

[2] Congressional Budget Office. (2025, October 28). Supplemental cost estimate for Public Law 119-21: Title VII, Finance, subtitle B, Health, chapter 1, Medicaid.
Budget and coverage estimate. Read source
[3] Centers for Medicare & Medicaid Services. (2026, April 8). Implementation of section 71109 “Alien Medicaid Eligibility” of the Working Families Tax Cut legislation (SHO 26-001).
Federal guidance. Read source
[4] Centers for Medicare & Medicaid Services. (2026, June 1). Medicaid community engagement requirement for certain individuals’ interim final rule with comment period (CMS-2454-IFC).
CMS rule fact sheet. Read source
[5] Centers for Medicare & Medicaid Services. (2026, March 6). Section 71107: Implementation of “Eligibility Redeterminations” (SMD 26-001).
Federal guidance. Read source
[6] Centers for Medicare & Medicaid Services. (2026, July 21). Amending the indirect hold harmless threshold of health care-related taxes proposed rule (CMS-2452-P).
Proposed rule fact sheet. Read source
[7] Centers for Medicare & Medicaid Services. (2025, November 18). Summary of Working Families Tax Cut legislation provisions. CMCS informational bulletin.
Federal implementation summary. Read source
[8] Centers for Medicare & Medicaid Services. (2026, June 11). Budget neutrality and certification by the Chief Actuary of CMS for section 1115 Medicaid demonstration projects (SMD 26-003).
Federal guidance. Read source
[9] Centers for Medicare & Medicaid Services. (2026, February 2). Section 71116 of the Working Families Tax Cut legislation on state directed payments.
Federal guidance. Read source
[10] Centers for Medicare & Medicaid Services. (2026). Caregiver training, community health integration, principal illness navigation, and physical activity and nutrition risk assessment services: Frequently asked questions.
Medicare billing guidance. Read source
[11] Centers for Medicare & Medicaid Services. (2026, July 17). Approval of California state plan amendment 25-0016. Effective April 1, 2025.
State plan approval. Read source
[12] California Department of Health Care Services. (n.d.). DHCS CHW G-code billing decision tree. Retrieved September 23, 2026.
State billing guidance. Read source
[13] Centers for Medicare & Medicaid Services. (2026, September 8). Implementing medical frailty under community engagement: Section 71119 of WFTC legislation.
Federal technical assistance slides. Read source
[14] Sommers, B. D., Goldman, A. L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2019). Medicaid work requirements—Results from the first year in Arkansas. New England Journal of Medicine, 381(11), 1073–1082.
Peer reviewed research. Read source
[15] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid work requirements in Arkansas: Two-year impacts on coverage, employment, and affordability of care. Health Affairs, 39(9), 1522–1530.
Peer reviewed research. Read source
[16] Landis, R. K., Kapinos, K. A., Levine, P. R., & Stein, B. D. (2026). Association of coverage-promoting policies with initiation and discontinuation of buprenorphine treatment during Medicaid unwinding. Journal of Addiction Medicine.
Peer reviewed research. Read source

[17] Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Affairs, 39(2), 207–213.
Peer reviewed research. Read source

[18] Tsering, D., Stauffer, C. M., Gittzus, J. A., Byhoff, E., & Taylor, L. A. (2023). “More than just checking the box”: Community-based organizations on their role in Medicaid redesigns. Health Affairs Scholar, 1(5), qxad060.
Peer reviewed research. Read source

[19] Basu, S., Patel, S. Y., Robinson, K., & Baum, A. (2024). Financing thresholds for sustainability of community health worker programs for patients receiving Medicaid across the United States. Journal of Community Health, 49, 606–634.
Peer reviewed research. Read source

[20] Centers for Medicare & Medicaid Services. (2025, March 4). Rescission of guidance on health-related social needs. CMCS informational bulletin.
Federal guidance. Read source

[21] Centers for Medicare & Medicaid Services. (2025, December 29). CMS announces $50 billion in awards to strengthen rural health in all 50 states.
Federal program announcement. Read source

[22] Robinson Ventures. (2026, July). From charity to contract: Reimbursing SDOH/UDOH mitigation as health care infrastructure.
Prior Robinson Ventures white paper used for visual and editorial continuity; current policy was independently rechecked.

[23] Office of the New York State Attorney General. (2026, June 29). Attorney General James sues Trump administration to protect Medicaid coverage for vulnerable New Yorkers.
Primary source for the filing and allegations; not a court ruling. Read source