Policy Insight Series

Supporting the critical role of Medicaid for autistic people and their family members

Policy Brief

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Improving the care experiences and health outcomes of autistic individuals who use Medicaid-funded services involves a complex and critically important set of policy issues. We highlight 10 key issues, policy recommendations, and questions that state policymakers and and others can ask to learn more about Medicaid for people on the autism spectrum in their state.

This policy brief is a supplement to the data presented in our **Introduction to Medicaid and Autism Report**.

This report addresses the following policy issues:

- Medicaid has not kept pace with increases in autism prevalence.
- Medicaid waivers provide coverage for essential services, but few states have autism-specific waivers.
- Navigating Medicaid eligibility is complex and confusing.
- People with multiple service needs remain on waitlists for Medicaid waiver services for many years.
- There is a lack of supports for unpaid family caregivers.
- We lack Medicaid providers with expertise in serving autistic people.
- Disparities exist in access to Medicaid and service utilization.
- Developmental disability services, largely funded by Medicaid waivers, tend to fund facility-based care more than community-based services.
- Little is known about how autistic adults use long-term services and supports, especially as they age.
- State policies that tie Medicaid eligibility to work requirements are problematic for autistic adults.

ISSUE

1

Medicaid has not kept pace with increases in autism prevalence.

The prevalence of autism in the U.S. has continually increased since monitoring began in 2000, and states are increasingly creating Medicaid programs to insure autistic individuals. Approximately one in three children on the autism spectrum live in very low-income households and may qualify for public health insurance, a higher rate than children with and without other special health needs. Growth in the number of autistic youths who are aging into adulthood is also contributing to increased demands for services.

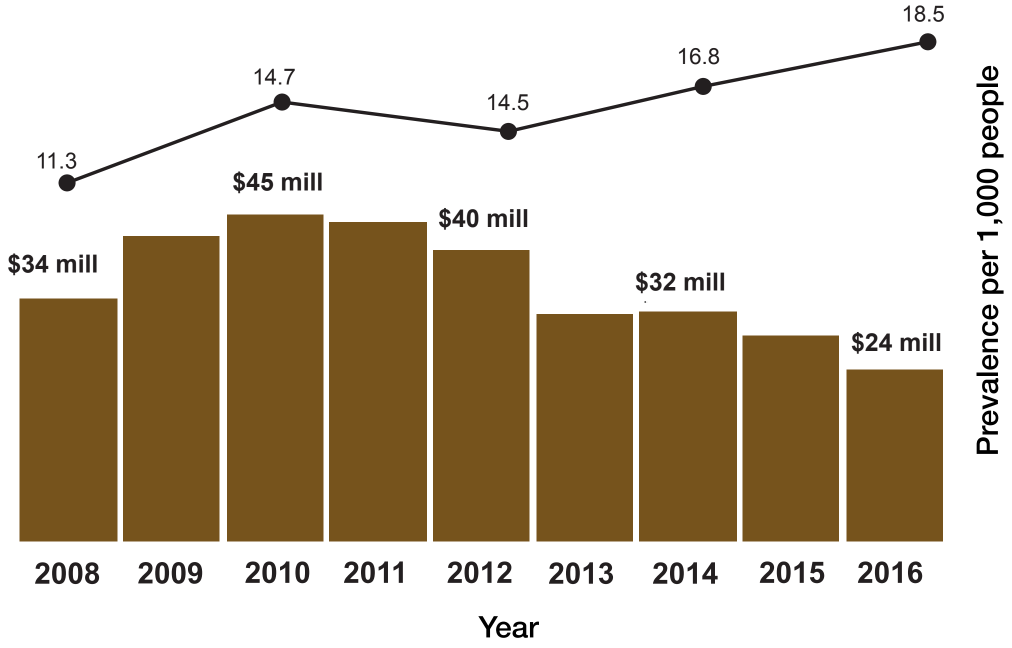
Medicaid spending for services used by autistic people is not keeping pace with growth in people diagnosed with autism. For example, while autism prevalence increased in children between 2008 and 2016, Medicaid expenditures for employment services for autistic adults decreased over time.

Medicaid is a key insurer for autistic individuals, particularly children. The number of autistic individuals who are enrolled in Medicaid has steadily increased over time.

Read more in our Introduction to Medicaid and Autism.

There is also a shortage of healthcare providers who accept Medicaid and specialize in treating people on the autism spectrum. It may take providers more time to serve autistic patients with more or greater levels of need, given that there is a lack of tools to help providers identify needs and support this group. When providers do not receive adequate reimbursement for providing intensive services, it may not be financially feasible to accept Medicaid insurance coverage.

As autism prevalence in children increased over time, Medicaid expenditures on employment services for autistic adults decreased.



Recommendations for action

1. **Generate opportunities for implementing autism-specific or autism-inclusive Medicaid programs.** Improving access to autism services via autism-specific waivers, or making sure autistic people qualify for waivers that serve people with intellectual and developmental disabilities, is critical for building capacity.
2. **Extend strategies implemented during the COVID-19 pandemic.** During the pandemic, emergency measures allowed for easing restrictions on out-of-state providers; temporarily modifying provider qualifications; and allowing provision of services via Telehealth). **Payment rates for providers were also successfully increased** temporarily during the COVID-19 pandemic. Continuation of these emergency measures is justifiable as the ongoing lack of providers to deliver home-and-community based services is an emergency.

Key policy questions

1. How many child and adult autism service providers in your state accept Medicaid? Is this adequate for the potential level of need in your state?
2. What emergency measures were put in place in your state during the pandemic? Which were successful and merit continuation?

ISSUE

2

Medicaid waivers provide coverage for essential services, but few states have autism-specific waivers.

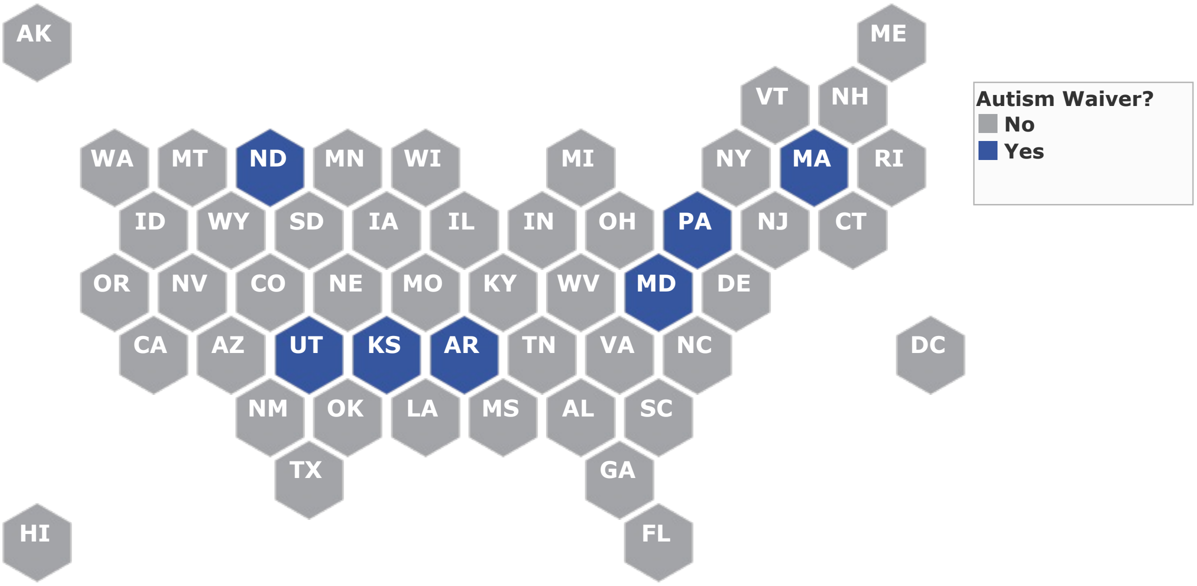
Most Medicaid waivers that serve autistic adults are designed for people with a range of intellectual and developmental disabilities (I/DD). Many I/DD waivers were designed in the 1980’s and were not intended to meet the needs of autistic people. To read more about Medicaid waivers, see our **Introduction to Medicaid and Autism**.

Autism waivers emerged in the 1990’s to provide funding for services for autistic children and adults, as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services were not meeting the needs of autistic children during that period.

Across states, most autism waivers focus on serving **children**. These waivers pay for services like intensive behavioral interventions, respite care, and other benefits. Only one state provides an autism-specific Medicaid waiver for **adults**: Pennsylvania. Adult waivers can also provide employment services and supports for community living and participation.

Medicaid differs by state. Some states have less restrictive eligibility requirements that make it easier for residents to qualify for benefits. States also differ in the types of services they cover through Medicaid. All states receive federal matching funds to help finance what they spend on Medicaid. But each state has a different federal match rate for Medicaid, and some states spend more on Medicaid per beneficiary/enrolled person.

The capacity of autism waivers to meet the needs of autistic people in this nation is extremely poor. The number of states with autism-specific waiver programs has declined over time – from 12 states in 2015 to seven at the end of 2022 after the Centers for Medicare & Medicaid (CMS) ruled that EPSDT must pay for services that autistic children need. Additionally, state autism waivers can only serve limited numbers of people. Each state sets a cap on how many people their autism waiver(s) can serve. The seven states that had an autism waiver as of the end of 2022 served a total of only 2,629 autistic individuals. This number ranged from 82 in Kansas to 1,100 in Maryland. In contrast, an estimated 5 million autistic adults live in the U.S.



Autism waiver information through 2022.

Recommendations for action

1. **Ensure existing I/DD waivers are adequate and appropriate for addressing the needs of autistic people.** Even though Medicaid coverage for adults is not an entitlement as it is for children, it would still be helpful for **CMS to issue clarification** about waiver services that are appropriate for transition-age youth and autistic adults, just like the bulletin they issued to clarify Medicaid coverage for children on the autism spectrum.

Key policy questions

1. Does your state offer an autism waiver? If so, how many people can the waiver serve? How many people are waiting for access to this waiver?
2. How many autistic people in your state are served through an I/DD waiver?
3. What happens to people who age out of a child autism waiver? Are they automatically placed in another type of waiver?
4. What services are covered that would meet the needs of autistic people?
5. If your state has an autism waiver, are there enough providers to meet service needs?

ISSUE 3

Navigating Medicaid eligibility is complex and confusing.

Medicaid enrollment and re-determination of eligibility are **complex and difficult processes** to navigate. It can take a lot of time to figure out the Medicaid system and complete the paperwork for enrollment. States often require Medicaid enrollees to reapply for eligibility every year which requires gathering many documents to prove income, rent, and other expenses. These **administrative burdens alter the effectiveness of programs like Medicaid**, as people may give up on trying to access programs that are complicated.

There is a sharp drop-off in Medicaid enrollment among autistic individuals after childhood. Once youth turn 18, they are required to be re-assessed for Medicaid eligibility as individuals, rather than as a member of a family. **One in four autistic transition-age youth lose their Medicaid eligibility during the transition to adulthood (at 16-24 years).**

Autistic children who were enrolled in Medicaid based on their disability are about **12 times less likely to be re-enrolled in Medicaid as adults**, compared to children who were enrolled based on poverty or other reasons. This might happen because autistic people who don't have an intellectual disability are less likely to qualify for Medicaid based on disability. (See Issue 6: Disparities in access to Medicaid and service utilization).

During the COVID-19 public health emergency, the Medicaid Continuous Enrollment Provision in the Families First Coronavirus Response Act (FFCRA), was designed to ensure that individuals maintain their Medicaid coverage. In April 2023, states began to "unwind" these protections as the public health emergency ended, placing **up to 14 million people at risk of losing Medicaid coverage**. This policy change could potentially have a significant impact on autistic adults who often rely on Medicaid for healthcare services and supports. Individuals may experience disruptions in their access to critical healthcare and home and community-based services (HCBS) and may face increased financial burdens associated with healthcare costs.

Additionally, autistic adults are more likely to qualify for Medicaid based on disability if they have a consistent need for services. However, some autistic people have service needs that are more episodic. How well people function, and their needs for support, may vary from day to day, and month to month, based on the stressors in their environment and changes in their health and mental health status. Medicaid funding is generally not set up to respond to continually changing service needs.

Recommendations for action

1. **Rethink the eligibility process.** The Affordable Care Act (2010) **required states to streamline the process for how people become eligible and enroll in Medicaid**. This policy change allowed more low-income individuals, including adults who do not have children, to qualify for Medicaid in states that chose to expand Medicaid eligibility. Continued attention is needed to simplify the process of re-enrollment as autistic youth (and youth with other special health needs) enter adulthood. Consider auto-enrollment into Medicaid for youth (at age 18) who already have documentation of disability, or are already enrolled in a Medicaid waiver.

Recommendations for action *(continued)*

2. **Provide "Systems Navigators."** Specialized navigators could help autistic people to navigate complex systems like Medicaid, as has been used in HIV care and in helping youth with Type 1 Diabetes to transition to adult care. Navigators answer questions, provide guidance, and can assist with complicated processes like completing application forms. However, navigators must have explicit training in how to respectfully communicate with and support autistic people who may have limited financial resources.
3. **Increase capacity of Medicaid waivers to meet the needs of autistic people.** In states with waivers, autistic transition-age youth enrolled in a waiver are six times less likely to experience disenrollment from Medicaid as they enter adulthood. As the growing group of autistic youth ages, greater capacity to serve them will be needed.

Key policy questions

1. How do autistic people qualify for Medicaid eligibility in your state? What are the eligibility criteria?
2. What is your state's process for people to re-establish eligibility for Medicaid at age 18? What tools are provided to help autistic adults and family members navigate this process?
3. What organizations or non-profit agencies in your state support people to access Medicaid?

ISSUE 4

People with multiple service needs remain on waitlists for Medicaid waiver services for many years.

States often have waitlists for home-and-community-based services (HCBS) for people with developmental disabilities, mainly because each state sets caps on how many people can access each of its HCBS waivers. In 2021, 37 states had a waitlist for HCBS services, and a total of 656,000 people were on a waiting list. Many individuals wait for years on waitlists before they receive a waiver.

Long waitlists for Medicaid HCBS waivers are especially challenging for people who need supportive services to live at home and function in the community. Some of these individuals receive other types of HCBS services while waiting, but these services don't usually meet their needs. A survey of autistic adults on a waiting list for waiver services in Pennsylvania found that over half had unmet needs for mental and behavioral health services, employment services, or services to learn functional skills.

Additionally, if you move to a new state, you must re-apply for Medicaid benefits in that state. If the new state has a waitlist for waiver services, you may experience a gap in services. Some families are surprised by this when they relocate and must start over.

Recommendations for action

1. **Consider directing more funding to HCBS waivers** to end waitlists. This movement is referred to as "Care Can't Wait" (#carecantwait).
2. **Collect state-level data from people on waitlists** to better understand their unmet service needs by region and try to find ways to meet these needs.
3. **Provide case management** to people who are on waitlists. This could help people find other options for assistance while they are waiting for waiver services.

Key policy questions

1. How many people are enrolled in Medicaid in your state? How many people are on waiting lists for home and community-based services funded by Medicaid waivers?
2. What happens to people who are on the waitlist? Are there any services they can receive while waiting, such as case management to identify other resources?

ISSUE 5

There is a lack of supports for unpaid family caregivers.

Some individuals who are autistic or have other developmental disabilities require supports to live in a home of their choosing and to function in the community. The bulk of these supports are provided by family members. **More than one in five Americans are unpaid family caregivers.** The **number of people identifying as caregivers increased between 2015 and 2020, from 43.5 million to 53 million**. These caregivers report financial impacts, difficulty coordinating care, and challenges with providing care for more than one person in the home. In 2018, Congress passed the **Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act** to create a national strategy for addressing the needs of this group. RAISE resources can be found **here**.

While most Medicaid HCBS waivers cover services for the individual with the disability, some states also use waivers to provide **supports for family members and caregivers**. Some states use waivers to pay for family and caregiver training, respite, family and peer mentoring supports, and family medical support assistance. Families might also receive assistance to apply for state and/or federal benefits, as well as support to plan for transitions their youth will make in the future (such as transitioning from pediatric to adult health care and/or transitioning from school to employment and adulthood). However, in our **Introduction to Medicaid and Autism** report, we noted that **only 5% of autistic adults who were enrolled in a Medicaid waiver received *caregiver support* as a home-and-community-based service**.

HCBS and long-term services and supports (LTSS) are provided by direct support providers. States have had **longstanding challenges finding enough workers to provide LTSS** for everyone who needs it, resulting in care being delivered by both paid and unpaid direct support providers – the vast majority of whom are family caregivers. During the COVID-19 pandemic, finding workers to deliver LTSS became even more difficult. While some states responded to this shortage by allowing family members to be temporarily paid for providing services, more permanent solutions are needed. As a part of the 1915(c) HCBS waivers, states have the discretion to determine who may provide HCBS. This means that states have the option of allowing waiver services to be provided by individuals who are related to the participant, including legal guardians, as long as they are not paid to provide personal care.

The financial strain of providing long-term care impacts caregivers' ability to pay bills and save for retirement. Caregivers also commonly report feelings of emotional and physical stress as a result of caregiving. As the reliance on family caregivers continues to grow, there is an even greater need to improve the support systems and services being offered to caregivers.

Recommendations for action

1. **Update the definition of who can be paid as caregivers.** By expanding states' definitions of who is formally recognized as a caregiver in the 1915(c) HCBS waivers, states can better support family members serving as caregivers. Adult caregivers report that this would be beneficial/helpful.
2. **Expand the services/supports for caregivers that are covered by 1915(c) HCBS waivers.** Consider additional services through waivers that would support family caregivers. Pennsylvania's adult autism waiver, for example, covers family supports.
3. **Read the RAISE Act State Policy Roadmap for comprehensive state policy recommendations.**

Key policy questions

1. What supports do family caregivers in your state report that they need? Have there been any recent needs assessments of family caregiver priorities and support needs?
2. Does your state have a family caregiving task force? Some states created these following the RAISE Act.
3. What are the current eligibility requirements for who can be paid as direct care providers in your state? Can family members receive pay for providing care? Or is pay limited to non-family members?
4. Does your state allow self-direction of Medicaid waiver funds to support family caregiver needs?

ISSUE 6

We lack Medicaid providers with expertise in serving autistic people.

It can be very difficult to find providers who accept Medicaid and are trained or experienced in serving autistic people. Many medical providers are not trained to recognize and offer care that is responsive to autistic people's needs.

Why is there a lack of Medicaid-funded providers who are competent in serving autistic people? Research has not kept pace with helping to understand this barrier. Providers may need support in the following areas:

1. **Limited Training:** Healthcare professionals receive limited training on autism and may not feel confident in their ability to provide appropriate care to autistic patients.
2. **Unique Sets of Needs:** Autism is a developmental disability that can present differently across different people, so there is no one-size-fits-all approach to care. Providers may feel overwhelmed or unprepared by the complexity of autism and unsure of how to provide effective and competent care.
3. **Stigma and Unchecked Bias:** There is still a significant amount of stigma and bias surrounding autism, which can affect how providers view and interact with autistic patients. This can lead to a lack of understanding and may make it more difficult for providers to develop the skills and knowledge needed to effectively serve autistic individuals.
4. **Lack of Incentives:** There may be a lack of financial incentives for providers to develop expertise in serving autistic patients, particularly in Medicaid programs that often have low reimbursement rates.

Recommendations for action

Addressing these challenges will require a multi-faceted, and dynamic approach, **including improved and increased training and education** for healthcare professionals, reducing stigma and bias, creating financial incentives for providers, and increasing resources for LTSS programs. Resources like the AASPIRE Healthcare Toolkit can be helpful in reducing barriers.

1. **Establish guidelines for value-based care** that is specific to autistic individuals along with criteria for provision of high-quality care.
2. Train healthcare providers regarding neuro-affirming care, skills for communicating with autistic patients, and guidelines for creating sensory friendly spaces. Training should occur both in medical school curricula as well as continued education formats.
3. **Create specialized training and tools** for direct support workers and other service providers who support autistic individuals.
4. **Set competency standards** for trainings that providers should complete prior to serving autistic individuals.

Key policy questions

1. What kind of education and training do healthcare and other service providers in your state receive regarding autism?
2. Are there financial incentives for healthcare providers to develop expertise in serving autistic patients?
3. What types of resources do healthcare providers in your state need to provide comprehensive care to autistic patients?

ISSUE 7

Disparities exist in access to Medicaid and service utilization

There are two key types of disparities that affect autistic people who are trying to access or utilize Medicaid services – those related to how they qualify for Medicaid based on their disability, and those related to underlying inequities that stem from racism and discrimination.

Disparities related to disability. Autistic people are not always automatically eligible for Medicaid. They must qualify in the same way as other people with and without disabilities – based on disability, poverty, or other reasons the state allows. It is sometimes easier for people who have autism and co-occurring intellectual disability to qualify for Medicaid, because **eligibility criteria in some states may require an intellectual disability**. However, many autistic children, youth and young adults, who were diagnosed after early intervention and special education services were mandated in the U.S., do not have a co-occurring intellectual disability.

People with disabilities who qualify for Supplemental Security Income (SSI) cash assistance are also eligible for Medicaid benefits in most states. However, it can be difficult for autistic people to qualify for SSI. This type of uneven qualification places autistic people at financial risk and cuts off an eligibility pathway to Medicaid.

Finally, eligibility for Medicaid waivers may require that the person's disability was diagnosed prior to 18 years of age. However, more autistic individuals are being diagnosed as adults. Despite increasing recognition of autism in adulthood, some have referred to the **"lost generation of adults with autism spectrum conditions"** given the difficulties and nuances of diagnosing autism in adulthood, inadequacies in the diagnostic process, and challenges of finding a diagnostician with expertise in differential diagnosis of autism in adults versus other psychiatric and medical conditions. Late diagnoses of autism can make it extremely difficult to qualify for public services.

Disparities related to race and ethnicity. Racial and ethnic disparities exist in access to and use of services among autistic Medicaid enrollees, just as they exist in the general population. Autistic children and adults of color enrolled in Medicaid are **less likely to receive services like occupational therapy** than their white peers. **Autistic Medicaid beneficiaries who are Black, Hispanic, or Asian are more likely to have diabetes**, and Black or Hispanic autistic Medicaid beneficiaries are more likely to be obese and have related conditions like nutrition issues.

There are also disparities at the intersection of disability, race, and ethnicity. In some states, such as **North Carolina**, children and adults of color with intellectual disability or autism are less likely to receive I/DD waiver benefits compared with non-Hispanic whites. In a study of autistic adults on a waiting list for autism waiver access in Pennsylvania, **Black autistic people had greater unmet needs for services**.

Recommendations for action

1. **Review eligibility criteria based on disability.**
    - Ensure that autistic people who do not have an intellectual disability can still qualify for waivers.
    - Modify criteria that prevent people who are diagnosed with autism during adulthood from qualifying for Medicaid funding based on their disability.

Recommendations for action *(continued)*

  - Base eligibility determinations on functional limitations at the time of application. Even if a person has a prior work history, or is able to communicate with speech, these characteristics should not prevent access to funding, as people's needs can change dramatically over time.

2. **Ensure sufficient numbers of providers in underserved geographic areas,** with a focus on achieving a diverse array of culturally competent providers.

Key policy questions

1. What are the criteria autistic adults must meet in your state to qualify for public benefits based on disability?
2. Do historically marginalized populations in your state have equal access to autism diagnosis and services?
3. How is information about culturally competent autism providers made public?

ISSUE 8

Developmental disability services, largely funded by Medicaid waivers, should prioritize and enhance community-based services.

Most state developmental disability (DD) services are funded by Medicaid waivers. These waivers fund services to support autistic people to live and work in their communities, but also fund services provided in more restrictive settings such as institutional care, sheltered workshops, and settings that offer daytime activities.

The bulk of the funding for state DD services comes from Medicaid Home and Community Based Services (HCBS) funds. Therefore, guidance from the Centers for Medicare and Medicaid Services (CMS) influences state DD services. CMS says that **integrated, community-based employment is a priority for how services funded through Medicaid waivers** are implemented in states. Despite this, **the number of people with I/DD who spend their days doing non-work activities has continued to grow over time**. When states were directed to focus their services on community-based settings, community-based non-work was initially used by states as a substitute for community employment.

A **community-based** setting is a place where most people do not have disabilities. A **facility-based** setting is a place where most people have disabilities.

The **Medicaid HCBS Settings Rule** is a provision that went into effect on March 31, 2023. The Settings Rule allows states to offer HCBS to individuals in their homes and communities rather than in institutional settings, such as nursing homes. The Settings Rule gives states the flexibility to design their own programs that meet the unique needs of their residents. Under the Settings Rule, states can offer a wide range of services, including personal care, respite care, and home modifications, to individuals who would otherwise require institutional care.

However, there are concerns that the Settings Rule might not be implemented evenly across states, paired with concerns that the rule does nothing to address the shortage of direct service providers who support persons with disabilities in their homes and communities. Read more about why the HCBS Settings Rule matters here.

Recommendations for action

1. **Monitor implementation of the HCBS Settings Rule** to ensure consistency across states and localities.
2. **Consider placing a cap** on the percentage of Medicaid HCBS funding that goes to facility-based care and increase the percent that must be allocated to community-based services.
3. **Create incentives for innovations** in community-based care.
4. **Address critical direct service provider shortages.**

Key policy questions

1. How much of your state's Medicaid spending goes to institutional care versus community-based services?
2. What is your state's plan for implementing the HCBS Settings Rule? How is your state planning to lead this transition toward community-based care?

ISSUE 9

Little is known about how autistic adults use long-term services and supports, especially as they age.

Medicaid is the primary payer of long-term services and supports (LTSS) related to daily living for individuals who struggle to complete these activities as a result of illness, disability, or older age. LTSS facilitate activities of daily living that are a part of basic living such as eating, meal preparation, bathing, dressing, medication management, and transportation. LTSS can be provided within institutions (such as nursing facilities or group homes for people with developmental disabilities), but more LTSS are being provided in the least restrictive setting possible (such as in an individual's home or in the community). LTSS are provided across the lifespan but primarily serve older persons with or without disabilities.

To date, little to no research has been conducted regarding how older autistic adults use LTSS. This is a critical research gap, as autistic adults may have distinct needs when it comes to using and navigating LTSS, especially as they grow older. We also need to understand more about how autistic adults use both Medicaid and Medicare benefits together, referred to as dual eligibility, and how to better coordinate and integrate care through these two insurers.

Autistic adults may have elevated rates of disability and chronic health conditions compared to the general population, which can increase their need for LTSS as they age. Many autistic adults who could benefit from LTSS do not receive them, which can lead to poorer health outcomes and increased caregiver burden. **Autistic adults who live with family are less likely to receive LTSS and have higher levels of unmet needs.**

Autistic adults may face obstacles to accessing LTSS, such as a lack of awareness of available services. It can be difficult to navigate complex eligibility criteria and enrollment procedures, and there is inadequate funding for LTSS programs.

Autistic adults may have unique needs and challenges related to LTSS, such as the need for **specialized care providers** who are specifically trained in working with individuals with autism and understand their sensory and communication needs.

Autistic adults may benefit from person-centered care approaches that take into account their individual needs, preferences, and goals for care.

Recommendations for action

1. **Invest in meaningful and translational research** needed to understand the needs of aging autistic individuals and their aging caregivers.
2. **Integrate care** across physical, health, mental health, and other community-based services to ensure continuity of care.
3. **Ensure access to long-term services and supports for autistic adults**, including by simplifying eligibility criteria and enrollment processes, increasing funding for LTSS programs, and promoting awareness of available services.
4. **Prioritize person-centered care** approaches that take into account the individual needs, preferences, and goals of autistic adults.
5. **Implement "No Wrong Door" systems** at the state level to streamline and integrate service delivery among individuals with autism and other disability that involve care across many systems.

Key policy questions

1. What is known about the needs of aging autistic adults in your state and at the local level? Have any needs assessments been conducted with this population?
2. Does your state have a No Wrong Door system in place?

ISSUE 10

State policies that tie Medicaid eligibility to work requirements are problematic for autistic adults.

Some states require Medicaid enrollees to be employed or be seeking employment to receive health coverage through Medicaid. Tying insurance to employment has proven to be a barrier to receiving health care and other needed services for people with and without developmental disabilities in the United States. Requiring disabled Medicaid beneficiaries to work is a controversial policy proposal. Proponents argue that work requirements could promote self-sufficiency and reduce reliance on government programs. Disability rights advocates argue that linking health care access and services to ability to "contribute to society" through employment is inherently ableist, as it connects a person's value to their productivity, which is potentially harmful and discriminatory towards individuals with disabilities.

Most state attempts to impose work requirements as a condition of receiving Medicaid benefits have failed or been blocked. However, **Georgia was allowed to implement work requirements** as an experiment in 2020 (through a Section 1115 waiver for demonstration projects).

Many autistic individuals face significant barriers to employment, including discrimination, limited job opportunities, and the need for accommodations. Additionally, many individuals with disabilities rely on Medicaid for critical healthcare services and supports that enable them to live independently and participate in their communities. Implementing work requirements could jeopardize access to these services, as individuals may lose coverage if they are unable to meet the requirements.

Although **some state work requirement policies exempt people with disabilities**, work requirements could be especially detrimental to autistic adults who sometimes qualify for Medicaid based on poverty, as opposed to receiving Medicaid through an HCBS waiver based on their disability.

Recommendations for action

1. **Researchers should examine the short and long-term consequences and impacts of work requirements** within states like Georgia. It is important to monitor outcomes among people with disabilities and across disability types, to determine whether some disability groups experience more impact than others.

Key policy questions

1. Does your state currently connect Medicaid eligibility with work requirements? Or is it considering proposals like this?

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