

Overview of MBI for Working Individuals with Disabilities

Since the enactment of legislation creating state Medicaid plan options that allow working individuals with disabilities to purchase Medicaid-financed services and supports (i.e., the “Balanced Budget Act of 1997” (BBA) and the “Ticket to Work and Work Incentives Improvement Act of 1999” (Ticket Act), approximately, 24 states, as of July 1, 2002, are operating a Medicaid Buy-In for Employed Persons with Disabilities (MA-EPD) optional benefit coverage.

Historically, persons with disabilities have relied upon two Social Security programs for assistance in meeting their day-to-day needs. An estimated 3.8 million adults receive benefits on the basis of disability the Supplemental Security Income (SSI) program and more than 4.9 million receive life-sustaining cash benefits through the Social Security Disability Insurance (SSDI) program. The number of beneficiaries on SSI and SSDI roles is expected to almost double by the year 2024.¹

SSDI, Title II of the Social Security Act, provides monthly cash benefits to severely disabled workers. Benefits are based on work history and the average benefit payment is about \$756 a month. After a two-year waiting period, these individuals also become eligible for Medicare Part A (hospital insurance) without paying a premium. They are also eligible for Medicare Part B, the medical insurance component of the program for a premium.

SSI, established in 1972 as Title XVI of the Social Security Act, is a means tested cash assistance program for persons with disabilities, severe visual impairments, or of advanced age. The average federally administered SSI payment is \$379. Payments vary by age group, ranging from an average of \$463 for those under 18 to \$303 for those age 65 and over. States also may provide monthly supplements to help persons not fully covered by federal SSI payments. States determine whether they will make a payment, to whom, and in what amount.

For both of these critical cash benefits programs, the corner stone of eligibility is a determination of disability based on the “substantial gainful activity” (SGA) standard. That is, disability for SSI and SSDI is defined as the inability to engage in SGA for more than twelve months. SGA currently is defined as earnings of more than \$740 per month or more. Once a SSI or SSDI beneficiary earns above this level, an array of mechanisms aimed at eliminating or reducing cash benefits are activated. Also jeopardized with the loss of SSI or SSDI is the elimination of access to publicly funded health care coverage which often is keyed to receipt of cash benefits. Thus, for years, individuals with disabilities receiving cash benefits and also reliant on publicly-financed health care

¹ *2000 SSI Annual Report*, dated May 30, 2001. Social Security Administration, Office of the Chief Actuary.

coverage have been forced to remain unemployed or to drastically limit the number of hours worked and/or dollars earned to maintain their eligibility status.

SSI beneficiaries have enjoyed some shelter under Sections 1619(a) and 1619(b) of the Social Security Act. The first of these “work incentive” provisions, Section 1619(a), allows workers with disabilities receiving SSI to increase their income above SGA and retain SSI cash payments. SSI payments gradually decrease consistent with increases in earned income. Ultimately, the SSI benefit reaches zero and Medicaid coverage is lost unless the individual is found eligible for the Section 1619(b) provision. Under Section 1619(b), even after the cash benefit payment has been eliminated by earned income, access to Medicaid can continue to be provided these individuals who: a) meet all SSI eligibility criteria except for earnings (i.e., a serious disabling condition); b) need Medicaid services to maintain employment (such as access to medications or therapy); and c) their gross earnings remain below state-specific “individualized” thresholds.

In regards to the later, access to Medicaid for SSI beneficiaries participating in 1619(b) is not boundless; states have income ceilings for their 1619(b) populations. However, the 1619(a) and (b) income limits are made more flexible by deducting the cost of certain impairment-related items and services that a working individual with a disability needs to work from gross earnings once SSA has established that countable earnings demonstrate performance of Substantial Gainful Activity (SGA). SSI beneficiaries also may save for items related to vocational goals and employment outcome under “Plans for Achieving Self-Sufficiency (PASS).

Unlike SSI beneficiaries, SSDI beneficiaries do not have available to them the graded protections offered by Sections 1619 (a) and (b). Instead SSDI beneficiaries have:

- A “trial work period” of nine months during which a person may work and continue to receive cash benefits from SSA; and
- An “extended eligibility period” of 36 months during which a person may work and, if necessary, return to their SSDI status if employment fail. Also, if earnings below SGA then get check

Once this benefit is lost, these individuals lose access to publicly financed health care coverage under the Medicare program. To learn more about SSI and SSDI work incentives as well as Medicare coverage for working individuals with disabilities, go to SSA’s Web site at www.ssa.gov/work.

In the late 1990’s, Congress crafted state Medicaid plan options for Medical Assistance for Employed Persons with Disabilities (MA-EPD) programs under the “Balanced Budget Act of 1997 (BBA; P.L. 105-33)” and the “Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act; P.L. 106-170) to offering a new mechanism for persons with disabilities, SSI and SSDI beneficiaries to work, increase their earned income, and maintain health care coverage that they otherwise would not be able to access and/or afford. The primary target populations include: a) SSDI beneficiaries who

cannot utilize Section 1619(a) and (b) protections ; b) persons receiving SSI who have or could exceed the state-established income limits or resource limits under Section 1619(b); and c) individuals with disabilities who have been working but have never, or are not currently, receiving Social Security benefits and/or on Medicaid roles. In addition to the MA-EPD options, the Ticket Act also made significant changes to Medicare access for working individuals with disabilities (see discussion below).

Buy-In Options. All three options, the one under BBA and two options under the Ticket Act (see below), allow states to develop a Medicaid eligibility category targeted to “working persons with disabilities who but for earnings in excess of the limit(s) established under a state plan would be considered to be receiving SSI.” The intent of the law is to increase employment opportunities for persons with disabilities by de-linking access to Medicaid-financed services from eligibility for cash assistance programs.

To date, based on a Summer 2001 state-by-state work incentives survey conducted by the APHSA Center for Workers with Disabilities, 28 states have implemented or soon will be implementing a MA-EPD program. Here, it is important to note that states have chosen to use different vehicles for establishing such eligibility categories and that there are differences between the two legislative options.

The Options. Twelve states (AK, CA, IA, ME, MS, NE, NM, SC, UT, VT and WI) are using the BBA option:

“(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums of other cost-sharing charges (set on a sliding scale based on income) that the state may determine;”

These states may cover all working individuals who meet the SSI definition of disability who are earning up to 250 percent of the federal poverty level (FPL) and may impose a cost-sharing mechanism on a sliding fee scale basis. SSI resource and asset limits still apply. These states also may utilize a variety of income and resource disregards reduce a potential MAEPD enrollee’s earned income level to 250 percent of FPL.²

² Some examples include: a) standard SSI deductions (see SSA’s Redbook); and b) Section 1902(r)(2) more liberal treatment of income and resources options.

Fifteen states (AR, AZ³, CO, CT, FL, IN, KS, MN, MO, NH, OK, PA, TX⁴ and WA) have utilized the “Expanded Health Care” under Title II of the Ticket Act:

Basic Coverage Group. “(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income, who is at least 16, but less than 65 years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the state may establish;”

States utilizing the Ticket Act may cover all working individuals who meet the SSI definition of disability who are earning up to 450 percent FPL. States may not draw down federal matching funds for persons earning over 450 percent. States also may impose a cost sharing mechanism on a sliding fee scale basis; however, the cost share may not exceed 7.5 of an individual’s annual income. Asset and resource limits are at state discretion.

The Ticket Act also offers a second coverage option:

Medical Improvement Group. “(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the state may establish, but only if the state provides medical assistance to individuals described in subclause (XV);”

Under this option, states may offer Medicaid coverage to working individuals with a “severe medically determinable disability.” These are working individuals with disabilities who because of treatment (therapy, medication, etc.) no longer meet the SSI definition of disability. Examples of the potential coverage group includes: a) persons with severe mental illness; b) persons with HIV/AIDS; c) and persons with epilepsy. The same financial guidelines apply to the Medical Improvement Group as the Basic Coverage Group. States picking up the Medical Improvement Group also must implement the Basic Coverage option. Of the states utilizing the Ticket Act, seven states (AZ, CO, CT, IN, KS, PA, and WA) have elected to implement both coverage options. Further distinctions between the BBA option and the Ticket Act options are described below. Of these seven states, only CT is operating an MAEPD program. CMS is scheduled to release an array of guidance materials to states on this coverage option in the coming year.

³ The state of Arizona operates its Medicaid program under the auspices of an 1115 Waiver program. The state’s MA-EPD program was established via an amendment to Arizona’s waiver program rather than a state Medicaid plan amendment.

⁴ The Texas Legislature passed a measure authorizing the executive branch to pursue an 1115 Waiver. This waiver would allow Texas to pilot TWWIIA in three counties. Texas will not implement TWWIIA statewide at this time.

When the architects of the Ticket Act first drafted the legislation, the conceptual framework was that the new law would “build on” the Medicaid Buy-In option created under the BBA. That is, BBA allowed states to establish a Medicaid Buy-In program for “families whose income is less than 250 percent of the income official poverty line,” states interested in utilizing this opportunity would enact BBA-based legislation and, then, enact state legislation based on the still nascent Ticket Act that contains much higher standards. In fact, under the Ticket Act states need not have asset or resource standards; the only requirements are that income is equal to or below 450 percent of poverty (as defined by the Internal Revenue Service (IRS)) in order to receive federal matching funds for services and that (see discussion below).

However, the statutory linkages between Ticket Act and the BBA health care coverage expansion provisions ended up on the “cutting room floor.” Thus, states can choose to utilize BBA or Ticket Act but are under no obligation to sequentially first implement BBA and then Ticket Act. The two statutory provisions are mutually exclusive. However, the insular nature of the provisions has proven to be a less than optimal arrangement for some states (see the “*Outlook*” section of this document).

States also may develop such programs under special Medicaid waiver arrangements. The state of Massachusetts has been providing health insurance that working persons with disabilities may purchase since 1989 first as a state general funded service and, in 1997, the state received an a Section 1115 Waiver to operate the program. Massachusetts’ publicly-funded health insurance program, including the MA-EPD program is called “Commonhealth.” The state of Colorado also explored this option but changed course with the passage of Ticket Act. Today, however, it is highly questionable that the Centers for Medicare and Medicaid Services (CMS) would entertain a waiver application for an MA-EPD program when two statutory options are available. An additional three states have resolutions to develop a MA-EPD program – these include Idaho, Louisiana, and Nevada.

Other “Expanded Health Care Coverage.” Overlaying the Medicaid options, the Ticket Act also contains significant changes to the federally administered Medicare program. It is important to note that these are changes in a federal program and apply to all states – those with out MA-EPD programs and those with a BBA or a Ticket Act Medicaid Buy-In programs for working individuals with disabilities. Prior to the Ticket Act people with disabilities who return to work, but still had a disabling condition that met SSA’s rules, were covered by Medicare for at least 39 months, or three years and three months, after they completed the nine-month trial work period. The Medicare hospital insurance (Part A) was free while Part B, doctors’ office visits, has a premium attached.⁵

⁵ For more information on Medicare coverage, go to <http://www.medicare.gov/basics/overview.asp>. For more information on Medicare coverage for persons with disabilities, go to <http://www.ssa.gov/work/ResourcesToolkit/Health/medicare2.html>.

Beginning in October 2000, TWWIA extended Medicare coverage for an additional four and one-half years beyond the current limit for people with disabilities who return to work. Thus, Medicare coverage continues for at least 93 months (seven years and nine months) after the nine-month trial work period. Premium requirements noted above remain the same. In general, an individual qualifies for the additional four and one-half years of Medicare coverage if he or she:

- Still has a disabling condition; and
- Is starting to work for the first time after his/her disability benefits began;
- Is in a trial work period; or
- Is in a 36 month extended period of eligibility which began after June 1997; or
- Medicare coverage under the law prior to P.L. 106-170 was not due to end until after September 30, 2000.

SSA has developed a tool for SSA Regional Office and Field Office staff to calculate new eligibility dates for working individuals with disabilities who also are receiving Medicare coverage. Additionally, the agency has developed a software package, entitled the “Medicare Wizard,” that makes the necessary calculations. The Wizard is currently only available for use within SSA but will become accessible for state agency staff in the late Fall.

For services and supplies covered by both the Medicare and Medicaid programs, Medicare is the primary payer. Medicaid, for dually eligible individuals, covers items that Medicare does not cover. Normally, these “cost-avoidance” requirements indicate that Medicaid may not pay a claim submitted by a provider or supplier before Medicare, unless: 1) the state has an approved cost-avoidance waiver for these claims; or 2) it is evident that there is no Medicare eligibility, coverage, or payment, and the provider or supplier furnishes such confirmation to Medicaid.

BBA and TWWIA Distinctions. While the intent and basic structure of BBA and the Ticket Act are analogous, there are some important differences for state policymakers to make note of as they develop new programs or, as early implementers consider “next steps” for current programs. As discussed above, BBA places a cap on how high a state may set the allowable “family” income; that is, participating “families” must have a net income below 250 percent of the federal poverty level.⁶ However, states may treat income more liberally than the SSI rules required by the BBA by adopting the recently clarified Section 1902(r)(2) rules. Additionally, resources may not exceed the SSI resource standards (i.e., \$2,000 for an individual and \$3,000 for a couple).

⁶ CMS, formerly the Health Care Financing Administration, has issued two state Medicaid directors’ letter illuminating treatment of “family” income under the BBA option. The second transmittal offers states a choice of not counting the income of co-habiting family members, creating a “house-hold of one,” or counting such income. To view the letter, go to <http://www.hcfa.gov/medicaid/bba4733.htm>

On the other hand, the Ticket Act contains no income standards, up to 450 percent, and no federally specified resource limits. States have broad discretion when setting financial rules for participation. Since BBA and the Ticket Act were not “built” one on to the other, states implementing the Ticket Act may go below the 250 percent limit set forth in BBA. For example, the state of Illinois’ Ticket Act-based MA-EPD activated with an income limit of 200 percent of the poverty limit with an eye towards increasing this amount in the out-years.

Conversely, some BBA states are considering much higher income levels by either converting the BBA program into a Ticket Act option or by applying the more liberal Section 1902(r)(2) income treatment rules. Some experts argue that because of the availability of Section 1902(r)(2) for BBA states that distinctions between BBA and the Ticket Act are in terms of income treatment are not significant. However, state officials have indicated that the Ticket Act was considered the simpler course because of the administrative complexities of using Section 1902(r)(2).

BBA states also may go below 250 percent but, unlike the Ticket Act states, may not go over that figure. Additionally, BBA states must ensure that program participants unearned income not exceed the SSI income standard (currently \$512 a month for an individual and \$769 for a couple) while the Ticket Act states, as with earned income, may set their own unearned income standards. Concurrently, BBA states also must adhere to the resource standards set forth in the 1997 law while Ticket Act states may set their own rules. See “Attachment A” for a summary and side-by-side comparison of the Ticket Act and the BBA.

Premiums and Cost-Sharing. Both statutes offer states the authority to require financial participation from MA-EPD consumers “set on a sliding scale based on income that the state may determine.” While the Ticket Act offers greater flexibility for states when establishing financial rules for participation in MA-EPD programs, some states have indicated that BBA provides more liberal rules for establishing premium and other cost sharing structures. BBA has no limits on how much a state may require a program participant to contribute.

Under the Ticket Act, however, states may require premiums or cost sharing set on a sliding scale based on income and charge 100 percent of the premium to individuals whose income exceeds 250 percent of the federal poverty level (FPL) provided that the premiums do not exceed 7.5 percent of the individual’s income. In these cases, states may subsidize premiums with unmatched state funds.

Most states have implemented a straight-forward premium structure keyed to income. However, the state of Oregon has both a premium and a cost share while the states of Arkansas and New Mexico have a co-payment for acute health care services.⁷ Both

⁷ New Mexico MA-EPD participants will be enrolled in the state’s Medicaid Managed Care program called, “SALUD.” Recently, the state renewed and revised its contracts with participating Managed Care Organizations (MCOs) to include provisions aimed at enhancing MCO services for persons with

states have carved long term care services out of the co-payment requirements. Regardless of the cost-sharing method employed, CMS has been crystal clear that any such arrangement must be on a sliding scale-basis keyed to income. The two states utilizing co-payments also have established utilization caps on their co-payments; once a certain dollar amount in co-payment is reached, the MAEPD participant no longer owes the cost share for a given period of time.

To date, fewer MA-EPD program participants nationwide are paying a premium than are not paying a premium or other cost share. In Nebraska, out of 120 participants only eight are paying a premium and in Oregon out of approximately 500 participants only 177-plus individuals have a financial responsibility to the state.

The Question of “Employed.” An additional key requirement for both the BBA and the Ticket Act MA-EPD programs are that the participants be “employed.” However, neither the BBA nor the “Basic Coverage” group of the Ticket Act offers a definition of the term, “employed.” The logical course, therefore, would be for states to define “employed” – most likely by earnings or hours worked building on some federal threshold or guidance. However, neither the BBA nor the Ticket Act “Basic Coverage” offer such a benchmark.

Furthermore, neither the SSI definition of “earned income” nor SSI earned income policy has minimum earnings or work hours described for the purposes of determining whether or not an individual is “employed.” Since states cannot be more restrictive than federal law allows, no entry level of earnings or hours worked can be established. Several states have indicated concern that individuals could become eligible for an MA-EPD program due solely to becoming nominally employed (e.g., earning a few dollars a month from parents for odd jobs or becoming minimally self-employed). Federal does not and state law cannot prohibit this practice.

However, such a strategy is directly at odds with the legislative intent to support the economic self-sufficiency of persons with disabilities. States can require proof of employment such as wages stubs showing FICA tax contribution, social security deductions, W2 forms, etc. The state of Minnesota, for example, requires that an individual receive earned income every 30 days.

The “Medical Improvement” group of the Ticket Act contains a definition of “employed:”

- The individual is earning at least the applicable minimum wage requirement and working at least 40 hours per month; or

- The individual is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the

disabilities. Several other states also will be enrolling MA-EPD participants in Managed Care arrangements. For more information, contact Mike Cheek at mcheek@apsha.org.

state and approved by the Secretary of the U.S. Department of Health and Human Services.

Should an MAEPD participant cease (i.e., “pink slip,” illness, economic factors, etc.) to be employed they must be removed from the program unless the state has special provisions creating a “grace period” to find new employment or a special program in which they can participate that also will allow them to remain in the MA-EPD group. Most MAPED states offer grace periods for cessation of employment and the states of Wisconsin, Vermont, and New Mexico offer special job development, job search and training programs in which MAEPD participants can enroll between jobs and remain eligible.

There are notable cases in which individuals currently in the states Medically Needy categories or who were previously not eligible for Medicaid have worked a “token” number of hours in order to become eligible for the MA-EPD program and/or avoid the rigorous “spend-down” associated with Medically Needy programs. Such practices have raised concerns in virtually all states operating MAEPD programs.

Maintenance of Effort (MOE). The Ticket Act also contains “maintenance of effort” requirements;” the BBA option does not. P.L. 106-170 contains the following requirement:

“with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph.

A state may meet an MOE requirement one of two ways: 1) by continuing to spend at the rate prior to implementation of the Medicaid option and then drawing down federal matching funds thereby up to doubling the dollars available; or 2) continuing to spend at the preceding rate, adding more funds and then drawing down federal matching for the newly added funds. Some states disagree with the concept of MOE requirements and found the BBA option a more desirable option for that reason.

A Final Distinction. A final important factor to consider when comparing the BBA option with the two options available to states under the Ticket Act is that access to the Ticket Act options is limited to working individuals with disabilities between the ages of 16 and 64. These age limits were inserted in eleventh hour negotiations with fiscally conservative members of the U.S. Senate concerned about cost. BBA 1997 contains no such age limits.

While the minimum age limit is not of major concern, the upper age limit presents some considerations. Several states have begun to consider what might befall individuals participating in a Ticket Act MA-EPD program who: a) have accumulated resources while in MA-EPD above the resource limits attached to the regular Medical Assistance program; and/or b) wish to continue working past the age of 64. State officials have concluded that MA-EPD participants in states with Ticket Act-based programs would have to disburse resources and assets accumulated above the limits set for participants in the regular Medical Assistance program. However, states may pursue the development of a special eligibility category within their regular Medical Assistance program that, as part of the eligibility criteria, disregards certain savings accounts that go beyond the regular resource limits. The state of Connecticut has such a state plan option. Individuals over age 64 also would either have to cease work activity or reduce their hours and/or wages in order to remain eligible for regular Medicaid.

States have considered several courses because of the age issue. Regarding the resource issue, a state could pursue the development of a Connecticut-like option. The state of Oregon is considering, as a possible option, the creation of a Ticket Act MA-EPD program while continuing to operate its BBA MA-EPD program. Oregon officials have indicated their hope is that individuals who wish to continue working past age 64 or who may have to continue to work past age 64 because of increases in the retirement age (i.e., already it has been increased to 67 and is likely to continue to rise) could continue to work by shifting from the Ticket Act category to the BBA category. An array of critical questions would have to be answered regarding linkages between the two programs plus what provisions a state also would need to utilize to make the BBA income and resource limits palatable to former Ticket Act participants.

Outlook. States and advocates alike are enthusiastic about the possibilities offered by the Medicaid Buy-In programs for persons with disabilities. They offer some persons with disabilities long trapped by archaic work incentive rules the opportunity to become employed or more fully employed. They also offer states the opportunity to unshackle a long-hindered and untapped pool of workers while also offering the possibility of increased revenue in the form of income taxes and/or sales taxes.⁸

While MAEPD programs have received broad support, in addition to the distinctions noted above, stakeholders also have paid careful consideration to the costs associated with these new and innovative programs. States have reported an array of budgetary projections. Factors driving costs include whether the state targeted enrollment to individuals who were previously enrolled under another Medicaid eligibility category – such as the Medically Needy category or whether the state has included a pool of potential enrollees who were previously not eligible for Medicaid. States with a Medically Needy category have reported up to 60 to 80 percent of their Buy-In participants were previously covered under the Medically Needy option. Enrollment in MAPED programs, shaped by these underlying Medicaid structures and outreach

⁸ A long standing argument for the MA-EPD program has been that with increased discretionary income, persons with disabilities could more fully participate in the local, state, and federal economy.

activities, ranges widely from 70 individuals in Mississippi to 6,000 in the state of Minnesota. Other factors impacting on cost include: a) the extent to which enrollees use or are able to access private insurance through employers and utilization of health care and long term care services; and b) premium or cost-share arrangements.

Another important consideration for states designing and/or operating MAEPD programs is that neither the BBA nor the Ticket Act made changes to standards governing receipt of SSDI cash benefits or other publicly-financed benefit programs. Therefore, SSDI beneficiaries now enjoy extended access to health care coverage) but not a gradual reduction in cash benefits under available under Section 1619(a) for SSI recipients. Thus, before returning to work SSDI beneficiaries must carefully consider whether increased income will offset the loss of their benefit check. Many SSDI beneficiaries enrolled in MAEPD programs continue to artificially limit their income in order to retain their SSDI benefit check. Such activity has a dampening effect on increased earnings and hours work for the MAEPD programs as a whole. The Ticket Act included a demonstration on a SSDI of a \$1 reduction in benefits for every \$2 earned, similar to Section 1619(a). Enrollees in MAEPD programs also must consider the impact of earned income on other benefits such as food stamps, public housing assistance and any benefits that other members of the household are receiving.

A final consideration for state official operating MAEPD programs is the inherent contradiction in the disability determination process when determining that a person meets the SSI disability standard while working. In general terms, disability determination agencies or SSA are put in the odd situation with MAEPD programs of using a standard intended to prove a person can not work while including the fact that these individuals are employed but still disabled. States have taken several approaches to resolve this policy conundrum.

CMS has available funds for states to finance MAEPD development efforts; these funds are distributed as Medicaid Infrastructure Grants. 38 states now are receiving such MIG funds. The genesis of MAEPD programs has forced often highly insular agencies, federal and state, serving persons with disabilities to work more closely than in the past. It is this phenomenon that will likely lead to further improvements in how government supports all persons with disabilities.