year, depending on the rate of participation, for up to a half a million new recipients. These estimated costs are a tenth of those estimated by the Congressional Budget Office for implementing the MiCASSA.

Kitchener, M., Ng, T. (2007) **Medicaid home and community-based services for the elderly: Trends in programs and policies.** *Journal of Applied Gerontology, 26(3), 305-324.* NARIC Accession Number: J54432. Project Number: H133B031102.
Abstract: Article presents 1999 to 2002 participant and expenditure trend data for three Medicaid home- and community-based services (HCBS) program that serve the elderly: the state plan personal care services (PCS) benefit, the 1915(c) waivers, and home health. It also presents findings from a national survey of eligibility and cost control policies on these programs. Although the program trends show a rise in elderly waiver and PCS programs and participation, they also reveal falling per-participant expenditures in PCS programs, declining annual growth in total HCBS expenditures, and large interstate variations in elderly waivers. The use of cost control policies such as spending caps and large waiver waiting lists in many states contribute to the gap between demand and supply for Medicaid HCBS for the elderly.

Kitchener, M., Ng, T. (2008) **Assistive technology in Medicaid home- and community-based waiver programs.** *The Gerontologist, 48(2), 181-189.* NARIC Accession Number: J54392. Project Number: H133B031102.
Abstract: Article presents national assistive technology (AT) expenditure and participation trends for Medicaid 1915 (c) waivers, the largest Medicaid home and community-based services program. A descriptive analysis examined trends in national participation and expenditures, interstate variations in participation and expenditures, and differences in provision between elderly adults and people with developmental disabilities. In addition to reporting the growing number of states that provide AT to Medicaid waiver participants, the results showed an increasing number of AT participants and expenditures. However, there has been much slower participant growth compared with the broader waiver program, and there is wide interstate variation in waiver AT provision. Not only do most waivers with AT serve people with developmental disabilities, AT spending for that group is nearly twice that for elderly or disabled waiver participants.

Miller, N., Elder, K. (2008) **Medicaid 1915(c) waiver use and expenditures for persons living with HIV/AIDS.** *Medical Care Research and Review, 65(3), 338-355.* NARIC Accession Number: J54394. Project Number: H133G010023.
Abstract: Study examined state-level factors that are associated with the provision of community-based care to people living with HIV/AIDS through Medicaid 1915(c) waivers. States with Democratic governors were more likely to offer waiver services and were found to have higher rates of use and greater expenditures and to devote a larger share of long-term care dollars to waiver services for people living with HIV/AIDS.

Lakin, K., Prouty, R. (2008) **Trends and milestones: Twenty-five years of Medicaid home and community based services (HCBS): Significant milestones reached in 2007.** *Intellectual and Developmental Disabilities (formerly Mental Retardation), 46(4), 325-328.* NARIC Accession Number: J55055. Project Number: H133B031116.
Abstract: Article provides state-by-state data on changes in expenditures and number of recipients for the Medicaid Home and Community Based Services (HCBS) waiver program from 1982 to 2007. The HCBS program permits states to provide a wide variety of community services to people with intellectual and developmental disabilities (IDD) to reduce the use of and per person expenditures for a nursing facility or intermediate care facility for people with mental retardation. Fiscal Year (FY) 1982 was the first year in which states could apply to use the new HCBS option. At the end of state FY 1982 (June 30, 1982), only two states (Montana and Oregon) offered HCBS to persons with IDD, with only 1,381 total service recipients. Nationally, FY 2007 HCBS programs for persons with IDD passed two milestones. On June 30, 2007, state HCBS programs in the aggregate were supporting for the first time more than 500,000 individuals with IDD. FY 2007 was also the first year in which state and federal HCBS expenditures exceeded $20 billion.

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RehabWire
News from the National Rehabilitation Information Center

Medicare and Medicaid
Volume 11, Number 1, January 2009

NARIC
National Rehabilitation Information Center

## NIDRR Grantees on the Cutting Edge

**Assessing the Impact of Medicare-D on SSDI Beneficiaries** *Washington State University* (H133G070055) led by James J. Kennedy, PhD. Kenneth D. Wood, PhD, Project Officer.
Abstract: This project assesses the impact of Medicare-D on younger beneficiaries in four distinct but interrelated studies: (1) quantitative analysis of access and utilization rates among beneficiaries under age 65, using successive panels of the Medicare Current Beneficiary Survey; (2) qualitative research on the impact of Medicare benefits on employment and continuity of medical care, based on repeated focus groups at two sites; (3) formulary analysis of coverage for critical medications among competing private Medicare Advantage and Prescription Drug Plans in Washington State; and (4) ongoing policy analysis of legislative and regulatory changes in Medicare and SSDI. Although younger beneficiaries comprise only 14.1 percent of the total Medicare population, they account for about 17 percent ($71.6 billion) of total program expenditures. Through dissemination of research findings, this project enhances awareness in the research and policy community of the unique Medicare-D concerns of younger beneficiaries with disabilities, consistent with the ultimate goal of improving access to affordable health services for people with disabilities.
Find out more at: www.spokane.wsu.edu/Academics/Health_Sciences/HPA/medicare/index.asp

**Impact of Prospective Payment and Rehabilitation Outcomes** *University of Texas Medical Branch* (H133G080163) led by Kenneth J. Ottenbacher, PhD. Scott Brown, PhD, Project Officer.
Abstract: This project examines associations and trends in key rehabilitation outcomes before and after the introduction of prospective payment (PPS). Research objectives are: (1) to examine the impact of differences in the scoring and recording methods used to measure functional status pre-PPS (FIM Instrument) and under the PPS (Inpatient Rehabilitation Facility-Patient Assessment Instrument); and (2) to compare associations and trends in outcomes for three years pre-PPS (1999-2001) to three years under the PPS (2002-2004). Outcomes examined include length of stay, functional status at admission, discharge and follow-up (3-6 months), living setting pre-admission, incidence of hospital readmission, and mortality. Research objectives are addressed using two data sets. The Uniform Data System for Medical Rehabilitation (UDSMR) is used to examine the impact of changes in rating and coding functional assessment data introduced with the PPS in 2002 (Objective 1). Association and trends are explored using both the UDSMR database and Centers for Medicare and Medicaid Services (CMS) files (Objective 2). The CMS information includes

According to the latest release from the Social Security Administration, 44 million Americans are currently enrolled in Medicare or Medicaid. Of those, 7.4 million are people with disabilities, 37.6 million are people 65 or older (aged).

*Source: Fact Sheet: 2009 Social Security/SSI/Medicare Information.* www.socialsecurity.gov/legislation/2009factsheet.pdf

*Please note: These abstracts have been modified. Full, unedited abstracts, as well as any available REHABDATA citations, are available at naric.com.*

**Thousands of additional resources on these topics are available from NARIC's resource pages at www.naric.com/public**

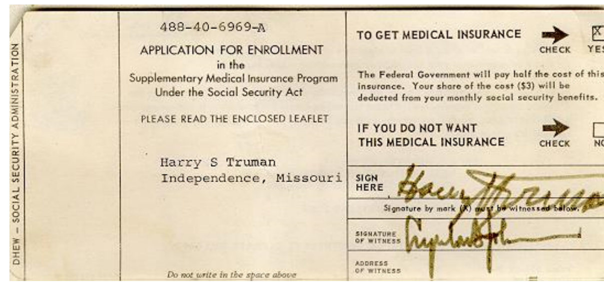
Research on Medicare and Medicaid services spans NIDRR's Health and Function, Participation and Community Living, and Disability Demographics priorities.

the Inpatient Rehabilitation Facilities-Patient Assessment Instrument file, the Medicare Provider Analysis and Review file, and the Medicare Denominator file.

**Midwest Regional Spinal Cord Injury Care System (MRSCIS)** *Rehabilitation Institute of Chicago* (H133N060014) led by David Chen, MD. Kenneth D. Wood, PhD, Project Officer.
Abstract: The Spinal Cord Injury Rehabilitation Program at the Rehabilitation Institute of Chicago and the Acute Spinal Cord Injury Program at Northwestern Memorial Hospital demonstrate the ongoing, comprehensive, multidisciplinary services that are provided to individuals with spinal cord injury (SCI) which allow them to optimize their rehabilitation outcomes and enhance their ability to return to productive, independent living in the community. In order to contribute to the improvement of outcomes for persons with SCI, the Site-specific research includes Disparities in Access to and Outcomes of Rehabilitation Care for Medicare and Medicaid Beneficiaries with Spinal Cord Injury.
Find out more at: www.ric.org/research/centers/MidwestRegionalSpinalCordInjuryCareSystem/MRSCICS.aspx

**University of Pittsburgh Model Center on Spinal Cord Injury** *University of Pittsburgh* (H133N060019) led by Michael L. Boninger, MD. Theresa San Agustin, MD, Project Officer.
Abstract: The UPMC-SCI continues its research focus on assistive technology (AT) for mobility. Pilot data collected during the previous funding cycle highlighted disparity in wheelchair prescription. Individuals from minority groups and people with low socioeconomic status received less and lower quality equipment. So that interventions can be developed, the project continues and expands this research to delve into the reasons for disparity. In addition, it investigates the impact of recent Centers for Medicare and Medicaid Services (CMS) changes for AT reimbursement. These changes will likely have a critical impact on the AT provided to individuals with spinal cord injury (SCI).
Find out more at: www.upmc-sci.org or www.rehabmedicine.pitt.edu

**Medicaid Quality Indicators for Individuals with Disabilities** *George Mason University* (H133A040016) led by Susan E. Palsbo, PhD. Phillip Beatty, PhD, Project Officer.
Abstract: This project develops and validates health service quality indicators for people with disabilities. The target population to be served is people with disabilities enrolled in managed Medicaid programs. The goal is to develop and field test quality measures for people with disabilities in managed care organizations. The specific aims are: (1) Case identification: Improve the computer algorithm for Medicaid plans to identify beneficiaries who have disabilities. (2) Plan-reported indicators: Select a subset of existing HEDIS Medicaid measures that are appropriate and statistically meaningful for indicating the quality of care for the people identified in Aim 1. (3) Consumer-reported indicators: Assess the content validity of the Axis-CAHPS survey. (4) Develop comparative reporting tools of the quality of care between and within health plans. This is a combined qualitative and quantitative study with three interrelated segments: (1) Extend previous research on using routine health claims data to identify beneficiaries who are at risk of needing modified help to access their Medicaid benefits and services; (2) review and refine the two most widely used Medicaid quality indicator tools, CAHPS and HEDIS; and extend work on refining the CAHPS instrument for people with physical disabilities; and (3) explore how people with disabilities, payers, and providers can use the indicators to improve practice and report outcomes using comparative reporting tools.
Find out more at: chhs.gmu.edu/ccid


DHEW – SOCIAL SECURITY ADMINISTRATION

488-40-6969-A

APPLICATION FOR ENROLLMENT
in the
Supplementary Medical Insurance Program
Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

Do not write in the space above

TO GET MEDICAL INSURANCE → CHECK [X] YES

The Federal Government will pay half the cost of this insurance. Your share of the cost ($3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT THIS MEDICAL INSURANCE → CHECK [ ] NO

SIGN HERE

Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS

ADDRESS OF WITNESS

Photo Credits: Social Security Administration History Page

Proposals for what would become Medicare and Medicaid were submitted to the House and Senate in January of 1965. The Mills Bill, which included Social Security improvements and an unprecedented package of health benefits, passed the House in March. President Lyndon Johnson signed it into law on July 30th and presented the first card to former President Harry Truman who proposed the idea of national healthcare in a message to Congress 20 years earlier.

**Where Can I Find More?**

A quick keyword search is all you need to connect to a wealth of disability and rehabilitation research. NARIC's databases hold more than 75,000 resources. Visit www.naric.com/research to search for literature, current and past research projects, and organizations and agencies in the US and abroad.

The Cochrane Collaboration lists 529 economic evaluations in a basic search for "Medicare." The NHS Economic Evaluation Database contains more than 7,000 quality assessed economic evaluations. Visit www.thecochranelibrary.org and search "Medicare" to review these and other systematic reviews.

## Current Literature - *Selections from REHABDATA*

Palsbo, S. E.; Mastal, M. (2006) ***Disability care coordination organizations - The experience of Medicaid managed care programs for people with disabilities.*** NARIC Accession Number: O17087. Project Number: H133B970003.
Abstract: Report describes the emergence of innovative managed care programs, referred to as disability care coordination organizations (DCCOs), that integrate health and social services for Medicaid beneficiaries with disabilities. The authors outline seven key recommendations for states to consider as they design and implement DCCOs for adults with disabilities: (1) ensure that DCCOs are grounded in the infrastructure of the community served; (2) develop mechanisms for formal input by beneficiaries into governance; (3) design fully capitated programs if possible; if not, at least partially capitate and ensure that DCCOs can financially benefit from care coordination savings; (4) allow DCCOs to compile all data on carved-out services, such as mental health or pharmacy expenditures; (5) ensure that DCCOs have a sophisticated management information system; (6) track quality of life outcomes, in addition to satisfaction, clinical, utilization, and financial outcomes; and (7) track utilization and pay for care coordination services.
**This document is available online at www.chcs.org/usr_doc/DCCOs.pdf**

Kitchener, M., Willmott, M. (2006) ***Medicaid managed long-term care: An introduction.*** NARIC Accession Number: O17217. Project Number: H133B031102.
Abstract: Paper provides an introduction to the development of Medicaid managed long-term care (MLTC) progams that deliver home and community-based services (HCBS). The first section reviews the (typically longer-standing) Medicaid MLTC programs that provide, at least some, HCBS. The second section discusses Medicaid MLTC programs that have been developed specifically to provide HCBS.
**This document is available online at naric.com**

Shah, P., Heinemann, A. (2007) **The effect of Medicare's prospective payment system on patient satisfaction: An illustration with four rehabilitation hospitals.** *American Journal of Physical Medicine and Rehabilitation, 86(3), 169-175.* NARIC Accession Number: J52110. Project Number: H133A030807.
Abstract: Surveys were conducted at four rehabilitation hospitals to measure the effects of the Medicare prospective payment system (PPS) on patient satisfaction with care. Analysis also examined the influence of the following patient characteristics on satisfaction ratings: respondent type (patient or proxy), age, gender, functional gain as measured by the motor and cognitive Functional Independence Measure (FIM) subscores, and discharge destination. Results showed that satisfaction increased after implementation of PPS, despite shorter lengths of stay and reduced functional gains. Motor FIM gain, discharge status, and respondent type were significantly associated with patient satisfaction.

LaPlante, M., Kaye, H. (2007) **Estimating the expense of a mandatory home- and community-based personal assistance services benefit under Medicaid.** *Journal of Aging & Social Policy, 19(3), 47-64.* NARIC Accession Number: J52675. Project Number: H133B031102.
Abstract: Study provides an estimate of the expense of a mandatory personal assistance services (PAS) benefit under Medicaid home and community-based services for people with low incomes, low assets, and significant disabilities, as proposed under the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA). Data from the 2003 Survey of Income and Program Participation was used to estimate the number of people living in households who would be eligible for the services and combined with additional survey data on annual expenditures under Medicaid programs providing PAS. New expenditures for PAS are estimated to be $1.4 to $3.7 billion per