Determining Disability and Health Program Value

2013 Annual Disability Statistics Compendium: Improving Disability Statistics: Recent and Future Developments

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D&H Program Value -- Questions

❑ Challenge – 18 D&H state programs '**are doing good work**' but their value is not understood

❑ How do we demonstrate state program value?

❑ How can we integrate what the state programs and **Public Health Prevention Resource Centers** (PHPRCs) are doing?

What do we know about our State **Populations**?

❑ PWDs are disproportionately

  ▪ Obese, Physically inactive, Cigarette smokers

  ▪ Less likely to receive preventive services

    • Mammograms

    • Oral health care

❑ Are these findings generalizable to people living with Limb Loss (LL), Intellectual Disability (ID), Paralysis (PS)?

  ▪ We **do not know** at a population level

Integrating D&H State and PRCs

❑ When we go out to various CDC programs and ask them to include these populations it is a challenge because we cannot say how many people have

- Limb Loss (LL)
- Intellectual Disability (ID)
- Paralysis (PS)

❑ In summary, we are hampered by a lack of info

- What we have is **not intuitive**

The Problems

- View can't drill down – "Disability definition is too broad"
    - People with ID, LL , etc. are not represented in national surveys
    - The state level view we have (PWDs) is from 40,000 feet
    - ACS Questions will help a little (30,000 feet)
- Many people with limiting conditions might not identify with disability
- Small budget
- Access
    - We talk about removing barriers to care in the hope that it will float all boats in terms of Health Improvement for PWDs … but this is problematic in that we do not have defined population(s) so we cannot gauge the waterline
    - Access info is limited in state-based pop. surveys

Problem Solving

- The Solution must
    - Define Value
        - Have a $ component

    - Define our population
        - Use diagnoses (**Dx.**)

    - Integrate States and **PH**PRCs
        - Population(s) level

Defining Value and our Populations

❑ Defining Value

- Intersection of cost and quality
    - Cost ($)
    - Quality of care

❑ List or Defined Population

- Medicaid Population (**Dx. driven**)
    - Intellectual Disability
    - Limb Loss
    - Paralysis

Why Medicaid?

- ❑ State-based
  - ▪ Each state has its **own** claims data

- ❑ Claims data
  - ▪ Will give us $ and Dx.

- ❑ Vulnerable population
  - ▪ Disproportionately poor
  - ▪ Many have disabilities

Medicaid Expenditures, 2010

❑ Medicaid MSIS Selected States, 2010 (Annual)[1,2].

State	Population (thousands)	Disability No. (thousands)	(%)	Exp. (billions $)	Disability Exp. (billions $)	(%)
IL	2,758	332	(12%)	$11.6	$4.9	(42%)
MT	126	20	(16%)	$0.8	$0.3	(38%)
NY	5,011	735	(15%)	$42.7	$20.1	(47%)
SC	953	154	(16%)	$5.1	$1.8	(35%)
[1.] Disability defined using Medicaid blind/disabled basis of eligibility						
[2.] Estimates rounded						
In NY, PWDs represent ≈15% of MA pop. but account for ≈ 47% of Exps.						

'Disability' Costs and Average Costs

❑ For Each State might want to determine (e.g. NY)

Medicaid Number	Medicaid Exp. (billions $)	Avge. Total 'Cost' ($)
Total -- 5,011,087	Total -- $42.7	$8,521
Disability -- 735,190	Disability -- $20.1	$27,340
Disability Type		
ID -- ?	?	$100,000+*
LL -- ?	?	?
PS -- ?	?	?
*Supplemental info NY (illustrative): "ID/DD Medicaid HCBS or ICF represent <5% of population and ≈20% of expenditures."		

Money's Worth – State Program Value

❑ Medicaid Intellectual Disability (ID)

  ▪ Average Cost $100,000+

❑ CDC Breast Cancer Program

  ▪ ≈$200 million to identify 400,000 people and have them screened

  ▪ Average Cost per identification and screening is $500

❑ Disability and Health Program

  ▪ <$5 million to describe x? number of people with ID, LL, and PS and opportunities to improve quality of care

  ▪ Example 1: Partner state ≈$300k ID ≈30,000 people

    • $10 per identification

D&H State Pilot Program working with Medicaid Data

❑ To analyze claims data to determine

MI Medicaid Program	ID Dx.	LL Dx.	PS Dx.	Total
Number				
Demographics				
Age, Gender, Race, DE				
Health Characteristics				
Mammograms				
Oral Health				
Hypertension				
Beh. Risks (MRR?)				

Limb Loss Example

❑ People with LL Dx.

	Male	Female	Total
Coexisting Conditions*			
Diabetes (yes)			
Quality of Care Diabetes Measures			
AIC			
Eye Exams			
Foot Exams			
Pre-diabetes			
* Can we ascertain if the LL is linked to diabetes?			

Benefits

- ❑ Integrates State Program and **PH**PRCs

- ❑ Data driven and Dx based
  - ▪ Get cost estimates (**money's worth analyses**)
  - ▪ Might help reduce the disability causality issue
  - ▪ Potentially add (characterize) other populations over time
    - • Hearing impaired; Visually impaired; Children with disabilities
  - ▪ Won't alienate groups that don't see themselves as having a disability

- ❑ Evidence based
  - ▪ Nothing about us without us

Other Benefits -- Questions

❑ Answer questions for each state

- What are the leading causes of disability that Medicaid covers?

- What are the costs associated with the leading causes of disability (e.g. Top 10)?

- What are hospitalization and ED use rates for people with the aforementioned conditions?

- What are the leading (e.g. Top 10) causes of ED use among people with ID?

In Summary

- ❑ Program value
  - ▪ Few understand what we do
  - ▪ Not integrated
  - ▪ No list or defined population -- **not** population based
    - • "Disability definition too broad"
    - • "Lack disability/condition specific data to inform program efforts"
- ❑ Solution proposed i.e. focusing on 4 sub-populations (ID, LL, PS, **SB**) within State Medicaid Programs
  - ▪ Defines value and would allow us to make impact statements
  - ▪ Integrates states and PHPRCs
  - ▪ Population-based AND evidence-based
  - ▪ Has the potential to integrate across CDC teams and programs

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