Determining Disability and Health Program Value

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

Brian S. Armour, Ph.D.

December 11, 2013
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 PHPRCs
    - 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)\(^1,2\).

<table>
<thead>
<tr>
<th>State</th>
<th>Population (thousands)</th>
<th>Disability No. (thousands)</th>
<th>(%), Exp. (billions $)</th>
<th>Disability Exp. (billions $)</th>
<th>(%),</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>2,758</td>
<td>332</td>
<td>(12%), $11.6</td>
<td>$4.9</td>
<td>(42%)</td>
</tr>
<tr>
<td>MT</td>
<td>126</td>
<td>20</td>
<td>(16%), $0.8</td>
<td>$0.3</td>
<td>(38%)</td>
</tr>
<tr>
<td>NY</td>
<td>5,011</td>
<td>735</td>
<td>(15%), $42.7</td>
<td>$20.1</td>
<td>(47%)</td>
</tr>
<tr>
<td>SC</td>
<td>953</td>
<td>154</td>
<td>(16%), $5.1</td>
<td>$1.8</td>
<td>(35%)</td>
</tr>
</tbody>
</table>

\(^1\) 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)

<table>
<thead>
<tr>
<th>Medicaid Number</th>
<th>Medicaid Exp. (billions $)</th>
<th>Avge. Total ‘Cost’ ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total -- 5,011,087</td>
<td>Total -- $42.7</td>
<td>$8,521</td>
</tr>
<tr>
<td>Disability -- 735,190</td>
<td>Disability -- $20.1</td>
<td>$27,340</td>
</tr>
<tr>
<td><strong>Disability Type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID -- ?</td>
<td>?</td>
<td>$100,000+*</td>
</tr>
<tr>
<td>LL -- ?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>PS -- ?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>MI Medicaid Program</th>
<th>ID Dx.</th>
<th>LL Dx.</th>
<th>PS Dx.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, Gender, Race, DE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammograms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beh. Risks (MRR?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Limb Loss Example

- People with LL Dx.

<table>
<thead>
<tr>
<th>Coexisting Conditions*</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (yes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care Diabetes Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Can we ascertain if the LL is linked to diabetes?
Benefits

- Integrates State Program and PHPRCs

- 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
Contact Information

Brian Armour
Centers for Disease Control and Prevention
1600 Clifton Road NE,
Mail Stop E-88
Atlanta, GA 30333
Tel. 404 – 498-3014
Email. barmour@cdc.gov

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: http://www.cdc.gov

Disclaimer: The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.