Advancing Health Justice for Medicaid Members with Disabilities – Including Those with Mental Illness and Substance Use Disorder

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EXPLORING THE LANDSCAPE OF BEHAVIORAL HEALTHCARE | WEBINAR SERIES

TODAY'S PRESENTERS

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OBJECTIVES

» Participants will be able to:

  » **Understand** what <u>health justice means</u> and why a <u>health justice</u> framework is essential to advancing health equity and reducing health disparities.

  » **Learn** how to <u>measure health disparities</u> affecting Medicaid members with disabilities – including those with mental illness and substance use disorder (SUD) – and why this must be made a Medicaid policy priority, with an emphasis on addressing disparities stemming from racism.

  » **Examine** <u>evidence on health disparities</u> from one state Medicaid program's efforts – within the data imperfections and evolving understanding of measurement.

  » **Consider** the <u>national implications</u> of this evidence on Medicaid and its members – using Medicaid data on health disparities as the evidence base.

  » **Review** what <u>actions policymakers</u> can take to advance health justice – and to health equity.

Why Focus on Medicaid?

27.6% of U.S. adults covered under Medicaid have mental illness

In addition, SUD estimates range from low-to-high teens

HEALTH JUSTICE

HEALTH JUSTICE AND AMERICAN VALUES

» Health justice is the underpinning of efforts to advance health equity and reduce disparities that result from bias and discrimination

  » The reason for using the term health justice is because inequities in health access and outcomes, and disparities that arise from bias and discrimination are contrary to the American ideals of equality and opportunity.

  » According to the CDC, "Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment." These are very much American values.

In addition to addressing the injustices that impact equity and health disparities and impact African-Americans and other Black, indigenous people of color (BIPOC), there are other injustices impacting the broader population of persons with mental health diagnoses or substance use disorder.

There is currently a mental health social justice bill pending in Congress.

If passed:

"This bill creates a grant program for states and local governments to train and dispatch mental health professionals to respond, instead of law enforcement officers, to emergencies that involve people with behavioral health needs."

HEALTH JUSTICE PRIORITIES– EXAMPLES

» Address health disparities in morbidity/mortality resulting from medical interventions:

   » Antipsychotic medication increases risk of diabetes
   » Lithium is associated with increased risk of kidney disease and renal failure

» Offer alternatives to psychiatric hospitals and incarceration:

   » Robust mental health treatment services
   » Respite and peer respite
   » Community-based diversionary services to redirect persons with behavioral health diagnoses involved in the criminal justice system away from incarceration
   » Crisis stabilization
   » Community-based acute treatment for dual diagnosis and observation/holding beds

HEALTH DISPARITIES AND HEALTH EQUITY

Health Disparities

"Healthy People 2020 defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.""

Health Equity (CDC)

"Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances.""

ADVANCING HEALTH JUSTICE

Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation

AcademyHealth in partnership with the Disability Policy Consortium (DPC)

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》 Urge state Medicaid programs to invest in data and analysis to measure health disparities

》 Provide information to support state Medicaid programs to measure and address health disparities

》 Highlight the essential contributions to the evidence base by one state's Medicaid program

》 Underscore racial injustice, discrimination, bias, and stigma in our health care system

》 Emphasize the importance of using an intersectional approach to disparity measurement

The analytical work presented in this report, although important, should only be considered an initial step in a long process to prioritize health equity. State Medicaid programs must move beyond measurement and take action to reduce health disparities, which will require significant effort and commitment.

HEALTH DISPARITY MEASUREMENT QUANTITATIVE & QUALITATIVE

BEHAVIORAL HEALTH DEFINITION

» "Behavioral health conditions include mental illnesses, such as anxiety disorders, major depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder, as well as substance use disorders (SUD), such as opioid addiction. These conditions range in severity, with some being more disabling than others. People with behavioral health needs may require a range of services, from outpatient counseling or prescription drugs to inpatient treatment."

» Source: KFF, 2017.

Behavioral health includes mental illnesses and substance use disorders

Some consider term to be stigmatizing

QUANTITATIVE METHODS TO ADVANCE EQUITY

» "Perfect is the enemy of the good"

> » We have a national crisis on our hands, as COVID-19 has shown

> » We must use the available methodologies and data to measure disparities and collaborate with communities, CBOs, providers, plans, and payers around health justice

> » We must proceed with measurement, despite the limitations, and continue to improve the process as we move forward – from addressing how to standardize the data to identifying the best data collectors – to evolve our understanding of disparities

> » We have encountered many data limitations in our health disparity measurement work and some obstacles in our ability to measure health disparities on an intersectional basis, mainly related to the lack of a robust data set on race and ethnicity and disability type

> » Note: Analyses of health disparities for people with disabilities was limited; such analyses should be stratified by disability type based upon the types of disabilities used in the Disability and Health Data System developed by the CDC. We have also not analyzed dually eligible individuals covered under Medicaid and Medicare, which have very high proportion of behavioral health conditions

QUALITATIVE METHODS TO ADVANCE EQUITY

There are several barriers to health justice under examination and study.

Misperceptions

As reported by Dr. Lisa Iezzoni and colleagues:

"More than sixty-one million Americans have disabilities, and increasing evidence documents that they experience health care disparities. Although many factors likely contribute to these disparities, one little-studied but **potential cause involves physicians' perceptions of people with disability**. In our survey of 714 practicing US physicians nationwide, 82.4 percent reported that people with significant disability have worse quality of life than nondisabled people"

Contrary Assumptions

First of its kind study by Community Catalyst reported that the assumption of abstinence being the focus of treatment is contrary to the responses of **900 people** lived experience of substance use disorders who among their priorities, the need for increased emphasis on interventions that increase survival rates, improve quality of life and mental health, and public policies that strengthen patient-identified outcomes

Coverage Gaps

A report by MACPAC found that Medicaid coverage of behavioral health services, including mental health and substance use disorder services, **varies greatly among states**

Missing Understanding

DPC is working with the Brandeis University Heller School on research that aims to **understand how and why people with disabilities** misuse opioids, health and access treatment recover from OUD, and moved toward their individually defined life goals

MEASUREMENT STEPS

STEPS TAKEN TO MEASURE HEALTH DISPARITIES

Step 1.
Identify available data

Step 2.
Establish a framework for examining health disparities

Step 3.
Define the population groups

Step 4.
Select measures of health disparities

Step 5.
Prepare an analytical plan

Step 6.
Develop the analytical dataset

Step 7.
Conduct the analyses and interpret the results

Step 8.
Report results and communicate results

STEP 1. IDENTIFY THE AVAILABLE DATA

using current data…

and creating better data collection methods

Collaboration: Medicaid, Public Health, Sister Agencies

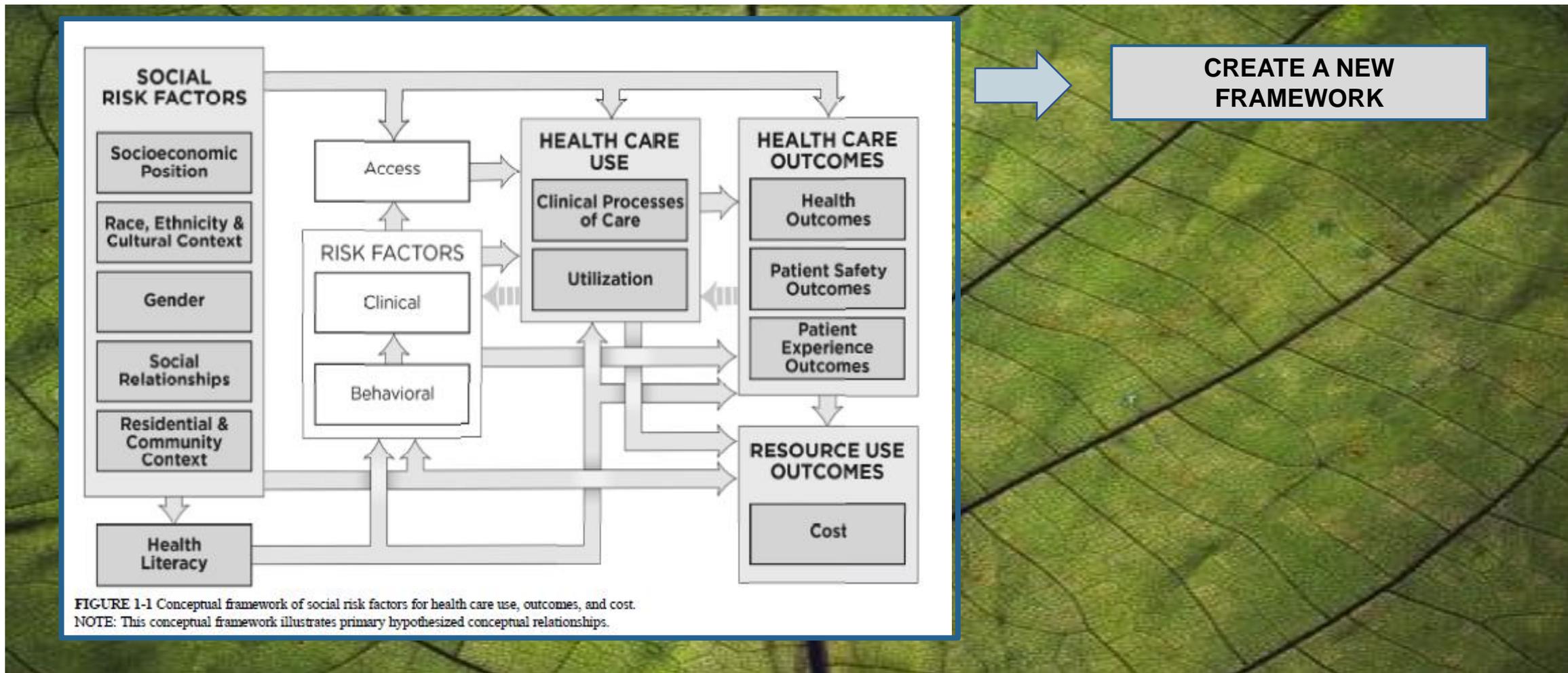| Medicaid Enrollment and Claims	Cash Assistance	Child Protective Services	Justice Involvement

STEP 2. ESTABLISH A FRAMEWORK

FIGURE 1-1 Conceptual framework of social risk factors for health care use, outcomes, and cost.
NOTE: This conceptual framework illustrates primary hypothesized conceptual relationships.

CREATE A NEW FRAMEWORK

STEP 3. DEFINE THE POPULATION GROUPS

Disability: 8.2% of adult population

Data Source: Medicaid eligibility status.

Description: Disability status was based on their eligibility for Medicaid, if the person qualified for disability-based Medical Assistance, This only includes persons who have been able to navigate the disability determination process; and would therefore exclude persons who have not been able to navigate this process. This category also includes a range of disabilities. Health disparities were measured combining all persons with disabilities into one group. As a result, health disparities by disability type could not be measured.

Serious and Persistent Mental Illness: Prevalence: 5.5% of adults

Note: 33.7% of persons with SPMI also qualify as having a disability based on Medicaid eligibility.

Data Source: Medicaid claims data.

Description: Persons with a diagnosis of SPMI were identified in the claims data based on certain diagnoses, and a high level of service use, using Medicaid claim forms for the 18 months ending in 2014. Persons identified as SPMI based on Medicaid claims and meeting criteria of having Schizoaffective Disorder, Borderline Personality Disorder, Major Depression Disorder or Bipolar disorder; and had to have received a high level of mental health care, often inpatient or residential treatment. Given that studies consistently show a delay in diagnosis, the use of this algorithm may produce an underestimate of the prevalence of this condition.

Substance Use Disorder: Prevalence: 14.4% of adults

Note: 16% of persons with a SUD also qualify as having a disability based on Medicaid eligibility.

Data Source: Medicaid claims data.

Description: Persons with a diagnosis of SUD were identified by using the Medicaid claims and having certain diagnoses.

STEP 4. SELECT MEASURES OF HEALTH DISPARITIES

The real benefit of **measurement** is to provide an evidence base against which Medicaid programs can establish priorities, tailor interventions, set appropriate goals, measure improvement …

Commit to addressing racism-based outcomes demonstrated through the disproportional level of burden of mortality rates, the prevalence of selected illnesses, disability, and lack of health care access.

- **Direct measures of health:**

  - **Mortality**
  - **Morbidity**
  - **Disability**

- **Healthcare measures related to access, use and quality**

- **Health care costs**

Step 5.
Prepare an analytical plan

Step 6.
Develop the analytical dataset

Step 7.
Conduct the analyses and interpret the results

Step 8.
Report results and communicate results

Highlight strengths, limitations, recommendations for future study

- STATE EVIDENCE -
IMPLICATIONS FOR THE NATION

OVERVIEW OF RESULTS

» We have produced many bivariate and regression results to create transparency around health disparities and to advance health justice

  » Today, we will present a limited set of bivariate and regression results for adults with coverage under Medicaid, with a focus on populations most relevant to this webinar series

    » We will present results on the intersectionality of poverty, race, disability and provide a sample of statistically significant outcomes from our regression analyses

    » We will present outcomes of health disparities for three populations: persons with disabilities, persons with SPMI, and persons with SUD

    » We will present mortality rates and provide a sample of measures of access, use, and quality – such as potentially preventable emergency department visits (PPVs) and hospital admissions (PPAs), to underscore lives cut short and poor access to care
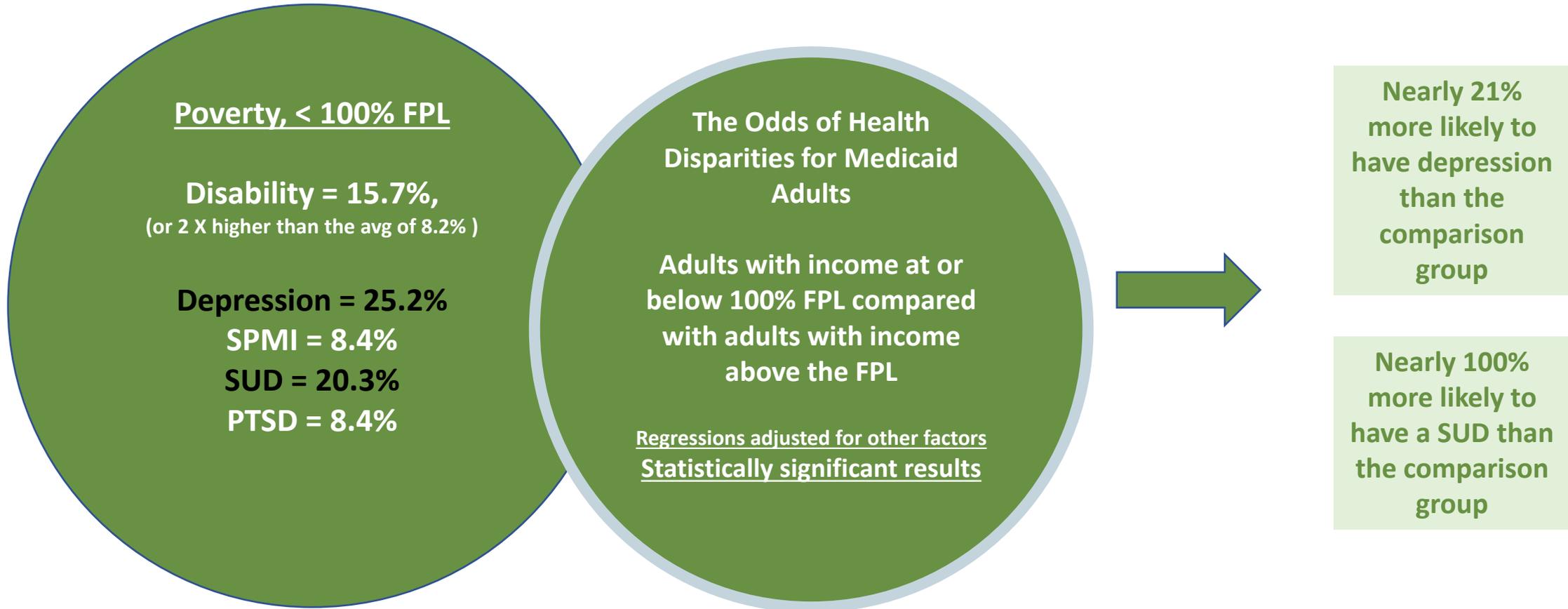
Bivariate Results for Adults Covered Under Medicaid < 65

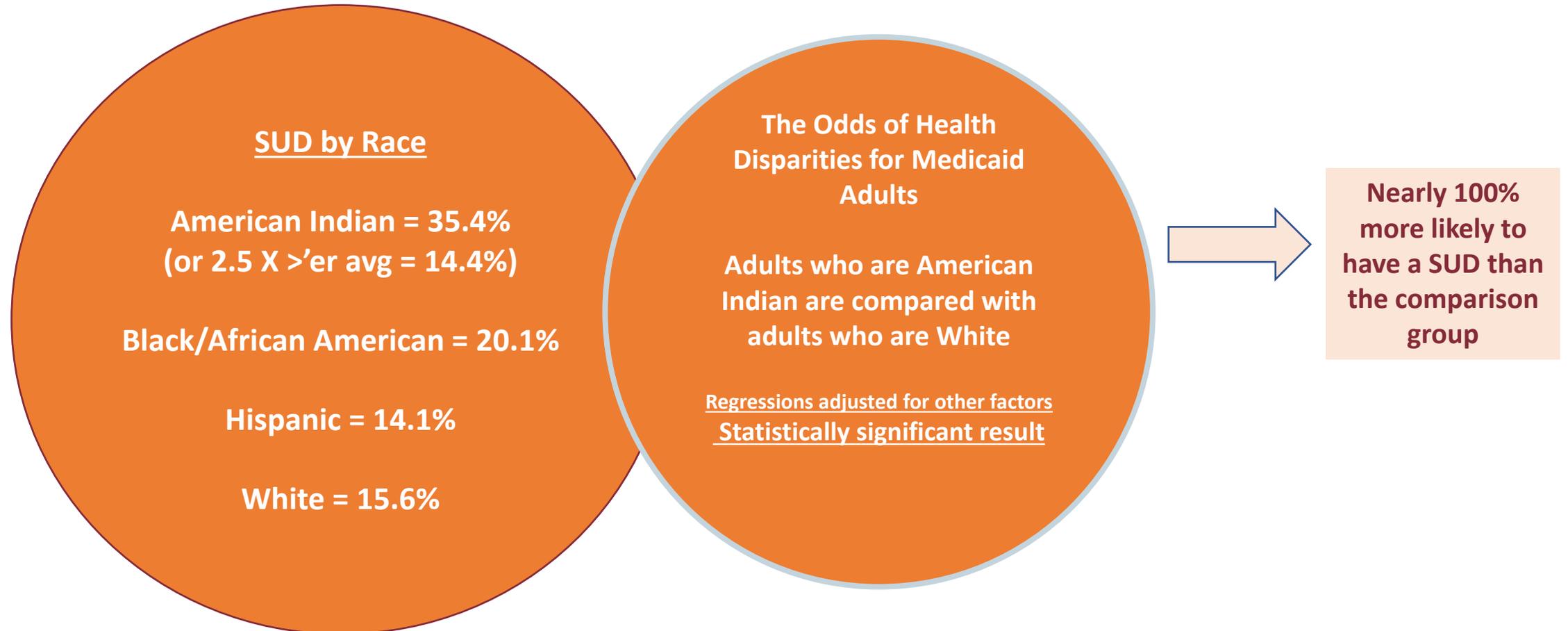| Health Disparity Measures	All	< 100% FPL	Homelessness	w/Disability	w/SPMI	w/SUD	American Indian	Black, African American (US Born)	Hispanic (US Born)	White (US Born)
		Very Low Income		**Disability** — Three Populations			**Race and Ethnicity**			
Number	550,341	240,350	38,721	45,050	30,529	79,349	23,464	66,093	16,907	296,992
Disability	8.2%	15.7%	10.8%	n.a.	33.7%	16.0%	10.5%	14.8%	6.6%	8%
Mortality	0.8%	1.3%	1.2%	3.9%	1.7%	2.5%	1.4%	0.8%	0.5%	1.0%
Morbidity										
Depression	19.2%	25.2%	32.2%	42.8%	n.a.	49.7%	30.3%	20.6%	19.2%	22%
SPMI	5.6%	8.4%	12.1%	22.8%	n.a.	19.4%	7.4%	7.1%	4.8%	6%
SUD	14.4%	20.3%	37.9%	28.2%	50.4%	n.a.	35.4%	20.1%	14.1%	15.6%
PTSD	5.9%	8.4%	13.0%	17.5%	39.7%	18.0%	10.5%	8.6%	6.1%	6%
Health Care Use and Costs										
PPVs	10.5%	13.5%	22.5%	16.6%	21.5%	20.8%	21.6%	19.3%	12.7%	9.3%
PPAs	0.6%	0.8%	1.1%	2.5%	1.4%	1.8%	1.1%	1.0%	0.5%	0.6%
CY expenditures per person	$7,104	$10,447	$9,833	$32,594	$26,816	$17,761	$11,578	$8,211	$6,159	$7,597

IMPACT OF POVERTY ON OUTCOMES

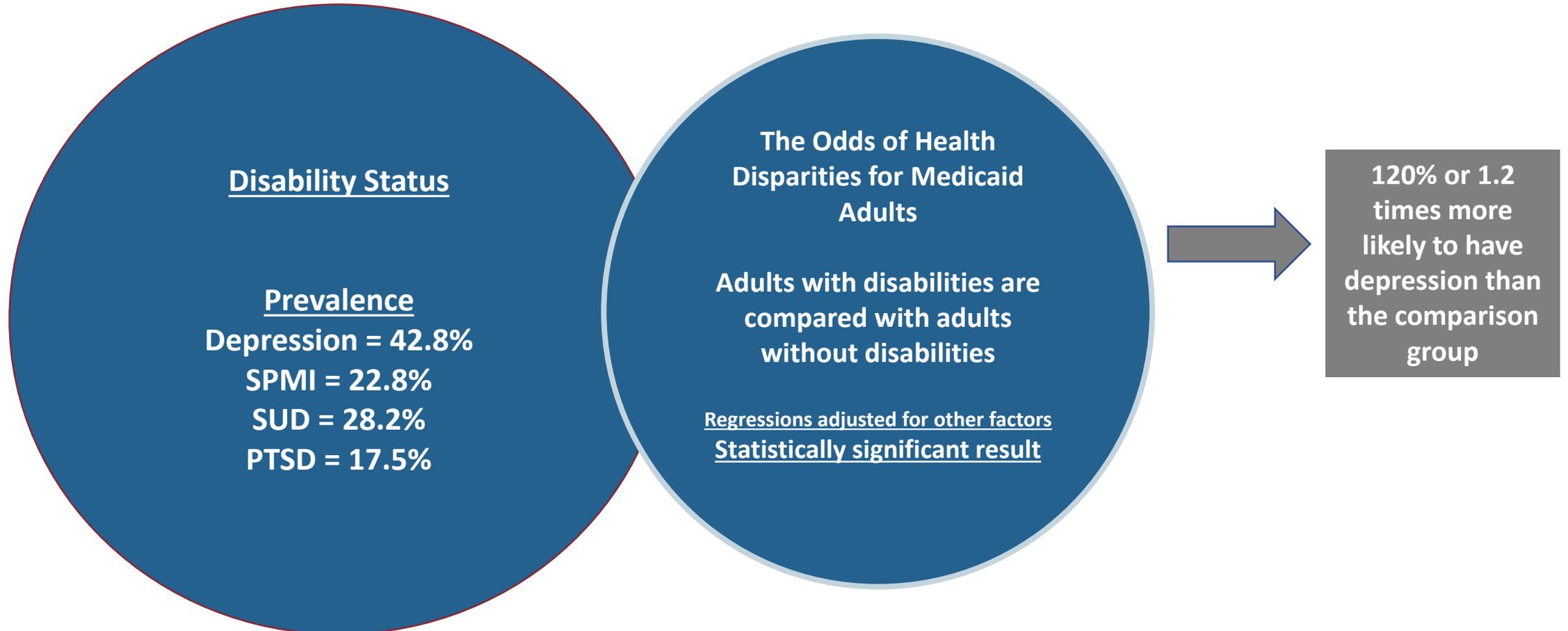» Intersectionality of Poverty and <u>Mental Illness and SUD</u>

Poverty, < 100% FPL

Disability = 15.7%,
(or 2 X higher than the avg of 8.2%)

Depression = 25.2%
SPMI = 8.4%
SUD = 20.3%
PTSD = 8.4%

The Odds of Health Disparities for Medicaid Adults

Adults with income at or below 100% FPL compared with adults with income above the FPL

<u>Regressions adjusted for other factors</u>
<u>Statistically significant results</u>

Nearly 21% more likely to have depression than the comparison group

Nearly 100% more likely to have a SUD than the comparison group

IMPACT OF STRUCTURAL RACISM ON OUTCOMES

» Intersectionality of Race and SUD

SUD by Race

American Indian = 35.4%
(or 2.5 X >'er avg = 14.4%)

Black/African American = 20.1%

Hispanic = 14.1%

White = 15.6%

The Odds of Health Disparities for Medicaid Adults

Adults who are American Indian are compared with adults who are White

Regressions adjusted for other factors
Statistically significant result

Nearly 100% more likely to have a SUD than the comparison group

IMPACT OF DISABILITY ON OUTCOMES

» Intersectionality of Disability and Depression

Disability Status

Prevalence
Depression = 42.8%
SPMI = 22.8%
SUD = 28.2%
PTSD = 17.5%

The Odds of Health Disparities for Medicaid Adults

Adults with disabilities are compared with adults without disabilities

Regressions adjusted for other factors
Statistically significant result

120% or 1.2 times more likely to have depression than the comparison group

HEALTH DISPARITIES – PREVALENCE

Disability Status

Disability = 100%
(focus pop)

Prevalence
Depression = 42.8%
SPMI = 22.8%
SUD = 28.2%
PTSD = 17.5%

SPMI

Prevalence
Disability = 33.7%

SPMI = 100% (focus pop)
SUD = 50.4% or 1 in 2
PTSD = 39.7%

SUD

Prevalence
Disability = 16%

Depression = 50% or 1 in 2
SPMI = 19.4%
SUD = 100% (focus pop)
PTSD = 18%

MORTALITY RATES FOR THREE POPULATIONS

Mortality

Chart showing mortality rates:
- All: 0.8%
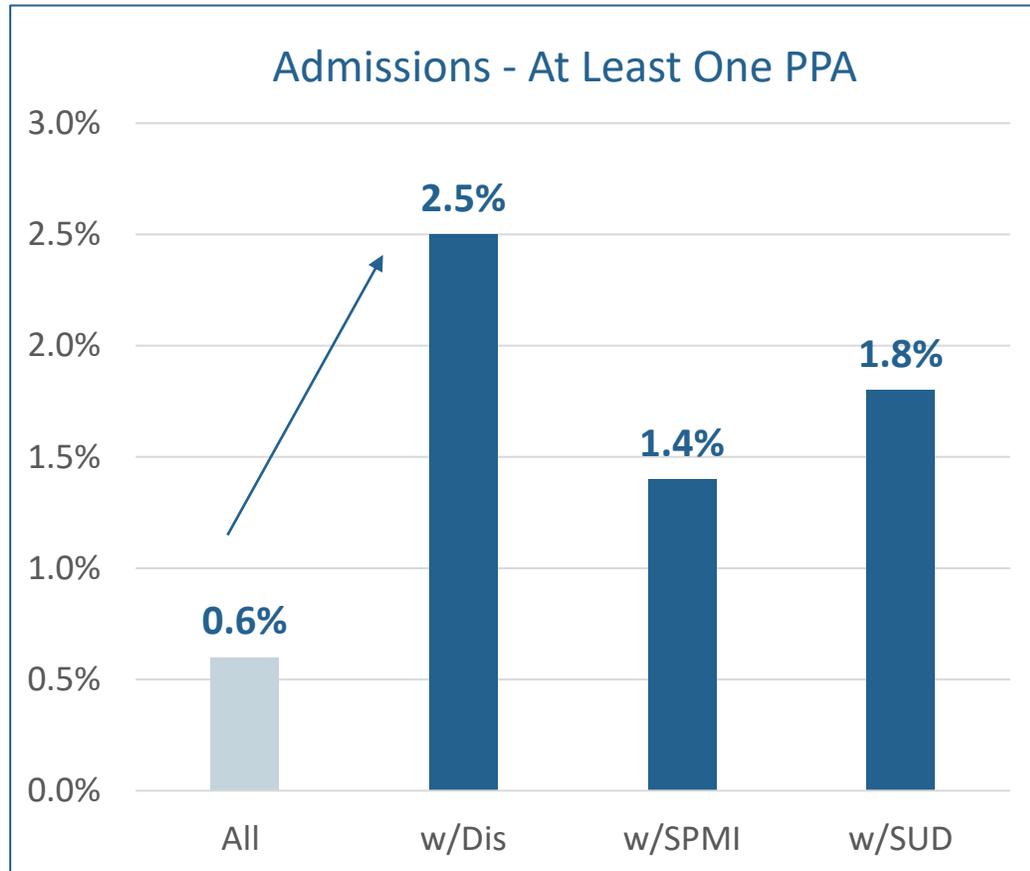- w/Disability: 3.9%
- w/SPMI: 1.7%
- w/SUD: 2.5%
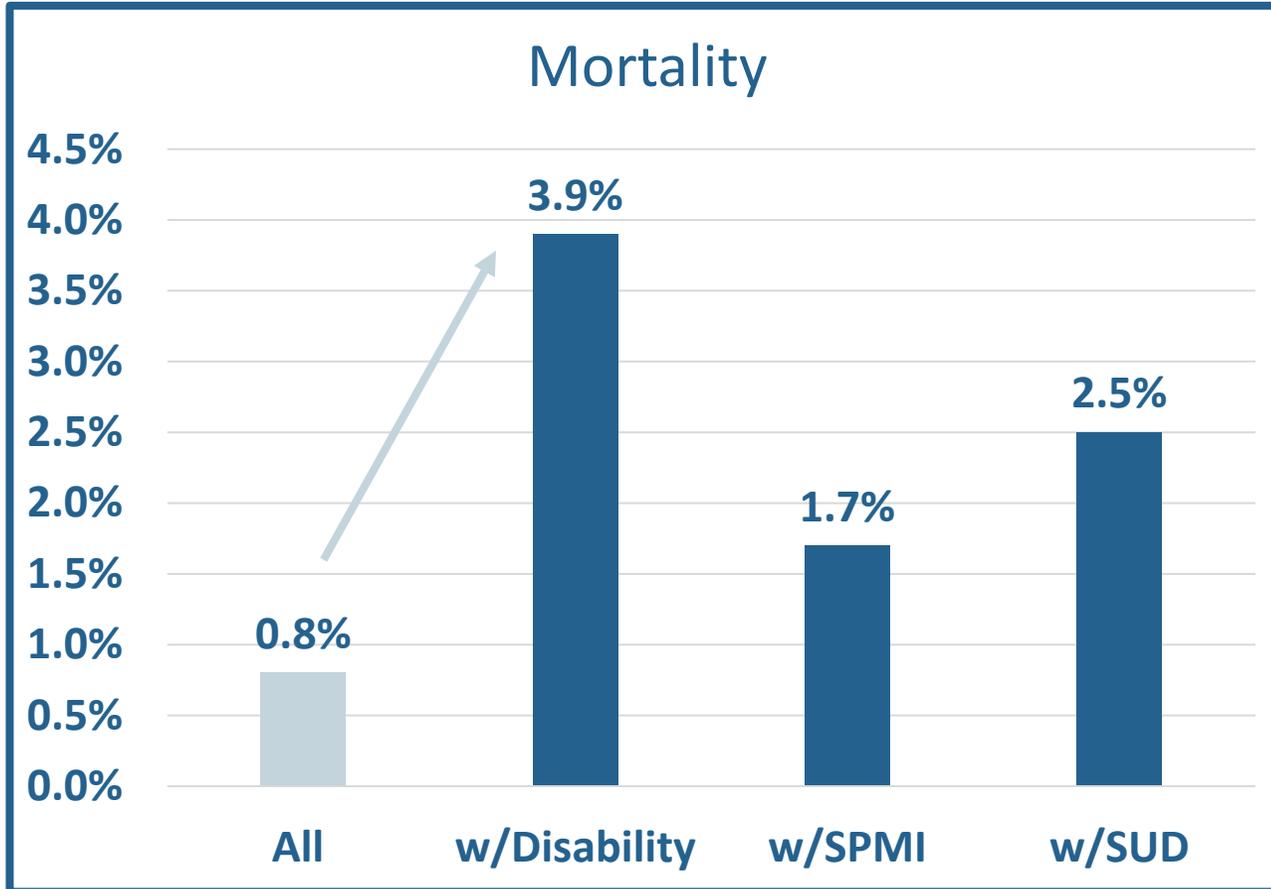
➤ Baseline mortality rate:

➤ **0.8 percent in the 2.5 years** it was measured for all adults.

➤ Compared to the average for all adults:

➤ Persons with disabilities: 5 X higher

➤ Persons with SPMI: 2 X higher

➤ Persons with SUD: 3 X higher

POTENTIALLY PREVENTABLE MEDICAL USE FOR THREE POPS
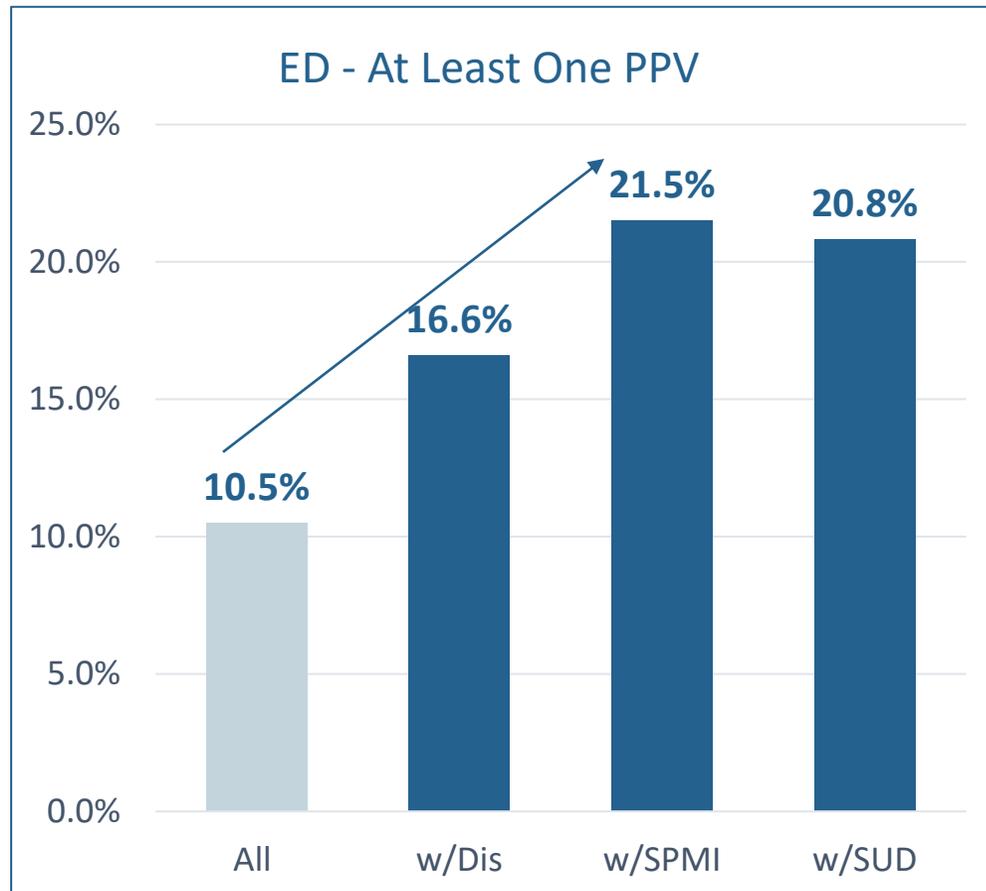
ED - At Least One PPV

- **Baseline PPVs:**

- **10.5 percent (or in 1 in 10)** of all adults covered under the Medicaid program had at least one potentially preventable emergency department visit

- Compared to the average for all adults:

- Persons with disabilities: 1.5 X higher

- Persons with SPMI: 2 X higher

- Persons with SUD: 2 X higher

# POTENTIALLY PREVENTABLE MEDICAL USE FOR THREE POPS

Admissions - At Least One PPA

Category	Percentage
All	0.6%
w/Dis	2.5%
w/SPMI	1.4%
w/SUD	1.8%

- ➤ Baseline PPAs:

- ➤ **0.6 percent (< 1%)** of all adults covered under the Medicaid program had at least one preventable hospital admission

- ➤ Compared to the average for all adults:

- ➤ Persons with disabilities: 4 X higher

- ➤ Persons with SPMI: 2 X higher

- ➤ Persons with SUD: 3 X higher

HEALTH DISPARITIES – COMPARE PREVALENCE

This analysis compares adults without a disability to adults with a disability, shows the higher proportion of mental illness and SUD in Medicaid adults – carries major implications

Adults Covered Under Medicaid with a Disability, Based on Disability Status			
Morbidity	Adults with a Disability	Adults without a Disability	Percentage Point Difference
Depression	42.8%	17.1%	26%
SUD	28.2%	13.0%	15%
SPMI	22.8%	4.0%	19%
PTSD	17.5%	4.9%	13%
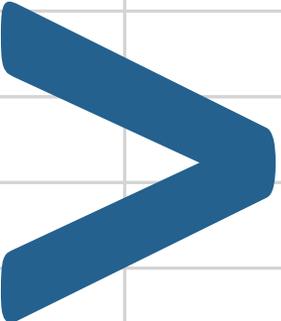
NATIONAL IMPLICATIONS – BALLPARK ESTIMATES

» Minnesota Data:

» Approximately 15% of adults covered under MN Medicaid have a SUD condition

» A few data points on health disparities:

» About 80,000 adults

» Mortality rate = 2.5%

» PPVs = 20.8% or 1 in 5 with at least one potentially preventable ED visit

» United States Example:

» About 28 million adults covered under Medicaid in the US. (2019)

» *What if we apply Minnesota's experience to all adults covered under Medicaid? What does this mean for health justice on a larger scale?*

» At the very least:

» As 4 million adults, dying at a rate 5 x higher than the average adult

» As many as 1 million adults with at least one potentially preventable ED visit

OPPORTUNITIES TO ADVANCE HEALTH JUSTICE

SEVEN OPPORTUNITIES FOR POLICYMAKERS

» Opportunity 1. Commit to a **Multi-State Effort** to Measure Health Disparities

» Opportunity 2. Launch State-Level Interagency and Cross-Sector Collaborative to Collect **Data**

» Opportunity 3. Partner with **Communities and Community-Based Organization (CBOs)**

» Opportunity 4. **Rebalance** Long-Term Services and Supports (LTSS) to Advance Health Equity

» Opportunity 5. Invest in **Person-Centered Care**

» Opportunity 6. Invest in **Prevention Strategies** for Ongoing Sustainability

» Opportunity 7. Secure Federal **Investment** and Incentivize **Value**

"Of all the forms of inequality, injustice in health care is the most **shocking** and **inhumane**"

The Rev. Martin Luther King, Jr.,
at the Second Annual
Convention of the Medical
Committee for Human Rights,
Chicago, March 25, 1966

Join the movement at
www.healthcare-now.org

UPCOMING WEBINARS

- July 15th: Children's Behavioral Health and the Intersect with Medicaid and Child Welfare

- July 20th: How Child Welfare and Behavioral Health Systems Can Support and Enhance Family Engagement and Collaborate on Child Welfare Prevention

The series, *Exploring the Landscape of Behavioral Healthcare,* will take place from April to August and explore central themes ranging from the impact of COVID-19 to the future of child welfare and behavioral health equity.

QUESTIONS & ANSWERS

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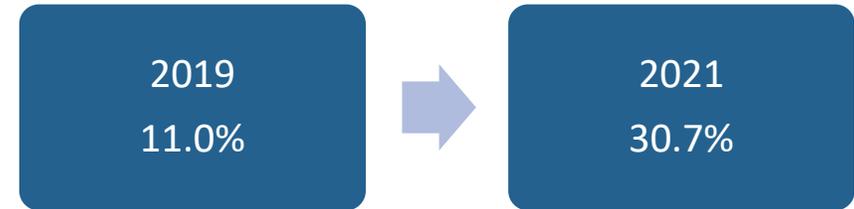
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» "Mental health symptoms have increased during the COVID-19 pandemic. From April 28 – May 10, 2021, 30.7% of adults in the U.S. reported symptoms of anxiety and/or depressive disorder, up from 11.0% in 2019."

2019		2021
11.0%	→	30.7%

» "Deaths due to drug overdose increased during the pandemic, primarily driven by synthetic opioid use. In the U.S., in the 12-month period ending in September 2020, there were 27.4 deaths due to drug overdose per 100,000, up from 21.3 per 100,000 in 2019."

2019		2020
21.3 deaths per 100,000	→	27.4 deaths per 100,000
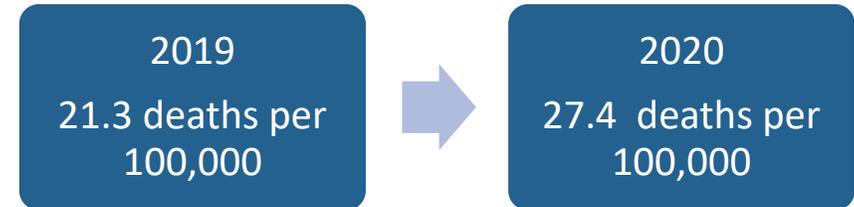
APPENDIX: SOURCES

» *https://academyhealth.org/sites/default/files/publication/%5Bfield_date%3Acustom%3AY%5D-%5Bfield_date%3Acustom%3Am%5D/advancinghealthjusticeusingmedicaiddata_jan2021_0.pdf*

» *https://www.congress.gov/bill/117th-congress/house-bill/1368?s=1&r=20*

» *https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html*

» *https://www.networkforphl.org/news-insights/health-justice-empowering-public-health-and-advancing-health-equity/*

» *https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf*

» *https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf*

» *https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries*

» https://www.kff.org/report-section/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals-issue-brief/

» https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/

» https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01452

» https://www.healthaffairs.org/do/10.1377/hblog20210325.480382/full/

» https://www.communitycatalyst.org/resources/tools/peers-speak-out/pdf/Peers-Speak-Out.pdf

» https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/

» https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/

» https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities