IMPACT OF MEDICAID DISCONTINUITY ON MEDICATION ADHERENCE AND HEALTH CARE RESOURCE UTILIZATION AMONG NON-ELDERLY ADULTS WITH CARDIOVASCULAR DISEASE AND ASSOCIATED COMORBIDITIES

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OBJECTIVES: Medicaid coverage among non-elderly adults is often characterized by drop-outs and churning – entering and exiting Medicaid – over short durations. Little is known about the impact of such disruptions in Medicaid coverage on health care resources utilization and adherence to cardiovascular and lipid-lowering medications among enrollees with cardiovascular disease (CVD).

METHODS: This was a retrospective, repeated cross-sectional study design employing data from 2002-2011 Medical Expenditure Panel Survey. Study sample included adults aged 18-64 years diagnosed with ≥1 CVD or associated comorbidity who reported having Medicaid coverage any time during survey year. Individuals with CVD having continuous, full-year Medicaid coverage (N=1,624) were compared to those with <12 months of coverage (N=3,394). Medication adherence was calculated as proportion of days covered by refills of any CVD medication class examined during the reference period, capped at 1, and analyzed using ordinary least squares regression and multivariate logistic regression. Utilization of 5 CVD-specific health care resources – inpatient, emergency (ER), outpatient, and office-based physician visits, and prescription medications – were estimated using zero-inflated negative binomial models controlling for sociodemographic, health status, disease burden, and Medicaid eligibility covariates, and year fixed effects.

RESULTS: Older age, White race, higher income, intermittent employment, any private insurance were significant predictors of Medicaid discontinuity (P<0.05). Individuals experiencing discontinuity in Medicaid coverage were predicted to have 0.03 more inpatient (P<0.01), 0.03 more ER (P<0.001), and 0.24 less office-based physician visits (P<0.05), and 0.02 more prescription medications (P<0.05), all other things being equal. Medication adherence was not significantly different between the two groups, nor was it a significant predictor in most outcome models.

CONCLUSIONS: Individuals with CVD having discontinuous Medicaid coverage had higher hospital, and lower primary care utilization than their counterparts with continuous Medicaid coverage. Medicaid programs will greatly benefit from implementing provisions that mitigate coverage instability and associated disruptions in continuity of care.