PCV118 IMPACT OF MEDICAID DISCONTINUITY ON HEALTH CARE RESOURCE UTILIZATION AMONG NON-ELDERLY ADULTS WITH CARDIOVASCULAR DISEASE
Mansini RD,1 Bailey JE,2 Relyea G2
1Division of Health Services Research Center, Memphis, TN, USA, 2University of Memphis, Memphis, TN, USA
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-measures-sectional study designed to employ data from the 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 in at least one time period during the survey year. Independents of 2011 CVD having 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 the United States, and is associated with increased mortality. A quality measure that contributes to a CMS Star Rating is that patients with hypertension and diabetes receive a renin-angiotensin system (RAS) inhibitor. The objective of this study was to compare the impact of a Diabetes Treatment Management (DTM) Program to improve the compliance of appropriate RAS inhibitors for diabetic patients, between dual eligible (DE) and non-DE Medicare Advantage beneficiaries. METHODS: This was a retrospective study of pharmacy claims data among Medicare Advantage beneficiaries ≥ 18 years of age in 2014. Members receiving ≥ 2 of one diabetes medication claim and one anti-hypertensive medication (calcium channel blockers or beta blockers) claim were included. The DTM program alerted the pharmacist to the potential need to add a CMI to improve adherence in non-eligible beneficiaries. Intervention success was defined when a recommended anti-hypertensive medication (renin angiotensin system antagonist, angiotensin converting enzyme, angiotensin receptor blocker, or direct renin inhibitor) was subsequently filled by the member of the intervention group. The primary outcome was the change in 30-day, all-cause, in-hospital mortality. RESULTS: This data represents 1,037,543 non-DE and 195,413 DE Medicare Advantage beneficiaries. A total of 32,154 members were eligible for the DTM program. Of these, 26,896 (84%) were among non-DE and 5,258 (16%) were among DE Medicare beneficiaries. The DTM program was successful in 26% of the overall population. The success rate was 27% (7,177/26,896) among non-DE compared to 23% (1,215/5,258) among DE Medicare beneficiaries receiving the intervention (p <0.001). CONCLUSIONS: The DTM program was more successful in the non-DE than in the DE Medicare Advantage population. However, further research is needed to understand the factors behind the difference in success for these populations.

PCV120 THE IMPACT OF DIFFERENT TYPES OF HEALTH INSURANCE ON THE HOSPITALIZATION SERVICES UTILIZATION OF PATIENTS WITH HEMORRHAGIC STROKE IN CHINA
Ma Y, Xiong X, Li Z.
China Medical Insurance Association, Beijing, China
OBJECTIVE: The study aimed to compare the direct medical cost difference of hemorrhagic stroke inpatients with different types of health insurance from 2010 to 2012 in three cities. A nationwide, cross-sectional sample, of 3,041,992 hemorrhagic stroke inpatients with disease code ICD-10 (I60, I61, I62) with basic medical insurance scheme for employees (BMISSE) and basic medical insurance scheme for urban residents (BMISUR) was extracted from the China Health Insurance Research Association claims database. A descriptive analysis was adopted. RESULTS: The inpatients number of BMISSE was 5,331, the inpatients number of BMISUR was 15,110. The average age was 63.08 and 62.34 years, respectively. Patients with BMISSE went to third-level hospitals, second-level hospitals and under second-level hospitals accounted for 57.03%, 33.71% and 9.27%, but for BMISUR, the percentage of distribution was 48.94%, 37.76% and 11.31%. From 2010 to 2012, the average hospitalization expenses of over 2,413,739 beneficiaries were 30,419.22 and 26880.57 yuan. The expenses of each visit was 21211.57, 18999.53 and 19088.96 yuan. Reimbursement by BMISSE in 2010, 2011 and 2012 was 71.01%, 74.12% and 68.25%; while the reimburse- ment by BMISUR was 45.95%, 53.49% and 51.16%. CONCLUSIONS: The insurance level by insurance scheme can affect the treatment regimen and benefits received by patients. People prefer to go to third-level hos- pitals, but people with BMISSE has higher proportion than people with BMISUR, about 10%. For the people with BMISUR, the out-of-pocket spending was 50% of total expenses, needing to raise reimbursement rate, setting up differentiated reimburse- ment for different income level groups. From 2011 to 2012, the reimbursement rate declined slowly, we need to study the cause in the future.

PCV121 THE EXPANSION OF STROKE CENTERS AND THE REDUCTION OF IN-HOSPITAL MORTALITY OF ISCHEMIC STROKE PATIENTS IN ALBERTA
O’Brien A1, Zheng Y1, Jearthalef T1, Thanh NXY, Klenabach S1, Hakkunn U1, Friesen D1, Kaul P1, Ruskei J1, Aristie R2, Jacobs P2
1University of Alberta, Edmonton, AB, Canada, 2Institute of Health Economics, Edmonton, AB, Canada, 3National Institute for Health and Welfare, Helsinki, Finland, 4Alberta Medical Association, Edmonton, AB, Canada, 5West Virginia University, Morgantown, WV, USA, 6Canadian Institute for Health Information, Ottawa, ON, Canada
OBJECTIVE: According to Canada, US and European guidelines and the Helsingborg Declaration, all eligible stroke patients should receive care in specialized stroke centers. During the last decade, partly due to the Alberta Provincial Stroke Strategy (APSS), 36 stroke centers were established in Alberta. This study examined the effect of expansion of stroke center for patients with ischemic stroke, adjusting for admission to non-stroke centers. METHODS: The study population was identified from the Discharge Abstract Database (DAD) from the province of Alberta, Canada. We included stroke patients with most response diagnostic code I63 (ICD10) with a first admission to acute care hospitals between 1st April 2004 and March 31st 2011. Disease specific co-morbidities were adapted from the literature review, including CHF and CAD. We utilized the information from the National Ambulatory Care Report System (NACRS) as the proxy of disease severity. The average marginal effect of stroke center on the 30-days in-hospital mortality was estimated in a bivariate probit model, using differential distance to hospitals as an instrumental variable to control for reverse causality adjusting for age, sex, co-morbidities, and disease severity. RESULTS: Among 9152 patients, 6405 (70%) were admitted to stroke centers (n=16) and 2747 (30%) to non-stroke centers. The overall 30-day all-cause mortality rate was 9.8% for patients first admitted to stroke centers and 11.1% for patients admitted to non-designated hospitals. Adjusting patient characteristics and other factors, we found first admission to a stroke center was associated with a 6.4% (95%CI: -1.2%, -11.3%) absolute reduction in 30-day mortality among non-stroke centers adjusted for co-morbidity. In an observational study, we provided new evidence to support the role of stroke center on the reduction in mortality in a publicly funded health care system.