ISSUE BRIEF

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TRENDS IN HEALTH CARE FINANCING

New Medicaid Drug Use and Cost Data Highlight Issues for States After Medicare Part D

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New data, prepared by Mathematica for the Centers for Medicare & Medicaid Services (CMS), provide detailed information on prescription drug cost and utilization for both nondual and dual eligible Medicaid beneficiaries for 2001 and 2002. These highly detailed and uniformly formatted tables, and accompanying chartbooks, allow states to compare themselves to national averages and to other states to identify areas in which their experience may diverge and warrant closer attention. The data and chartbooks can be found online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp. This issue brief highlights data on drug use and spending in 2002 for nondual Medicaid beneficiaries, for whose drug coverage states remain responsible after January 2006.

Life After Part D

The Medicare Part D prescription drug benefit, which went into effect on January 1, 2006, covers drugs for beneficiaries who are dually eligible for both Medicaid and Medicare. This change shifted approximately 55 percent of Medicaid prescription drug expenditures to Medicare, but state Medicaid programs remain responsible for prescription drug coverage for the 85 percent of Medicaid beneficiaries who are not dual eligibles. In providing this coverage, states face a number of issues:

- How to ensure that access to and use of drugs by nondual disabled and chronically ill Medicaid beneficiaries is appropriate and cost effective. About 59 percent of disabled Medicaid beneficiaries were not dual eligibles in 2002, and they accounted for 62 percent of all Medicaid drug costs for nonduals.
- How to assess whether costly and powerful psychotropic drugs are being appropriately used for children
- How to maintain states' ability to bargain with drug manufacturers for rebates on major types of drugs, such as antipsychotics, when over half of the amount Medicaid has been spending on such drugs has shifted to Medicare
- How to ensure that dual eligible nursing facility residents receive appropriate and cost-effective care when a major part of their care—prescription drugs—is being paid for by Medicare Part D health plans that have no responsibility to share data on duals' drug use or to coordinate their care with Medicaid
- Whether and how to provide access to certain classes of drugs, such as benzodiazepines, that are excluded by statute from Part D coverage

While a full analysis of these issues requires consideration of complex clinical, administrative, and budgetary concerns, cost and utilization data are an important starting point. One source for the needed drug data is state-by-state tables available on the CMS website that provide detailed information on prescription drug cost and utilization for both nondual and dual eligible Medicaid beneficiaries for 1999, 2001, and 2002. The text box on page 3 describes the tables and accompanying chartbooks derived from the data. The most important limitation of this information is that it represents drug use only in fee-for-service (FFS) settings. Drug use and expenditures data for those in capitated managed care programs are not included because states generally do not report these data fully to CMS. However,

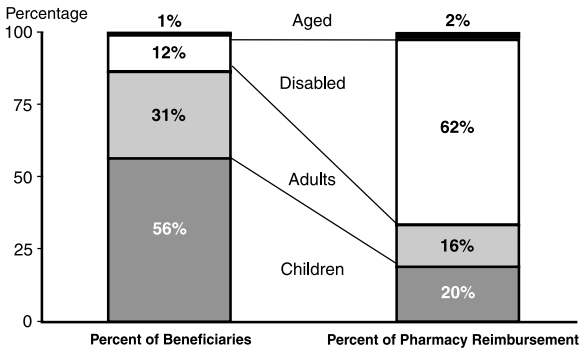
the heaviest users of Medicaid prescription drugs are generally not enrolled in capitated managed care programs.

Drug Use by the Nondual Disabled

As shown in Figure 1 below, disabled beneficiaries account for a disproportionate share of prescription drug use and expenditures among nondual FFS beneficiaries. In 2002, disabled individuals represented 12 percent of nondual beneficiaries but accounted for 62 percent of total nondual FFS Medicaid prescription drug expenditures. Their share of nondual drug expenditures ranged from a low of 40 percent in Nebraska to a high of 94 percent in Rhode Island (Table N.3). These beneficiaries used an average of 2.7 prescription drugs per benefit month, at an average monthly cost of $197. (A benefit month is a month in which a beneficiary had Medicaid prescription drug coverage, whether or not a drug was prescribed in that month.) Nondisabled adults, by contrast, used only 0.6 drugs per month at a monthly cost of $31, while children used 0.4 drugs at a cost of $19 (Table ND.4).

Nondual disabled beneficiaries were especially heavy users of antipsychotics (22 percent of males and 23 percent of females) and antidepressants (26 percent of males and 48 percent of females). In other nondual eligibility categories, about 1 percent of beneficiaries used antipsychotics, and less than 6 percent used antidepressants (Table ND7A).

Figure 1: Distribution of Beneficiaries and Total Pharmacy Reimbursement Among Nondual Beneficiaries, by Basis of Eligibility, 2002



Source: 2002 Chartbook, Exhibit 14.

High use of drugs by disabled Medicaid beneficiaries is not surprising, given their complex and chronic physical and mental health needs. In light of these needs, special attention to the appropriateness of their drug use is warranted, especially when the level of use appears to be out of line with that of other states.

Children's Psychotropic Drug Use

There are ongoing concerns about children's potentially inappropriate use of psychotropic drugs. In 2002, nearly 347,000 nondual children under age 21 received antipsychotic medications; approximately 632,000 received antidepressants (Table ND7A). Disabled males had the highest rates of antipsychotic use, at 17 percent of beneficiaries for males ages 6 to 14, and 19 percent for those ages 15 to 20 (compared with 2 percent and 3 percent among nondisabled males). Patterns were similar for females, although the rates were lower (10 percent among disabled females ages 6 to 14, and 16 percent among disabled females ages 15 to 20, with lower rates among nondisabled females). Disabled children also had higher rates of antidepressant use than nondisabled children, although in this case females had higher rates than males. In the 15 to 20 age group, disabled females had the highest rates of antidepressant use (23 percent), followed by disabled males (19 percent), nondisabled males (6 percent), and nondisabled females (6 percent) (Table ND7A). Comparisons with national averages and other states can suggest whether use of psychotropic drugs by children in one state is unusually high or low in Medicaid, providing a starting point for closer examination.

Leverage For Supplemental Rebates

Many states have expressed concern that the shift of dual eligible drug expenditures to Medicare may reduce states' bargaining leverage with drug manufacturers for supplemental rebates, since total state Medicaid payments for particular types of drugs will decrease. In 2002, the three most costly drug groups in terms of total Medicaid FFS reimbursement were antipsychotics ($3.3 billion), antidepressants ($1.9 billion), and ulcer drugs ($1.8 billion). Dual eligibles accounted for 57 percent of antipsychotic reimbursement, 54 percent of antidepressant reimbursement, and 66 percent of ulcer drug reimbursement (Tables

7, ND7, and D7). While reimbursement for these drugs for nonduals is still sizable, Medicaid agency purchasing power has been substantially diminished as a result of Part D.

Drug Use in Nursing Facilities

Ninety percent of the 1.5 million Medicaid beneficiaries who were full-year or part-year residents of nursing facilities in 2002 were dual eligibles, and they accounted for 13 percent of total Medicaid FFS expenditures on prescription drugs (Tables ND2, D2, and N.1a). Although responsibility for prescription drug coverage for these dual eligibles shifted to Medicare in January 2006, Medicaid continues to provide their long-term nursing facility care.

Prescription drugs are important in the care of nursing facility residents and can have significant impacts on both quality and cost of care. Full-year dual eligible nursing facility residents used an average of 5.9 prescription drugs per benefit month in 2002, at an average cost per benefit month of $282 (Table D8). Forty-two percent of full-year dual eligible nursing facility residents used antipsychotics in 2002, 54 percent used antidepressants, 43 percent used ulcer drugs, 35 percent used antihypertensive drugs, and 30 percent used antidiabetic drugs (Table D10). These drugs are used to treat complex medical conditions that usually require extensive care in addition to prescription drugs, particularly among nursing home residents with multiple chronic health conditions. Assessing, monitoring, and managing overall nursing facility care requires current and complete data on drug use by facility residents.

The advent of Part D has made access to drug use data problematic for state Medicaid agencies. Part D drugs in nursing facilities are provided by stand-alone prescription drug plans (PDPs) and Medicare Advantage (managed care) prescription drug plans (MA-PDs). Some MA-PDs are Special Needs Plans (SNPs) that specialize in serving nursing facility residents. Several different Part D plans may cover the residents of a single nursing facility. There is no federal requirement that these Part D plans share any data on drug use by dual eligibles with state Medicaid agencies. While some states may be able to gain access to these data from the Part D plans themselves, the data are unlikely to be as complete, accurate, and current as

BACKGROUND ON THE DATA

State-By-State Data Tables. Under contract with CMS, Mathematica has developed 49 data tables for the nation, each state, and the District of Columbia for 2001, and 51 tables for 2002. Fourteen tables focus on nondual Medicaid beneficiaries, and 14 comparable tables focus on dual eligibles. There are also seven tables that focus on all Medicaid beneficiaries and six supplemental tables on dual eligibles. Finally, there are eight national comparison tables that show state-by-state comparisons based on a number of key measures included in the full set of tables. The full set of tables, called a "Statistical Compendium," is available online in both PDF and Excel formats at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp.

Chartbook. Mathematica also developed chartbooks (available at the same website as the tables) from data in the tables. The chartbooks for 2001 and 2002 contain 37 exhibits, including two tables and 35 graphs that highlight major features and comparisons. Eleven of the graphs focus on dual eligibles, three highlight use and reimbursement for drugs excluded by statute from Part D, and four show comparisons between 1999, 2001, and 2002.

Mathematica developed the state-by-state data tables from Medicaid Analytic eXtract (MAX) files for 1999, 2001, and 2002 prepared by CMS from Medicaid claims and eligibility data states submitted electronically through the Medicaid Statistical Information System (MSIS). The MAX files link claims data on all Medicaid services to beneficiary eligibility files, creating a "person summary file" for each beneficiary. The tables include data for all months in which beneficiaries had FFS Medicaid coverage in each year. They do not include data for months that beneficiaries were in capitated managed care programs, since claims data were generally incomplete or unavailable for those months. About a quarter of beneficiaries were in capitated managed care programs in 2002, but they accounted for only three percent of Medicaid pharmacy reimbursement captured in the MAX files. This is largely because of missing data for managed care, but also because dual eligible and other disabled Medicaid beneficiaries—who have the highest drug use—were generally not in managed care in 2002. (Approximately 27 percent of nonduals were in capitated managed care for all of 2002, but only 8 percent of duals and 18 percent of nondual disabled were. Appendix tables A.3 and A.6 in the 2002 compendium provide state-by-state detail on managed care penetration rates.)

what was available before 2006. Analysis of pre-2006 data on Medicaid prescription drug use in nursing facilities can provide an important benchmark and basis for comparison that can be used if and when states and others are able to obtain access to Part D drug data for dual eligibles in nursing facilities.

Drugs Excluded by Statute From Part D

The statute that established Part D excludes from Medicare coverage several types of drugs that Medicaid has been allowed to exclude from coverage since 1990, including benzodiazepines, barbiturates, and nonprescription drugs. States have chosen to cover many of these drugs, however, and CMS requires states that cover the drugs for any Medicaid beneficiaries to continue covering them for dual eligibles after 2006.

In 2002, 47 percent of dual eligibles used at least one of the drugs excluded from Part D, and 23 percent of nonduals used at least one (Chartbook, Exhibit 31). States made $451 million in FFS payments to provide these drugs to dual eligibles (representing 3 percent of total Medicaid drug expenditures for duals), and $553 million to provide them to nonduals (accounting for 5 percent of expenditures for nonduals) (Tables D11 and ND11). For duals, the largest total payments were for benzodiazepines ($123 million), nonprescription drugs ($115 million), and vitamins and minerals ($72 million). For nonduals, the largest total payments were for nonprescription drugs ($212 million), cough and cold medications ($129 million), and benzodiazepines ($95 million) (Tables D13 and ND13).

Many Medicaid beneficiaries—both duals and nonduals—rely on the drugs that the Medicare statute excludes from Part D coverage. States that have chosen to provide these drugs to Medicaid beneficiaries should consider options for agreements with Part D plans that could facilitate continued access to these drugs by dual eligibles and limit state administrative burdens.

Looking Ahead

This issue brief highlights a number of issues that are affected by the transition of Medicaid dual eligibles into the Medicare Part D drug benefit. The data in the 2002 compendium provide a starting point for states that are dealing with these issues and do not substitute for more recent information states have on their own Medicaid programs. However, these data allow consistent state-by-state comparisons that are not possible at this time with more recent data. These comparisons can highlight areas in which states may differ from other states or national averages, triggering more careful and thorough analysis.

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