

# SOCIAL RISK FACTORS AMONG MEDICARE BENEFICIARIES WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

Alzheimer's Disease and Related Dementias (ADRD) is among the costliest diseases in the US, with high direct medical costs for patients and indirect costs for caregivers. Identifying the populations in need and the best ADRD care practices allows the delivery of higher value care to underserved populations. Home-based primary care (HBPC) can deliver high-value, quality care to complex patients with chronic conditions and functional limitations. Understanding the role of social risk factors in the care of ADRD can inform policies and improve care.

## OBJECTIVES

- Describe the prevalence of ADRD, characteristics and Medicare utilization of individuals with ADRD, and HBPC use for beneficiaries stratified by dual eligibility, race/ethnicity, and geography
- Expand understanding of the interaction between chronic disease and social risk factors
- Explore ways to enhance providing value-based care to all individuals

## STUDY DESIGN

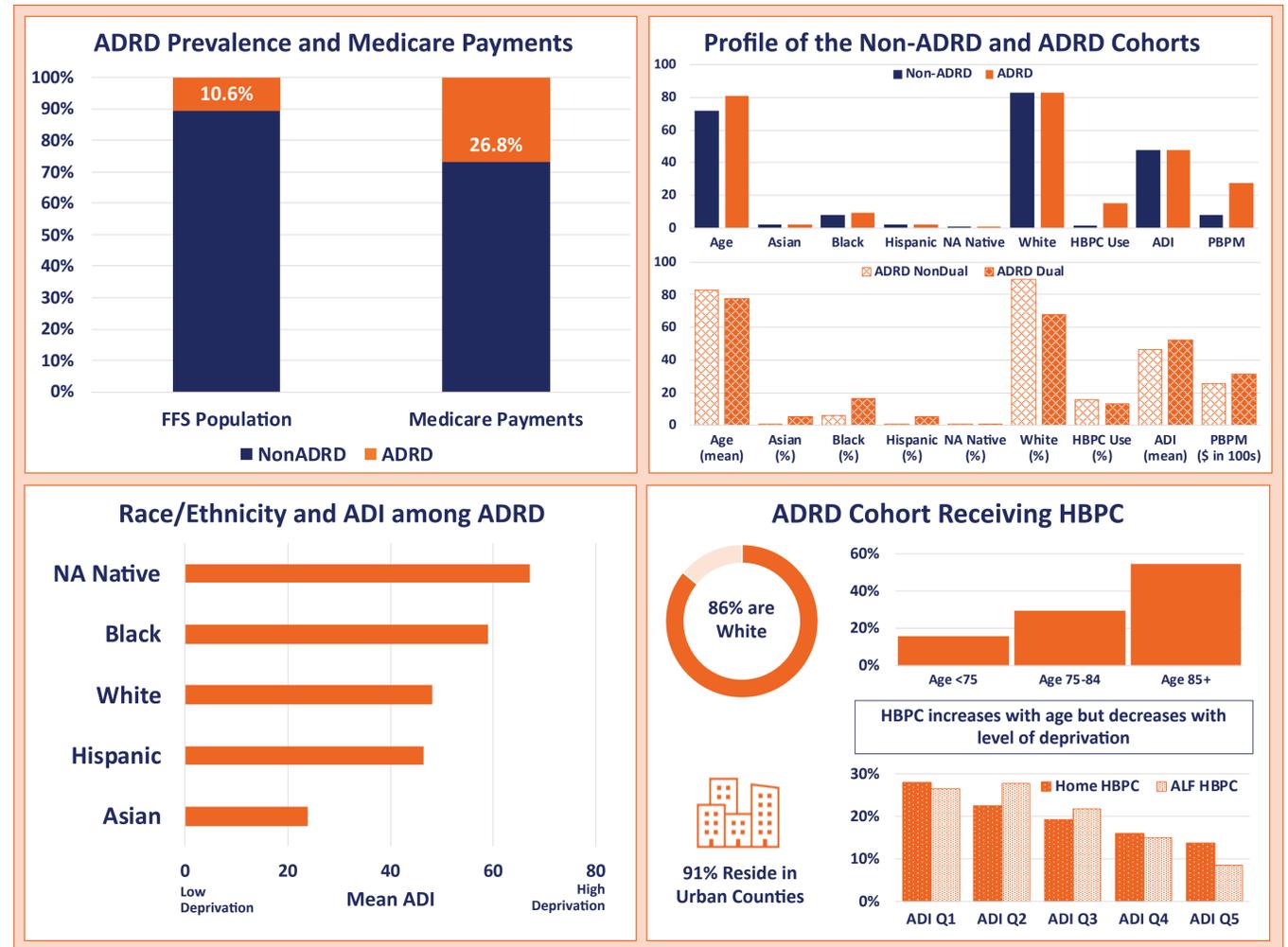
Cross-sectional cohort study of January CY2021 Medicare FFS (Parts A and B) enrollees. ADRD was identified using CCW Chronic Conditions algorithm. HBPC was identified using procedure and place of service codes; HBPC practices were identified by grouping providers with common billing identifiers and practice locations. Beneficiaries were attributed to HBPC practices following CMS' Shared Savings and Losses and Assignment Methodology Specifications.

## FINDINGS

- ADRD patients represent 10.6% of the FFS cohort, while accounting for 26.8% of Medicare payments
- The ADRD and non-ADRD cohorts are similar in their race/ethnicity and Area Deprivation Index (ADI)
- The ADRD cohort is older, with more dual eligibles (30% vs 16%), and has 3 times higher Medicare payments than the non-ADRD cohort
- Dual eligible beneficiaries with ADRD are less likely to be white, more likely to live in higher deprivation areas, and have higher Medicare payments
- ADRD race/ethnicity categories of North American (NA) Natives and Black have higher mean ADI
- Fifteen percent of the ADRD cohort received HBPC; among which the White, non-dual, urban, and lower ADI cohorts have the highest HBPC use; home based HBPC reaches more patients in areas of higher deprivation than assisted living facility (ALF) HBPC

## DISCUSSION

These differences suggest opportunities to enhance and expand innovative care delivery models and other CMS policies that target improved health equity. Analyses reveal differences in race/ethnicity, dual eligibility, and ADI between the ADRD and non-ADRD cohorts, as well as differences in HBPC use across these subgroups and among those attributed to HBPC practices. Of the 2,426 HBPC practices identified, their attributed patients include 63% ADRD, 31% dual, 17% non-white, and 27% residing in areas of high deprivation (ADI >60). ADRD patients in these HBPC practices are more likely to be non-dual, white, have lower ADI, meet complex/high-need criteria, and have higher payments than non-ADRD patients, with complex/high-need ADRD patients accounting for 58% of the practice payments.



Authors:  
Kubisiak J., Lee A., Rosin I., Weinberg D., and Balan-Cohen A. of Westat, Rockville, MD; Esposito D. of Westat Insight, Arlington, VA; Kinosian B. of Geriatrics Department, Hospital of University of Pennsylvania, Philadelphia, PA

