PREDICTORS OF DISENROLLMENT AMONG MEDICARE FEE-FOR-SERVICE BENEFICIARIES WITH DEMENTIA

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Medicare enrollment among people with Alzheimer’s Disease and Related Dementias (ADRD) has reached an all-time high with about 12% of beneficiaries having an ADRD diagnosis. The federal government has special interest in providing healthcare alternatives for Medicare beneficiaries. However, limited studies have focused on understanding disenrollment from fee-for-service, especially among those with high-needs. In this study we identified predictors of disenrollment among beneficiaries with ADRD. We used the 2017-2018 Medicare Master Beneficiary Summary File to determine enrollment, sociodemographic, clinical characteristics and healthcare utilization. We included all fee-for-service beneficiaries enrolled in 2017 who survived the first quarter of 2018. Our primary outcome was disenrollment from fee-for-service between 2017 and 2018. Regression models included age, sex, race/ethnicity, dually eligibility to Medicare and Medicaid, chronic and disabling conditions (categorized by quartiles), total health care costs including outpatient, inpatient, post-acute care and other costs (categorized by quartiles) and county fixed-effects. There were 1,797,047 beneficiaries enrolled in fee-for-service with an ADRD diagnosis. Stronger predictors of disenrollment included race/ethnicity and dual eligibility. Disenrollment rates were 7.9% (95% CI, 7.2 – 8.5) among African Americans, 6.6 (95% CI, 6.2 – 7.0) among Hispanics and 4.3 (95% CI, 4.2 – 4.3) among Whites. Duals were 1.9% (95% CI, 1.4 – 2.3) more likely to disenroll from fee-for-service to Medicare Advantage (MA). The inclusion of MA special need plans and additional benefits for those with ADRD and complex chronic conditions may be valuable for those beneficiaries with ADRD, and who may not have Medigap coverage when enrolling in fee-for-service.

RURAL AND URBAN DIFFERENCE IN LONGITUDINAL TRENDS IN PREVALENCE OF DEMENTIA IN MEDICARE CLAIMS AND SURVEY DATA

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Shortage of physicians in rural areas can lead to lower diagnosis and underestimation of dementia prevalence in these communities. We used data from the nationally representative Health and Retirement Study and a 20-percent sample of Medicare claims to study rural-urban differences in dementia prevalence. The survey dementia diagnosis is free from medical assessment while the claims diagnosis needs a physician diagnosis. We estimated the trends in dementia prevalence from 2002 to 2016 based on cognitive tests (using survey data) and diagnosis codes (using claims data) utilizing ordinary least squares regression. Dementia prevalence based on diagnosis codes declined in both urban and rural areas over the course of the study, with a sharper decline in urban areas. Dementia prevalence using diagnosis codes showed significantly higher rates in urban areas during all years (0.024 vs 0.018 in 2002 and 0.017 vs 0.013 in 2014 in rural vs urban areas, respectively). Dementia in the cognitive test sample was higher in rural areas (0.11 vs 0.08 in 2000 and 0.08 vs 0.7 in 2014 in rural vs urban areas), a difference that was significant only in 2004. Our results indicate lower dementia prevalence rates in rural areas in claims based sample compared to survey sample which its dementia prevalence is free medical assessment. Claims data are valuable sources for tracking dementia in the US population, however they are based on medical diagnosis. In rural areas, where there is shortage of physicians and a lack of access to health care services, claims based studies may underestimate dementia rates.

Session 1065 (Symposium)

DIVERSITY OF ACTIVITIES, EMOTIONS, AND PLEASANT EVENTS AND THEIR ASSOCIATIONS WITH MENTAL AND COGNITIVE HEALTH

Chair: Soomi Lee Co-Chair: Emily Urban-Wojcik
Discussant: David Almeida

The COVID-19 pandemic dramatically changed the structure of our daily lives. One of the most significant changes is a limited opportunity to engage in face-to-face social interactions and enjoy diverse daily activities. This raises a public health concern, because diverse experiences are critical sources of health by increasing social integration, cognitive reserve, and psychological resources. Recently, two lines of research have consistently shown that activity diversity or emodiversity is associated with multiple health outcomes. However, still more integrated efforts are needed to better understand diversity of daily experiences in various aspects and their contributions to health. This symposium brings together different endeavors towards understanding how diversity of daily experiences – activity diversity, emodiversity, and variety in positive experiences – are associated with health and well-being across adulthood. The topic of this symposium is timely to discuss potential prevention approaches to protect population well-being as the pandemic evolves. Paper 1 examines activity diversity (breadth and evenness of daily activity participation) and how it is related to positive and negative emodiversity (rich and balanced emotional experiences) differently by age groups. Paper 2 investigates the longitudinal relationship between activity variety across cognitive, physical, and social domains and cognitive functioning. Paper 3 examines variety in pleasant events and its associations with mental health outcomes. Paper 4 examines whether and how negative emodiversity is associated with mental illness during COVID-19. The discussant, Dr. David Almeida will integrate key findings from these studies, discuss their theoretical and methodological contributions, and consider opportunities for future research.

RICH AND BALANCED EXPERIENCES OF DAILY EMOTIONS ARE ASSOCIATED WITH ACTIVITY DIVERSITY ACROSS ADULTHOOD

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