

Ambulatory Care Delivery for Medicare Beneficiaries With Dementia by Subpopulation: Variations by Clinician Type, Services Delivered, and Care Setting

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Key Finding: Among 2 million Medicare beneficiaries with dementia, 49% received care exclusively from primary care clinicians and not geriatricians or ADRD specialists. Vulnerable subpopulations (rural, dually enrolled, high-SVI, and minoritized racial/ethnic groups) are more likely to rely solely on primary care

Background and Significance

Growing ADRD Burden

6.7 million Americans live with ADRD today; projected to reach 13.9 million by 2060

Black/African American, Hispanic/Latino, and rural-residing older adults face higher ADRD risk, delayed diagnosis, and worse outcomes

Care Recommendations

- Guidelines recommend primary care clinicians (PCCs) lead ADRD management with specialist access for complex cases
- Prior 2019 claims data showed PCCs deliver most ADRD ambulatory care, but did not examine service types or settings by subpopulation

Research Objective: To examine differences in ambulatory care delivery (clinician type, services, and care settings) among Medicare beneficiaries with dementia, overall and by subpopulation

Methods

- Data:** 100% Medicare fee-for-service Part B claims, 2022–2023 (N=2,029,593 beneficiaries with ADRD)
- Cohort:** CCW ADRD algorithm; 12+ months continuous Part A & B enrollment; ages 65–105; excluded nursing home-only and ESRD
- Clinicians:** Primary care clinicians (PCCs), geriatricians, and ADRD specialists (neurology, psychiatry, neuropsychiatry, geriatric psychiatry); identified via NPES taxonomy
- Subpopulations:** Rural/urban (RUCA), race/ethnicity, dual Medicare-Medicaid enrollment, Social Vulnerability Index (SVI)
- Analysis:** Visit rates per 1,000 beneficiary-years; Poisson models with age- and sex-adjusted rate ratios (RRs)

Overall Findings

- 93% of PLWD saw a PCC; 38% saw an ADRD specialist; 16% saw a geriatrician
- 80% of all visits made to PCCs; 14% to ADRD specialists; 6% to geriatricians
- E&M was the dominant service across all specialties; care coordination was second most common for PCCs/geriatricians

Results

Figure 1. Clinician Specialty Service Utilization by Subpopulation (Adjusted Rate Ratios)

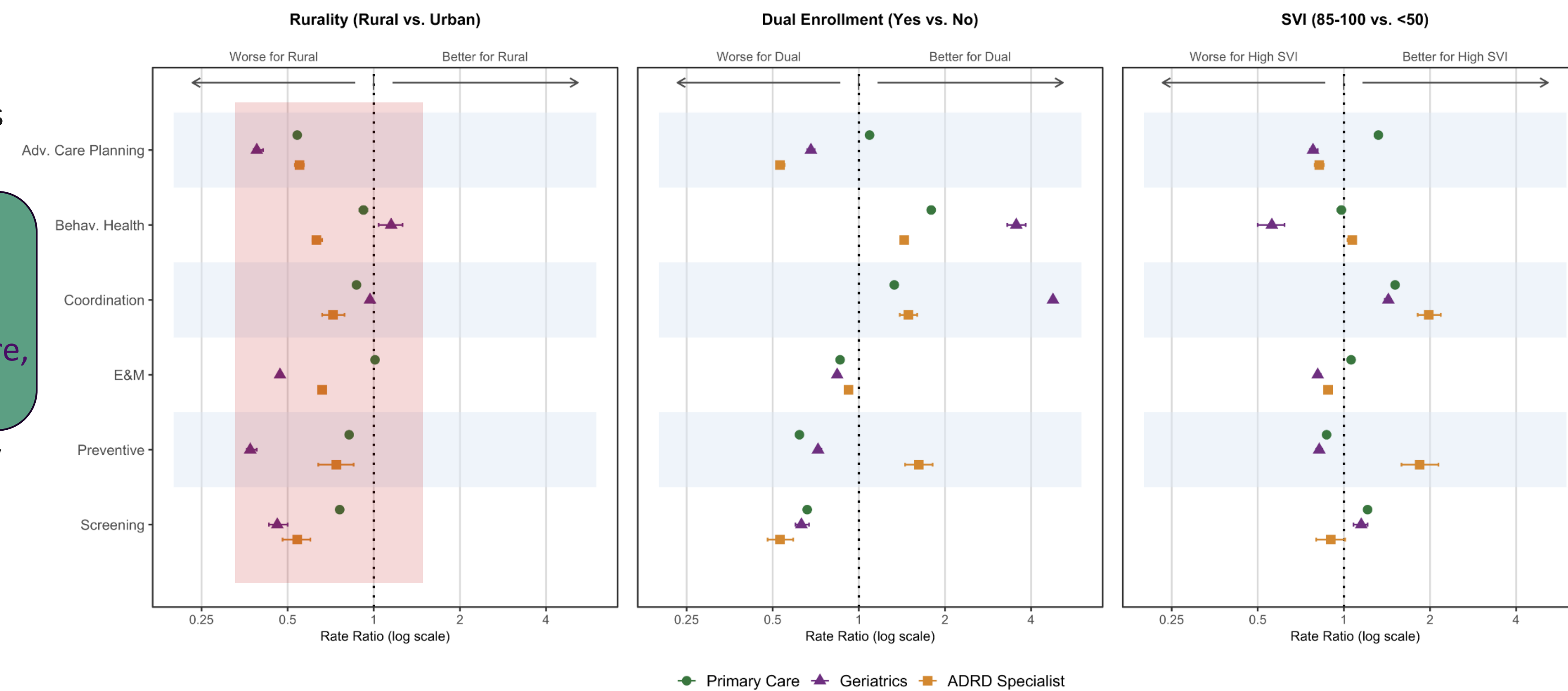
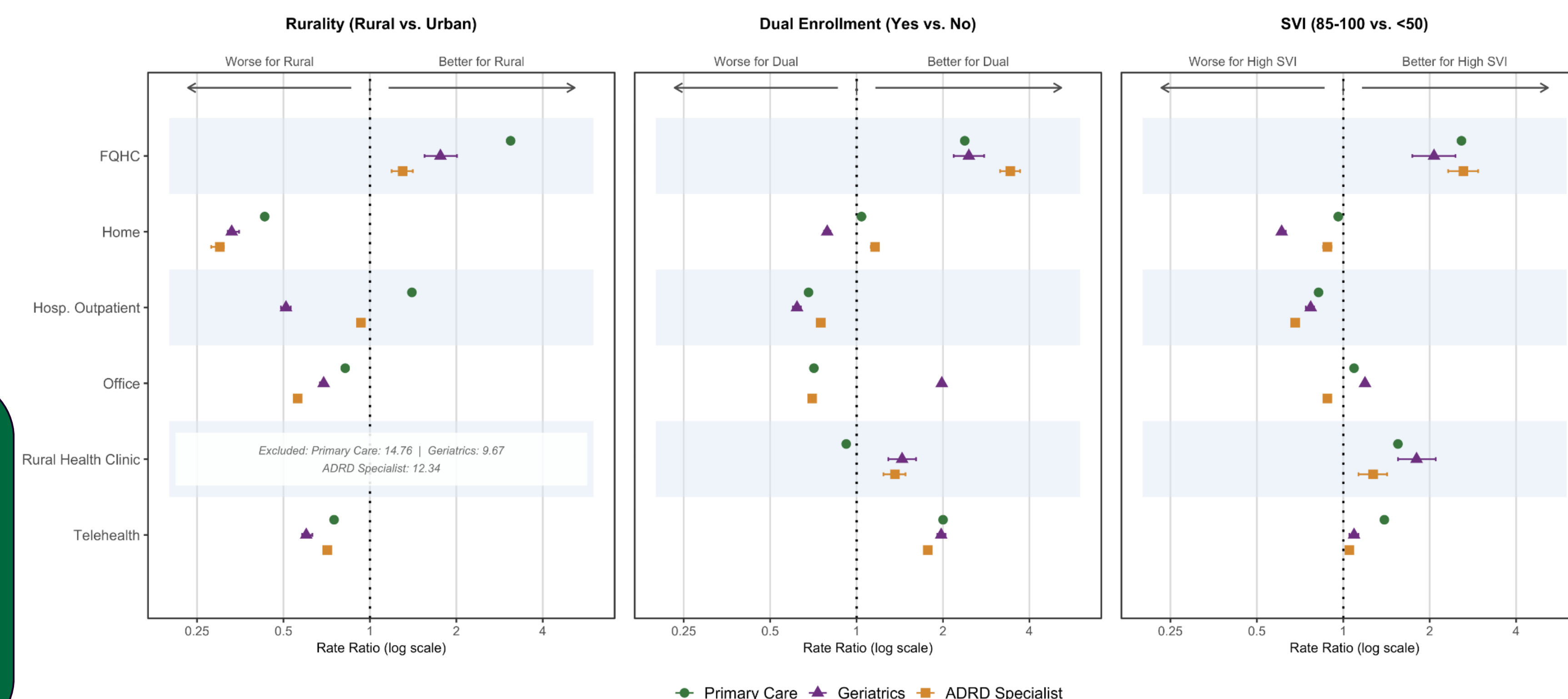


Figure 2. Healthcare Setting by Specialty and Subpopulation (Adjusted Rate Ratios)



Discussion

PCCs are the de facto hub of dementia care across sub-populations at higher risk

Most concerning gaps exist for rural PLWD who receive fewer services and rely heavily on safety-net settings (RHC RR 14.76)

Outside of these settings, ED use is still common

Policy Implications

Investing in PCC-based models, creating sustainable funding, and improving training for ADRD care is essential to sustain and improve existing capabilities.

Targeted policies expanding capacity within FQHCs and Rural Health Clinics may be most beneficial for subpopulations at risk (particularly rural, dual-enrolled, and high-SVI PLWD)

Redirecting ED use toward community-based primary care could reduce costs, enhance continuity, and improve outcomes for PLWD.