of dementia-specific classifications require that all staff receive initial dementia training, compared to only one-third (33%) of general AL classifications. This trend is similarly reflected in cognitive-screening requirements, present in 67% of dementia-specific classifications and 42% of general AL classifications. Regulatory theory describes how licensing agencies respond to various forces and values. Within-state AL regulatory variation reflects a combination of oversight mandates, population-specific needs (e.g., people with dementia), historic policies, and provider influence, with implications for consumers, policy-makers and researchers. Part of a symposium sponsored by Assisted Living Interest Group.

THE INTERSECTION OF MEDICAID AND ASSISTED LIVING FOR RESIDENTS WITH DEMENTIA

Brian Kaskie,[1] Seamus Taylor,[1] and Lili Xu,[2] *1. University of Iowa, Iowa City, Iowa, United States, 2. University of Iowa, University City, Iowa, United States*

Medicaid has increasingly offered coverage to persons residing in assisted living (AL). However, the scope of coverage across states is unknown. We sourced 2019 state administrative regulations specific to Medicaid and AL and determined forty-five (45) states link Medicaid with AL. Twenty-seven (27) do so as part of their state plan, 32 use a §1915(c) waiver, and 11 use a §1115 waiver. Forty-four states limit Medicaid coverage to a specific population, 16 limit coverage to those with a diagnosed disability, and 1 state limits coverage to a specific geographic region. In addition, 33 states provide payment for room and board with 28 states upholding a payment cap. In regards to services, 13 states reimburse a limited range of services while 32 offer a more expansive range of services. As Medicaid programs have extended coverage to residents of AL, researchers must now consider the impact on AL access and residents' outcomes. Part of a symposium sponsored by Assisted Living Interest Group.

GEOGRAPHIC DISPARITIES IN ACCESS TO SPECIALIZED DEMENTIA CARE

Portia Cornell,[1] Wenhan Zhang,[2] Lindsey Smith,[3] Shekinah Fashaw,[2] and Kali Thomas,[2] *1. Providence VA Medical Center, Providence, Rhode Island, United States, 2. Brown University, Providence, Rhode Island, United States, 3. PSU School of Public Health, Portland, Oregon, United States*

With novel, previously undescribed data on the availability of dementia-specific assisted living communities (ALs), we analyzed variation among counties in the availability of this important service for persons with dementia. In twenty-one states, we identified 6,961 ALs (16%) with a dementia-specific license/certification. Counties with at least one AL providing dementia-specific care had substantially higher college attainment versus counties that had at least one AL, but no dementia-specific beds: 25% versus 18% ($p<0.01$). Counties with dementia care also had significantly greater median incomes ($54,000 vs. $46,400), and home values ($159,000 vs. $113,000), lower poverty rates (13.7 percent vs. 16.3 percent), and lower proportions of Black residents (7.8 percent vs. 8.7 percent). Our findings are suggestive of a mismatch in need and availability of residential care options for older adults with ADRD that are also low-income or racial/ethnic minorities. Part of a symposium sponsored by Assisted Living Interest Group.

STATE VARIABILITY IN EMERGENCY DEPARTMENT VISITS AMONG ASSISTED LIVING RESIDENTS WITH DEMENTIA

Cassandra Hua,[1] Wenhan Zhang,[2] Portia Cornell,[3] Momotazur Rahman,[1] David Dosa,[4] and Kali Thomas,[2] *1. Brown University School of Public Health, Providence, Rhode Island, United States, 2. Brown University, Providence, Rhode Island, United States, 3. Providence VA Medical Center, Providence, Rhode Island, United States, 4. Brown University, Barrington, Rhode Island, United States*

Emergency department (ED) visits are associated with poor outcomes; however, state variation in ED use among assisted living (AL) residents is not well understood. Using 2017 Medicare data, we identified a cohort of 88,880 beneficiaries with dementia residing in larger ALs (25+ beds) and calculated risk-adjusted rates of all-cause and injury-related ED use per 100 person years, by state, adjusting for demographics and chronic conditions. Risk-adjusted state rates of all-cause ED visits ranged from 129.5 visits/100 person-years (95%CI=114.6,148.2) in New Mexico to 246.1 visits/100 person-years (95%CI= 224.9,274.8) in Rhode Island. The risk-adjusted rate of injury-related ED visits ranged from 91.4 visits/100 person-years (95%CI=83.0,101.4) in New Mexico to 135.9 visits/100 person-years (95%CI=126.9,146.6) in Montana. Potential reasons for these state variations will be discussed. Part of a symposium sponsored by Assisted Living Interest Group.

THE IMPACT OF CHANGES IN DIRECT CARE STAFFING POLICIES AND OUTCOMES FOR ASSISTED LIVING RESIDENTS WITH DEMENTIA

Kali Thomas,[1] Portia Cornell,[2] Wenhan Zhang,[1] Paula Carder,[3] Lindsey Smith,[4] Cassandra Hua,[5] and Momotazur Rahman,[5] *1. Brown University, Providence, Rhode Island, United States, 2. Providence VA Medical Center, Providence, Rhode Island, United States, 3. Portland State University, Portland, Oregon, United States, 4. PSU School of Public Health, Portland, Oregon, United States, 5. Brown University School of Public Health, Providence, Rhode Island, United States*

We identified a cohort of 410,413 Medicare beneficiaries residing in 10,623 large (25+bed) assisted living (AL) communities between 2007 and 2017. We conducted linear probability models with a difference-in-difference framework to examine the association between hospitalization and changes in regulations pertaining to staff training (model 1) and staffing levels (model 2), adjusting for time trends, resident characteristics, and state-license fixed effects. During this 11-year period, six states changed their staff training requirements and two states introduced/increased direct care staffing levels. A change in regulations related to staffing levels was associated with a reduction in the probability of hospitalization during the month of -0.0056 percentage points (95%CI=-0.008,-0.003). A change in regulations related to staff training was associated with a reduction in the probability of hospitalization during the month of -0.0035 percentage points (95%CI=-0.006,-0.002). The policy effects represent clinically important differences of approximately 21% in the mean monthly hospitalization rate. Part of a symposium sponsored by Assisted Living Interest Group.