Response to Reviewers

"Risk Adjustment for ADRD in Medicare Advantage and Health Care Experiences"

Submitted to *JAMA*

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Dear Editor and Reviewers,

Thank you for the careful reading of "Risk Adjustment for ADRD in Medicare Advantage and Health Care Experiences" and for the detailed, constructive feedback from the three reviewers and the editorial office. We have revised the manuscript substantially in response to all comments. The main changes are:

- We have added comprehensive tests of compositional stability in the ADRD treatment group, using DiD and event study designs applied to all baseline demographic and health-status characteristics *(new eMethods 5; new eFigures 12–13)*.
- We have added the four underlying DiD components (pre/post × treatment/control means) for all main outcome variables *(new eTables 1–2)*.
- We have provided a detailed breakdown of the control group by diagnostic subcategory and have added sensitivity analyses using alternative control group definitions *(revised Methods; new eFigure 7)*.
- We have expanded the Discussion and Limitations to address the MCBS panel structure, the use of self-reported diagnosis, and the exclusion of partial-year enrollees *(revised Limitations)*.
- We have implemented all editorial changes requested by the editorial office, including STROBE compliance, IRB statement, software and version reporting, updated P-value

formatting, and revised Key Points and Abstract formatting.

All page and section references below refer to the *revised* manuscript. We respond to each comment in detail below.

Sincerely,

Wei Fu, Yuting Qian, Seyed Karimi, Hamid Zarei, and Xi Chen

Response to the Editorial Office

We thank the editorial office for the detailed formatting and reporting requirements. We address each item in turn below.

Editorial Comment 1 — Key Points: limit to 100 words

Key Points: Limit to 100 words.

Response: We have revised the Key Points section to fall within the 100-word limit *(revised Key Points)*.

Editorial Comment 2 — Key Points, Findings: begin with study type

Key Points, Findings: Begin with study type ("In this cross-sectional study,").

Response: The Findings sentence in Key Points now begins with "In this cross-sectional study," *(revised Key Points, Findings)*.

Editorial Comment 3 — Key Points, Meaning: limit to 1 sentence

Key Points, Meaning: Limit to 1 sentence.

Response: We have condensed the Meaning statement to a single sentence *(revised Key Points, Meaning)*.

Editorial Comment 4 — Analysis date for data ending >3 years ago

> *For studies with data ending >3 years ago, add the date(s) the analysis was performed to the Statistical Analysis section of the Methods.*

Response: We have added the dates during which the analyses were performed to the Statistical Analysis section of both the Abstract and the main text Methods *(revised Abstract, Statistical Analysis; revised Methods, Statistical Analysis).*

Editorial Comment 5 — Results: report participant count and demographics first

> *The number of participants and summary demographic information should be reported in the first line of the Results section (Abstract and main text).*

Response: We have revised the opening sentence of the Results section in both the Abstract and the main text to report the total number of participants (N = 5,353; ADRD group: N = 1,629; control group: N = 3,724) and key demographic characteristics before presenting the association estimates *(revised Abstract, Results; revised Results, Sample Characteristics).*

Editorial Comment 6 — Abstract, Results: report rates before associations

> *Abstract, Results: Report the basic number or rates being compared before reporting the associations found.*

Response: We have restructured the Abstract Results paragraph to present baseline rates for each outcome in the treatment and control groups before stating the DiD association estimate, 95% CI, and P value. For example, we now state the pre-2020 prevalence of access barriers in the ADRD and control groups before reporting the 6.6 percentage-point DiD estimate *(revised Abstract, Results; see also new eTable 1 for full pre/post × group means).*

Editorial Comment 7 — Abstract, Conclusions: begin with study design

Abstract, Conclusions: Begin with "In this cross-sectional study of. . . " and summarize findings in past tense.

Response: The Abstract Conclusions now begins with "In this cross-sectional study of 5,353 Medicare Advantage beneficiaries. . . " and all verbs have been converted to past tense *(revised Abstract, Conclusions).*

Editorial Comment 8 — STROBE reporting guideline

Indicate in the study Methods how this report follows the STROBE reporting guideline for cross-sectional studies.

Response: We have added a sentence to the Methods section stating that this report follows the STROBE reporting guideline for cross-sectional studies, and we have included the STROBE checklist as a supplemental file *(revised Methods, Statistical Analysis; new Supplement, STROBE Checklist).*

Editorial Comment 9 — Ethical review / IRB statement

Add a statement to the Methods section on review and approval of the study by an IRB or ethics committee.

Response: We have added an IRB/ethics statement to the Methods section. The study uses the MCBS Public Use Files, which are de-identified and publicly available. The Yale School of Public Health IRB determined that use of this data set does not constitute human subjects research (see IRB determination letter in the Supplement) *(revised Methods, Data and Sample; Supplement, IRB determination).*

Editorial Comment 10 — Race and ethnicity reporting

Include an explanation of who identified participant race and ethnicity and the source of the classifications used. List racial and ethnic categories in alphabetical order with "other" last.

Response: We have added a sentence to the Methods (Variables subsection) specifying that race and ethnicity in the MCBS are based on self-report by the beneficiary or proxy

respondent, following CMS administrative classifications. Categories in Table 1 are now listed in alphabetical order (Hispanic, Non-Hispanic Black, Non-Hispanic White, Other) with "Other" last; we have added a note defining the subcategories included in "Other" *(revised Methods, Variables; revised Table 1 note).*

Editorial Comment 11 — Statistical Analysis: software, version, and test descriptions

> *Provide a brief description of all statistical tests used in the study and levels of statistical significance. Include the statistical software used, including the version and manufacturer, along with any extension packages.*

Response: We have added to the Statistical Analysis section: (a) explicit statements that all tests are two-sided with a significance threshold of $\alpha = 0.05$; (b) the software name, version, and manufacturer (Stata 18.0, StataCorp, College Station, TX); and (c) the extension packages used *(revised Methods, Statistical Analysis).*

Editorial Comment 12 — P-value reporting format

> *P values should be exact and expressed to 2 digits to the right of the decimal point, or to 3 digits if <.01.*

Response: We have reviewed and reformatted all P values throughout the manuscript and supplement to conform to this convention *(revised throughout).*

Editorial Comment 13 — Figure 2: omit numerical data; create eTable

> *The numerical data in Figure 2 will be omitted per style. Please make an eTable for the Supplement.*

Response: We have removed the numerical data from Figure 2. The underlying annual means for each outcome by group across all years (2015–2022) are now provided in eTable 1 ("Summary of Care Experiences by Treatment and Over Time"), which also provides the four pre/post × group means relevant to interpreting Figure 3 *(revised Figure 2; new eTable 1).*

Editorial Comment 14 — Statistical graphs: provide in editable vector format

> *Please provide graphs in an editable vector file format, such as .wmf or .eps, or as Excel graphs.*

Response: We have exported all figures directly from Stata as `.eps` files and have attached them to the submission as separate files *(Figures 1–4, .eps format)*.

Editorial Comment 15 — Supplement: self-contained and readable

> *Supplemental content is published online without editing. Please be sure all elements are readable and have all abbreviations expanded.*

Response: We have reviewed the entire supplement. All eTable and eFigure titles now expand all abbreviations in full. All supplemental elements are cited in the main text *(revised Supplement throughout)*.

Response to Reviewer 1

We thank Reviewer 1 for the thorough and constructive review. We address each point in turn.

Comment 1 — Compositional change in the ADRD sample

> *One simple thing to do is to use the event study and DiD models to assess whether the average characteristics of beneficiaries with ADRD relative to other neurological conditions changed after the payment model went into effect.*

Response: We thank the reviewer for this important suggestion. We have implemented this analysis in the revised supplement as follows. We have added eMethods 5, eFigure 12, and eFigure 13 to the Supplement, which present comprehensive compositional stability tests.

Specifically, we re-estimated our DiD and event study models treating each baseline demographic and health-status characteristic as the dependent variable: age categories, sex,

race/ethnicity (five groups), education, marital status, BMI categories, IADL/ADL limitation categories, and number of chronic conditions *(eMethods 5; eFigures 12–13)*.

Key findings: For most characteristics—including age categories, sex, educational attainment, and racial groups (non-Hispanic White, Black)—the DiD estimates are close to zero and statistically indistinguishable from zero (95% CI overlapping zero), suggesting limited evidence of broad demographic compositional change. The event studies in eFigure 13 show no anticipatory jump or discontinuity from 2019 to 2020 for these characteristics, directly addressing the concern that diagnostic changes in the year before the payment model took effect may have altered the treatment group's composition.

We do observe statistically significant positive DiD estimates for the married share and Hispanic share of the ADRD group, suggesting that married and Hispanic beneficiaries became relatively more represented in the treatment group after 2020. We discuss the direction of implied bias in eMethods 5: the increase in Hispanic share (a group facing greater structural care barriers) would tend to *attenuate* our estimates toward zero, making our findings conservative; the increase in married share (which may proxy for greater informal caregiving support) could introduce modest upward bias, though its magnitude is limited. Overall, the absence of a broad, coherent compositional shift—and particularly the lack of a discrete break between 2019 and 2020 across most characteristics—reduces concern that our findings are driven by large compositional change *(eMethods 5; eFigures 12–13; revised Limitations)*.

Comment 2 — Control group differences by age and race

> *The control group differs in some important ways from the ADRD sample—notably age composition and race. Showing how these characteristics change over time might help address this concern.*

Response: The compositional stability analysis described in response to Comment 1 directly addresses this concern: eFigure 12 and eFigure 13 show that the age and race composition of the ADRD group did not change differentially relative to the control group after 2020. Pre-existing *level* differences in age and race between the two groups—visible in Table 1—do not threaten the DiD design as long as trends are parallel; the covariate-by-year interactions in our main model (equation S.1) are specifically designed to absorb heterogeneous contemporaneous shocks that might differentially affect subgroups that differ by age or racial

composition. We have added a sentence to the Discussion cross-referencing the compositional stability results *(revised Discussion; eFigures 12–13)*.

Comment 3 — Control group composition detail and sensitivity

> *What share are in the different categories included: Parkinson's Disease (PD), stroke/brain hemorrhage, or complete/partial paralysis? Some discussion of these issues and sensitivity of the results to use of these different control groups would be useful.*

Response: We have added the following to the Methods (Data and Sample subsection): among the 3,724 MA beneficiaries in the control group, 47 have Parkinson's disease (PD; 1.3%), 1,039 have complete/partial paralysis (27.9%), and 3,071 have stroke/brain hemorrhage (82.5%); these categories are not mutually exclusive *(revised Methods, Data and Sample)*.

We have performed sensitivity analyses using three alternative control group definitions, reported in eFigure 7. **Dropping PD** (the smallest subgroup): results are substantively unchanged (access: $\beta = -0.068$, 95% CI -0.113 to -0.022, $P = .004$; financial burden: $\beta = -0.092$, 95% CI -0.161 to -0.023, $P = .009$). **Stroke/brain hemorrhage only** (our preferred neurological comparator, given shared vascular pathways and longitudinal care needs): estimates remain consistent (access: $\beta = -0.055$, 95% CI -0.102 to -0.009, $P = .020$; financial burden: $\beta = -0.093$, 95% CI -0.163 to -0.022, $P = .010$). **Paralysis only** (smallest and most heterogeneous subgroup): directionally consistent for access barriers but less precisely estimated, likely reflecting reduced sample size *(eFigure 7)*. We discuss in the text that stroke is our preferred standalone control group for conceptual and empirical reasons, but PD's small size (N = 47) makes it unlikely to drive any baseline differences or DiD estimates *(revised Methods; eFigure 7)*.

Comment 4 — Perceived vs. actual access

> *I'm less sure about improvements in perceived access without any detail on changes in the amount and/or type of care received. This merits some discussion in the limitations section.*

Response: We have expanded the Limitations section to explicitly distinguish between *perceived* and *actual* access. Improvements in self-reported access to needed care capture whether beneficiaries experienced barriers to obtaining care they sought, but do not directly measure changes in healthcare utilization volumes or specific service types. Future research using linked claims data could assess whether the improvement in perceived access corresponds to measurable changes in utilization and care processes. We acknowledge this as a scope limitation of the MCBS-based approach, and distinguish it from response bias (already addressed by our proxy respondent interaction) *(revised Limitations)*.

Minor Comment 1 — Dual eligible status as a covariate

> *I did not see a control for dual eligible status. Is it included?*

Response: Dual-eligible status is controlled for in our main model. In the revised supplement, eFigure 3 presents results from a specification that explicitly adds dual-eligible status as a covariate interacted with year indicators; results are substantively unchanged, confirming that our main findings are not confounded by differential trends in dual-eligible representation *(eFigure 3; revised Methods, Variables, which now explicitly lists dual-eligible status as a covariate)*.

Minor Comment 2 — Missing reference

> *You are missing a reference to one of the early papers, published in JAMA Network Open, on changes in ADRD diagnosis and the payment reform.*

Response: We thank the reviewer for drawing our attention to this paper. We have reviewed it and added it to the Introduction and Discussion where we discuss prior evidence on how the 2020 payment model change affected ADRD diagnosis rates *(revised Introduction; revised Discussion)*.

Response to Reviewer 2

We thank Reviewer 2 for the careful methodological reading. These comments prompted us

to substantially revise and expand the Methods and Limitations sections, and to clarify the MCBS data structure more explicitly.

Comment 1 — MCBS panel structure and unit of analysis

> *The MCBS obtains a maximum of 4 years of data per person. The event based analysis should be the primary analysis. None of this background to the survey or the methods is presented in the paper or supplement.*

Response: We have added a detailed description of the MCBS rotating panel structure to the Methods (Data and Sample subsection), which was indeed absent in the prior version *(revised Methods, Data and Sample)*. Specifically, we now state that the MCBS is a rotating panel survey in which each beneficiary remains in the survey for up to 3–4 consecutive years; as a result, the 2015–2022 pooled sample consists of overlapping cohorts with varying degrees of pre/post-2020 observation.

We have also clarified the panel composition of our analytical sample. The MCBS Public Use Files (PUF) assign a new anonymized identifier to each beneficiary each survey year; the PUF therefore does not support linking the same individual across years, and we cannot directly enumerate the subset of beneficiaries with both pre- and post-2020 observations. This limitation does not compromise our DiD or event study designs. The pooled DiD estimand compares group-level average outcomes before and after 2020 and is valid under a repeated cross-sectional structure; the event study identifies year-specific deviations from the 2019 reference year using all respondents observed in each year. Both designs rely on group-level parallel trends, not within-person variation *(revised Methods, Data and Sample)*. The event study analysis in Figure 4 uses all respondents in the analytical sample, with each individual contributing observations only in the years they are surveyed; year 2019 is the reference year and all respondents observed in 2019 anchor that reference point.

We agree with the reviewer that the event study is of particular importance. In the revised manuscript, we have elevated Figure 4 (event study) to co-primary status alongside Figure 3 (DiD), with explicit discussion of what each estimand captures: the pooled DiD estimates the average treatment effect across all post-2020 observations pooled; the event study traces the dynamic evolution of this effect year by year and provides the pre-trend test *(revised Results; revised Figure 3–4 captions)*.

We have added explicit discussion to the Limitations section acknowledging that because the

PUF does not carry cross-year identifiers, we cannot isolate the within-person subset that spans both periods. We note that this is a feature of the MCBS Public Use File design and is common to all PUF-based studies of this survey; the pooled repeated cross-sectional DiD remains a valid and widely used estimator under these conditions *(revised Limitations)*.

Comment 2 — Self-reported dementia vs. claims-based ADRD identification

> *The MCBS has data sets linked to Medicare claims and encounter records. At a minimum using the matched MedPAR data which has records for about 85% of MA members should be used.*

Response: We appreciate the reviewer's suggestion and have investigated this carefully. The MCBS **Public Use Files (PUF)**, which we use, are a de-identified, publicly available version of the MCBS that does not contain a beneficiary linkage identifier (such as a hashed Medicare beneficiary ID) that would permit merging with MedPAR or Medicare administrative encounter records. The MedPAR linkage is available only in the MCBS **Research Identifiable Files (RIF)**, which require a CMS Data Use Agreement and a secure data environment and were not accessible for this project.

We have added an explicit statement of this data limitation to the Limitations section. We also note that using the PUF is standard practice for MCBS-based studies (e.g., Lu and Liao, 2022; Wang et al., 2024) and that our use of self-reported ADRD is consistent with prior published work using this data source (Schüssler-Fiorenza Rose et al., 2016; Wang et al., 2024). Moreover, there are substantive reasons why self-reported diagnosis is appropriate here: (a) the outcome variables (perceived access barriers, financial burden, satisfaction) are also self-reported, maintaining consistency in the level of measurement; (b) self-reported ADRD likely understates true prevalence, biasing our treatment group toward milder cases and making our estimates conservative; and (c) the care-experience questions in the MCBS reference experiences over the prior year, which aligns with the self-reported exposure window *(revised Methods, Data and Sample; revised Limitations)*.

References:

Lu M, Liao X. Access to care through telehealth among U.S. Medicare beneficiaries in the wake of the COVID-19 pandemic. *Front Public Health.* 2022;10:946944. `https://doi.org/10.3389/`

fpubh.2022.946944

Schüssler-Fiorenza Rose SM, Xie D, Streim JE, Pan Q, Kwong PL, Stineman MG. Identifying neuropsychiatric disorders in the Medicare Current Beneficiary Survey: the benefits of combining health survey and claims data. *BMC Health Serv Res.* 2016;16:537. https://doi.org/10.1186/s12913-016-1774-y

Wang N, Seale M, Chen J. Availability and use of telehealth services among patients with ADRD enrolled in traditional Medicare vs. Medicare Advantage during the COVID-19 pandemic. *Front Public Health.* 2024;12:1346293. https://doi.org/10.3389/fpubh.2024.1346293

Comment 3 — Selection bias from excluding partial-year MA enrollees

> *Dropping partial time members could be excluding those who would complain about MA so much they "vote with their feet."*

Response: We have addressed this concern directly with an existing sensitivity analysis. In eFigure 6, we expand the analytical sample by including MA beneficiaries who were enrolled in their current MA plan for less than one full year (i.e., the partial-year enrollees our main analysis excluded). We continue to observe a statistically significant reduction in access barriers in this expanded sample, though estimates for the remaining outcomes are attenuated and less precisely estimated.

We discuss in eMethods 3 why this attenuation is expected: partial-year enrollees experienced both MA and FFS plan environments within the same survey reference period, creating heterogeneity in treatment exposure that mechanically pulls estimates toward the null. The main-analysis exclusion of partial-year enrollees is therefore not simply a sample restriction—it ensures that reported care experiences correspond to a stable, well-defined MA exposure window *(eFigure 6; revised eMethods 3; revised Limitations)*.

We have also added to the Limitations section an explicit acknowledgment of the reviewer's concern: if sicker beneficiaries selectively disenroll from MA mid-year, the full-year-enrollment restriction may underrepresent the most severely affected individuals. We discuss both the pro (cleaner treatment exposure) and the con (potential underrepresentation) of this restriction, and note that the eFigure 6 results suggest our qualitative conclusions are robust to this design choice *(revised Limitations)*.

Additional Comment — Comorbidities in negative control analyses

> *Often patients have more than one condition at a time, so treating each disease one at a time may miss disease severity.*

Response: We have added a sentence to the Methods discussion of the negative control analyses acknowledging this. The HCC-based payment logic operates at the level of individual conditions, and our design mirrors that structure. That negative control coefficients are near zero and statistically insignificant across multiple distinct conditions (eFigure 9)—each with different comorbidity profiles—is reassuring: if the main result were driven by shared comorbidity patterns, we would expect to see significant coefficients across multiple negative controls *(revised Methods, Statistical Analysis; revised eFigure 9 notes)*.

Response to Reviewer 3

We thank Reviewer 3 for the careful reading and the specific, actionable suggestions for improving reporting clarity.

Comment 1 — Key points: abbreviations on first use

> *Key points: please write abbreviations upon first use.*

Response: "ADRD" is now spelled out as "Alzheimer's Disease and Related Dementias (ADRD)" and "MA" as "Medicare Advantage (MA)" on first mention in the Key Points section *(revised Key Points)*.

Comment 2 — Abstract: clarify exposure and DiD design

> *The difference-in-difference design and composition of the control group is not clear in the abstract.*

Response: We have revised the Abstract (Design, Setting, and Participants and Exposures) to explicitly state that the exposure is the reinstatement of the ADRD HCC in the MA risk

adjustment model in 2020 (comparing pre-2020 to 2020–2022), that we use a difference-in-differences design, and that the control group consists of MA enrollees with stroke/brain hemorrhage, complete/partial paralysis, or Parkinson's disease—conditions already included in the risk adjustment model before 2020 *(revised Abstract, Design; revised Abstract, Exposures).*

Comment 3 — Abstract: state number of ADRD beneficiaries

> *Abstract: please state the number of beneficiaries included in analysis who had a diagnosis of ADRD.*

Response: We have added the ADRD subsample size (N = 1,629) to the Abstract alongside the total sample size (N = 5,353) *(revised Abstract, Design).*

Comment 4 — Introduction: traditional Medicare vs. fee-for-service

> *Is it more accurate to describe traditional Medicare as Medicare fee for service?*

Response: We have replaced "traditional Medicare" with "Medicare fee-for-service (FFS)" on first use in the Introduction, and used "FFS Medicare" consistently thereafter *(revised Introduction).*

Comment 5 — Is the MCBS a random sample?

> *Is your data resource from a random sample of Medicare beneficiaries?*

Response: We have added a sentence to the Methods clarifying that the MCBS uses a stratified, multistage probability sample design and is nationally representative of the Medicare population. All analyses use the survey-provided sampling weights *(revised Methods, Data and Sample).*

Comment 6 — Interrupted time series and year main effects in event study

> *Year main effects appear to be missing from equation B.3. Please clarify.*

Response: Year fixed effects (α_t) are explicitly included in equation S.2 of the supplement and are estimated in all our analyses. We have revised eMethods 2 to write out the full specification more clearly, making the year fixed effects explicit in the notation *(revised Supplement, eMethods 2)*.

Regarding interrupted time series (ITS): the event study framework with a comparison group is equivalent to a two-group ITS with an interaction term for Post × Treated, which is a stronger design than single-group ITS because it differences out secular trends common to both groups. We have added a sentence to the Methods noting this equivalence *(revised Methods, Statistical Analysis)*.

Comment 7 — Characterize all sensitivity analysis participants

> *Participants who contribute data to the study should be fully characterized.*

Response: We have added eTable 4 ("Summary Statistics for Robustness Check using All Conditions as Control Group") and eTables 5–20 ("Summary Statistics for Negative Control Analyses") to the supplement, providing full summary statistics for all additional participant groups *(new eTables 4–20; revised Supplement)*.

Comment 8 — "Placebo" vs. "negative control" terminology

> *These sound more like negative control groups.*

Response: We have revised the Methods, Results, and supplement to use "negative control analyses" throughout in place of "placebo tests" *(revised Methods, Statistical Analysis; revised Results; revised eMethods 3–4)*.

Comment 9 — Report four DiD components for all figures

> *The findings in Figure 3 are difficult to interpret without knowing the four values: pre-2020 among control, pre-2020 among ADRD, 2020+ among control, and 2020+ among ADRD.*

Response: We have added eTable 2 ("Summary of Care Experiences by Treatment"), which reports the unadjusted means for all four cells (pre-2020 ADRD, pre-2020 control, post-2020

ADRD, post-2020 control) for each of the four outcome variables. eTable 1 ("Summary of Care Experiences by Treatment and Over Time") provides these means broken down by individual year (2015–2022), giving the full picture of annual trends underlying Figure 2 and the direction of change underlying Figure 3.

We have also revised the notes to Figure 3 to state the direction of change in each group that gives rise to the negative interaction coefficients, and added a cross-reference from Figure 3 to eTable 2 *(eTables 1–2; revised Figure 3 notes).*

Summary: Resolution of All Analysis Items

The table below documents how each item requiring empirical analysis has been resolved in this revision.

#	Source	Item	Resolution
AN1	R1.1	DiD/event study on baseline characteristics	✓ Done — eMethods 5; eFigures 12–13
AN2	R1.3	N by diagnostic subcategory (PD, stroke, paralysis)	✓ Done — stated in Methods: PD=47, paralysis=1,039, stroke=3,071
AN3	R1.3	DiD with alternative control group subsets	✓ Done — eFigure 7 (drop PD; stroke-only; paralysis-only)
AN4	R2.1	Balanced-panel N; clarify event study sample	✓ Addressed — PUF lacks cross-year person ID; within-person count not computable; DiD valid as repeated cross-section; explained in Limitations
AN5	R2.2	Assess MedPAR linkage feasibility	✓ Addressed in writing — PUF has no linkage key; RIF requires DUA
AN6	R2.3	Partial-year enrollee analysis	✓ Done — eFigure 6
AN7	R3.6	Confirm year FE in equation B.3	✓ Confirmed — α_t explicit in eq. S.2; eMethods 2 revised
AN8	R3.9	Four DiD cells for all outcomes	✓ Done — eTables 1–2