March 17, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD

Dear Ms. Verma:

On behalf of the nearly 30 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association provides the following comments on the Healthy Indiana Plan (HIP) 2.0 Section 1115 Waiver Extension Application.

According to the Centers for Disease Control and Prevention, 462,000 adults in Indiana have diabetes and another 272,000 are at risk for developing diabetes. Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid. In Indiana, the diabetes prevalence for individuals with annual household incomes of less than $15,000 is 15.3%, compared to 6.8% for those with annual household incomes of $50,000 or higher. For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a study conducted in California found “amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state.”

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. As such, the Association continues to support Indiana’s decision to accept federal funding to extend Medicaid eligibility to low-income adults. We do, however, have concerns regarding some of the provisions of Indiana’s HIP 2.0 waiver extension application, and provide the following comments and recommendations to help ensure the needs of low-income individuals with diabetes and prediabetes are met by the state’s Medicaid program.
Expanded Incentives Program

The HIP 2.0 waiver extension application does not provide much detail on how it will expand the HIP 2.0 program incentives, but notes a goal of achieving certain “cost reductions.” In addition, the extension application says participating managed care plans will be expected to offer members incentives for “completion of specified milestones and healthy targets” in chronic disease management programs, including diabetes management.

The Association supports voluntary wellness programs that encourage individuals to adopt healthy lifestyles and provide support for doing so. However, we have concerns about programs that use premium or other health care cost rewards and penalties tied to achievement of a health status or outcome. Use of such incentives should in no way jeopardize access to health care or be used as a proxy for discrimination on the basis of health status. Currently, there is insufficient peer-reviewed research demonstrating the efficacy of financial incentives in motivating long-term behavior change. It is critical financial rewards intended to motivate behavior change are designed in a way that protects individuals from discrimination based on health status and preserves access to adequate and affordable health coverage.

Imposing increased cost-sharing or premiums based on an enrollee’s health status can create barriers to obtaining care needed to manage the individual’s health. In general, cost-sharing deters individuals from seeking medical care. Specifically, a Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.” The Association is strongly opposed to linking Medicaid cost-sharing to health outcome objectives. Therefore, the Association strongly urges CMS ensure the proposed incentive programs in the HIP 2.0 waiver extension program do not discriminate on the basis of health status and do not impose barriers to obtaining needed medical care.

In addition, we strongly urge CMS to work with Indiana and other states to encourage providing Medicaid enrollees with prediabetes—in both the expansion population and the traditional population—access to the National Diabetes Prevention Program (National DPP) instead of implementing untested behavior incentive programs. The National DPP is an evidence-based lifestyle intervention program that works to prevent type 2 diabetes in adults with prediabetes, with long-term impact. Research shows that even after 10 years, people who completed the program were one-third less likely to develop type 2 diabetes, providing states a long-lasting impact for their investment.

POWER Account Incentives

The Association remains concerned the financial “incentive” scheme in the HIP 2.0 program will be detrimental to enrollees diagnosed with diabetes. Diabetes is complex, chronic illness requiring continuous medical care with multifactorial risk reduction strategies beyond glycemic control. Ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications. Providing a HIP 2.0 enrollee with diabetes a financial
incentive to not use medical services—and therefore have a remaining balance in the POWER account at the end of the year—is irresponsible, and could result in increased costs for state and federal healthcare programs in the long-term. For example, studies show intensive diabetes management can delay the onset and progression of diabetic nephropathy, which is the leading cause of end stage renal disease. If a low-income individual with diabetes is enrolled in the HIP 2.0 program, the financial incentive offered by the program may dissuade him from obtaining the medical care, supplies and medications he needs to manage his diabetes.

Unfortunately, the interim evaluation report by the Lewin Group included with Indiana’s application does not provide enough detail to determine whether the POWER Account roll-over incentive is actually deterring enrollees from obtaining care. Specifically, the Lewin Group report notes that 50% of HIP Plus members with diabetes used primary care between February 2015 and January 2016, and just over 68% obtained specialty care. Only 31% of HIP Basic members with diabetes used primary care during that time, while almost 62% obtained specialty care. Based on the information in the Lewin Group report, it is unclear whether a large portion of HIP 2.0 program enrollees with diabetes did not receive any care—whether primary or specialty—during the time reviewed. The Association recommends CMS require additional information on how the POWER Account incentives are impacting access to needed care for individuals with diabetes and prediabetes.

Summary
The Association is pleased Indiana is continuing its Medicaid expansion program. However, we are concerned the proposed incentives are potentially detrimental to the health of HIP 2.0 program enrollees with chronic health conditions, such as diabetes. In addition, we recommend Indiana and other states consider providing Medicaid coverage for the National DPP instead of untested behavior incentive programs for program enrollees with prediabetes.

We appreciate the opportunity to provide comments on Indiana’s HIP 2.0 Section 1115 Waiver Extension Application. If you have any questions, please contact Krista Maier, JD, Interim Vice President of Public Policy, at KMaier@diabetes.org or 703-253-4365.

Sincerely,

Dr. LaShawn McIver, MD, MPH
Senior Vice President, Advocacy
American Diabetes Association
3 Stevens CD, Shrigger DL, Raffetto B, et. al, Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California, 8 Health Affairs 33, August 2014.
6 American Diabetes Association, Standards of Medical Care in Diabetes—2014, Diabetes Care, S43, January 2014. Available at http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract