January 11, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Verma:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments on the state of Tennessee's Section 1115 Demonstration Waiver for the TennCare II Amendment 38.

As the global authority on diabetes, the ADA funds research to better understand, prevent and manage diabetes and its complications; publishes the world's two most respected scientific journals in the field, Diabetes and Diabetes Care; sets the standards for diabetes care; holds the world's most respected diabetes scientific and educational conferences; advocates to increase research funding, improve health care, enact public policies to stop diabetes, and end discrimination against those denied their rights because of the disease; and supports individuals and communities by connecting them with the resources they need to prevent diabetes and better manage the disease and its devastating complications.

According to the Centers for Disease Control and Prevention (CDC), over 11.4% of adults in Tennessee have diagnosed diabetes.[1] Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionally covered by Medicaid.[2] 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.

Expanding Medicaid Eligibility

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing disparities in access to care and health status. Specifically, in Medicaid expansion states, more individuals are being screened for and diagnosed with diabetes than states that haven't expanded.[3] Additionally, a new study found expansion states have a higher rate of prescription fills for diabetes medications than non-expansion states.[4] Regular medication use with no gap in health insurance

coverage leads to fewer hospitalizations and less use of acute care facilities.[5,6] **Rather than implementing changes that impose significant barriers to obtaining and maintaining Medicaid coverage, the ADA recommends the Centers for Medicare and Medicaid Services (CMS) work with the state to ensure all low-income individuals in Tennessee have access to adequate, affordable health care coverage.**

Work Requirements

The ADA is deeply concerned by Tennessee's proposal to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed work or community engagement standards. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. In Tennessee alone, over 57% of Medicaid recipients are working.[7] Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.[8] For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.[9] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.[10,11]

A study by the National Bureau of Economic Research concluded Medicaid coverage increases utilization of primary and preventative services, lowers out-of-pocket medical spending and medical debt, and results in better self-reported physical and mental health.[12] CDC data show prevention programs and early detection can prevent the onset of type 2 diabetes and reduce state spending.[13] As Tennessee has not expanded Medicaid, implementation of work requirements will not create an avenue out of poverty, but rather push individuals into the coverage gap, making healthcare coverage unaffordable and inaccessible. Tennessee's proposal to limit access to Medicaid services through the implementation of work requirements will decrease access to care for low-income Tennessee residents with diabetes and increase state health care costs.

Administrative Burden

Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked which significantly increases the administrative burden of health care. Increasing the administrative requirements to maintain eligibility will likely decrease the number of individuals with Medicaid coverage, even for those who meet the requirements or qualify for an exemption. An analysis of expected Medicaid disenrollment rates after implementation of work requirements shows most disenrollment would be due to administrative burdens or red tape.[14,15] Medicaid enrollees who are working may experience difficulty obtaining the required documentation from their employer on a timely basis.

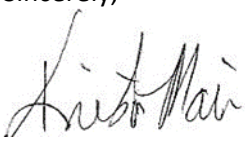
Diabetes is a complex, chronic illness that requires continuous medical care,[16] so Medicaid enrollees with diabetes cannot afford a sudden gap in health insurance coverage. A recent study found that people with type 1 diabetes who experience a gap or interruption in coverage, are five times more likely to use acute care services (i.e. urgent care facilities or emergency departments) than those with continuous coverage.[17] Adding administrative barriers and burdens will impede access to health services that Tennessee residents with diabetes need.

Conclusion

Research shows work requirements are not likely to have a positive impact on long-term employment.[18] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans. **We strongly urge CMS to reject the 1115 Demonstration Waiver for Amendment 38 as it creates barriers to accessible, affordable, and adequate healthcare for low-income Tennesseans with diabetes who rely on the program. The ADA asks CMS to instead encourage the state to work toward extending eligibility to adults earning up to 138% of the federal poverty level, which is shown to improve access to care and improve health.**

The ADA appreciates the opportunity to comment on behalf of the Tennessee residents with diabetes and prediabetes. Our comments include numerous citations to supporting research, including direct links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited – made available through active hyperlinks – and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act. If you have any questions, please contact me at KMaier@diabetes.org or 703-253-4365.

Sincerely,



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