Dear Dr. Wittman:

Thank you for submitting your manuscript to Diabetes Care. The editors have decided that your manuscript is not acceptable for publication in its present form. However, we would be willing to consider a version that has been substantially revised if you feel you can adequately address all the comments from the editors and/or reviewers. Please note that we make no commitment to publishing your revised manuscript given the important points that have been raised.

If you choose to submit a revised version of your manuscript, please provide a point-by-point response to the reviewers’ comments, with each comment verbatim in bold or italics followed by your response. If you have made substantive changes to your manuscript, in addition to highlighting them in track changes in the resubmitted version of the paper, please also provide in your response to the reviewers a detailed description of these changes and indicate where they appear in the manuscript. If you have inserted key sentences, paragraphs, or sections in response to the comments, please be clear about their location in your response. Further, if you have made any deletions, please also indicate the location of these changes.

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Thank you once again for submitting your work to Diabetes Care. We look forward to receiving your revised manuscript.

Yours sincerely,

Steven E. Kahn, M.B., Ch.B.

Editor-in-Chief, Diabetes Care

Professor of Medicine

VA Puget Sound Health Care System

University of Washington

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Abstracts are limited to 250 words. You currently have 251.

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EDITOR COMMENTS:

REVIEWER COMMENTS:

Reviewer: 1

Comments to the Author

Thank you for the opportunity to review this manuscript. I think this paper is addressing the persistent issues in diabetes care (i.e., lack of receipt in guideline recommended preventive care) using MEPS data. Methods are appropriate and manuscript is overall well written. Here are my comments for authors’ consideration.

Major

1. Abstract: provide sample size of this study.

We added “(*n* = 25,616)” to the abstract and methods on page 6 L99.

2. I was wondering whether data on urine albumin testing is available in MEPS.

Unfortunately, data on urine albumin testing do not appear to be available in MEPS.

3. Page 5: “To our knowledge, the proportion and trend of receipt of preventive services addressed in the Medical Expenditure Panel Survey (MEPS) has not been reported.” It would be nice to state the relative strengths of MEPS data compared to other national data sources (eg, NHANES and BRFSS).

On p. 5 L72 of the introduction, we added a brief statement on the advantages of working with data from MEPS: “Analysis of MEPS data provides advantages over other surveys, as it is nationally representative and available yearly. Meanwhile, NHANES is not annual and has smaller sample sizes; BRFSS is administered at the state level, and the diabetes module is not available in every state in every year.”

4. Page 5: The authors mentioned “examining any effects of the COVID-19 pandemic….”, but the study period is up to 2020 (only beginning of the pandemic). Studying the effects of pandemic is a primary objective in this study? I found this sentence is confusing.

We clarified that the inclusion of data from 2020 was to show how the onset of the pandemic impacted the reported receipt of preventive services, as opposed to impacts over the duration of the pandemic. On p. 6, L78 we added: “… examining any effects the start of the COVID-19 pandemic may have had on receipt of these services, and providing benchmarks for future studies.”

5. Page 6: MEPS data collection was not interrupted (or modified) after the start of pandemic in 2020?

Data collection was changed from in-person interviews to phone surveys, although the DCS remained a paper-and-pencil survey that was mailed to respondents. We added a sentence in the methods on page 6, L91 to clarify this: “In 2020, the computer-assisted personal interviews were changed from in-person to phone interviews due to the COVID-19 pandemic.”

6. Methods: I think the study population is individuals with diagnosed diabetes, but it is not super clear by the way it was written in the methods. For example, average annual number of 32,170 individual respondents are those with diabetes?

We clarified on page 6, L98 that data were drawn from respondents to the DCS sub-survey and provided numbers appropriate for that survey. “In this analysis, we used data from the full-year consolidated MEPS files for adults with diabetes that responded to the DCS survey (*n* = 25,616). Response rates for the DCS survey ranged from 92.4% in 2008 to 57.1% in 2020.”

6. Page 8: Results: What is the sample size for this study?

We added the sample size on page 6, L99 (n=25,616).

7. Page 12-13: “Other studies on trends in preventive care using different data sources report some conflicting findings. A study using NHANES data from 2005 to 2018 found increases in the proportion of adults with diabetes who reported: having a primary care doctor, receiving an annual check-up with a physician, having had at least two A1C tests in a year, having their cholesterol levels tested, and having an annual foot exam by a doctor” This sentence is misleading (i.e., increased in all these components) and needs to be changed. In this study, proportion of receiving ADA recommended care meeting all five criteria in the past year (having a primary doctor for diabetes and one or more visits for this doctor, HbA1c testing, an eye examination, a foot examination, and cholesterol testing) increased from 25% to 34%. However. when looking at the individual component, only A1C testing was increased (Please see the Supplemental Figure 2 in the paper). I suggest to revise the sentence to accurately reflect the prior study.   
On p. 14, L279 we added text to this sentence to clarify that it was receipt of all 5 practices, and not necessarily any individual practice:  
 “A study using NHANES data from 2005 to 2018 found increases in the proportion of adults with diabetes who reported receiving all of the following: having a primary care doctor, receiving an annual check-up with a physician, having had at least two A1C tests in a year, having their cholesterol levels tested, and having an annual foot exam by a doctor (12). However, when evaluated individually, only A1C testing increased, which is similar to our findings”

Related to this, what is the trends of receipt of all of six preventive services in your study?   
On p. 11 L208, we added text to the results to describe the trend and proportion of adults receiving all six services; the trend was flat from 2008 to 2019:  
For both adults with diabetes that reported receiving none of the six recommended preventive services and adults reporting receiving all of them, trends were flat from 2008 to 2019 (zero services: 3.1% [95% CI: –4.5%, 11.3%]; all services: 1.4% [–0.9%, 3.7%]; Supplemental Table 2). The percentage of adults that reported receiving all six preventive services in 2008 was 7.1% (4.5%, 9.6%), 10.8% (7.4%, 14.1%) in 2019 and 7.9% (5.3%, 10.5%) in 2020 (Supplemental Table 2).

8. “Another study that reported on data from NHANES, NHIS, and BRFSS found that foot exams, influenza vaccinations, and A1C testing increased from 1999 to 2016, although dilated eye exams stayed roughly constant (10).” In this study, what is the frequency of A1C testing? >=1 per year or >=2 per year like your study? I think this distinction is important and may contribute to the discrepancies between the studies in A1C testing trends.   
In this study Fang used “biannual A1C” testing, or >= 2 tests a year, the same as ours. This has been clarified in the discussion on page 15, L283:  
“Another study that reported on data from NHANES, NHIS, and BRFSS found that foot exams, influenza vaccinations, and two or more A1C tests in a year increased…”

9. If sample size allows, characterize people who did not receive any preventive services.   
Due to the unreliability of estimates in some sub-populations in some years, we do not characterize this any further. A sentence has been changed in the methods on page 7, L110 to clarify this:  
“We also created binary variables classifying adults with diabetes who received none of the recommended preventive care services or all of the recommended services, although these results are presented only for the overall population due the unreliability of estimates of some sub-populations in some years (17)”

Minor

1. page 4 article highlights: Last bullet point is not supported by the data.   
In the last bullet of the article highlights, we stated, “These data highlight services and specific subgroups that could be targeted to improve preventive care among adults with diabetes.” In our study, we found that adults in the youngest age group reported lower rates of receipt of eye exams, foot exams, cholesterol testing, and A1C testing. Adults with less than a high school education were less likely to visit the dentist. Reported foot examination rates have been decreasing since 2011. Adults age 45-64 years had a decreasing trend in receipt of cholesterol testing since 2016, as did males and adults with less than a high school education. We feel that all of these data points highlight the subgroups that could be targeted to improve preventive care.

2. Page 7. First sentence: provide an appropriate reference.   
A reference to Kim et al 2000 has been added to the methods on page 8, Line 136

3. Page 7: “We reported the estimated proportions for 2020 in Table 1 and as points in Figure 1 and Figure 2, but 2020 was excluded from trend analysis because of the decreased medical care utilization associated with the COVID-19 pandemic.”. I think it would be better to describe the analytic methods without mentioning the result figures.

We revised this sentence on page 8, L127 as follows: “We excluded 2020 from trend analysis because of the decreased medical care utilization associated with the COVID-19 pandemic. However, we presented the estimated proportions for 2020 in the results to show how the onset of the pandemic affected the reported receipt of preventive services.”

4. Page 8: Adults with Medicaid had an AAPC of -2.3% (-3.6%, (-1.0%). Remove “(“ before -1.0%.

We made this change as suggested.

5. In figure 1, change from percentage to % in Y axis. It is too crowded. Also, I would remove circle marker in the figure legend. Line seems better.

We changed the Y axis label and removed the circle from the legend.

6. Figure 1 and 2 should be mentioned in the results text.

On p. 9, L150 we added:

“Figures 1 and 2 display trends, overall and by subgroup.”

Reviewer: 2

Comments to the Author

This study reported trends in receipt of six American Diabetes Association recommended preventive care services during 2008 – 2020 using MEPS data and joinpoint analysis. The analysis is straightforward. Clarify of the manuscript could be improved, and some critical references are missing. Specific comments are provided below.

1. Under Abstract, under Results, line 4, “Trend analysis at the subgroup level was heterogeneous: influenza vaccination, A1C testing, and dental visits tended to improve while, among the uninsured, foot exams, cholesterol testing, and dental visits tended to decline.” – It seems contradicting here for dental care. Need to define the group in the first sentence: overall group?  
This section has been rewritten slightly to make this clearer:

“Trend analysis of subgroups was heterogeneous: influenza vaccination and A1C testing showed improvements among several subgroups, while cholesterol testing (45-64 year age, < high school education, Medicaid insurance) and dental visits (uninsured) declined.”

2. On page 5, line 3, “Diabetes is also costly: total direct and indirect costs are estimated at $327 billion”, need to provide year for the cost estimation.   
This has been clarified.

“Diabetes is also costly: total direct and indirect costs in 2017 were estimated at $327 billion”

3. On page 5, second paragraph, line 1: “Access to preventive services is important to minimize diabetes-related complications and reduce rates of hospitalization.” Need references, and a short description of the association between receiving the preventive services and the reduction of diabetes-related complications and reduce rates of hospitalization will be informative.

We revised the text on page 5 L63 to:

“Complications of diabetes include both microvascular (retinopathy, neuropathy, and diabetic nephropathy) and macrovascular complications (coronary artery disease, peripheral arterial disease, and stroke) (7). Access to preventive services to control glycemia, lipids, and blood pressure and the early identification of diabetic retinopathy and foot lesions is important to minimize diabetes-related complications and reduce rates of hospitalization (8,9).”

We added another citation as suggested:

10. Gregg EW, Li Y, Wang J, Rios Burrows N, Ali MK, Rolka D, et al. Changes in Diabetes-Related Complications in the United States, 19902010. New England Journal of Medicine [Internet]. 2014 Apr 17;370(16):1514–23. Available from: http://dx.doi.org/10.1056/NEJMoa1310799”

4. On page 5, second paragraph, line 5, “To our knowledge, the proportion and trend of receipt of preventive services addressed in the Medical Expenditure Panel Survey (MEPS) has not been reported”: Why was using MEPS data to measure the trend important? what are the advantages of MEPS over BRFSS and NHANES for this study?

On p. 5, L72 of the introduction, we added a brief statement on the advantages of working with data from MEPS: “Analysis of MEPS data provides advantages over other surveys, as it is nationally representative and available yearly. Meanwhile, NHANES is not annual and has smaller sample sizes; BRFSS is administered at the state level, and the diabetes module is not available in every state in every year.”

Next sentence, “We reported the proportion of and trends in the receipt of six preventive care services recommended by the American Diabetes Association (ADA)” needs reference.   
We added a citation as suggested:

7. ElSayed NA, Aleppo G, Aroda VR, Bannuru RR, Brown FM, Bruemmer D, et al. Introduction and Methodology: *Standards of Care in Diabetes2023*. Diabetes Care [Internet]. 2022 Dec 12;46(Supplement\_1):S1–4. Available from: <http://dx.doi.org/10.2337/dc23-Sint>

.

5. On page 5-6, under “Data source”, needs references describing MEPS data for the first a few sentences. In the same section, “We chose the years 2008 to 2020 due to method changes in MEPS starting in 2008, and the consistency of questions related to preventive care during that time period.”: What were the changes? Need a reference here. Also need a reference for DCS.   
The major method changes was the change in questions related to preventive care on the survey between 2007 and 2008. Examining data from 2008 onward allowed us to evaluate trends that were generated from the same questions over time. We revised the text on page 6, L86 and included a reference to the MEPS documentation:

“We chose the years 2008 to 2020 due to consistency of questions related to preventive care during that time period starting in 2008.”

Last sentence under “Data Source”: the response rate for 2020 was very low. The authors may want to exclude the data in 2020, since we know the health care access was interrupted by the pandemic.

We originally reported the response rate for the overall MEPS survey but have changed the text on page 6, L 99 to include the response rate for the DCS survey, which was higher. Additionally, we clarified that the inclusion of data from 2020 was to show how the onset of the pandemic impacted the reported receipt of preventive services, as opposed to impacts over the duration of the pandemic. We added the following text in the introduction on page 5, L77:

“These data are valuable for identifying groups that may be under-utilizing health care services, examining any effects the start of the COVID-19 pandemic may have had on receipt of these services, and providing benchmarks for future studies.”  
In the methods, we added another sentence on page 8, L128:  
“However, we presented the estimated proportions for 2020 in the results to show how the onset of the pandemic affected the reported receipt of preventive services.”  
  
6. Under “Outcome Measures”, the last sentence: “although these results are presented only for the overall population due to small sample sizes in many of the examined subgroups.” : not clear what the authors mean here. The sample size for this binary variable should be the same as the measurement for the 6 preventive services individually. Why there is small sample size issue only for this variable?

The number who report having none of these services is small (<0.5% in some cases), leading to unreliable estimates in some years for some sub-populations as described in the NCHS data presentation standards for proportions document. This has been clarified in the methods on page 7, Line 110.

“We also created binary variables classifying adults with diabetes who received none of the recommended preventive care services or all of the recommended services, although these results are presented only for the overall population due the unreliability of estimates of some sub-populations in some years (17).”

We also cite the NCHS document below:

18. Parker J, Talih M, Malec DJ, Beresovsky V, Carroll MD, Gonzalez JF, et al. National Center for Health Statistics data presentation standards for proportions. National Center for Health Statistics. Vital Health Stat [Internet]. 2017 [cited 2023 Jun 12];2. Available from: <https://www.cdc.gov/nchs/data/series/sr_02/sr02_175.pdf>

7. Under “Analysis”, the authors said, “accounted for complex survey design”. Needs to specify whether the weights are for the DCS survey or the whole MEPS weights. They are different, and here, the DCS survey should be used. Please see <https://meps.ahrq.gov/survey_comp/standard_errors.jsp>

“These situations include analyses based solely on data from MEPS event files, which only contain sample persons that received a particular type of care, and analyses of data from MEPS supplements (e.g., the diabetes supplement data in PUF HC-070), which require the use of special analytic weights that exclude the sample persons who were not included in the supplement.”  
On page 7, Line 118, we clarified that we used DCS survey weights:  
“Our analysis accounts for the complex survey design used, including clustering and stratification, using the weights provided for the DCS (18).”

8. Under “Analysis”, second paragraph, “We reported the estimated proportions for 2020 in Table 1 and as points in Figure 1 and Figure 2”: 2020 data was not meaningful in this case, unless the authors want to show the impact of pandemic on receiving the diabetes preventive care services. If yes, the authors may want to add it as on objective.  
Data from 2020 were not included in trend analysis and are provided to show change in reported receipt of preventive services at the start of the pandemic. See previous text in response to item 5 that has been added to clarify this. We also noted it as an objective on page 5, L 77: “These data are valuable for identifying groups that may be under-utilizing health care services, examining any effects the start of the COVID-19 pandemic may have had on receipt of these services, and providing benchmarks for future studies.“.

9. On page 8, under “Results”: “All values pertaining to individual preventive practices presented here, as well as those that are not described, can be found in Supplemental Table 1”: No mentioning of the main tables and figures in the text. Are all the results in Supplemental Table 1? Did not find it in the PDF.

We added references to the table/figures in each section of the Results. Supplemental Table 1 (and the new Supplemental Table 2) are now more clearly labeled.

10. On page 10, Under “Absence of Preventive Care Services”, “In 2019, this estimate was 6.1% (3.7%, 8.5%) and in 2020 it was 8.2% (4.5%, 11.9%).”: Why did not report the results for the trend analysis here as for the other services?

We clarified that the trend was not statistically significant by adding the following text and APC value on page 11, L208:

“For both adults with diabetes that reported receiving none of the six recommended preventive services and adults reporting receiving all of them, trends were flat from 2008 to 2019 (zero services: 3.1% [95% CI: –4.5%, 11.3%]; all services: 1.4% [–0.9%, 3.7%]; Supplemental Table 2). In 2008, 5.1% (2.7%, 7.5%) of adults with diabetes reported receiving none of the six recommended care services (Supplemental Table 2). In 2019, this estimate was 6.1% (3.7%, 8.5%) and in 2020 it was 8.2% (4.5%, 11.9%) (Supplemental Table 2). The percentage of adults that reported receiving all six preventive services in 2008 was 7.1% (4.5%, 9.6%) (Supplemental Table 2). This percentage increased to 10.8% (7.4%, 14.1%) in 2019, but was lower in 2020 (7.9% [5.3%, 10.5%]) (Supplemental Table 2).”

11. On page 11, under “Discussion”, the first sentence: since the authors mentioned this mechanism, did the authors consider doing specific trend comparisons before and after 2010? If not, the authors may want to put this in the later part as explanation or implications of the findings.

We did not specifically evaluate differences before and after 2010. However, the Joinpoint analysis would have detected changes if they were there. Overall, with the exception of receipt of influenza vaccine, we did not see any significant increases after 2010.

In the same page, line 5, “Among subgroups, influenza vaccine uptake, A1C testing, and dental visits tended to improve.”: adding a word "all" or "most" might be more accurate.

We made the change as suggested.

In the same paragraph, “While the passing of the ACA led to an increase in the number of adults with diagnosed and undiagnosed diabetes who have health insurance, and an increase in their use of health care services”: the six preventive health care services are also health care services. Suggest adding the types of health care services studies in the literature to be more specific.

We revised this sentence on page 13 to better reflect our meaning: “While the passing of the ACA led to an increase in the number of adults with diagnosed and undiagnosed diabetes who have health insurance, and an increase in their access to health care (25,26), detecting corresponding increases in the receipt of preventive care has proved more elusive.”

In the same paragraph, “This percentage grew to 8.2% in 2020 during the onset of the COVID-19 pandemic.”: 2020 data is an outlier. Unless the authors want to show how pandemic interrupted receiving the preventive care services, the authors may not want to use this data point to show the trend.   
We agree that 2020 is an outlier. As mentioned earlier, we included data from 2020 to show how the onset of the pandemic impacted the reported receipt of preventive services. This data point serves as a comparison to the earlier trend and not as part of the trend. We revised the text on page 13 L242 as follows:

“As of 2019, 6.1% of adults with diabetes had not received any of the six preventive services, and this percentage was 8.2% in 2020 during the onset of the COVID-19 pandemic.

Continued monitoring will help to understand the extent to which the pandemic interrupted preventive care service utilization.”

12. Second paragraph under “Discussion”: the authors cited findings from NHANES data for 2005–2018 as well as BRFSS for 2004–2014. It seems contradicting with the description in the “background”, “Other studies have reported on trends in receipt of some preventive services in the 2000s using data from various surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Health and Nutrition Examination Survey (NHANES).”

In the introduction, we highlight that other studies have reported on trends over similar time periods for some preventive care practices, but we clarify that our study using MEPS data has certain advantages, which are reflected on page 5 L72: “Analysis of MEPS data provides advantages over other surveys, as it is nationally representative and available yearly. Meanwhile, NHANES is not annual and has smaller sample sizes; BRFSS is administered at the state level, and the diabetes module is not available in every state in every year.”

In the discussion we then compare our results to those studies cited in the introduction.

In the same paragraph, “Future research may wish to examine those adults with diabetes who reported receiving none of the six preventive care services, and factors contributing to this lack of care.”: suggest adding literature on the risk of not receiving the six preventive care services at all: worse diabetes control, more complications? Both in the introduction and/or the discussion parts.  
We added text in the introduction on page 5 L63 briefly addressing the role of preventive services in reducing complications and identifying what some of those complications are.

“Complications of diabetes include both microvascular (retinopathy, neuropathy, and diabetic nephropathy) and macrovascular complications (coronary artery disease, peripheral arterial disease, and stroke) (7). Access to preventive services to control glycemia, lipids, and blood pressure and the early identification of diabetic retinopathy and foot lesions is important to minimize diabetes-related complications and reduce rates of hospitalization (8,9)”

13. On page 12, second paragraph, first sentence, “A1C testing and influenza vaccinations were the only two preventive services that showed increases either among the overall population or various subgroups”: seems inconsistent with the abstract. In the abstract, the authors also mentioned dental care was increasing. In the same paragraph, “These services can be administered at the point-of-care during regular physician visits, whereas a dilated eye exam or dental visit require separate appointments.”: seem contradicting with the abstract, where it said dental care increased overall and only decline in unsured.   
Dental care did not increase overall, but it did increase in some subgroups (65-74 and 75+ year age groups and non-Hispanic Whites). The abstract has been changed to make this clearer:

“Trend analysis of subgroups was heterogeneous: influenza vaccination and A1C testing showed improvements among several subgroups, while cholesterol testing (45-64 year age, < high school education, Medicaid insurance) and dental visits (uninsured) declined.”

14. On page 13, first paragraph, the second sentence to the last: despite the differences, what were the overarching/consistent conclusions from the studies?  
Text was added to highlight consistencies between the cited studies and our own.

Page 15, L282: “However, when evaluated individually, only A1C testing increased, which is similar to our findings.”  
  
Page 15, L292: “Our finding that A1C testing increased is consistent with what has been reported in other studies. Discrepancies with other survey results may be due to differences in how questions are phrased, differences in the population surveyed, and trend analysis of time periods of different length.”

15. On page 13, under “Limitation”, the last two sentence in the first paragraph, “in 2013, MEPS implemented efforts to improve collection of complete information by using field interviewers, with the goal of improving under reporting. This effort may have improved data quality after 2014 and could have impacted our trend analyses”: the authors mentioned a method change in 2008 thus they choose the study period starting in 2008. Was this 2013 change another method change? If yes, why not limiting the study period to start in 2014?   
On page 6 L86, we clarified that the changes in 2008 were related to the questions on the survey and consistency of those questions:

“We chose the years 2008 to 2020 due to consistency of questions related to preventive care during that time period starting in 2008.”

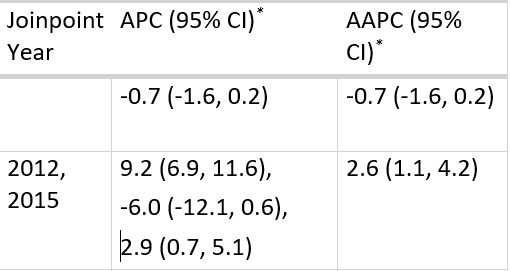
The changes in 2013 were methods intended to improve under-reporting, but the survey questions remained the same. This is clarified on page 15 L300: “In 2013, MEPS implemented efforts to improve collection of complete information by using field interviewers, with the goal of improving under reporting. This effort may have improved data quality after 2014 and could have impacted our trend analyses.”

The next paragraph, “There has been a steadily declining response rate for both MEPS and DCS from a peak during the studied time period from 59.3% and 92.4%, respectively in 2008 to 39.5% and 65.8%, respectively, in 2019 and 27.6% and 59.3%, respectively in 2020.”: don't understand what the authors mean here, and what the numbers represents.   
This sentence has been rewritten for clarity on page 15, Line 303.

“Additionally, there has been a steadily declining response rate for both MEPS and DCS. During the studied time period both MEPS and DCS response rates peaked in 2008 at 59.3% and 92.4%, respectively, fell to 39.5% and 65.8%, respectively, in 2019, and fell further to 27.6% and 57.1%, respectively, in 2020.”  
  
16. On page 14, the last sentence under “Discussion”: if jointpoint regression is not suited for survey analysis, why not use other methods? or at least test whether the results from other methods were consistent with the joinpoint regression, e.g., simple trend analysis comparing the overall trend from 2008 to 2019, or at several data points in the years which receiving services might be affected, e.g., 2010, when ACA was enacted.   
Joinpoint regression is suitable for the analysis of survey data (see Ingram DD, Malec DJ, Makuc DM, Kruszon-Moran D, Gindi RM, Albert M, et al.  
National Center for Health Statistics Guidelines for Analysis of Trends. National Center for  
Health Statistics. Vital Health Stat 2(179). 2018.) After consideration, we have removed this paragraph for clarity.

17. On page 18, under “Table 1”, under the column “APC (95% CI)”: please explain what the numbers mean in the footnote. What were the numbers in the rows when there were joinpoint detected? Did the APC compare one time period to another time period? If a joinpoint detected, why some of the 95% confidence intervals were covering zero? What are the differences of the APC and AAPC? Please explain how the APC and AAPCs were calculated in the footnote and in the methodology section.

APC does not compare one time period to another. The Joinpoint detects changes in direction or magnitude over the entire time period. For example, in the 2nd line of the table below, for entire time period of 2008-2019, there were 2 joinpoints (2012 and 2015). The APC values show the annual percent chance over the specified time period. For example, from 2008-2012, there was a significant increase of 9.2% per year (the CI doesn’t cross 0 so it is significant). From 2012-2015 there was a reduction of 6% per year (but the CI crosses 0 so it was not significant). From 2015-2019, the increase was 2.9% per year and it was statistically significant (CI doesn’t cross 0). AAPC pertains to the trend over the entire time period (2008-2019). In this case it was a significant increase of 2.6% per year.



Text has been added to the table and the methods on page 8, L136 to better explain the values and the discrepancy between Joinpoint years and APC intervals:   
“Joinpoint regression uses permutation tests to detect statistically significant changes at a pre-specified alpha of 0.05 in direction or magnitude of trends (24). The Joinpoint software also provided estimates of the annual percent change (APC), or slope, for each trend segment and the average annual percent change (AAPC), or overall slope, for the entire trend. The test of significance for APC is an asymptotic t-test. Due to the omnibus nature of the permutation test used to identify Joinpoint years and the use of all the data in identifying those years, the permutation tests are more powerful (24). In some cases, Joinpoint years are identified but the corresponding intervals for the APC will overlap zero due to this power difference.

18. On page 19, figure 1, title: did not mention the subgroups at all.

We revised the text as suggested: “Figure 1–Age-adjusted trends in proportions of U.S. adults with diagnosed diabetes overall and by sub-group who reported receiving recommended medical examinations from 2008 to 2019. The dashed black line is the overall trend, while dots represent percentages for 2020. Data from 2020 were not included in the trend analysis.”

19. On page 21, figure 2, title: did not mention the subgroups at all.

We revised the text as suggested, as above.

20. On page 25: should it be Appendix Table 1? Same comment for this table as for Table 1 above.

The table on page 21 is Table 1. Supplemental Tables are labeled Supplemental Table 1 and Supplemental Table 2