CMS Must Improve Diabetics' Access To Glucose Monitors

By **George Huntley** (July 6, 2021)

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Access to continuous glucose monitoring, or CGM, for Medicare patients with diabetes is encumbered by too many nonsensical barriers preventing patients who need this potentially lifesaving technology.

These barriers are especially burdensome on communities of color who already are disproportionately hit by the ravages of diabetes. For example, a Black American is 60% more likely to have diabetes than a white American and is twice as likely to suffer an avoidable amputation.[1]

Numerous medical studies have shown that use of CGM improves diabetes control and reduces severe hypoglycemia (low blood sugar) which can result in coma and death, in people with both type 1 and type 2 diabetes.[2]

Unlike traditional blood glucose fingerstick testing, CGM uses a sensor that samples glucose consistently providing readings every few minutes — and, very importantly, the rate and direction of glucose change, which enables patients to take immediate action these levels are fluctuating outside of the target range.

In January 2017, the Centers for Medicare & Medicaid Services began coverage of CGM for insulin-treated Medicare beneficiaries with diabetes.

However, eligibility requirements include: (1) diabetes diagnosis; (2) proof of fingerstick testing at least four times day; (3) multiple daily insulin injections (or pump use); (4) proof of frequent insulin adjustments based on glucose levels; (5) face-to-face consultation with clinician prior to starting; and (6) follow-up face-to-face clinical consultations every six months.

As a result, many patients who would benefit from CGM access are denied coverage, and these barriers are disproportionately felt by minority groups illustrated by the fact that in the first year of CGM coverage, 90% of beneficiaries were white.[3]

Earlier this year, CMS revisited its CGM eligibility criteria. Recognizing that requiring people to prove fingerstick testing at least four times daily has no scientific basis, the agency is proposing to eliminate this requirement. We applaud this decision, but it is only the first step. CMS needs to fully review its eligibility policies in order to reduce remaining barriers to CGM access.

For example, several new research studies show that CGM improves blood sugar control and reduces severe hypoglycemia in people treated with less intensive insulin therapy and even non-insulin medications.[4]

Additionally, requiring people to frequently adjust their insulin based on blood sugar levels completely ignores that CGMs warn people when their blood sugar is going too high or too low. And, today's telemedicine technologies make face-to-face doctor visits unnecessary for many patients especially during a pandemic. Temporary waivers of this requirement should be made permanent.

Besides removing unnecessary access barriers, CMS should also simplify and streamline

paperwork required for obtaining CGM coverage. Current requirements place an unwarranted burden on doctors and office staff to gather and submit substantial documentation on behalf of their patients. With time constraints, many clinicians are unwilling or unable to assist patients with this submission.

Given the growing diabetes epidemic and rising health care costs associated with poorly controlled diabetes, all people with diabetes and their doctors must have access to technology that will promote patient care.

Sixty percent of Medicare beneficiaries with diabetes have an inpatient hospital stay each year and nearly 90% have an inpatient stay or emergency room visit.[5] Focus needs to be on management of the disease to reverse these staggering numbers.

As advocates for improving quality of care for all Americans with diabetes, we urge CMS to modify the CGM eligibility requirements and streamline administrative processes to enable all who would benefit from access to this technology, especially our most vulnerable communities that are least likely to overcome unnecessary barriers to care.

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[1] https://www.liebertpub.com/doi/10.1089/dia.2021.0107.

[2] https://www.liebertpub.com/doi/10.1089/dia.2021.0107.

[3] https://diabetes.diabetesjournals.org/content/69/Supplement_1/68-LB.

[4] https://www.liebertpub.com/doi/10.1089/dia.2019.0303.

[5] https://diabetes.diabetesjournals.org/content/69/Supplement_1/68-LB.