Improving Access to Continuous Glucose Monitoring in Oregon's Medicaid Program

For people living with diabetes, continuous glucose monitors (CGM) provide significant, potentially life-changing benefits for diabetes management through avoidance or delay of serious complications, hospitalizations and even death. This technology provides greater information to patients and their health care providers than traditional blood glucose meters do by continuously monitoring an individual's blood glucose level. The information the devices provide can result in better blood glucose management and reduce the risk for premature death and disabling complications including heart disease, stroke, kidney failure, new cases of blindness among adults, and non-traumatic amputation of the lower extremities.

Utilization controls and restrictive coverage policies sometimes prevent these devices from being accessible to individuals who would benefit from them. A recent study conducted by the American Diabetes Association (ADA) found CGM utilization among Medicaid beneficiaries, particularly among older people, and Black and brown people, to be lowest across all payers. According to the study, Medicaid beneficiaries who take insulin were two to five times less likely to use a CGM than those with commercial health insurance coverage. This disparity in coverage is particularly troubling considering individuals with diabetes are more than twice as likely to receive their health care from Medicaid as those without diabetes.

To ensure appropriate access to CGMs, ADA advocates for expanded coverage and elimination of overly restrictive barriers. Through this work, ADA is partnering with people with diabetes, health care professionals, advocacy groups, and policy makers to address disparities with CGM access in Medicaid programs. Together, we are working for health equity through improved access and positive health care outcomes for people with diabetes.

In Oregon, the ADA is requesting the following changes to utilization requirements:

1. Remove burdensome and outdated criteria that does not align with the American Diabetes Association *Standards of Care* including that a beneficiary has a baseline A1C of 8% and that they are on short-or intermediate-acting insulin
2. Align with CMS which states that a beneficiary is insulin-treated or has a history of problematic hypoglycemia

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