
Expanding Medicaid Access to Continuous Glucose Monitors

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

Introduction

Approximately 14 percent of Medicaid beneficiaries have diabetes.¹ Medical expenditures associated with diabetes by Medicaid programs were roughly \$25.7 billion in 2013.² In five years, from 2012 to 2017, the cost of diabetes grew by 26 percent because of an increase in the prevalence of diabetes and cost of care per person with diabetes.³ As these medical expenditures continue to rise, related indirect costs are also rising such as reduced productivity, inability to work, and absenteeism.⁴ Compared to people with commercial insurance, Medicaid beneficiaries have higher rates of suboptimal diabetes management, worse glycemic control, experience more barriers to care, and have more acute- and long-term diabetes-related complications.⁵ Within Medicaid, health care costs for people with diabetes are 1.5 to 4.4 times more than for those without diabetes.⁶

Continuous glucose monitors (CGMs) are an accepted standard of care for treating people with type 1 diabetes and people with type 2 diabetes on insulin pumps or multiple daily insulin injections, and a recommended tool for people with type 2 diabetes on any form of insulin.^{7,8} In contrast to fingerstick blood glucose monitoring, which reveals data for one moment in time, CGMs provide people with diabetes access to continuous data on their glucose levels so they can better manage their disease. It is the equivalent of a movie versus a still photo. CGMs can also alert people when their glucose level is too high or too low. Depending on the type of CGM, studies have shown that the use of CGMs can lead to better health outcomes and quality of life.^{9,10} In addition to improvements in health outcomes and quality of life, the work absenteeism rate and diabetes-related hospital admission rate can decrease significantly.¹¹ Additionally, data suggest that CGM devices are cost effective.^{12,13,14,15} Studies show reductions in rates of acute diabetes-related events and rates of hospitalization in people with type 2 diabetes with insulin

TAKEAWAYS

- Continuous glucose monitors (CGMs) are the standard of care for treating people with type 1 diabetes and people with type 2 diabetes on insulin pumps or multiple daily insulin injections, and a recommended tool for people with type 2 diabetes on any form of insulin.
- Studies demonstrate that CGMs can: (1) improve clinical quality, health outcomes, and quality of life; (2) reduce health care costs; and (3) support broader efforts by state Medicaid agencies and their partners to address structural and systemic racism and related health inequities.
- There is no consistent Medicaid CGM policy in the U.S., with 40 states and the District of Columbia, providing some level of CGM fee-for-service coverage with wide variations in coverage. Ten states do not have published fee-for-service CGM coverage except through medical necessity.
- This paper explores the current landscape of state Medicaid CGM coverage, highlights state approaches to CGM coverage, identifies state opportunities to expand Medicaid coverage of and access to CGMs, and provides recommendations to the diabetes community to support increased access and coverage across the states.

therapy.¹⁶ Retrospective data from Kaiser Permanente Northern California showed reductions in Hemoglobin A1c (A1c) levels — a key indicator of blood glucose management — and lower rates of emergency department visits and hospitalizations for hypoglycemia for people with diabetes receiving insulin therapy.¹⁷

Additionally, diabetes disproportionately affects communities of color and populations with lower socioeconomic status.^{18,19} The COVID-19 pandemic uncovered and exacerbated these disparities, increasing vulnerability to complications and associated mortality for people with COVID-19 and uncontrolled diabetes, particularly among patients who are Black and Latino.²⁰ Activities to increase access to recommended approaches to managing diabetes — including CGMs plus patient and provider education²¹ — can support broader efforts by state Medicaid agencies and their partners to address structural and systemic racism and related health inequities.^{22,23,24}

Medicaid coverage for CGMs, which was identified through interviews with state Medicaid agencies and publicly available information, varies significantly across state Medicaid programs. As of December 1, 2021, 13 states are covering certain CGMs for any patient for which it is ordered under preferred drug lists or preferred diabetic supply lists, 28 states are covering CGMs for specified populations when conditions have been met, and ten states do not have published coverage and are covering CGMs only as a medical necessity or as a value-added service voluntarily provided by a Medicaid managed care plan. CGM coverage criteria may be based on population and age, and may require prior authorization and diabetes-specific requirements and documentation that may limit beneficiary access or even harm beneficiaries in some cases.^{25,26}

With support from The Leona M. and Harry B. Helmsley Charitable Trust, this paper explores the current landscape of state Medicaid coverage of CGMs, highlights state approaches to CGM coverage, identifies opportunities for states to expand Medicaid coverage for and access to CGMs, and provides recommendations to support state expansion. It is intended to inform state Medicaid leaders, as well as stakeholders in the diabetes community.

To develop the paper, the Center for Health Care Strategies (CHCS) conducted 24 interviews with patients, health care providers, diabetes peer support coaches, diabetes organizations, CGM manufacturers, and state Medicaid officials. The interviews explored current CGM coverage policies in Medicaid programs, decision making and implementation of policy changes, and barriers and opportunities for expanding access to CGMs for Medicaid beneficiaries. Except where explicitly noted, observations about the processes and drivers of state Medicaid coverage decisions come from interviews with state leaders who participated in this project.

Why Access to CGMs Matters

Technological advances such as CGMs have significantly improved the ability of providers to treat diabetes and for patients to manage their blood glucose levels. CGMs allow for improved glucose control because patients can see in real time what their glucose levels are without the burden of performing a fingerstick, and the use of CGMs can eliminate the need for finger stick blood glucose monitoring.²⁷ Even more importantly, CGMs provide immediate information on whether glucose levels are rising, falling, or staying the same. This information allows for safer glucose management. Finally, some CGM systems provide alerts, not only to alert for a low or high glucose levels, but to predict that a glucose level is falling too low. This allows a person with diabetes to act before developing hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).

For Medicaid agencies that can cover and increase access to CGMs for their beneficiaries, and for the larger health care system, there is strong evidence that supports the benefits of CGM use for all people who are insulin-treated with an insulin pump or multiple daily insulin injections, and emerging evidence is showing the benefit of CGMs in patients on basal insulin. Existing studies, both randomized control trials and observational studies, demonstrate that CGMs can: (1) improve clinical quality, health outcomes, and quality of life; (2) reduce health care costs; and (3) support broader efforts by state Medicaid agencies and their partners to address structural and systemic racism and related health inequities. The evidence provided through the research described in this section can help facilitate pathways to implementing or expanding CGM coverage across Medicaid state agencies.

What is a CGM?

A CGM is a medical device including: (1) a small sensor; (2) a transmitter; and (3) a monitoring system that automatically tracks glucose levels continually and as often as every five minutes. The sensor is inserted by the patient just beneath the skin (usually on a patient's arm or stomach), which is connected to a transmitter that sends information to a monitor. The CGM can either be attached to an insulin pump that triggers an insulin injection when needed or transmit information to a separate small handheld device or app on a smartphone.

CGMs Can Improve Clinical Quality, Health Outcomes, and Quality of Life

CGMs generally include the following types:

(1) real-time CGMs (rtCGMs) with alerts that automatically transmit data to a smart phone or receiver; and (2) intermittently scanned CGMs (isCGMs), which require scanning for a result and do not have predictive alerts. Randomized controlled trial (RCT) data demonstrates improved disease management and outcomes such as the glycemic benefits of rtCGMs in people with type 1 and type 2 diabetes on insulin pumps or multi-daily injection, in adults, including seniors.^{41,42} RCT data also exist showing the benefit of rtCGMs in people with type 2 diabetes on basal insulin.⁴³ Much of the data supporting the use of isCGMs comes from observational and longitudinal studies that show improvement in A1c levels and reduction in diabetes-related complications and work

absenteeism.⁴⁴ In nearly all studies with any CGM system, people show a high level of satisfaction with the device compared to fingerstick blood glucose monitoring. Some studies show improvements in patient-reported outcomes, including health-related quality of life⁴⁵ and reduction in diabetes distress.⁴⁶

The ability to monitor continuous day and night patterns in blood glucose levels provides an opportunity for patients to better react to their diabetes in real-time and for providers and patients to retrospectively analyze the data to search for trends. CGMs allow providers to remotely monitor their patients and/or download a detailed report of their patients' glucose profile data. Fingerstick blood glucose monitoring alone, a clinical practice that is still frequently used in Medicaid settings,⁴⁷ involves finger sticks multiple times per day and obtaining an A1c measure. This method is not as safe for treating diabetes because it only provides a single measure in a moment in time without immediate trend information.⁴⁸ By comparison, CGMs allow providers to improve their delivery of care and manage their patients' diabetes through better understanding of patients' 24/7 behaviors and blood glucose levels and for patients to better self-manage their diabetes.

The Benefits of CGMs At-a-Glance

Studies have shown that CGMs can:

- ✓ Serve as the standard of care for insulin-treated people with diabetes.²⁸
- ✓ Reduce an elevated A1C level.²⁹
- ✓ Reduce the frequency and severity of episodes of hypoglycemia.^{30,31}
- ✓ Improve patient satisfaction compared to fingerstick monitoring.^{32,33}
- ✓ Improve patient-reported outcomes, including health-related quality of life.³⁴
- ✓ Reduce hospitalizations for acute diabetes-related issues.³⁵
- ✓ Reduce work absenteeism.³⁶
- ✓ Facilitate communication of data with health care providers.
- ✓ Provide health care cost savings.^{37,38,39,40}

Patient Success Story: Back in Control with CGM

Laura, a 28-year-old working mom with type 1 diabetes, arrived for her first appointment at our health center. She was recently discharged from the emergency department after she developed significant diabetic retinopathy, a diabetes complication that left her blind in one eye.

As we talked, I learned that living with type 1 diabetes was nothing new to Laura. Diagnosed at the age of seven, Laura received care at a local children’s hospital. Her treatment, which was covered by Medicaid, included CGM and was instrumental in keeping her diabetes under control throughout her early life.

However, when Laura aged out of pediatric coverage, she faced a health care crisis. She couldn’t afford the infusion sets that had previously been covered by Medicaid. Instead of the local children’s hospital, she now relied on the emergency department for her care. As a result, Laura was admitted several times for diabetic ketoacidosis, a serious diabetes complication.

At our first appointment, my top priority was to help Laura obtain Medicaid and get her back on CGM, so that she could return to continuously tracking her A1c levels and be alerted when she was out of a healthy range. In our follow-up appointments, Laura shared the relief she felt to be back in control of her diabetes for the first time since childhood. Today, her CGM and access to diabetes education empowers Laura to better manage her diabetes and improve her diabetic retinopathy.

If it wasn’t for the CGM and the care she received at our clinic, Laura would continue to turn to the emergency department for care and be at risk for serious diabetes complications that would significantly affect her quality of life and ability to work and take care of her children.

- Anne Peters, MD, professor of clinical medicine at the Keck School of Medicine and the University of Southern California (USC) and the Director of the USC Clinical Diabetes Programs

CGMs Can Reduce Health Care Costs

There can be health care savings associated with CGM use for people with type 1 diabetes. While CGMs have upfront and ongoing costs, the use of them can lead to cost savings through a reduced number of non-severe hypoglycemic events.⁴⁹ CGMs can also reduce costs associated with daily test strip use. Over a lifetime, CGMs have been shown to be cost-effective at \$100,000 per quality-adjusted life years,⁵⁰ and key drivers of this cost-effectiveness can include improved quality of life associated with the decrease in experiencing diabetes distress and fear of hypoglycemia, reduction or elimination in fingerstick testing, and change in A1c.⁵¹ Because CGM use can reduce short- and long-term complications for people with diabetes, there can also be associated reductions in hospitalizations, emergency department visits, and outpatient visits and procedures for people with type 1 diabetes.⁵² One study shows that patient adoption of CGMs for just nine months results in health care costs savings of \$4,000 compared to a patient without a CGM.⁵³

CGMs Can Support State Medicaid Agencies' Efforts to Address Health Disparities

Diabetes disproportionately affects communities of color and people with lower incomes. According to the American Diabetes Association, diabetes prevalence is highest in Native Americans (14.7 percent), Latinos (12.5 percent), and Black people (11.7 percent) compared to white people (7.5 percent).⁵⁴ With twice as many Black, Latino, and Native American beneficiaries covered by Medicaid/Children Health Insurance Program (CHIP) as compared to white beneficiaries,⁵⁵ the higher prevalence of diabetes for these populations is an important consideration.

Compared to people with commercial insurance, Medicaid beneficiaries have higher rates of poor diabetes management, worse glycemic control, experience more barriers to care (including access to and coverage of continuous glucose monitors and other diabetes technologies), and experience more acute- and long-term complications related to diabetes.^{56,57,58} CGM use is the standard of care for insulin-treated people with diabetes,⁵⁹ and more widespread use of and access to CGMs can help to improve both health and racial equity.

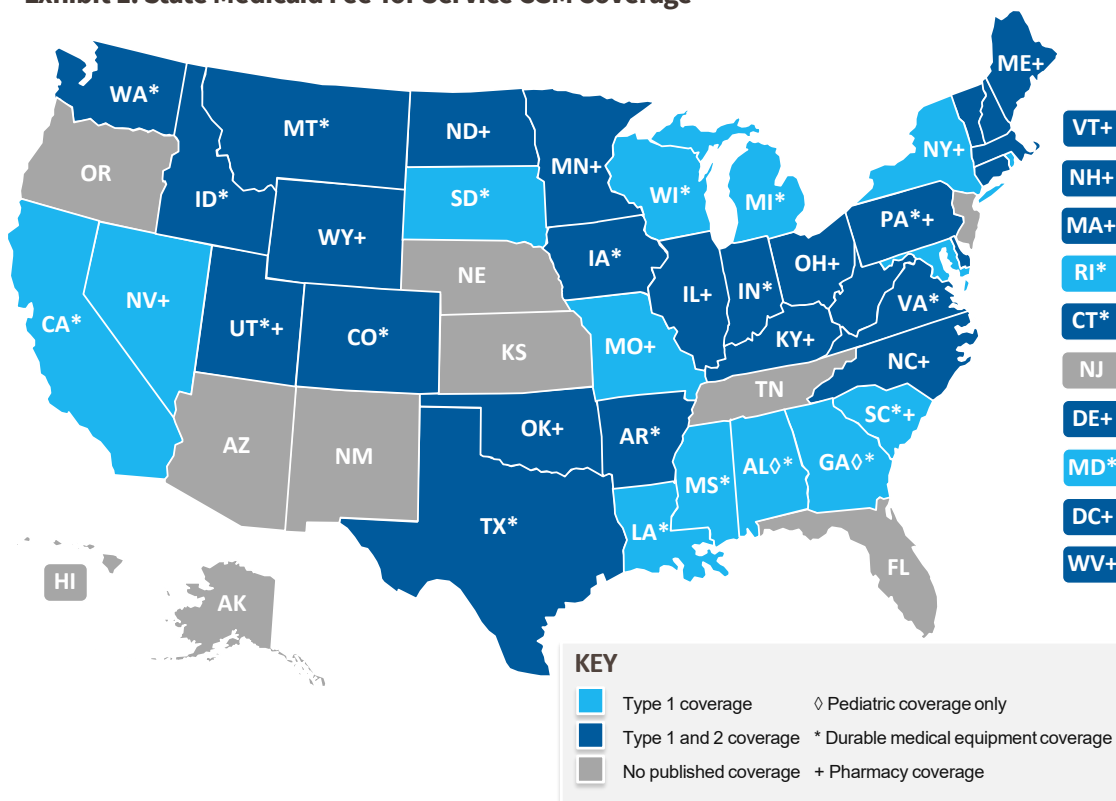
The Current Medicaid Coverage Landscape

Medicaid coverage decisions are made on a state-by-state basis, subject to minimum federal standards. While there is no consistent Medicaid CGM policy across all states, there are common components among state Medicaid agencies that cover CGMs.

Across the U.S., 40 states and the District of Columbia, provide some level of CGM fee-for-service coverage with variations in coverage that include: (1) classification as a durable medical equipment (DME) versus pharmacy benefit; (2) coverage for people with type 1 versus type 2 diabetes; (3) coverage for children versus adults; (4) prescriber requirements; (5) need for prior authorization; and (6) diabetes-specific requirements and medical documentation.

A detailed overview of these coverage components is described in **Appendix A** (see **Exhibit 1** for a summary) and an at-a-glance summary of policies is outlined in **Appendix B**. Ten states do not have published fee-for-service CGM coverage. In these states, CGMs may be covered through medical necessity (see “Medical Documentation” on page 13) or as a value-added service voluntarily provided by a managed care plan.

Exhibit 1. State Medicaid Fee-for Service CGM Coverage



Durable Medical Equipment or Pharmacy Benefit

Of the 40 states and the District of Columbia that provide coverage, 20 cover CGMs as a DME benefit and 21 cover CGMs as a pharmacy benefit. The DME benefit generally includes medical equipment, supplies, and appliances used for medical purposes (e.g., wheelchairs, oxygen equipment and accessories, and infusion pumps). A few states that cover CGMs as a pharmacy benefit, also provide the option for coverage through DME, or require nonpreferred CGMs to be approved and billed through DME. For states that offer coverage as a DME benefit, patients connect with DME distributor companies once their provider orders the CGM. DME companies can have their own separate set of exclusionary criteria that makes it challenging to navigate, and processing can take up to four to six weeks. Moreover, even once an order for a CGM is placed, getting refills can require frequent (as often as monthly) prior authorizations to obtain more supplies. For states that offer CGM coverage as a pharmacy benefit, CGMs are covered the same way as prescription drugs. Once a provider prescribes a CGM, the patient can pick up the CGM through their local pharmacy along with their other medications or supplies to manage their diabetes.

CGMs were initially covered as a DME benefit in all states, most likely because of Medicare’s policy of classifying CGMs under Part B, which includes DME. In recent years, more states are changing their policies to cover CGMs as a pharmacy benefit due to increasing affordability and availability.

Despite the advantages for patients in providing CGMs as a pharmacy benefit, interviewees noted a few concerns about the adoption of CGMs as a pharmacy benefit. First, test strip coverage through local pharmacies under Medicare has become an increasingly cumbersome process, and providers fear that more complex processes in obtaining CGMs through pharmacies could be enacted in the future. Second, the pharmacy benefit can look different across states. While states have flexibility to expand access by putting certain CGMs on the preferred drug list or preferred

A Note about Pharmacy Benefits, Preferred Drug Lists, and Managed Care

When CGMs are covered as a pharmacy benefit, they can be included on the state’s preferred drug list or preferred diabetic supply list for their fee-for-service (FFS) pharmacy program. For states with managed care programs where the managed care organizations (MCOs) provide the pharmacy benefits (pharmacy is “carved-in” to MCO contracts), federal law requires that prescription drug coverage under Medicaid MCOs be consistent with the FFS program. Further, MCOs are not allowed to have medically necessary criteria for prescription drugs that are more stringent than FFS.⁶⁰ A growing number of managed care states use a uniform preferred drug list, which requires all MCOs to cover the same drugs as the state.⁶¹ In some cases in states where CGMs are not covered by Medicaid, MCOs cover CGMs for their members as a value-added benefit.

diabetes supply list, they can also limit access with restrictive criteria. Third, pharmacy benefit managers, who act as a third-party, might negatively affect rebates and affordability for states. Fourth, some providers find navigating pharmacies more challenging because of requirement to write prescriptions each month. Finally, either through pharmacy or DME benefits, use of CGM can be limited to one type, such as isCGM. Certain eligible patients who require rtCGMs, such as those experiencing hypoglycemia unawareness where the individual is unaware of his/her symptoms or experiencing frequent hypoglycemic events, also have the additional need for documentation and prior authorization. This can make these devices impossible for patients to obtain. Choice of CGM devices need to be individualized, particularly for patients on intensive insulin therapy.

Medicaid CGM Coverage for People with Type 1 versus Type 2 Diabetes

Medicaid CGM coverage criteria vary across states based on the type of diabetes. Of the 40 states and the District of Columbia that provide coverage, 27 currently cover CGMs for people with both type 1 and type 2 diabetes on intensive insulin therapy. Some cover CGMs for people with both type 1 and type 2 diabetes on intensive insulin therapy, while other cover CGMs only for people with type 1 diabetes. Originally, Medicaid agencies began covering CGMs for people with type 1 diabetes because CGMs were studied by researchers in this patient population due to their higher risk for hypoglycemia and hypo-unawareness. States' CGM coverage then expanded to include people with type 2 diabetes on intensive insulin therapy. More recently, CGMs have been found to be beneficial for people with type 2 diabetes on basal insulin, and even in people on non-insulin therapies. While CGMs are currently not covered for these populations, state Medicaid agencies continue to update coverage policies for CGMs as they are studied for efficacy in additional populations.

What is the difference between type 1 and type 2 diabetes?

Type 1 diabetes and type 2 diabetes are very different. **Type 1 diabetes** is often diagnosed in children, teens, and young adults, but can also develop in adulthood. Symptoms in youth often develop quickly, while symptoms in adults usually develop slowly overtime. It is an autoimmune reaction that stops the body's ability to make insulin. Type 1 diabetes affects 5-10 percent of people with diabetes.⁶² People with type 1 diabetes need to take insulin every day to survive, and there is no known prevention strategy or cure.

Type 2 diabetes affects 90-95 percent of people with diabetes.⁶³ People with type 2 diabetes experience both insulin resistance and insulin deficiency. It is often diagnosed in adults although can occur in youth. Unlike type 1 diabetes, type 2 diabetes can be prevented by engaging in healthy lifestyle changes (e.g., exercising, healthy eating, and maintaining a healthy weight).⁶⁴ In addition to lifestyle modification, people with type 2 diabetes often need treatment with both non-insulin and insulin therapies. Type 2 diabetes is particularly severe in youth who develop the disease.

Coverage for Children Versus Adults

CGM coverage criteria that is inclusive of all ages is commonly found across state Medicaid agencies. There are only three states that provide coverage for only children or adults. Two states only cover children — one state only covers children with type 1, whereas the other state only covers children with type 1 and type 2 diabetes on insulin pumps or multiple daily insulin injections. Just one state covers only adults with type 1 diabetes and not children. Age restrictions can pose challenges for individuals whether that be losing coverage when they become an adult or only having coverage as an adult.

Prescriber Requirements

State Medicaid CGM coverage also specifies who is authorized to prescribe a CGM. The authorized prescribing physician varies across states and can be limited to endocrinologists, or can include primary care providers, nurse practitioners, physician assistants, or pharmacists. Of the 40 states and the District of Columbia that cover CGMs, seven require endocrinologists to prescribe or to provide consultation on a prescription. Other state Medicaid programs that do not have this requirement allow for primary care providers or other licensed care professionals to prescribe. Limiting prescriber requirements to only endocrinologists restricts access to CGMs, particularly in medically underserved communities where there are often shortages of specialists. Finally, interviewees noted that in some cases the documentation required for CGM approval is so detailed that it is beyond the knowledge base of many general practitioners.

Prior Authorization

Prior authorization, also known as pre-authorization, requires that the prescribing provider obtain approval by Medicaid before the CGM is covered and provide documentation to Medicaid that the CGM is medically necessary for the patient.⁶⁵ Although prior authorization can be an effective way for Medicaid agencies to reduce unneeded medications and manage costs, patients and providers interviewed for this paper noted that this process can be a barrier to receiving timely, evidence-based care.

Medical Documentation

Medicaid CGM policies, except for states with certain CGMs listed on their preferred drug lists or preferred diabetic supply lists, require meeting diabetes-specific medical documentation to provide evidence that the CGM is medically necessary. Diabetes providers interviewed for this paper suggested that most if not all medical documentation requirements present barriers to CGM access with limited clinical upside (see quoted perspectives below). While the extent of documentation varies across states, it can include that an individual experience one or more of the following:

EXAMPLES OF DIABETES-SPECIFIC MEDICAL DOCUMENTATION REQUIREMENTS	PERSPECTIVES FROM CLINICAL INTERVIEWEES ON REQUIREMENTS
<p>Hypoglycemic episodes (low blood sugar)</p>	<p><i>“This is a potentially dangerous requirement because it could provide an incentive for someone taking insulin to induce a dangerous low blood sugar reaction in order to qualify for a CGM.”</i></p>
<p>Nocturnal hypoglycemia (low blood sugar at night)</p>	<p><i>“Similarly, this is a dangerous requirement because a patient can withhold a bedtime snack in order to go low to qualify, for example.”</i></p>
<p>Refractory postprandial hypoglycemia (low blood sugar that occurs after a meal and for a long duration)</p>	<p><i>“This is a dangerous requirement because it can be completely inducible by the patient.”</i></p>
<p>Hypoglycemia unawareness or history of unawareness resulting in seizure, loss of consciousness, or need for emergency care (individual is not aware of their symptoms, but it may have been witnessed by others)</p>	<p><i>“Most individuals with type 1 diabetes have some element of hypoglycemia unawareness. Requiring a severe outcome to happen to qualify for a CGM may put patient safety in jeopardy.”</i></p>
<p>Recurring diabetic ketoacidosis (a serious complication when an individual cannot produce enough insulin and there is a high production of ketones)</p>	<p><i>“Patients should not have to experience a serious complication more than once to get a CGM.”</i></p>
<p>Suboptimal glyemic control despite compliance with multiple daily injections of insulin — minimum of three per day</p>	<p><i>“Any number of injections should qualify. Data show that rtCGMs can improve glycemia in people who receive a varying range of daily injections.”</i></p>
<p>Documented frequency of standard fingerstick monitoring of blood glucose (self-monitoring blood glucose)</p>	<p><i>“There is no relationship between the ability to perform fingerstick monitoring of blood glucose and CGM outcomes. This is a barrier to CGM use, especially low-income populations who often have physically demanding jobs and less time to test and document than their higher socioeconomic status counterparts.” (See sidebar on the next page for more information.). “Arguably, those who do not frequently test stand to benefit the most from continuous data because they need to do more monitoring.”</i></p>
<p>An insulin pump used for maintenance of blood sugar control</p>	<p><i>“Pumps can be difficult to obtain through Medicaid.”</i></p>
<p>Regular visits with an endocrinologist or another health care provider</p>	<p><i>“As Medicaid beneficiaries may have more limited access to specialty care, this requirement can pose a barrier unrelated to clinical need.”</i></p>

The diabetes-specific medical documentation commonly seen in policies often require patients with diabetes to demonstrate poor health to access a CGM. However, patients who have achieved excellent diabetes outcomes could also benefit from a CGM, and potentially improve their clinical success.^{66,67}

More on Self-Monitoring Blood Glucose Disparities

The self-monitoring blood glucose (SBMG) requirement in many states is a barrier to CGM access. Of the 40 states and the District of Columbia that provide CGM coverage, 19 currently require beneficiaries to document blood glucose levels using finger sticks (at least 4 times per day) to demonstrate ongoing need for a CGM. Patients that are unable to afford or to access test strips may be denied CGM coverage because of this requirement. In July 2021, Medicare eliminated this requirement for beneficiaries given the barrier to access.⁶⁸ This specific eligibility criteria posed controversy for Medicare beneficiaries because coverage was only provided for three test strips per day for insulin- treated beneficiaries and required self-monitoring blood glucose four times per day. States may choose to revisit their policies given the Medicare precedent.

State Medicaid Approaches to Covering CGMs

Approval Process

The formal process for making Medicaid coverage decisions for CGMs shares similar elements across states, including agency staff involvement in reviewing relevant resources and conducting policy analysis, external advisory boards for evaluating clinical data, and legislative input and oversight. This section outlines state approaches to covering CGMs drawn from interviews with state Medicaid officials.

MEDICAID AGENCY STAFF

Staff at various levels of a state's Medicaid agency are involved in the CGM approval process, including policy analysts, pharmacy and medical directors, and senior agency leaders. Policy analysts collect publicly available resources on clinical outcomes, budgetary impact, and stakeholder input (see a description of these considerations beginning on page 16). After collecting publicly available resources, analysts and program staff prepare reports for external advisory groups, senior agency leaders, and interested legislative staff. Pharmacy and medical directors also review clinical and cost data, and often participate in external advisory groups to provide both clinical expertise and an agency perspective on the impact of a proposed coverage decision. Executive agency leaders, including the Medicaid director, review reports provided by their staff, consider stakeholder input, and make recommendations to and consult with department leaders and Governor's office staff.

EXTERNAL ADVISORY BOARDS

States typically engage external advisory boards to provide feedback for making CGM coverage decisions and advising agency leaders on administering pharmacy and DME programs. Federal law requires states to establish a Drug Utilization Review Board to guide pharmacy activities, including establishing standards for and conducting drug utilization review and identifying problems in pharmacy programs.⁶⁹ Thirty-nine states⁷⁰ also use a Pharmacy and Therapeutics Committee to provide clinical input on decisions related to the state's preferred drug list, including guidelines for drug placement and prior authorization and community prescribing standards.⁷¹ External advisory boards are typically comprised of pharmacists and physicians that serve Medicaid beneficiaries, Medicaid agency pharmacy and medical directors, managed care plan representatives, and consumers. Although most states lean heavily on the input from

external advisory boards, there are no federal rules about how states process or use this input to make coverage decisions.

For example, **Washington State** uses an independent Health Technology Clinical Committee, comprised of community health care practitioners, to make coverage determinations for medical devices and procedures based on scientific evidence and public input. State purchased health care programs, including Medicaid, follow these determinations.⁷²

LEGISLATURE

State legislatures play a significant role in the CGM decision-making process, both formally and informally. Some states have statutory requirements that the legislature needs to be consulted on pharmacy and device decisions if there is a significant projected budgetary impact. Other states recognize the informal influence that legislators have in impacting agency coverage decisions and choose to engage them in the decision-making process. One state noted that it maintains good relationships with legislators to monitor needs and concerns from constituents around the state.

Decision Drivers

States cited various factors in their consideration of coverage for CGMs, including clinical evidence, budget impact and alignment with the state's overall health priorities, stakeholder input, and coverage by other public and private insurers. While there are many common factors that drive state decision making, there is no single pathway for states that have approved coverage of CGMs, and there is no certain formula for gaining approval. Also, none of the factors discussed in this section would solely determine a state's coverage decision. While the importance of the factors varies among states, most states noted that clinical evidence and budget impact were the key decision drivers.

CLINICAL EVIDENCE

When considering coverage for new devices or therapies, states indicated that their primary concern is whether a proposed therapy has been proven effective in treating the disease. For CGMs, and other diabetes therapies, states indicated that they relied on information from reputable sources to determine clinical efficacy, such as:

- **Medical literature:** Peer-reviewed research studies that include randomized controlled trials.
- **Research organizations:** For example, the Institute for Clinical and Economic Review, a research program at Harvard Medical School, is an independent non-

profit organization that engages key stakeholders to evaluate clinical and economic evidence on prescription drugs, devices, medical tests, and delivery system innovations.⁷³ The Pacific Northwest Evidence-based Practice Center is a collaboration of the Oregon Health & Science University (OHSU), the University of Washington, and Aggregate Analytics that reviews clinical and quality evidence on health care topics for federal and state agencies, professional associations, and foundations.⁷⁴ Also housed at OHSU, the Center for Evidence-based Policy, through its partner collaborative,⁷⁵ the Medicaid Evidence-based Decisions Project, provides reports to a consortium of 21 participating states on the effectiveness and safety of treatments and services to inform their decision making, including a January 2021 report on rtCGMs and sensor augmented insulin pumps.

- **Disease-specific organizations:** The American Diabetes Association publishes the annual Standards of Medical Care in Diabetes, which includes clinical practice recommendations for the treatment of diabetes and the evaluation of the quality of care.⁷⁶ The Endocrine Society, comprised of clinicians and research scientists, publishes evidence-based recommendations for clinical care and practice to treat patients with endocrine disorders.⁷⁷ The American Association of Clinical Endocrinology publishes the Advanced Diabetes Technology Guideline, which is an evidence-based clinical practice guideline addressing the latest advancements in technology options, including CGMs, for patients with diabetes.⁷⁸
- **Multi-state prescription drug purchasing pools:** Groups like the Sovereign States Drug Consortium, which is comprised of 13 state Medicaid programs, collectively solicit and evaluate offers from manufacturers for state supplemental and DME rebates.⁷⁹ They also provide information to their member states on clinical and administrative best practices on pharmacy and DME issues.
- **Providers:** States may consult with providers, both formally and informally, to learn about their experiences — both patient outcomes and effectiveness of new therapies — ordering devices under consideration for coverage. States with academic medical or research centers (e.g., a Diabetes Center of Excellence) receive requests from and consult with experts in these facilities about new therapies such as CGMs.
- **U.S. Food and Drug Administration (FDA):** The FDA’s Center for Devices and Radiological Health evaluates the safety and effectiveness of medical devices and will approve them if the product’s benefits outweigh the risks for patients.⁸⁰ Devices approved by the FDA are considered more favorably by state decision makers.

BUDGET IMPACT

While documented clinical outcomes are a persuasive factor, the cost of covering new therapies weighs heavily in state decision making. State Medicaid leaders review data on costs and return on investment (ROI), often using analyses from sources described on the previous pages, to determine budget impact. Also important is the availability of state dollars to pay for upfront costs for implementing coverage changes. For CGMs, as noted earlier, cost savings, such as reductions of inpatient hospitalizations, are more likely seen in future budget years. While a positive ROI is a compelling argument, state budget officials are usually more interested in immediate cost savings and understand that any new coverage will increase costs in the near term.

States are faced with myriad health concerns and limited resources in their Medicaid budgets to address them. In almost every state, diabetes is one of the top health concerns and a significant cost driver for Medicaid. Therapies for managing diabetes, particularly those that have been proven to be clinically and cost effective like CGMs, present promising opportunities for states. Even a coverage change with a relatively small initial budget impact, however, can face approval challenges when considered with other critical state health needs.

Several states noted that although having evidence to make a compelling case for ROI is important, they made decisions to cover CGMs without this extensive evidence. These states felt confident that their clinical due diligence and experience approving other drugs and therapies was sufficient to project a positive ROI. One state, for example, noted that the cost of a CGM for a patient would be less than one emergency department visit.

STAKEHOLDER INPUT

State Medicaid leaders solicit formal input from stakeholders, including patients, providers, and others in the diabetes community, through external clinical and non-clinical advisory boards beyond those with a clinical focus. In **North Dakota**, which added coverage for CGMs in 2021, the Medicaid Medical Advisory Committee, which is a federally mandated committee to advise the state’s Medicaid leaders, identified coverage for CGMs as one of the top issues for state action. In **Texas**, the Diabetes Council, which was created by state legislation to promote diabetes prevention and awareness throughout the state, focused its attention on state coverage for CGMs.

States also receive direct, unsolicited input from patients, providers, and others in the health care system. States also value input from providers who are on the front lines of diabetes care. Several states noted that before they decided to cover CGMs, state staff

reached out to specific community providers to get their input on the value of CGMs for their patients.

View from Stakeholders: California and Colorado

Colorado and California approved Medicaid coverage for CGMs in 2021. Members of the diabetes community involved in these states who were interviewed for this paper offered reflections on achieving coverage.

COLORADO: Interviewees in Colorado identified three key factors that helped sway decision-making around CGMs in the state:

- **Data.** Presenting data to state Medicaid officials that highlighted a potential ROI was essential particularly because there would be an initial budget impact with expanding coverage.
- **Health equity.** Without approving CGM coverage, Colorado would be perpetuating a two-tier health system in the state that could cause further inequities between Medicaid and commercial members.
- **Patient voice.** Incorporating patient voice was critical in Colorado. Diabetes organizations facilitated discussions between Medicaid leaders and patients with type 1 diabetes so that they could directly share their personal experiences and how they benefitted from using a CGM.⁸¹

CALIFORNIA: California expanded its CGM coverage from including only children to covering both children and adults. Prior to approval in 2021, the State Assembly twice passed bills that were vetoed by two different governors. Interviewees pointed to several factors that contributed to the change in coverage:

- **Health equity.** Black, Indigenous, Latino, and other people of color in California were and continue to be disproportionately impacted by COVID-19. Approving CGMs for coverage helped meet the needs of people with diabetes and provide a tool for effective diabetes management, especially during the COVID-19 crisis.
- **Governor's priorities.** The Governor included Medicaid CGM coverage in his annual budget proposal.

In both states, forming relationships with state leaders was essential. The diabetes community and key stakeholders (e.g., patient organizations, state medical associations, providers, and social justice organizations) formed relationships and participated in ongoing dialogue with state leaders to discuss the importance and benefits of CGM coverage.

EXAMPLES OF OTHER PUBLIC AND PRIVATE COVERAGE

States often look at other states' Medicaid programs to find out how they cover a new therapy and what the states' experiences have been since adding coverage. Some states look to others with similar populations or program characteristics, while other states review coverage in every state, typically using resources from neutral organizations. Another source of information is the Medicaid Medical Directors Network, run by Academy Health,⁸² which provides a forum for senior state clinical leaders to share best practices.

States also look at commercial insurance coverage practices, both within their state and nationally. State Medicaid medical directors often consult with their commercial peers, as well as review publicly available insurance policy information. In many instances, like with CGMs, commercial insurers cover new therapies earlier than state Medicaid programs.

While states are familiar with what Medicare covers with regard to pharmacy and DME, interviewees expressed different perspectives on the role of Medicare policy in making coverage decisions. Some states review Medicare policies, others noted that Medicare is generally not a major factor in state Medicaid coverage decisions, primarily because it serves a population with different age and demographic characteristics, except for dually eligible beneficiaries. While Medicare began covering some CGMs in 2017 and has expanded the types of covered CGMs and removed requirements for accessing them, states have not necessarily followed suit.

Recommendations

State Medicaid Agencies

Following are pathways for states that currently do not cover CGMs to do so, and opportunities for states that cover CGMs to eliminate barriers that make it harder for patients to access them.

For states considering CGM coverage:

- **Include CGM coverage in the state's equity portfolio.** Addressing racial health inequities is at the forefront of many state and federal priorities. Using proven, evidence-based interventions like CGMs, is a concrete way that states can move the needle on disparities in diabetes care. CGM data is useful for telemedicine visits, which benefits patients in rural settings. Providing CGMs to low-income beneficiaries, as well as Black, Indigenous, Latino, and other beneficiaries of color, also reduces disparities in access to technology.
- **Align CGM coverage with other health priorities.** Improving care and reducing costs for chronic diseases like diabetes is a key priority for state policymakers. Linking CGM coverage to quality chronic disease care helps build the case for this proven technology. Other health priority areas where CGMs can drive better quality is maternal health (gestational diabetes) and for children with diabetes who are impacted by COVID-19. Separately, many states have advanced primary care initiatives that aim to bolster the capacity of primary care practices to provide better care. These initiatives, which often emphasize chronic disease management, such as diabetes, would align with efforts to expand access to CGMs.
- **Understand the impact of CGMs on beneficiaries.** States should seek opportunities to hear from beneficiaries directly about their experiences managing diabetes, including experiences related to CGMs. State advisory boards include consumers that may provide their own experiences or be able to point to other consumers. State and national diabetes organizations can connect state officials to patients with diabetes. Providers (primary care and specialists) and provider organizations can also offer feedback on their experiences helping patients manage diabetes.
- **Address budget concerns.** To build the case for covering CGMs, Medicaid agencies can review resources cited in this paper that highlight opportunities for cost savings.

- **Connect with other states.** Medicaid staff and leaders in states that cover CGMs are a good source of information for building the case for CGM coverage and can provide lessons from their experiences implementing this benefit. Interested state leaders can contact peers in other states directly or leverage national forums such as the Medicaid Medical Directors Network.

For states with existing CGM coverage:

- **Update diabetes measures to reflect current standards of care.** States should consider adopting Time in Range (TIR) as a quality measure. TIR is defined as the amount of time a patient is in a clinically acceptable and healthy glucose range, which varies per patient. It provides actionable information for the patient and provider and was new to the Standards of Medical Care in 2021.⁸³ States with value-based payment programs that include diabetes targets could update measures, include additional measures, and develop incentives for providers and health plans to adopt and use CGMs to better manage patients with diabetes.
- **Cover CGMs as a pharmacy benefit rather than a DME benefit.** Patients report that accessing a CGM and its components is more convenient through a pharmacy than through a DME supplier. Beneficiaries with diabetes who already access insulin and other pharmaceuticals through a pharmacy would not have to navigate the requirements of another entity. For states with a preferred drug list, Medicaid officials could also consider expanding the brands of CGMs that are available to beneficiaries, as some brands are not interchangeable with others. States may also benefit from rebates that would make covering CGMs more cost effective.
- **Remove burdensome provider documentation.** Exclusions in the coverage criteria make it difficult for people who need CGMs to access them. Requirements that providers produce extensive documentation and that patients test blood glucose or inject insulin a certain number of times daily is inconsistent with widely accepted clinical guidelines. For states that require prior authorization by an endocrinologist, access to CGMs may be particularly limited by low numbers of endocrinologists.
- **Allow providers to identify the CGM that is best for the patient.** CGM devices are not all the same. RCT data supports use of rtCGMs which provides predictive alerts for low and high blood glucose levels. Although more expensive, they are necessary for patients with type 1 diabetes who have episodes of any level of hypoglycemia and/or hypoglycemia unawareness. These devices are also necessary as part of automated insulin delivery systems. For others, particularly people with type 2 diabetes where rates of hypoglycemia are lower, isCGMs may be preferred. Finally,

some patients prefer one CGM device over another and patient preference is very important when it comes to selecting a device that is worn on the body 24/7/365 days a year.

- **Include coverage for both type 1 and type 2 populations.** While coverage is commonly seen for people with type 1 diabetes, people with type 2 diabetes who require insulin can also benefit from CGMs. States can potentially realize cost savings, better health outcomes for members, and reductions in disparities in this population.
- **Include coverage for both children and adults.** Children who age-up to the adult population should not lose access to CGMs.

Diabetes Community

For the diabetes community — patients, providers, manufacturers, researchers, and diabetes-focused organizations — following are recommendations to support state Medicaid agencies in expanding coverage for and eliminating barriers to accessing CGMs.

- **Develop pilot projects to demonstrate the value of CGMs.** Before making programmatic changes, particularly those that involve financial investments, states often look favorably on pilot projects that demonstrate desired outcomes. States that do not cover CGMs could find value in seeing positive outcomes of CGM use in a population of beneficiaries. A pilot could focus on a discrete outcome, such as reducing disparities, or measuring impact on cost, health, and quality of life. Pilots could be for a geographic area or a specific population, like children with type 1 diabetes.
- **Create resources for Medicaid staff.** As described earlier, Medicaid staff and leaders often look to external resources from trusted sources to make decisions about coverage. In addition to resources that demonstrate clinical and cost outcomes, states could benefit from resources that are tailored to the state’s Medicaid population and unique health needs and priorities.
- **Evaluate data to demonstrate the value of Medicaid coverage of CGMs.** While states review CGM utilization data, most states lack the resources to do robust evaluations of the effectiveness of policy changes. With state specific outcome or ROI data, states would be more likely to remove restrictions in their CGM policies, and states that do not cover CGMs would be more comfortable covering them.

- **Leverage existing stakeholder groups and external boards.** As noted on the previous page, states often look to external, independent sources for input on policy decisions. Existing boards are an opportunity to advance ideas for policy changes. Creating new task forces or groups within these existing entities to focus on CGMs and other diabetes supports can provide an additional source of credible information for state policymakers.
- **Engage state Medicaid leaders by sharing experiences of patients with diabetes.** Medicaid staff and leaders are often removed from direct, daily interactions with the individuals they serve. While most agencies value input from people with lived experience, particularly on policy changes that are under current consideration, they do not always have immediate access to those people. People with diabetes can uniquely speak to the value of CGMs, and their experiences make an impact on decision-makers.

Conclusion

CGMs have become the standard of care for people with diabetes who are insulin-treated. Observational studies and RCT data show that CGMs can help improve patient-reported outcomes including health-related quality of life, reduce hospitalizations for acute diabetes-related issues, reduce work absenteeism, and provide health care cost savings. Widespread use of and access to CGMs, along with education and follow-up, can also help to improve health equity.

Medicaid coverage for CGMs currently varies significantly across state Medicaid programs and strict requirements for initial and ongoing coverage can interfere with access to CGMs and the ability to improve diabetes management. Recommendations in this paper for both state Medicaid programs and the diabetes community aim to facilitate increased coverage for and access to CGMs.

Appendix A. 50-State Overview of Fee-for-Service CGM Coverage Policies

STATE	FFS COV. ¹	COVERAGE CRITERIA							ADDITIONAL COVERAGE NOTES
		T1	T2	PEDIATRICS ONLY	DME BENEFIT	RX BENEFIT	MIN. 4X/DAY FINGERSTK. BGM	ENDOCRIN. PRESCRIBER REQNT.	
Alabama ²	✓	✓		✓	✓		✓		Covers children with type 1 diabetes who are 20 years old and younger with an EPSDT screening
Alaska									
Arizona									
Arkansas ³	✓	✓	✓		✓				Legislature passed coverage of CGM in 2021; coverage criteria is not yet available; policy will go into effect in 2022
California ⁴	✓	✓			✓			✓	Governor proposed to expand Medicaid CGM coverage to adults in 2021-2022 budget; legislation to expand Medicaid coverage to adult with type 1 diabetes passed and policy will go into effect in 2022
Colorado ⁵	✓	✓	✓		✓				Has a 3x/day requirement for fingerstick BGM
Connecticut ⁶	✓	✓	✓		✓		✓		
Delaware ⁷	✓	✓	✓			✓			
District of Columbia ⁸	✓	✓	✓			✓			
Florida									
Georgia ⁹	✓	✓	✓	✓	✓			✓	

¹ Among the ten states listed in this table as having no published CGM coverage, nine states (AZ, FL, HI, KS, NE, NJ, NM, OR, TN) provide benefits for at least 83% of their Medicaid beneficiaries through Medicaid managed care organizations ([Share of Medicaid Population Covered under Different Delivery Systems, Kaiser Family Foundation](#)), which have the option to cover CGMs for their members. One state, AK, only has a FFS program and no published coverage was found for CGMs.

² Alabama Medicaid. Provider Manual: Durable Medical Equipment, Supplies, Appliances, Prosthetics, Orthotics and Pedorthics. https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.3G_July2021/Jul21_14.pdf. July 2021. Accessed 11/22/2021.

³ Arkansas State Legislature. SB521 – To mandate that the Arkansas Medicaid program cover a continuous glucose monitor for an individual with diabetes. <https://www.arkleg.state.ar.us/Bills/Detail?id=SB521&ddBienniumSession=2021/2021R>. April 2021. Accessed 11/22/2021.

⁴ DiaTribe Change. CGMs to be Covered Under California Medicaid’s Medi-Cal. <https://diatribechange.org/index.php/news/cgms-be-covered-under-california-medicaids-medi-cal>. August 2021. Accessed 11/22/2021.

⁵ Colorado Medicaid. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. <https://hcpf.colorado.gov/DMEPOS-manual#toc>. Updated October 5, 2021. Accessed November 23, 2021.

⁶ Husky Health Connecticut. Provider Policies and Procedures for CGM. https://www.huskyhealthct.org/providers/provider_postings/policies_procedures/Continuous_Glucose_Monitors.pdf. March 2019. Accessed 11/22/2021.

⁷ Delaware Health and Social Services. 2021 Delaware Medicaid Preferred Drug List (PDL). https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=940&language=en-US&PortalId=0&TabId=94. March 2021. Accessed 11/29/2021.

⁸ District of Columbia Department of Health Care Finance. Pharmacy Diabetic Supply List (DSL). https://dc.fhsc.com/downloads/providers/DCRx_Diabetic_Supply_Program_Listing.pdf. October 2021. 11/29/2021.

⁹ Georgia Medicaid. Part II: Policies and Procedures for Durable Medical Equipment Services. <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Part%20II%20Policies%20and%20Procedures%20for%20Durable%20Medical%20Equipment%20Services%20-%20JAN%202022%2020211221134041.pdf>. January 2022. Accessed 1/10/2022.

STATE	FFS COV. ¹	COVERAGE CRITERIA							ADDITIONAL COVERAGE NOTES
		T1	T2	PEDIATRICS ONLY	DME BENEFIT	RX BENEFIT	MIN. 4X/DAY FINGERSTK. BGM	ENDOCRIN. PRESCRIBER REQMNT.	
Hawaii									
Idaho ¹⁰	✓	✓	✓		✓		✓		
Illinois ¹¹	✓	✓	✓			✓			
Indiana ¹²	✓	✓	✓		✓		✓		
Iowa ¹³	✓	✓	✓		✓		✓		
Kansas									
Kentucky ¹⁴	✓	✓	✓			✓			
Louisiana ¹⁵	✓	✓			✓				
Maine ¹⁶	✓	✓	✓			✓			CGMs are on the preferred drug list. There are age requirements based on the brand: 2 years of age or older for Dexcom G6, ≥ 14 years for Medtronic Guardian, or ≥ 11 years for Freestyle Libre
Maryland ¹⁷	✓	✓			✓		✓	✓	

¹⁰ Idaho Medicaid. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Prior Authorization Policy and Medical Criteria. <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2525&dbid=0&repo=PUBLIC-DOCUMENTS>. Accessed 11/22/2021.

¹¹ Illinois Department of Healthcare and Family Services. Illinois Medicaid Preferred Drug List. <https://www2.illinois.gov/hfs/SiteCollectionDocuments/PDLFinal.pdf>. April 2020. Accessed 11/22/2021.

¹² Indiana Medicaid. Durable and Home Medical Equipment Supplies. <https://www.in.gov/medicaid/files/durable%20and%20home%20medical%20equipment%20and%20supplies.pdf>. March 2021. Accessed 11/22/2021.

¹³ Iowa Medicaid Department of Human Services. Continuous Glucose Monitoring Clinical Criteria. <https://dhs.iowa.gov/sites/default/files/Continuous%20Glucose%20Monitoring.pdf?032320211648>. February 2020. Accessed 11/22/2021.

¹⁴ Kentucky Medicaid. Fee-For-Service Pharmacy Provider Notice #249 – Diabetic Supply Changes. <https://chfs.ky.gov/agencies/dms/dpo/ppb/Documents/DiabeticSuppliesKentuckyProviderNotice.pdf>. January 2021. Accessed 11/29/2021.

¹⁵ Louisiana Department of Health. Durable Medical Equipment Provider Manual. <https://www.lamedicaid.com/provweb1/Providermanuals/manuals/DME/DME.pdf>. July 2021. Accessed 11/22/2021.

¹⁶ Maine Department of Health and Human Services. Preferred Drug Lists. <http://www.mainecarepdl.org/pdl>. July 2021. Accessed 11/22/2021.

¹⁷ Maryland Department of Health and Mental Hygiene. https://health.maryland.gov/mmcp/MCOupdates/Documents/pt_%2008-17.pdf. Maryland Medical Assistance Program General Provider Transmittal No. 83. October 2016. Accessed 11/22/2021.

STATE	FFS COV. ¹	COVERAGE CRITERIA							ADDITIONAL COVERAGE NOTES
		T1	T2	PEDIATRICS ONLY	DME BENEFIT	RX BENEFIT	MIN. 4X/DAY FINGERSTK. BGM	ENDOCRIN. PRESCRIBER REQMT.	
Massachusetts ¹⁸	✓	✓	✓			✓			In a November 2021 email, Dr. Mohammad Dar, Senior Medical Director, said the state removed clinical coverage guidelines requiring 4x/day of fingerstick BGM. Changes have been made to pharmacy-side billing and approved on the medical side. This has not been published yet, as this state is navigating the process of the intended changes. Changes can take several months before publication.
Michigan ¹⁹	✓	✓			✓				The following language for fingerstick BGM criteria is used: "The beneficiary's treatment plan recommends testing blood glucose a minimum of four times per day."
Minnesota ²⁰	✓	✓	✓			✓			
Mississippi ²¹	✓	✓			✓		✓		
Missouri ²²	✓	✓				✓	✓		
Montana ²³	✓	✓	✓		✓		✓		
Nebraska									
Nevada ²⁴	✓	✓				✓			
New Hampshire ²⁵	✓	✓	✓			✓			Dexcom CGMs are the preferred continuous glucose monitoring systems; does not cover non-preferred monitors unless the physician has requested an override
New Jersey									

¹⁸ Massachusetts MassHealth. Guidelines for Medical Necessity Determination for Diabetes Management Devices: Continuous Glucose Monitoring Systems and Insulin Pumps. <https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-diabetes-management-0/download>. August 2021. Accessed 11/22/2021.

¹⁹ Michigan Department of Health and Human Services. Medicaid Provider Manual. <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>. October 2021. Accessed 11/22/2021.

²⁰ Minnesota Department of Human Services. Minnesota Fee-for-Service and Managed Care Medicaid. https://mn.gov/dhs/assets/preferred-drug-list-2021-10-01_tcm1053-499882.pdf. October 2021. Accessed 11/29/2021.

²¹ Mississippi Division of Medicaid. Title 23: Medicaid Part 209 Durable Equipment and Medical Supplies. <https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf>. September 2018. Accessed 11/22/2021.

²² Missouri Department of Social Services. Provider Bulletin Volume 42 Number 36: Diabetes Supplies – Updated. <https://dss.mo.gov/mhd/providers/pdf/bulletin42-36.pdf>. March 2020. Accessed 12/1/2021.

²³ Montana Department of Public Health and Human Services. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies Manual. <https://medicaidprovider.mt.gov/manuals/durablemedicalequipmentprostheticsorthoticsandmedicalsuppliesmanual>. December 2020. Accessed 11/22/2021.

²⁴ Nevada Department of Health and Human Services. Diabetic Supply Policy Changes for Nevada Medicaid. https://www.medicaid.nv.gov/Downloads/provider/web_announcement_2061_20191230.pdf. December 2021. Accessed 11/22/2021.

²⁵ New Hampshire Department of Health and Human Services. New Hampshire Medicaid Pharmacy Program: New Hampshire Medicaid Diabetic Supply Program. https://nhcontent.magellanmedicaid.com/Downloads/provider/NHRx_notification_20211001.pdf. October 2021. Accessed November 30, 2021.

STATE	FFS COV. ¹	COVERAGE CRITERIA						ADDITIONAL COVERAGE NOTES	
		T1	T2	PEDIATRICS ONLY	DME BENEFIT	RX BENEFIT	MIN. 4X/DAY FINGERSTK. BGM		ENDOCRIN. PRESCRIBER REQMT.
New Mexico									
New York ²⁶	✓	✓				✓		✓	
North Carolina ²⁷	✓	✓	✓			✓	✓		
North Dakota ²⁸	✓	✓	✓			✓			
Ohio ²⁹	✓	✓	✓			✓			
Oklahoma ³⁰	✓	✓	✓			✓	✓		Policy does not include children with type 2 diabetes
Oregon									
Pennsylvania ³¹	✓	✓	✓		✓	✓			Dexcom products are a preferred pharmacy benefit, meaning prior authorization will not be required; all other CGMs products are available through DME
Rhode Island ³²	✓	✓			✓		✓		
South Carolina ³³	✓	✓			✓	✓	✓	✓	After July 1, 2019, certain CGMs are covered under the pharmacy benefit; however, CGMs are still offered as a DME benefit
South Dakota ³⁴	✓	✓			✓		✓	✓	

²⁶ New York State Department of Health. Update to NYS Medicaid Fee-for-Service Preferred Diabetic Supply Program. https://newyork.fhsc.com/downloads/providers/NYRx_provider_notification_20210628.pdf. July 2021. Accessed 11/24/2021.

²⁷ North Carolina Medicaid. Outpatient Pharmacy Prior Approval Criteria: Systems (CGM) and Related Supplies. <https://medicaid.ncdhhs.gov/media/9011/open>. April 2021. Accessed 11/24/2021.

²⁸ North Dakota Medicaid. North Dakota Medicaid Preferred Diabetic Supply. <http://www.hidesigns.com/ndmedicaid/pdsl.pdf>. October 2021. Accessed November 24, 2021.

²⁹ Ohio Department of Medicaid. 2021 Preferred Diabetic Supply List. https://pharmacy.medicaid.ohio.gov/sites/default/files/20210701_OH_July_2021_PDSL.pdf. July 2021. Accessed 11/24/2021.

³⁰ Oklahoma Health Care Authority. Diabetic Supplies for Pharmacy. <https://oklahoma.gov/ohca/providers/types/pharmacy/diabetic-supplies-for-pharmacy.html>. May 2021. Accessed 11/22/2021.

³¹ Pennsylvania Department of Human Services. Provider Quick Tips: DexCom Continuous Glucose Monitoring Products Coverage. <https://www.dhs.pa.gov/providers/Quick-Tips/Documents/PROMISEQuickTip248.pdf>. May 2020. Accessed 11/22/2021.

³² State of Rhode Island Executive Office of Health and Human Services. Coverage Guidelines for Durable Medical Equipment. <https://eoehs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx>. Accessed 11/24/2021.

³³ South Carolina Department of Health and Human Services. Durable Medical Equipment Services Provider Manual. <https://provider.scdhhs.gov/internet/pdf/manuals/dme/Manual.pdf>. October 2021. Accessed 11/24/2021.

³⁴ South Dakota Medicaid. Billing and Policy Manual: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Durable_Medical_Equipment.pdf. October 2021. Accessed 11/24/2021.

STATE	FFS COV. ¹	COVERAGE CRITERIA							ADDITIONAL COVERAGE NOTES
		T1	T2	PEDIATRICS ONLY	DME BENEFIT	RX BENEFIT	MIN. 4X/DAY FINGERSTK. BGM	ENDOCRIN. PRESCRIBER REQNT.	
Tennessee ³⁵									
Texas ³⁶	✓	✓	✓		✓		✓		
Utah ³⁷	✓	✓	✓		✓	✓			Covers Dexcom G6 CGM under preferred drug list; Freestyle Libre and Guardian Connect as non-preferred; non-preferred must be approved and billed through DME
Vermont ³⁸	✓	✓	✓			✓			Covers Dexcom G6 and Freestyle Libre CGMs under preferred drug list, and Medtronic CGMs as non-preferred
Virginia ³⁹	✓	✓	✓		✓		✓		Policy does not include children with type 2 diabetes
Washington State ⁴⁰	✓	✓	✓		✓		✓		Minimum 4x/day fingerstick blood glucose monitoring only required for adults with type 2 diabetes
West Virginia ⁴¹	✓	✓	✓			✓	✓		
Wisconsin ⁴²	✓	✓			✓		✓	✓	CGMs are covered only for adults 25 years of age or older with type 1 diabetes
Wyoming ⁴³	✓	✓	✓			✓			

³⁵ There is no published FFS coverage, however, most Medicaid consumers in Tennessee receive services through Medicaid managed care organizations which can provide coverage.

³⁶ Texas Health and Human Services. Texas Medicaid Provider Procedures Manual: Volumes 1 & 2. <https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2021-08-TMPPM.pdf>. August 2021. Accessed 11/24/2021.

³⁷ Utah Department of Health. Preferred Drug List. <https://medicaid.utah.gov/pharmacy/preferred-drug-list/>. October 2021. Accessed 11/24/2021.

³⁸ Department of Vermont Health Access Pharmacy Benefit Management Program. Vermont Preferred Drug List and Drugs Requiring Prior Authorization. <https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/VERMONT%20PDL.pdf>. October 2021. Accessed 11/24/2021.

³⁹ Virginia Medicaid. Provider Manual: Durable Medical Equipment & Supplies, Chapter IV Covered Services and Limitations. <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual/>. June 2021. Accessed 11/24/2021.

⁴⁰ Washington State Health Care Authority. Home Infusion Therapy and Parenteral Nutrition Program Billing Guide. <https://www.hca.wa.gov/assets/billers-and-providers/Home-infusion-therapy-bg-20211001.pdf>. October 2021. Accessed 11/24/2021.

⁴¹ State of West Virginia Department of Health and Human Resources Bureau for Medical Services. Office of Pharmacy Service Prior Authorization Criteria: Continuous Glucose Monitors (Freestyle Libre & Dexcom). <https://dhr.wv.gov/bms/BMS%20Pharmacy/Documents/Continuous%20Glucose%20Monitors%202019.2d.pdf>. May 2019. Accessed 11/24/2021.

⁴² Wisconsin Department of Health Services. BadgerCare Plus and Medicaid. Handbook Area: Disposable Medical Supplies: Prior Authorization. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=16&s=3&c=11&nt=>. Accessed 11/24/2021.

⁴³ Wyoming Department of Health. Wyoming Medicaid: Preferred Drug List. <http://www.wyomedicaid.org/sites/default/files/ghs-files/pdl/2021-10-18/pdl101821.pdf>. October 2021. Accessed 11/30/2021.

Appendix B. State Fee-for-Service CGM Coverage Policies At-A-Glance

CGMS COVERED UNDER ⁴⁴	STATES
<ul style="list-style-type: none"> Preferred drug list⁴⁵ Preferred diabetic supply list⁴⁶ 	Delaware, District of Columbia, Illinois, Kentucky, Ohio, Pennsylvania, ⁴⁷ Maine, Massachusetts, ⁴⁸ Minnesota, New Hampshire, North Dakota, Utah, ⁴⁹ Vermont, Wyoming
CGM COVERED FOR	STATES
<ul style="list-style-type: none"> T1 & T2 on insulin pumps or multiple daily insulin injections All ages Pharmacy benefit With prescriber and/or fingerstick monitoring requirements 	Oklahoma, North Carolina, West Virginia
<ul style="list-style-type: none"> T1 & T2 on insulin pumps or multiple daily insulin injections All ages DME benefit Without prescriber and/or fingerstick monitoring requirements 	Arkansas, Colorado, Virginia ⁵⁰
<ul style="list-style-type: none"> T1 & T2 on insulin pumps or multiple daily insulin injections All ages DME benefit With prescriber and/or fingerstick monitoring requirements 	Connecticut, Idaho, Indiana, Iowa, Montana, Texas, Washington State
<ul style="list-style-type: none"> T1 only All ages 	California, Louisiana, Maryland, Michigan, Mississippi, Missouri, ⁵¹ Nevada, ⁵² New York, ⁵³ Rhode Island, South Carolina, ⁵⁴ South Dakota
<ul style="list-style-type: none"> T1 and/or T2 on insulin pumps or multiple daily insulin injections Children or adults only 	Alabama, ⁵⁵ Georgia, ⁵⁶ Wisconsin ⁵⁷
States with no published coverage ⁵⁸	Alaska, Arizona, Florida, Hawaii, Kansas, Nebraska, New Jersey, New Mexico, Oregon, Tennessee

⁴⁴ In states where CGMs is on the preferred drug list or preferred diabetic supply list there are not strict exclusionary criteria. While this is the easiest method for Medicaid patients to have access to CGM, it is not very common. Of these states, some include all CGM brands as preferred, while some only include one. There is no clear pattern, however, Dexcom and Abbott are the CGM manufacturers most seen as preferred products.

⁴⁵ Delaware, District of Columbia, Minnesota, New Hampshire, Pennsylvania, Vermont, Utah, Maine, Illinois, Wyoming, and Oregon have at least one CGM brand in their Preferred Drug List.

⁴⁶ North Dakota, Ohio, and Kentucky have at least one CGM brand in their Preferred Diabetic Supply List.

⁴⁷ Pennsylvania's non-preferred products must be approved and billed through DME.

⁴⁸ CHCS was unable to find CGMs included in a Preferred Diabetic Supply List or Preferred Drug List in Massachusetts, however, Massachusetts is the only other state that provides CGM coverage for people of all ages with type 1 and type 2 diabetes on insulin pumps or multiple daily insulin injections, as a pharmacy benefit, and without prescriber and fingerstick monitoring criteria.

⁴⁹ Utah's non-preferred products must be approved and billed through DME.

⁵⁰ Virginia does not include coverage for CGMs for children with type 2 diabetes on insulin pumps or multiple daily insulin injections.

⁵¹ Missouri covers CGMs under pharmacy benefit.

⁵² Nevada covers CGMs under pharmacy benefit.

⁵³ New York covers CGMs under pharmacy benefit.

⁵⁴ South Carolina covers CGMs as a DME and pharmacy benefit.

⁵⁵ Alabama covers CGMs for children with type 1 diabetes only.

⁵⁶ Georgia covers CGMs only for children with type 1 and type 2 diabetes on insulin pumps or multiple daily insulin injections.

⁵⁷ Wisconsin covers CGMs for adults with type 1 diabetes only.

⁵⁸ Arizona, Florida, Hawaii, Kansas, Nebraska, New Jersey, New Mexico, Oregon, and Tennessee provide benefits for at least 83% of their Medicaid beneficiaries through Medicaid managed care organizations ([Share of Medicaid Population Covered under Different Delivery Systems, Kaiser Family Foundation](#)), which have the option to cover CGMs for their members. Alaska's Medicaid population is covered under FFS.

ENDNOTES

¹ B.P. Ng, S.S. Sundar, A. Lanza, B. Smith, and P. Zing. “Medical Expenditures Associated with Diabetes Among Adult Medicaid Enrollees in Eight States.” *Preventing Chronic Disease*, 15 (2018). Available at: https://www.cdc.gov/pcd/issues/2018/18_0148.htm

² Ibid.

³ American Diabetes Association. “Economic Costs of Diabetes in the U.S. in 2017. *Diabetes Care*.” *Diabetes Care*, 41 (May 2018): 917-928. Available at: <https://care.diabetesjournals.org/content/41/5/917>

⁴ Ibid.

⁵ O. Ebekozien, O. Odugbesan, N. Riales, S. Majidi, N-H.Y. Jones, and M. Kamboj. “Equitable Post-COVID-19 Care: A Practical Framework to Integrate Health Equity in Diabetes Management. *JCOM*, 27(6) (2020): 256-259. Available at: <https://cdn.mdedge.com/files/s3fs-public/issues/articles/jcom02706256.pdf>

⁶ B.P. Ng, et al., op. cit.

⁷ D. Deiss, A. Szadkowska, D. Gordon, A. Mallipedhi, I. Schutz-Fuhrmann, E. Aguilera, et al. “Clinical Practice Recommendations on the Routine Use of Eversense, the First Long-Term Implantable Continuous Glucose Monitoring System. *Diabetes Technology & Therapeutics*, 21(5) (2019): 254-264. Available at: <https://pubmed.ncbi.nlm.nih.gov/31021180/>

⁸ American Diabetes Association Professional Practice Committee. “7. Diabetes technology: Standards of Medical Care in Diabetes—2022.” *Diabetes Care*, 45(1) (2022): S97-S112. Available at: https://diabetesjournals.org/care/issue/45/Supplement_1

⁹ T.R. Gilbert, A. Noar, O. Blalock, and W.H. Polonsky. “Change in Hemoglobin A1c and Quality of Life with Real-Time Continuous Glucose Monitoring Use by People with Insulin-Treated Diabetes in the Landmark Study.” *Diabetes Technology & Therapeutics*, 23(1) (2021): S35-39. Available at: <https://www.liebertpub.com/doi/pdf/10.1089/dia.2020.0666>

¹⁰ M. Fokkert, P. van Dijk, M. Edens, E. Barents, J. Mollema, R. Slingerland, et al. “Improved well-being and decreased disease burden after 1-year use of flash glucose monitoring (FLARE-NL4).” *BMJ Open Diabetes Res Care*, 7(1) (2019): 1-10. Available at: <https://pubmed.ncbi.nlm.nih.gov/31875133/>

¹¹ Ibid.

¹² M. Gill, C. Zhu, M. Shah, and H. Chhabra. “Health Care Costs, Hospital Admissions, and Glycemic Control Using a Standalone, Real-Time Continuous Glucose Monitoring System with Commercially Insured Patients with Type 1 Diabetes.” *Journal of Diabetes Science and Technology*, 12(4) (2018): 800-807. Available at: <https://journals.sagepub.com/doi/pdf/10.1177/1932296818777265>

¹³ W. Wan, M.R. Skandari, A. Minc, A.G. Nathan, A. Winn, P. Zarei, et al. “Cost-effectiveness of Continuous Glucose Monitoring for Adults with Type 1 Diabetes Compared with Self-Monitoring of Blood Glucose: the DIAMOND Randomized Trial.” *Diabetes Care* (2018): 1-8. Available at: <https://care.diabetesjournals.org/content/diacare/early/2018/03/16/dc17-1821.full.pdf>

¹⁴ J.R. Frank, D. Blissett, R. Hellmund, and N. Viridi. “Budget Impact of the Flash Continuous Glucose Monitoring System in Medicaid Diabetes Beneficiaries Treated with Intensive Insulin Therapy.” *Diabetes Technol Ther*, 23 (2021): S36-S44. Available at: <https://pubmed.ncbi.nlm.nih.gov/34546079/>

¹⁵ S. Roze, J.J. Isitt, J. Smith-Palmer, P. Lynch. “Evaluation of the Long-Term Cost-Effectiveness of the Dexcom G6 Continuous Glucose Monitor versus Self-Monitoring of Blood Glucose in People with Type 1 Diabetes in Canada.” *Clinicoecon Outcomes*, 13 (2021): 717-725. Available at: <https://pubmed.ncbi.nlm.nih.gov/34408456/>

¹⁶ R.M. Bergenstal, M.S.D. Kerr, G.J. Roberts, D. Souto, Y. Nabutovsky, and I.B. Hirsch. “Flash CGM Is Associated With Reduced Diabetes Events and Hospitalizations in Insulin-Treated Type 2 Diabetes.” *Journal of the Endocrine Society*, 5(4) (2021): 1-9. Available at: <https://pubmed.ncbi.nlm.nih.gov/33644623/>

¹⁷ A.J. Karter, M.M. Parker, H.H. Moffet, L.K. Gilliam, and R. Dlott. “Association of Real-time Continuous Glucose Monitoring With Glycemic Control and Acute Metabolic Events Among Patients With Insulin-Treated Diabetes.” *Journal of the American Medical Association*, 325(22) (2021): 2273-2284. Available at: <https://pubmed.ncbi.nlm.nih.gov/34077502/>

¹⁸ S. Majidi, O. Ebekozien, N. Noor, S.K. Lyons, R. McDonough, K. Gandhi, et al. “Inequities in Health Outcomes in Children and Adults With Type 1 Diabetes: Data From the T1D Exchange Quality Improvement Collaborative.” *Clinical Diabetes*, 39(3) (2021): 278-283. Available at: <https://clinical.diabetesjournals.org/content/39/3/278.full>

¹⁹ American Diabetes Association. “Statistics about Diabetes.” Updated March 22, 2018. Available at: <https://www.diabetes.org/resources/statistics/statistics-about-diabetes>

- ²⁰ O. Ebekozien, S. Agarwal, N. Noor, A. Albanese-O’Neill, J.C. Wong, T. Seeherunvong, et al. “Inequities in Diabetic Ketoacidosis Among Patients With Type 1 Diabetes and COVID-19: Data From 52 US Clinical Centers.” *Journal of Clinical Endocrinology & Metabolism*, 106(4) (2021): e1755-e1762. Available at: <https://pubmed.ncbi.nlm.nih.gov/33410917/>
- ²¹ P.A. Sequeira, L. Montoya, V. Ruelas, D. Xing, V. Chen, R. Beck, et al. “Continuous glucose monitoring pilot in low-income type 1 diabetes patients.” *Diabetes Technol Ther*, 15(10) (2013): 855-8. Available at: <https://pubmed.ncbi.nlm.nih.gov/23865840/>
- ²² N. Noor, O. Ebekozien, L. Levin, S. Stone, D.P. Sparling, R. Rapaport, et al. “Diabetes Technology Use for Management of Type 1 Diabetes Is Associated With Fewer Adverse COVID-19 Outcomes: Findings From the T1D Exchange COVID-19 Surveillance Registry.” *Diabetes Care*, 44(8) (2021): e160-e162. Available at: <https://care.diabetesjournals.org/content/44/8/e160.full>
- ²³ D.J. DeSalvo, N. Noor, C. Xie, S.D. Corathers, S. Majidi, R.J. McDonough, et al. “Patient Demographics and Clinical Outcomes Among Type 1 Diabetes Patients Using Continuous Glucose Monitors: Data From T1D Exchange Real-World Observational Study.” *Journal of Diabetes Science and Technology* (2021). Available at: <https://pubmed.ncbi.nlm.nih.gov/34632823/>
- ²⁴ A.F. Walker, K.K. Hood, M.J. Gurka, S.L. Filipp, C. Anez-Zabala, N. Cuttriss, et al. “Barriers to Technology Use and Endocrinology Care for Underserved Communities With Type 1 Diabetes.” *Diabetes Care*, 44(7) (2021): 1480-1490. Available at: <https://pubmed.ncbi.nlm.nih.gov/34001535/>
- ²⁵ J.E. Anderson, J.R. Gavin, D.F. Kruger. “Current Eligibility Requirements for CGM Coverage Are Harmful, Costly, and Unjustified.” *Diabetes Technology and Therapeutics*, 22(3) (2020): 169-173. Available at: <https://www.liebertpub.com/doi/full/10.1089/dia.2019.0303>
- ²⁶ D. Kruger and J.E. Anderson. “Continuous Glucose Monitoring (CGM) Is a Tool, Not a Reward: Unjustified Insurance Coverage Criteria Limit Access to CGM.” *Diabetes Technology & Therapeutics*, 23(S3) (2021): S45-S55. Available at: <https://www.liebertpub.com/doi/full/10.1089/dia.2021.0193>
- ²⁷ National Institute of Diabetes and Digestive and Kidney Diseases. “Continuous Glucose Monitoring.” Updated June 2017. Available at: <https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring>
- ²⁸ American Diabetes Association Professional Practice Committee. “7. Diabetes technology: Standards of Medical Care in Diabetes—2022.” et al., op. cit.
- ²⁹ A.J. Karter, et al., op. cit.
- ³⁰ Ibid.
- ³¹ T.R. Gilbert, et al., op. cit.
- ³² Ibid.
- ³³ M. Fokkert, et al., op. cit.
- ³⁴ T.R. Gilbert, et al., op. cit.
- ³⁵ A.J. Karter, et al., op. cit.
- ³⁶ M. Fokkert, et al., op. cit.
- ³⁷ M. Gill, et al., op. cit.
- ³⁸ W. Wan, et al., op. cit.
- ³⁹ J.R. Frank, et al., op. cit.
- ⁴⁰ S. Roze, et al., op. cit.
- ⁴¹ A.J. Karter, et al., op. cit.
- ⁴² T.R. Gilbert, et al., op. cit.
- ⁴³ R.M. Bergenstal, et al., op. cit.
- ⁴⁴ M. Fokkert, et al., op. cit.
- ⁴⁵ Ibid.
- ⁴⁶ T.R. Gilbert, et al., op. cit.
- ⁴⁷ J.E. Anderson, et al., op. cit.
- ⁴⁸ M. Gill, et al., op. cit.
- ⁴⁹ et al., op. cit.

⁵⁰ Ibid.

⁵¹ S. Roze, et al., op. cit.

⁵² M. Gill, et al., op. cit.

⁵³ Ibid.

⁵⁴ American Diabetes Association. “Statistics about Diabetes.” et al., op. cit.

⁵⁵ Kaiser Family Foundation. “Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity.” Available at: <https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁵⁶ O. Ebekozi, et al., op. cit.

⁵⁷ S. Majidi, et al., op. cit.

⁵⁸ N. Noor, et al., op. cit.

⁵⁹ American Diabetes Association Professional Practice Committee. “7. Diabetes technology: Standards of Medical Care in Diabetes—2022.” et al., op. cit.

⁶⁰ Centers for Medicare & Medicaid Services. “Medicaid and CHIP Managed Care Final Rule (CMS-2390-F).” Available at: <https://www.medicaid.gov/medicaid/downloads/mco-cod-presentation.pdf>

⁶¹ K. Gifford, A. Winter, L. Wiant, R. Dolan, M. Tian, and R. Garfield. “How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020.” *Kaiser Family Foundation*. Published April 29, 2020. Available at: <https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/>

⁶² Centers for Disease Control and Prevention. “Diabetes.” Updated November 16, 2021. Available at: <https://www.cdc.gov/diabetes/basics/diabetes.html>

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Juvenile Diabetes Research Foundation. “How To Obtain Prior Authorizations.” Available at: <https://www.jdrf.org/t1d-resources/living-with-t1d/insurance/how-to-obtain-prior-authorization/#section1>

⁶⁶ D. Kruger et al., op. cit.

⁶⁷ J.E. Anderson, et al., op. cit.

⁶⁸ American Diabetes Association. “New Medicare Coverage Requirements Make CGMs More Accessible.” *Devices and Technology*. Available at: <https://www.diabetes.org/healthy-living/devices-technology/cgm-medicare-coverage-requirement-change-accessibility>

⁶⁹ K. Gifford, et al., op. cit.

⁷⁰ Ibid.

⁷¹ Pennsylvania Department of Human Services. “Pharmacy and Therapeutics (P&T) Committee.” Updated September 16, 2021. Available at: <https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Pharmacy-Committee.aspx>

⁷² Washington State Health Care Authority. “Health Technology Assessment.” Available at: <https://www.hca.wa.gov/about-hca/health-technology-assessment>

⁷³ Institute for Clinical and Economic Review. “Frequently Asked Questions.” Available at: <https://icer.org/who-we-are/faqs/>

⁷⁴ Oregon Health & Science University, Pacific Northwest Evidence-Based Practice Center. “About Us.” Available at: <https://www.ohsu.edu/evidence-based-practice-center/about>

⁷⁵ Center for Evidence-based Policy. “What we do.” Available at: <https://centerforevidencebasedpolicy.org/what-we-do/>

⁷⁶ American Diabetes Association. “Introduction: Standards of Medical Care in Diabetes—2021.” *Diabetes Care*, 44(1) (2021). Available at: https://care.diabetesjournals.org/content/44/Supplement_1/S1

⁷⁷ Endocrine Society. “Clinical Practice Guidelines.” Available at: <https://www.endocrine.org/clinical-practice-guidelines>

⁷⁸ American Association of Clinical Endocrinologists. “Clinical Practice Guidelines.” Available at: <https://pro.aace.com/disease-state-resources/diabetes/guidelines>

⁷⁹ Sovereign States Drug Consortium (SSDC). “CGM Approved Medicaid Supplemental Rebate Pool Fact Sheet.” Published March 8, 2021. Available at:

https://rxssdc.org/sites/default/files/uploaded_files/SSDC%20CY2022%20SSDC%20Fact%20Sheet_20210308_v1.pdf

⁸⁰ For more information: Food and Drug Administration. “Medical Devices.” Available at: <https://www.fda.gov/medical-devices>

⁸¹ As reported by Christine Fallabel and Lisa Murdock of the American Diabetes Association in a phone call on June 16, 2021.

⁸² For more information: Academy Health. “Medicaid Medical Directors Network (MMDN).” Available at:

<https://academyhealth.org/about/programs/medicaid-medical-directors-network-mmdn>