The Medicaid CGM Coverage Model

This section discusses legislation ensuring people with diabetes have coverage for individualized care that can prevent or delay the onset of costly and life-limiting complications.

Efforting to provide their constituents adequate coverage, legislators in Arkansas and Louisiana have recently enacted legislation mandating their Medicaid program cover continuous glucose monitors (CGMs) for individuals with diabetes in accordance with guidelines from the Centers for Medicare & Medicaid Services (CMS).

Innovative technologies such as CGMs, smart devices, and closed loop CGM+ pump or “artificial pancreas” systems provide individuals a vital tool to manage their diabetes, quickly adjust behavior and avoid preventable complications and ER visits.

As these innovations become routine and more data is gathered, clinical guidelines have evolved. The American Diabetes Association now recommends CGMs as the standard of care for treating any insulin-dependent adult, regardless of type, as well as for all children with type 1 and type 2 diabetes who use rapid-acting insulin.

Despite these recommendations, Medicaid coverage of CGMs remains a complex patchwork of prescription or durable medical equipment (DME) benefits. Across the country, coverage differentiates between people with type 1 versus type 2 diabetes as well as between children and adults. Some states go further to require prior authorization alongside prescriber requirements and diabetes-specific requirements.

The 37 million people living with diabetes generate a staggering 16 million annual ER visits with nearly half resulting in an inpatient admission.
Under this patchwork coverage, studies reveal that Medicaid beneficiaries with diabetes struggle—suffering higher rates of poor diabetes management, worse glycemic control, and facing more acute- and long-term complications related to diabetes.

While federal laws and regulations set standards for coverage under Medicaid for both the traditional and expansion populations, individual states determine the finer points of what is and is not covered, and how programs are administered.

It is important to contain costs wherever possible, but it’s similarly important to design plan coverage to drive overall cost efficiencies versus any single line item. The purpose of CGM coverage is to promote better diabetes management and importantly, to reduce higher cost spend on the major medical side of the plan. One study shows that patient adoption of CGMs for just nine months results in healthcare costs savings of $4,000 compared to a patient without a CGM.

In covering CGMs through Medicaid, Arkansas and Louisiana offer protection to some of their most vulnerable citizens while properly managing its resources by preventing the greater costs associated with diabetes-related hospitalizations and treatment complications.