Center for Health Care Strategies

Implementing Continuous Glucose Monitors as a Pharmacy Benefit: A Policy Checklist for States

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Continuous glucose monitors (CGMs) are an accepted standard of care for treating all adults with type 1 diabetes and adults with type 2 diabetes on intensive or basal insulin therapies.[1] For children with type 1 or type 2 diabetes, CGMs are an accepted standard of care for treating those on intensive insulin therapy regimens.[2] Emerging research also suggests that CGMs are clinically effective for people with type 2 diabetes using any form of insulin, as well as for individuals with gestational diabetes.[3,4] Unlike fingerstick blood glucose monitoring, which provides moment-in-time data, CGMs offer people with diabetes access to continuous data on their glucose levels so they can better manage their condition.[5] Studies demonstrate that CGMs can improve clinical quality, health outcomes, and quality of life, as well as reduce health care costs.[6]

CGMs can also support broader efforts by state Medicaid agencies and their partners to address disparities and advance health equity. Diabetes disproportionately impacts communities of color and people with lower incomes.[7] Moreover, people served by Medicaid often experience more barriers to accessing CGMs than individuals on commercial insurance or Medicare.[8,9]

While state Medicaid programs have traditionally covered CGMs as a durable medical equipment (DME) benefit, some states have begun offering CGM coverage as a pharmacy benefit instead. States have noted the benefits of this shift, including: (1) eased access to CGMs for members; (2) reduced clinician burden; (3) aligned coverage with commercial insurers; (4) improved tracking of utilization data; and (5) potential cost savings.[10]

This checklist can support states interested in transitioning their CGM coverage from a DME benefit to a pharmacy benefit. It can also support states newly implementing CGM coverage and considering doing so as a pharmacy benefit. The checklist highlights seven key steps for states implementing a pharmacy benefit, including:

1. Determine the policy process
2. Assess changes to reimbursement rates
3. Consider the implementation approach
4. Conduct a cost analysis
5. Engage with Medicaid managed care organizations
6. Engage other key stakeholders
7. Consider additional CGM coverage updates

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State Checklist for Implementing a CGM Pharmacy Benefit

1. Determine the Policy Process

- Determine whether the CGM pharmacy benefit will be implemented through a Centers for Medicare & Medicaid Services (CMS)-approved State Plan Amendment (SPA) or an administrative policy change. If a state is seeking to only update coverage type for CGMs, a SPA is likely not required; however, if an agency wishes to broaden pharmacy benefit coverage to include additional medical devices beyond CGMs, a SPA is likely required.
- Engage in the necessary rule-making process for state policy changes, which may include public notification, comment periods, and regulatory review.

The Department of **Vermont** Health Access successfully implemented a Medicaid CGM pharmacy benefit in 2019. Following the determination that a state plan amendment was not required, the state's Drug Utilization Review Board evaluated and endorsed criteria for incorporating CGMs into the state's Medicaid pharmacy benefit.

- Consider whether maintaining CGM coverage as a DME benefit, but making coverage available to members through pharmacy point-of-sale systems, is preferable to a full transition to a pharmacy benefit. A point-of-sale approach can help streamline access for patients while preserving the DME classification for reimbursement and prior authorization purposes.

2. Assess Changes to Reimbursement Rates

- Consult with state Medicaid pharmacy benefits management staff to determine how reimbursement rates for CGMs will be calculated. States often use a "lower of" calculation method, benchmarking reimbursement rates against various pricing benchmarks like the National Average Drug Acquisition Cost or the state maximum allowable cost. This approach can lead to cost savings compared to fee schedules used for DME reimbursement.
- Investigate the possibility of negotiating rebates with CGM device manufacturers. These negotiations have the potential to further reduce overall procurement costs associated with CGMs.

While the transition to a pharmacy benefit for CGMs may result in cost savings through changes in device procurement and reimbursement rates for CGM prescriptions, it would not affect reimbursement received by providers for related patient care, such as sensor placement and interpretation of CGM results.

3. Consider the Implementation Approach

- Evaluate and update workflows for claims processing. For example, the responsibility for managing prior authorizations for CGMs may transition from clinical staff to drug utilization staff or external pharmacy benefit managers.
- Decide whether to include CGMs on the state's preferred drug list (PDL). Doing so can streamline access for members and aid in the negotiation of pharmacy rebates with manufacturers.
  - Conduct a market analysis to determine the clinical effectiveness, pricing, and utilization levels of different CGMs for PDL inclusion.
  - Allow continued coverage of prescriptions for CGMs not included in the PDL, to ensure continuity of care for existing users during the transition period.
- Determine whether to offer CGMs concurrently as a DME and pharmacy benefit for a limited time. This approach can help minimize disruptions in coverage for members during the transition period. Additionally, crossover CGM claims for individuals dually eligible for Medicare and Medicaid may require processing through the DME benefit.

> To ensure a smooth transition for members and providers, **Vermont** maintained CGM coverage simultaneously under both DME and pharmacy benefits for all members over an initial two-year period. This allowed Vermont Medicaid staff time to proactively work to ensure that members with prior authorizations for CGMs through the DME benefit maintained continuous coverage for their devices.

4. Conduct a Cost Analysis

- Assess the number of members with active CGM prescriptions under the current DME benefit. This will serve as a baseline for estimating the fiscal impact of transitioning to a pharmacy benefit. Include the expected reimbursement rate and any negotiated rebates with manufacturers in these assessments.
- Consider potential increases in CGM adoption resulting from expanded accessibility through the pharmacy benefit.
- Determine the fiscal impact associated with transitioning CGMs to a pharmacy benefit, which may be lessened by reductions in other utilization resulting from increased CGM use. For example, a retrospective analysis of private insurance and Medicare Advantage patient data among CGM users revealed notable reductions in acute diabetes-related events, all-cause hospitalizations, and HbA1c levels for patients with both type 1 and type 2 diabetes in the six months following a CGM prescription.[11]

> For insights into the clinical and fiscal benefits of CGM utilization, see the **Fiscal Impact** and **Clinical Outcomes** sections of CHCS' *Accelerating Access to Continuous Glucose Monitors in Medicaid Resource Center*.

5. Engage with Medicaid Managed Care Organizations

If a state operates a Medicaid managed care system, additional steps will need to be taken to ensure that the new pharmacy benefit for CGMs is properly implemented and offered to members. In states where pharmacy benefits are "carved into" managed care contracts, managed care organizations (MCOs) will be responsible for reimbursing or managing a new CGM pharmacy benefit. In "carved out" states, MCOs are often still responsible for coordinating access to pharmacy benefits and will still need to be engaged on this policy change. To guide this process, states can:

- Assess the number of members with active CGM prescriptions under the current DME benefit. This will serve as a baseline for estimating the fiscal impact of transitioning to a pharmacy benefit. Include the expected reimbursement rate and any negotiated rebates with manufacturers in these assessments.
- Seek input from MCOs on the proposed transition, including potential challenges and opportunities. MCOs may offer valuable perspectives on patient and provider experiences with CGM coverage and related policy implementation considerations. National health plans might have experience administering similar benefits in other states.
- Collaborate closely with MCOs to ensure a seamless transition. MCOs may have additional member communication resources, such as member outreach staff, informational pamphlets, and online tools that can be used to facilitate greater awareness about the policy change.
- Communicate with MCOs about implementation of the new pharmacy benefit, changes in prior authorization processes, and revised procedures for processing CGM claims if pharmacy benefits are carved into a state's managed care contracts. Offering training can help MCO staff understand the changes in reimbursement for CGMs.
- Notify MCOs that they are no longer responsible for reimbursing providers or patients for CGMs as a DME benefit if pharmacy benefits are carved out of the state's managed care contracts. MCOs may still be responsible for coordinating access to CGMs as a pharmacy benefit.
- Establish or confirm mechanisms for data sharing and coordination between the Medicaid agency and MCOs. Data-sharing processes and agreements may be needed to:
  - Evaluate the impacts of the coverage change on CGM utilization and member costs.
  - Perform utilization review, particularly if a state removes prior authorization requirements.
  - Proactively communicating to members and prescribing providers with pre-existing CGM prescriptions to ensure continuity of care during the transition period.
- Evaluate state MCOs' CGM coverage policies to ensure alignment with state published Medicaid coverage policy and communicate updates to MCOs as needed.
- Assess potential impact on MCO capitation rates. Adjustments or updated negotiations may be needed to account for changes in utilization or reimbursement rates resulting from the transition of CGM coverage to the pharmacy benefit.

6. Engage Other Key Stakeholders

Seek opportunities to engage with providers, members, and other key stakeholders to identify barriers to CGM access, such as understanding and navigating the prior authorization process. Use this information to collaborate with MCOs to improve CGM access. Engagement strategies and aims for various stakeholders include:

For insights on engaging with stakeholders to encourage CGM adoption, see the **Stakeholder Engagement & Education** section of CHCS' *Accelerating Access to Continuous Glucose Monitors in Medicaid Resource Center*.

Providers

- Ensure providers are aware of the changes in coverage policy and any new processes for submitting reimbursement claims.
- Use clear and concise notifications, provider bulletins, and webinars to communicate policy and process changes.
- Pair information about reimbursement and benefit changes with educational resources on best practices for prescribing CGMs and integrating the devices into diabetes care management. Consider partnering with MCOs to support these efforts.

Members

- Conduct targeted outreach to Medicaid members who currently have CGM prescriptions to limit disruptions to coverage. Consider partnering with MCOs to support this outreach.
- Create and disseminate culturally and linguistically appropriate resources highlighting the benefits of CGMs.
- Collaborate with community-based organizations to expand outreach.

Public Health Agencies

- Explore partnerships with statewide diabetes prevention efforts to align messaging and improve reach.

Suppliers

- Proactively notify CGM manufacturers, pharmacies, and DME suppliers of the transition.
- Provide advance notice to pharmacies to ensure they order an adequate supply of CGMs.
- Share member information with pharmacy benefit managers to facilitate the smooth transition of benefits.

7. Consider Additional CGM Coverage Updates

- Consider updating state eligibility criteria for CGM coverage to expand access to other populations who may benefit from CGM use. For example, in December 2023, **South Dakota** Medicaid made CGMs available through a pharmacy benefit, while also expanding coverage to members with type 2 diabetes requiring short and/or rapid acting insulin.

National CGM Coverage Policy Landscape

- In April 2023, CMS revised its Medicare CGM coverage policy, now encompassing all individuals with diabetes treated with insulin or experiencing problematic hypoglycemia.
- As of May 2022, 37 states provide some form of CGM coverage for both type 1 and type 2 diabetes. Notably, Delaware, Indiana, Kentucky, New York, and Minnesota have eliminated prior authorizations for CGMs in their pharmacy benefit programs.

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ENDNOTES

[1] American Diabetes Association Professional Practice Committee. (2024). 7. Diabetes Technology: Standards of Care in Diabetes—2024. *Diabetes Care, 47*(Supplement_1), S126–S144. https://doi.org/10.2337/dc24-S007

[2] American Diabetes Association Professional Practice Committee, 2024.

[3] American Diabetes Association Professional Practice Committee, 2024.

[4] García-Moreno, R. M., Benítez-Valderrama, P., Barquiel, B., González Pérez-de-Villar, N., Hillman, N., Lora Pablos, D., & Herranz, L. (2022). Efficacy of continuous glucose monitoring on maternal and neonatal outcomes in gestational diabetes mellitus: a systematic review and meta-analysis of randomized clinical trials. *Diabetic Medicine: A Journal of the British Diabetic Association, 39*(1), e14703. https://doi.org/10.1111/dme.14703

[5] Howe, G. & Chavis, J. (2022, January). Expanding Medicaid Access to Continuous Glucose Monitors [Report]. *Center for Health Care Strategies.* https://www.chcs.org/resource/expanding-medicaid-access-to-continuous-glucose-monitors/

[6] Howe et al., 2022.

[7] Ebekozien, O., Agarwal, S., Noor, N., Albanese-O'Neill, A., Wong, J.C., Seeherunvong, T., Sanchez, J., DeSalvo, D., Lyons, S.K., Majidi, S., Wood, J.R., Acharya, R., Aleppo, G., Sumpter, K.M., Cymbaluk, A., Shah, N.A., Van Name, M., Cruz-Aviles, L., Alonso, G.T., Gallagher,

M.P., Sanda, S., Feuer, A.J., Cossen, K., Rioles, N., Yayah Jones, N.-H., Kamboj, M.K., & Hirsch, I.B. (2021) 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), e1755-e1762. https://doi.org/10.1210/clinem/dgaa920

[8] Majidi, S., Ebekozien, O., Noor, N., Lyons, S.K., McDonough, R., Gandhi, K., Izquierdo, R., Demeterco-Berggren, C., Polsky, S., Basina, M., Desimone, M., Thomas, I., Rioles, N., Jimenez-Vega, J., Malik, F.S., Miyazaki, B., Albanese-O'Neill, A., Yayah Jones, N.-H., & T1D Exchange Quality Improvement Collaborative Study Group. (2021). Inequities in Health Outcomes in Children and Adults With Type 1 Diabetes: Data From the T1D Exchange Quality Improvement Collaborative. *Clinical Diabetes, 39*(3), 278-283. https://doi.org/10.2337/cd21-0028

[9] Howe et al., 2022.

[10] Brouillette Hurteau, L., & Hogue, N.J. (2023). Pharmacy Benefit Considerations for Continuous Glucose Monitoring Acquisition: Vermont Medicaid Experience. Journal of Managed Care & Specialty Pharmacy, *29*(5). https://doi.org/10.18553/jmcp.2023.29.5.550

[11] Miller, E., Roberts, G. J., Joseph, J. M., Nabutovsky, Y., Reyes, I. J., Souto, D., Virdi, N., & Hirsch, I. B. (2023). Comparing Clinical Outcomes Between Two Continuous Glucose Monitors: Similar Diabetes-Related Events, All-Cause Hospitalizations, and HbA1c Reductions in Type 1 and Type 2 Diabetes. *American Journal of Medicine Open, 9.* https://doi.org/10.1016/j.ajmo.2022.100008