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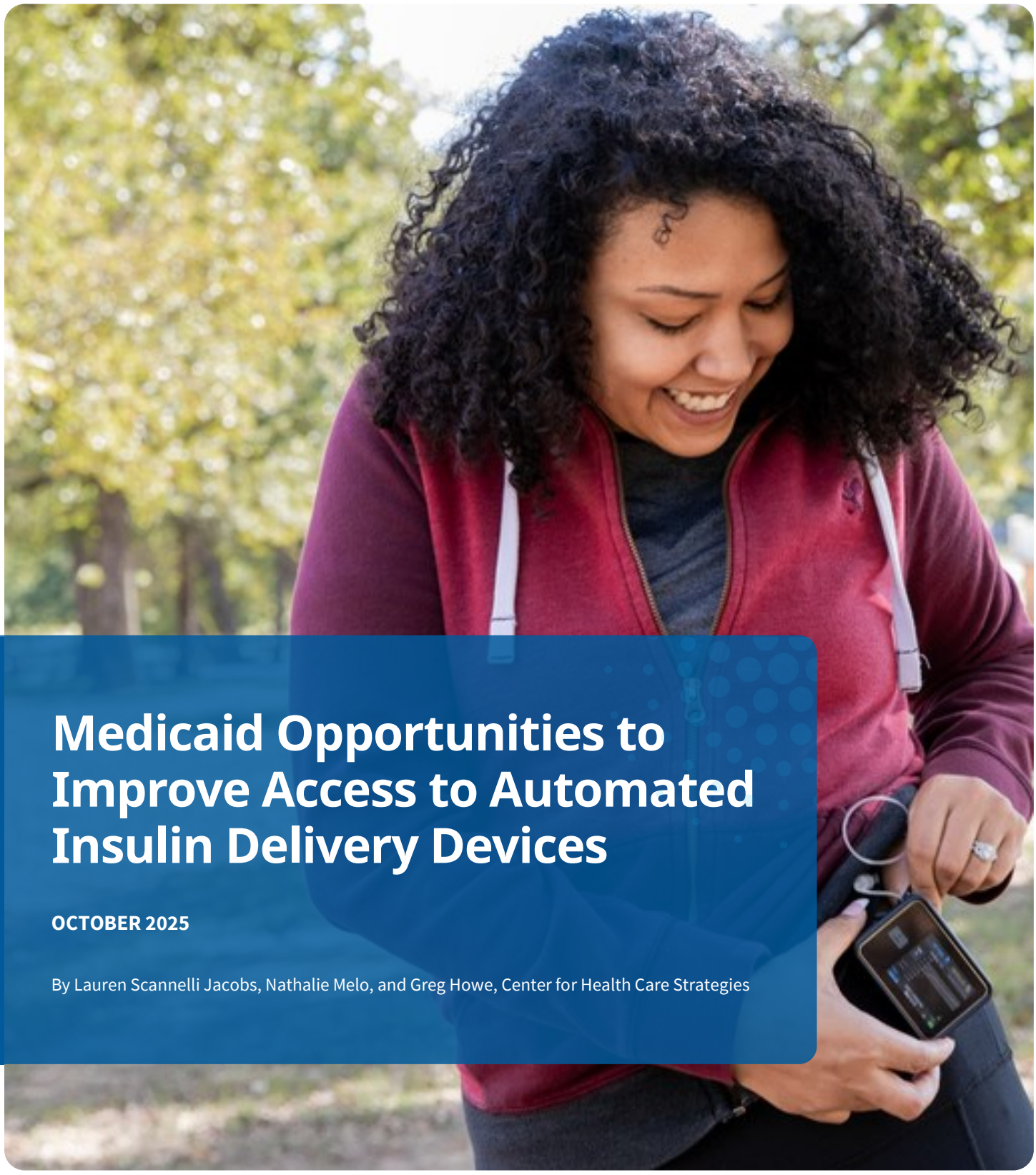

Medicaid Opportunities to Improve Access to Automated Insulin Delivery Devices

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Contents

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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**.

TAKEAWAYS

- Automated insulin delivery (AID) devices are the standard of care for individuals with insulin-requiring diabetes, especially those with type 1 diabetes. These devices help improve glycemic control, reduce complications, and lower health care costs.
- While the benefits of AID devices are vast, Medicaid beneficiaries face persistent barriers to access. Fragmented coverage policies, overly burdensome prior authorization processes, and limited provider and patient education hinder access to these devices.
- This report outlines the current Medicaid landscape and offers targeted recommendations to improve access and outcomes for low-income individuals living with diabetes.

Introduction

Diabetes is a chronic condition that impacts more than 38 million Americans and is the eighth leading cause of death in the United States, with an estimated annual cost of over $412 billion.[1,2,3] Among those impacted, Medicaid covers about 23 percent of individuals with diabetes nationwide, making it a critical lever for improving care access and outcomes.[4]

Insulin is a life-saving medication for individuals with type 1 diabetes (T1D) and is often critical for individuals with type 2 diabetes (T2D) and gestational diabetes. In recent years, automated insulin delivery (AID) devices have allowed patients to better monitor insulin dosing, glucose levels, and enable a more effective approach to diabetes care.

Expanding Medicaid coverage and access to AID devices for all age groups can help reduce complications, support better health outcomes, enhance quality of life, and lower health care costs. However, many low-income families face a variety of barriers to accessing AID devices, including coverage of necessary medical supplies, education, and administrative hurdles.[5] Medicaid can play a critical role in alleviating these barriers.

This report, supported by The Leona M. and Harry B. Helmsley Charitable Trust, explores how Medicaid beneficiaries living with T1D currently access AID devices, and how that access might be expanded to include more Medicaid beneficiaries with diabetes. It is informed by a literature review, publicly available state Medicaid policies, and interviews with health care providers, diabetes organizations, AID device manufacturers, and state Medicaid officials. The report explores:

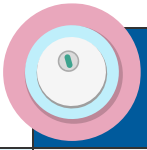
1. AID devices and their impact on health;
2. The current landscape of state Medicaid policy for AID devices; and
3. Recommendations for states to expand Medicaid access to AID devices.

AID Devices and Their Impact on Health

What is an AID Device?

AID devices are the standard of care for people with T1D and other types of insulin-dependent diabetes.[6] The American Diabetes Association Standards of Care in Diabetes - 2025 recommends that individuals, with support from their providers, have access to the full range of devices currently on the market, enabling them to choose the option best suited to their individual circumstances.[7] AID devices consist of three major components worn on the body — an insulin pump, a continuous glucose monitor (CGM), and a controller or algorithm that allows the pump and monitor to share information — allowing the system to track glucose levels in real time and deliver insulin as needed.[8]

Exhibit 1. Overview of AID Device Components and Medicaid Coverage

	 Continuous Glucose Monitor	 Insulin Pump
Usage	Worn on or under the skin.	Tubed pumps are worn on clothing, with a cannula inserted under the skin to deliver insulin. Tubeless pumps are worn on the skin.
Purpose	Monitors glucose levels in real-time.	Delivers a continuous infusion of a single type of insulin.
Parts	Sensor, transmitter, receiver/smartphone app. Requires sensor insertion every 7-15 days. May need calibration by user and/or provider.	Pump, insulin reservoir, infusion set OR a pod and controller. Requires infusion set changes every 2–7 days.
Covered Population	Typically covered for people with T1D or people with T2D who use insulin.	Typically covered for people with T1D, or people with T2D requiring multiple daily insulin injections.
Distribution Channel	Durable medical equipment (DME) or pharmacy	Primarily DME.*
Prior Authorization	Required by most states.	Required by most states.

* The Omnipod system, a specific brand and type of AID device, is delivered as a pharmacy benefit. It is a tubeless, wearable insulin pump that works together with a CGM and a smartphone app or controller to automatically adjust insulin delivery.

Types of AID Devices

AID devices use either rapid acting or ultra-rapid acting insulin and infuses the insulin in small pulses under the skin. The pulses of insulin are increased or decreased depending on glucose levels to keep blood sugar levels stable and in the normal range, without highs or lows. In most cases, when an individual eats, they push a button to give insulin for the meal through the pump. AID systems also give correction insulin doses if glucose levels go too high, helping to keep glucose levels within a normal range.

There are several types of AID devices. Partial closed-loop systems/hybrid systems are the most common type of AID devices that are approved by the FDA. These systems include the three major components: insulin pump, CGM, and an algorithm that automates insulin suspension when glucose is low or predicted to go low and increases insulin delivery when glucose values are high. The partial-closed or hybrid closed-loop system eliminates the need for routine manual adjustment of pump administration rates. The CGM and insulin pump work together to calculate and administer the insulin dose requirements; however, individuals still need to calculate and administer pre-meal insulin.

A closed-loop system has the same components as the hybrid system (insulin pump, CGM, and an algorithm that determines insulin delivery); however, these systems require no additional calculation or manual administration of insulin when the device is operating.[9] The algorithm in a closed-loop system can identify increases in blood sugar, typically after a meal, and adjust the insulin dosage independently.

As of 2025, there are eight FDA-approved AID device systems on the market, in addition to "do-it-yourself" systems where individuals use a commercially available CGM system and insulin pump and connect them to an open-source algorithm.[10] AID devices offer numerous features and compatibilities to accommodate a variety of lifestyles.[11] For example, some pumps have features that are easier to use for older individuals with less dexterity, while other pumps offer less maintenance, a lower profile, and can accommodate an active lifestyle, including waterproof options. [12]

Health Outcomes and Cost Effectiveness

AID devices allow patients and providers to closely monitor T1D and have been shown to improve health outcomes for people with T1D, including improved A1C levels, time in range, and hypoglycemia awareness.[13,14] Evidence also shows reductions in long-term complications (e.g., diabetes-related neuropathy, retinopathy, cardiovascular disease) can occur through effective and consistent glucose control.[15,16,17]

In addition to the clinical benefits, individuals using these devices can also benefit from: less anxiety by reducing the risk of hypoglycemia, increased confidence due to

more time in target range, improved sleep due to more stable glucose readings overnight, and fewer daily tasks required to manage glucose readings and less overall time thinking about diabetes management.[18]

AID devices have also been found to be cost-effective by helping to prevent life-threatening complications that can result in emergency department visits and hospitalizations.[19] These complications typically arise from poor glycemic control, which AID devices address. Overall health care costs may be reduced by preventing complications and avoiding the need for emergency department visits and inpatient admissions.

Medicaid Coverage of AID Devices

State Medicaid programs typically cover AID devices by offering separate CGM and insulin pump benefits. While most states do not have a specific AID device benefit, Medicaid beneficiaries can still access an AID device by receiving separate approvals for a CGM and insulin pump.

While AID devices are comprised of both a CGM and insulin pump, states may keep the coverage policies separate as the components can also be used by individuals independently of one another. CGMs, for example, offer a variety of benefits for individuals with T1D, T2D, and gestational diabetes, regardless of insulin usage. CGMs help lower elevated A1C levels, decrease the frequency and severity of episodes of hypoglycemia, reduce hospitalizations for acute diabetes-related issues, and improve patient satisfaction compared to fingerstick monitoring.[20,21]

While AID devices were first approved by the U.S. Food and Drug Administration (FDA) in 2016, non-automated insulin pumps have been available in the U.S. for over 40 years.[22,23] Given this history, most state Medicaid programs already include policies to cover insulin pumps. Insulin pumps remain valuable even with the emergence of AID devices as individuals with T2D who require insulin may use them. As the AID system is currently primarily for individuals with T1D, their use by individuals with T2D is increasing as more devices gain FDA clearance for use in T2D, growing evidence supports their use, and standards of care expand to include T2D.[24] In addition, individuals with T1D sometimes prefer using insulin pumps without a CGM.[25]

There are benefits and drawbacks to covering the components of an AID device as separate benefits. Providing coverage for CGMs and insulin pumps as separate benefits allows states to create policies that permit a larger cohort of eligible Medicaid beneficiaries to access the separate devices regardless of whether they plan on using an AID system. However, state Medicaid agencies should consider how the two policies work together for beneficiaries accessing an AID device. Interviewees noted that in some instances where the state Medicaid CGM coverage policy was recently updated,

the insulin pump policy was not reviewed and includes outdated language that makes it difficult for beneficiaries to access the device. In the absence of a comprehensive policy for AID devices, it is important for states to align policies for the separate components and update policies regularly to include the newest technology.

Barriers to Access

There are various policies and educational barriers that limit Medicaid beneficiaries' access to AID devices. This section reviews how these barriers affect both patients and providers in accessing AID devices.

MEDICAID ELIGIBILITY AND REDETERMINATION

Medicaid eligibility requirements differ by state, and beneficiaries go through a redetermination process to confirm eligibility on an annual basis. While changes in financial circumstances may lead to a person becoming ineligible for Medicaid, studies show that beneficiaries can lose coverage during the redetermination process due to administrative errors.[26] For individuals with T1D, gaps in coverage can limit a beneficiary's ability to access the diabetes supplies needed to manage the disease. For individuals using an AID device, they may lose functionality of the device during gaps in coverage, which can result in life threatening complications and increased health care utilization costs.

Children with T1D who receive Medicaid benefits may lose access to their AID device when they age out of the program — meaning they may no longer qualify for Medicaid benefits as an adult. This can make continued access to an AID device extremely difficult if they do not have access to other coverage. Also, for states that only cover AID devices for beneficiaries under 21, when a child ages out, they may keep their Medicaid benefits but lose access to the AID device, requiring them to switch to manual insulin injections, which are no longer the recommended standard of care.

PRIOR AUTHORIZATION AND ADDITIONAL DOCUMENTATION CRITERIA

Most states require separate prior authorizations for a CGM and an insulin pump. Federal regulations allow Medicaid to use prior authorization to limit services to prevent over utilization.[27] The process involves provider submission of documentation indicating that the patient meets coverage requirements, administrative review, and an appeals process in the event of denial, all of which can cause delays in accessing care. Since most states have separate policies for CGMs and insulin pumps, Medicaid providers must request separate prior authorizations for each device.

Prior authorization criteria for an AID device can include the patient's diagnosis, justification of medical necessity, and additional criteria. States may include medical necessity criteria that convey either the longevity of the condition, the severity of the

condition, and/or failure of other treatment options. Additional criteria may include attending a diabetes self-management education and support class, having either the cognitive ability or dexterity to operate the device, and/or willingness or motivation to use the device to improve the patient's health outcomes.

While prior authorization processes may help ensure compliance and reduce fraudulent claims, requiring individuals with T1D to continually prove their need for insulin — despite the fact that there is no cure — places an unnecessary burden on patients and providers. In addition, some requirements may be difficult to document. For example, it is easier to prove that a patient is educated on the use of the pump by sharing records of attending training sessions; however, it becomes more difficult to show a patient's motivation and willingness to use a pump. Additional required documentation to support the prior authorization request may include qualifying lab results, documentation of other interventions that the patient has used, and a prescription from a specified provider. States decide the level of specificity they require for prior authorization. For example, the prescribing provider may be a Medicaid-eligible provider or there may be specific provider qualifications, such as requiring that providers work closely with a team that includes nurses, diabetes care and education specialists, and/or registered dietitians.[28]

Moreover, states may require reauthorization for continued use. For example, some states provide an initial approval, sometimes only lasting three months, followed by a reauthorization process that requires additional documentation to continue receiving supplies for the AID device. The reauthorization process can lead to delays and sometimes even gaps in supply access.

To manage the level of effort needed to ensure the prior authorization and reauthorization process runs smoothly, clinics often have dedicated staff to manage the process for their patients. Depending on the needs of the practice, this may mean hiring additional administrative staff or incorporating these responsibilities into the role of expanded care team members, such as diabetes care and education specialists or community health workers. While these individuals offer crucial support, including care coordination for patients with T1D, they often cannot bill their services through Medicaid. This requires practices to use other financial sources to keep these individuals on staff. While endocrinology clinics may have the resources to hire staff to help patients navigate insurance requirements, primary care practices — often managing a variety of conditions and only a few patients with diabetes — may lack the time or resources to dedicate staff to handling prior authorization for AID devices.

RECEIVING SUPPLIES

States decide whether beneficiaries receive the CGM and insulin pumps through either a pharmacy or a durable medical equipment (DME) benefit. DME benefits include medically necessary equipment and supplies intended for repeated use, such as wheelchairs or oxygen equipment.[29] States contract with DME providers to supply Medicaid beneficiaries with approved equipment. In most cases, insulin pumps are covered by the state's DME benefit due to their long-term use.[†]

DME suppliers can create their own criteria for approvals, and processing claims can be a more complicated and time-consuming process as compared with pharmacy claims.[30] Providers must submit the correct documentation to DME suppliers to ensure patients receive the necessary devices. Interviewees noted that Medicaid beneficiaries have experienced delays when trying to receive supplies due to changes in the state's DME supplier. States can also stipulate replacement criteria for pumps, which can, in some cases, delay access to the most up-to-date technologies for Medicaid beneficiaries.

While insulin pumps are almost always covered under the DME benefit, state Medicaid programs are increasingly moving toward a pharmacy benefit for CGMs because of the convenience for patients who also access diabetes supplies through their pharmacy. [31] In some cases, pharmacists provide additional in-person education and support for patients with diabetes.

Common hurdles for Medicaid beneficiaries when receiving their supplies include limitations on supply quantities, in-person versus mail order pharmacy benefits, and coordination of supplies:

- **Limitations on supply quantities**: Interviewees noted that one of the biggest barriers to accessing AID devices is the limitations imposed on the quantity of supplies. AID devices require at least four types of supplies to be replaced regularly to maintain functionality. For the insulin pump, replaceable supplies include a battery, cartridge or reservoir of insulin, tubing, and infusion set.[32] These items, on average, need to be replaced every two to three days. For the CGM, typical supplies include a sensor that lasts 7-15 days and some CGMs require a separate battery lasting on average 90 days. Medicaid, like other insurers, will offer diabetes supplies in quantities of 30-, 60-, or 90-day supply. These quantities do not account for technological malfunction or human error that may require individuals to use supplies at a faster rate. For example, it is not uncommon for a person to accidentally knock a CGM off their arm or for a sensor to stop working, both of which require a new sensor to be used sooner than the typical replacement period.

[†] The only current exception is the Omnipod insulin pump, which is tubeless and disposable.

Without additional supplies, an individual may run out of sensors earlier than the 90-day supply period allows, and they may be unable to access replacement supplies to cover the gap.

- **Mail order and in-person pharmacy**: Another hurdle is how and where beneficiaries receive their supplies. Some states allow Medicaid beneficiaries to use a mail order pharmacy to fill prescriptions, shipping them directly to the home. However, mail order pharmacy benefits have their own unique challenges, particularly for diabetes supplies like insulin, which should be refrigerated.[33] If no one is present to receive the package, supplies may have to sit out for hours until someone can retrieve them, potentially compromising an insulin delivery. Additionally, interviewees mentioned concerns around package theft that necessitate another prior authorization request to replace the stolen supplies causing further delay in accessing needed supplies.

  While in-person pharmacy visits can be beneficial since pharmacists often provide additional guidance to patients, it may be difficult for Medicaid beneficiaries to get to the pharmacy due to various factors, such as limited business hours or limited access to transportation.

- **Coordination of supplies**: Patients must stay up to date on supply inventory to avoid gaps in supply quantity and follow up with supply vendors if there are mistakes with the order — which can be time consuming. They also need to stay on top of refill requirements, particularly for supplies that require prior authorization. When coordinating supplies becomes too burdensome, individuals may opt out of using an AID device and potentially sacrifice improved health outcomes for easier but less clinically optimal methods of diabetes management.

DEVICE EDUCATION

The availability of AID device training for both providers and patients to ensure usability and comfort with the device can be a barrier.

- **Patient education**: Due to the complexity of AID devices, patients require training on how to use them, how to replace the various components, and how to read the data to accurately administer insulin. Patients need to feel confident with the technology, have access to resources to troubleshoot issues, and have a clear back-up plan if the technology fails. Moreover, interviewees explained that patients can be apprehensive about using an AID device initially as they may not be comfortable with a device attached to their body. Language barriers may also make it difficult for patients to access the information needed to adequately use the device. To better support patients using AID devices, providers may offer additional appointments, access to a 24/7 support line, and opportunities to connect with other T1D patients.

However, these appointments and resources may not be reimbursable by Medicaid, potentially limiting providers to offer only free resources, such as those offered directly by device manufacturers, rather than referring patients to formal diabetes self-management education and support classes.

- **Provider engagement**: Diabetes technology, including AID devices, is constantly improving, making it important for providers to stay up to date on new, effective technology available for their patients. With eight FDA-approved AID devices on the market in 2025, providers working with patients with T1D need to understand the various device mechanisms and the nuances of each device to prescribe one that fits with each patient's lifestyle and preference and have the tools to understand the data provided by the AID devices to improve their patients' health outcomes. In addition to understanding the various devices that are available to patients, providers need to feel confident in their ability to educate patients on their options. Accessing an AID device requires providers to write a prescription, so if a provider is not confident in how the technology works or does not have staff with this specialized knowledge, they may not offer an AID device as a potential treatment option.

  Interviewees also described bias around Medicaid beneficiaries as a barrier in accessing AID devices. For example, they noted that providers may have internalized the qualities of an ideal candidate and when a patient does not meet the provider's internal criteria, they may not be offered an AID device as a treatment option.

  Endocrinology offices may have more time and staff capacity than primary care offices to understand the various diabetes treatment options, but there is currently a shortage of endocrinologists participating in Medicaid programs. For Medicaid patients, it may take much longer to get an appointment with an endocrinologist, delaying access for patients who would benefit from using an AID device. While Medicaid patients may have greater access to primary care providers, they may not have the bandwidth to support and monitor a patient using an AID device, stay current with advancements in diabetes technology, feel confident prescribing the technology, or afford to hire a dedicated diabetes care and education specialist to serve as an in-house expert.

Recommendations to Increase Access to AID Devices for Medicaid Beneficiaries

Medicaid agencies can remove barriers to accessing AID devices through policy changes and by supporting beneficiaries and providers through education and engagement.

Policy Opportunities

States can address barriers to access by enacting the following policy changes:

- **Conduct journey mapping to inform policy changes and innovation**. The process between prescribing and receiving an AID device is complicated and challenging for both the patient and provider. As described above, state policies for insulin pumps, CGMs, and AID devices were often created independently. To better understand what the beneficiary goes through from diagnosis to obtaining and using an AID device, state staff can document this process through journey mapping and identify policy changes, or the creation of a new, streamlined policy that could improve access.

- **Reduce burdensome criteria, including prior authorization and reauthorization requirements**. These requirements can result in patients and providers spending onerous amounts of time and resources.[34] Until there is a cure for T1D, people living with this disease will always need to monitor their glucose level, use insulin, and have the supplies to administer it. States can look to Minnesota, which approved legislation that limits prior authorization for chronic conditions to one-time approval.[35] Interviewees noted that commercial payers have begun removing prior authorization requirements and streamlining their criteria. In addition to removing reauthorization for individuals with T1D, states can consider removing prior authorization requirements for insulin pumps, CGMs, and AID devices for patients with diabetes. States can also consider ways to streamline the criteria for receiving these supplies for beneficiaries with a diagnosis of diabetes and using insulin. In lieu of removing prior authorization, states can mitigate concerns about overutilization by certifying diabetes providers who meet predetermined criteria and allow them to bypass any preauthorization criteria.

- **Align and coordinate CGM and insulin pump policies by developing an explicit policy for AID devices**. Having an explicit AID device policy can simplify prescribing and accessing these devices since it would avoid navigating two sets of approval processes for AID systems. If the components of the AID system are delivered through different channels, i.e., DME and pharmacy, the state can use the same criteria for approval. Within the policy, states can also consider covering a variety of devices to meet the diverse needs of patients and allow providers to prescribe the most appropriate device for their patients.

- **Align timeframes for reordering supplies for insulin pumps and CGMs by:**
  - **Increasing timeframes and quantities for supplies**. Timeframes for reordering supplies can be expanded beyond 30 days to reduce the burden of placing orders frequently and within narrow reordering windows. States can also allow patients to receive additional supplies to replace lost, defective, or damaged supplies; and
  - **Aligning policies with managed care organizations (MCOs)**. In states where pharmacy is carved into MCOs, and particularly in states with a lower penetration of managed care, officials will need to ensure that health plan policies are aligned with the state's fee-for-service program. States with a pharmacy carveout for their managed care programs can proactively align timeframes and requirements as described above for AID devices and their components to ensure access. These states could consider delivering AID devices and all of their components through the pharmacy for the convenience of their beneficiaries.
- **Clarify and pay for more frequent review of device data**. Some states limit how often providers can bill for reviewing CGM and insulin pump data, which is an important component of caring for patients with diabetes, and more frequent monitoring of this data has been shown to lead to better health outcomes.[36] These limits are sometimes greater than commercial policies, which often allow for more frequent billing for data analysis. In addition, in some cases, the specific allowable activities are unclear. States can allow providers to bill for reading device data at frequencies aligned with standards of care and clarify what activities are allowed.
- **Consider which delivery channel — pharmacy or DME — allows greater access to AID devices**. Many states deliver CGMs through the pharmacy channel because patients have reported that pharmacies are more convenient for accessing their diabetes supplies, including insulin.[37] Because many insulin pumps are delivered through the DME benefit, states could consider covering insulin pumps and AID devices through the pharmacy benefit. Alternatively, states could allow and/or encourage pharmacies to also serve as DME providers.
- **Increase coverage for additional visits or time with diabetes care and education specialists**. States can review their payment policies related to diabetes self-management education and support and CGM and pump training services to ensure that all patients with diabetes have access to this critical support for managing their disease.

Supporting Patients and Providers

While state Medicaid agencies can significantly increase access to AID devices through their coverage policies, they can also offer support to both patients and providers who use them.

To better support patients, Medicaid agencies and public health partners can:

- **Work with MCOs to coordinate and prioritize efforts**. States with managed care programs can work with their MCOs to identify opportunities to provide education and support for their members. For example, members with a new diabetes diagnosis or newly using insulin could be connected to a diabetes care and education specialist or case manager who can provide personalized support, help navigate treatment options, and ensure adherence to prescribed care. States can establish workgroups with regular meetings to coordinate these activities, either voluntarily or through a contract requirement.

- **Expand the workforce that supports patients living with diabetes**. States can seek opportunities for health care workers, such as diabetes care and education specialists and community health workers, to connect with and support patients. For example, Kentucky currently licenses diabetes educators and is exploring ways that licensed diabetes educators can bill for their services through Medicaid.[38] Other states allow accredited diabetes self-management education and support programs to bill for their services under a registered dietitian, physician, or other Medicaid-eligible provider. Medicaid can partner with public health agencies to explore ways to work together to expand the use of diabetes self-management education and support programs.

To better support providers, Medicaid agencies and health plans can:

- **Work with MCOs to assist provider efforts**. As described above for patients, states with managed care programs can identify ways for MCOs to support providers who care for patients living with diabetes, including understanding and addressing provider education gaps and needs, as well as revising policies to simplify approvals and delivery of AID devices. Health plans can also work with providers to address barriers and identify solutions for integrating device data in the electronic medical record to better serve their patients.

- **Support patient navigators**. Specialty diabetes practices and some primary care practices have staff whose job descriptions include helping patients navigate coverage requirements. These staff members spend time navigating prior authorization requirements and documenting that patients meet clinical criteria, which involves submitting forms, answering questions in writing and on the phone from insurers and DME suppliers, and interacting with patients. In addition to

eliminating unnecessary requirements and streamlining approval processes, states and health plans can explore ways to support staff in these practices to reduce the time and resources spent navigating the health care system.

- **Create online resources and explore other ways to help providers understand state coverage policies and requirements and communicate policy changes**. Several states, including Colorado and Kentucky, have created dedicated web sites that provide information to both providers and patients about state coverage policies and requirements.[39,40] These web sites can make it easier and quicker for patients to access the information they need.
- **Invest in primary care**. Because of the scarcity of endocrinologists in many areas, states can explore how they can increase the capacity of primary care providers to care for patients who require insulin. For example, some states and health plans invest in Project ECHO, a proven case-based learning model that offers diabetes programs to build the capacity of PCPs to provide specialty care in their practices.[41] States can also explore how they can enhance diabetes self-managed education and support services in these practices.

Conclusion

AID devices can improve the health and well-being of Medicaid beneficiaries living with insulin-requiring diabetes — and are the standard of care for people living with T1D. These devices — which include CGMs, insulin pumps, and an automating algorithm — play a crucial role in managing blood glucose levels in real-time. Despite the benefits, barriers to access for Medicaid beneficiaries remain, including coverage gaps, overly burdensome prior authorization requirements, complex processes for getting supplies, and lack of patient and provider education. The recommendations provided in this report aim to address these barriers by removing obstacles to accessing AID devices through policy changes and by supporting beneficiaries and providers through education and engagement. By expanding and aligning Medicaid coverage for AID devices, states can ensure that individuals with T1D have the necessary tools to manage their condition effectively, improving their quality of life and health outcomes.

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