TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

PARTNERING FOR BETTER DIABETES OUTCOMES

Kentucky Department for Medicaid Services

Physicians TAC

October 17, 2025

Accelerating Access to CGMs in Medicaid to Improve Diabetes Care

- Supported by The Leona M. and Harry B. Helmsley Charitable Trust
- **Project Goals**: Increase CGM access, improve clinical health outcomes and quality of life, reduce health care costs, and reduce disparities
- The *CGM Access Accelerator* supports **Iowa**, **Kentucky**, **Michigan**, **New Jersey**, **Oklahoma**, **South Dakota**, and **Texas** to accomplish these goals via:
  - Tailored technical assistance and peer learning opportunities
  - Up to $75,000 to support their CGM efforts
  - *Resource Center* that houses peer-reviewed articles and practical tools
- Ad hoc technical support available to other states

Center for Health Care Strategies

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Continuous Glucose Monitor (CGM) Policy

Updated Summary for Preferred CGMs through Pharmacy Benefit effective 6/2024:

The patient has one of the following diagnoses:

- Insulin-dependent Diabetes Mellitus Type 1 (ICD-10 group E10); **OR**
- Insulin-dependent Diabetes Mellitus Type 2 (ICD-10 group E11); **OR**
- Gestational Diabetes Mellitus (ICD-10 group O24); **OR**
- Has a history of problematic hypoglycemia defined as:
  - Recurrent level 2 hypoglycemic events (glucose < 54 mg/dL) that persist despite multiple (2 or more) attempts to adjust medication(s) and/or modify the diabetes treatment plan; **OR**
  - A history of one level 3 hypoglycemic event (glucose < 54 mg/dL) characterized by altered mental and/or physical status requiring third-party assistance with for treatment of hypoglycemia.

- *For full supply list and criteria, visit: kyportal.medimpact.com*
- *Managed Care Organizations may cover CGMs through their Medicaid Supply Equipment and Appliances policy formally Durable Medical Equipment Policy*

KY Focus Study: Disparities in Access to Continuous Glucose Monitors (CGM) Focus Study Fall 2025

- CGMs are the standard of care for individuals with diabetes on insulin therapy (MDI or CSII), per American Diabetes Association (ADA) and American Association of Clinical Endocrinology (AACE) guidelines.
- ADA (2024): Recommends CGMs for adults and youth with T1D or T2D on insulin; use in pregnancy (T2D or Gestational Diabetes Mellitus (GDM)) should be individualized.
- AACE (2021): Strongly recommends CGMs for pregnant women with T1D or T2D on intensive insulin, and individuals with severe/frequent hypoglycemia.
- Moderate support for CGM use in GDM not on insulin and in T2D on less intensive therapy (Grade B evidence).

KY Focus Study: Disparities in Access to Continuous Glucose Monitors Continued

- Kentucky Department for Medicaid Services (KDMS) expanded CGM coverage (June 2024) to include Gestational Diabetes Mellitus (CDM), problematic hypoglycemia, and insulin-dependent T1D & T2D. Access gaps were identified in GDM patients not on insulin and those with frequent hypoglycemia
- (KDMS, 2024).Racial/ethnic disparities persist — Non-Hispanic Black and Hispanic individuals with T1D underutilize CGMs compared to Non-Hispanic Whites.
- Recent Medicaid study shows CGMs reduce Emergency Room visits and hospitalizations across most racial groups in insulin-dependent T2D.

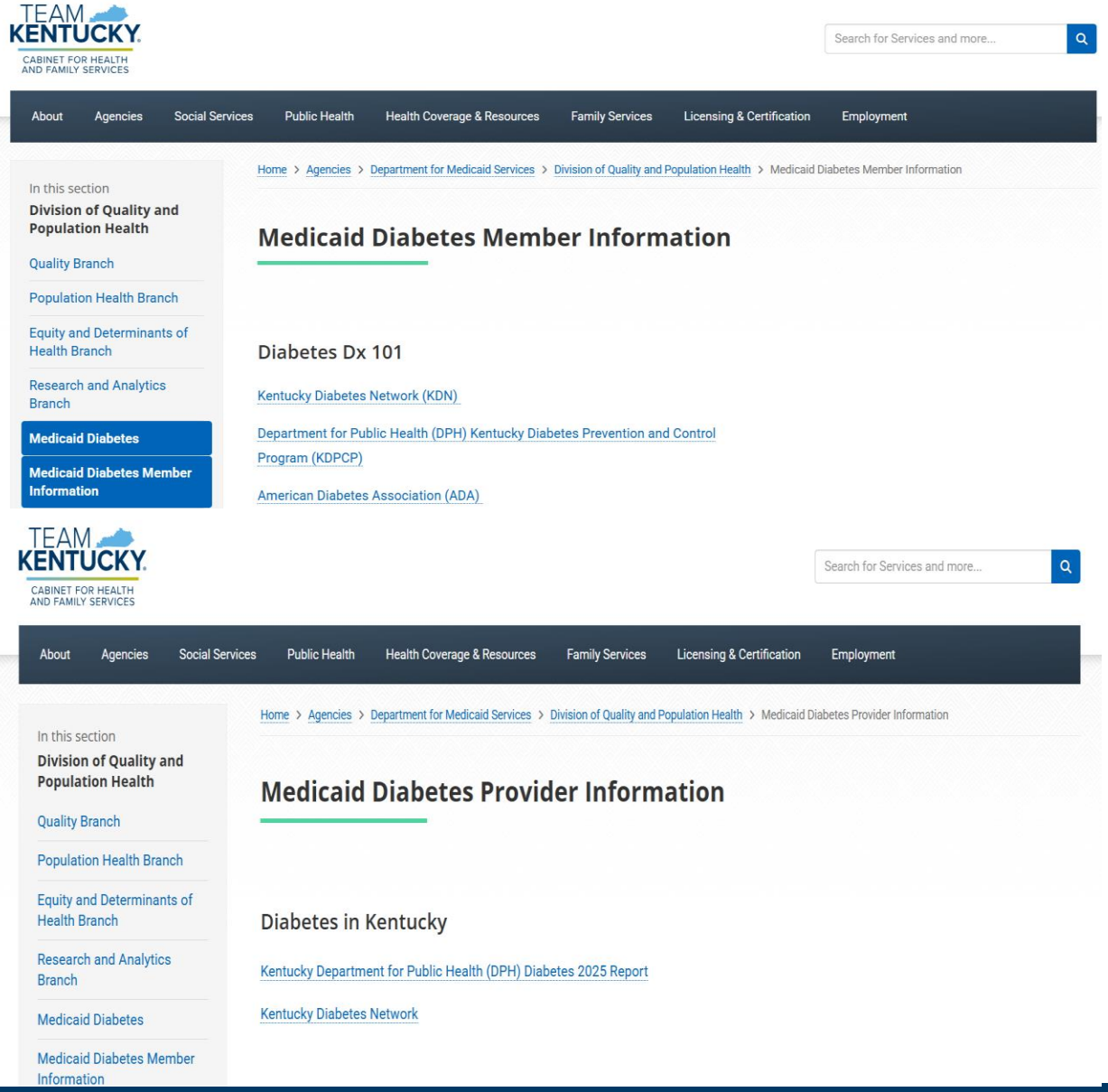
CGM Focus Study Aim & Objectives

- Objective #1: Evaluate disparities in the outcome of CGM access and risk factors for lack of CGM
- Objective #2: Evaluate disparities in CGM device PA approvals, denials, and appeals by Managed Care Organization (MCO) and MedImpact, the KY Pharmacy benefits manager
- Objective #3: Identify the reasons for PA denials for CGM devices, by MCO and MedImpact.
  - Methodology: The focus study will utilize administrative data to quantify disparities in CGM access (as measured by access to CGM devices, supplies and provider services) during the measurement period from January 1, 2025, through June 30, 2025 (Objective #1). As of January 1, 2025, KY MCO enrollees were no longer enrolled in Anthem; therefore, the measurement period begins January 1, 2025, to restrict the analysis to MCOs with enrollees during January 1, 2025-June 30, 2025.
  - Island Peer Review Organization will also utilize MCO and MedImpact listings of enrollees with prior authorization requests for CGM devices, from January-June 2025, to evaluate disparities in CGM device PA approvals, denials, and appeals (Objective #2); again, for KY MCO enrollees as of January 1, 2025. A random sample of enrollees with CGM device PA denials will be selected for IPRO review of enrollee MCO utilization management charts to qualitatively summarize the reasons for PA device denials (Objective #3).

Lessons Learned from Provider Survey

- Survey Respondents- mostly from PCPs, pediatricians, and FQHCs. Only Providers in Eastern KY Region and Jefferson County (Louisville) were surveyed.
- Provider Role in Diabetes Management
  - Providers report strong involvement in patient diabetes education. Many offer referrals to diabetes educators and support services.
  - There are gaps in consistent use of diabetes tools like CGMs and DSMES.
  - Printed Handouts were #1 resource shared with patients.
- CGM Use in Practice
  - Less than half of providers regularly prescribe CGMs.
  - Many rely on endocrinologists or specialists to manage CGM use.
  - Some providers express uncertainty about coverage and eligibility.
- Diabetes Self-Management and Education Support (DSMES) Referrals and Challenges in Provider Engagement
  - Most providers refer patients to DSMES but often rely on internal or familiar referral sources
  - Common barriers include limited availability of programs and unclear referral processes
  - Some providers lack awareness of where to send patients or how to initiate DSMES referrals
  - There's a strong need for better referral tools, streamlined processes, and education on available DSMES resources

Medicaid Member/Provider Resource Web Pages



- Members: Medicaid Diabetes Member Information - Cabinet for Health and Family Services
- Providers: Medicaid Diabetes Provider Information - Cabinet for Health and Family Services
- Sign up for GovDelivery when you visit the pages. Select channels of interest to receive information from the Cabinet.

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Message 1 | Reading Level – Grade 6

Subject: Check Your Blood Sugar with Ease – No More Fingersticks!
Preheader: CGM can make managing diabetes easier. Learn how!

Discover an Easier Way to Manage Diabetes with CGM

Managing diabetes can be tough, but there's an easier way. In 2025, about **482,000 adults and over 3,000 kids in Kentucky have diabetes.** For many people, including those with Type 2 diabetes, Continuous Glucose Monitors (CGMs) are a helpful tool. They make it easier to control blood sugar, lower health risks, and cut down on medical costs. If you or someone you love has diabetes, a CGM could make daily life easier.

A CGM is a small device that checks your blood sugar all day and night. It gives you real-time updates without the pain of routine finger pricks. It can also warn you if your blood sugar is getting too high or too low, helping you stay safe and make good choices for your health.

Why Use a CGM?

- **No more routine finger pricks** – No more painful tests throughout the day.
- **Better blood sugar control** – A CGM helps prevent highs and lows by showing your levels in real time. Studies show that people with Type 1 and Type 2 diabetes who use a CGM have better blood sugar control and lower A1C levels. (ADA)
- **More freedom** – Whether you're sleeping, working, or exercising, a CGM keeps you informed.
- **Better care from your doctor** – Your doctor gets detailed blood sugar data to create a plan that's right for you.

Many Medicaid members **may qualify for a CGM at no cost!**

[[See How CGM Works]]

Campaign for Members and Providers

Campaign #1-Messaging campaign for members and providers:

- Manage diabetes easily with a CGM, no more daily finger pricks.
- Get real-time blood sugar updates to help avoid highs and lows.
- Medicaid may cover CGMs at no cost for eligible members

Campaign started June 2025

Department of Public Health

Diabetes Prevention and Control Program - Cabinet for Health and Family Services

DPP

Diabetes Prevention Program lifestyle coaches will help you reach your health goals! Virtual and in-person sessions offered.

FOR MORE INFO SCAN THE QR CODE OR VISIT:

Diabetes Prevention Program Calendar

HLWD

Healthy Living With Diabetes program has licensed diabetes educators that will help you learn knowledge, skills and tools to manage your diabetes.Virtual and in-person sessions offered.

FOR MORE INFO SCAN THE QR CODE OR VISIT:

HLWD Program Calendar

DIABETES 101

A self-guided approach to understanding diabetes, free to access on your computer or tablet.

FOR MORE INFO SCAN THE QR CODE OR VISIT:

Diabetes 101 Module

Diabetes Resources

Links and downloads on the KDPCP Website

Contact us: diabetes@ky.gov

Email our Certified Community Health Worker (CCHW) for help finding diabetes or diabetes prevention resources.

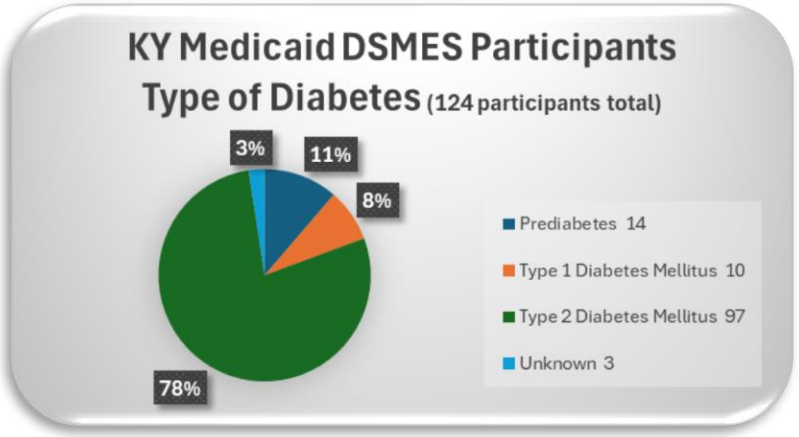
FOR MORE INFO SCAN THE QR CODE OR VISIT:

Kentucky Diabetes Prevention and Control Program Website

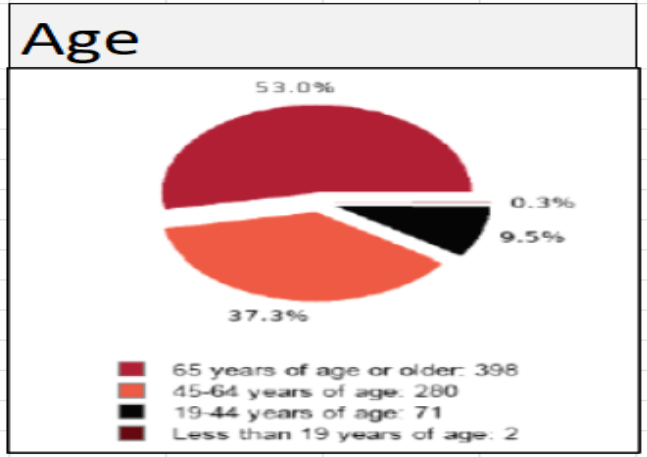
KDPCP= Kentucky Diabetes Prevention and Control Program

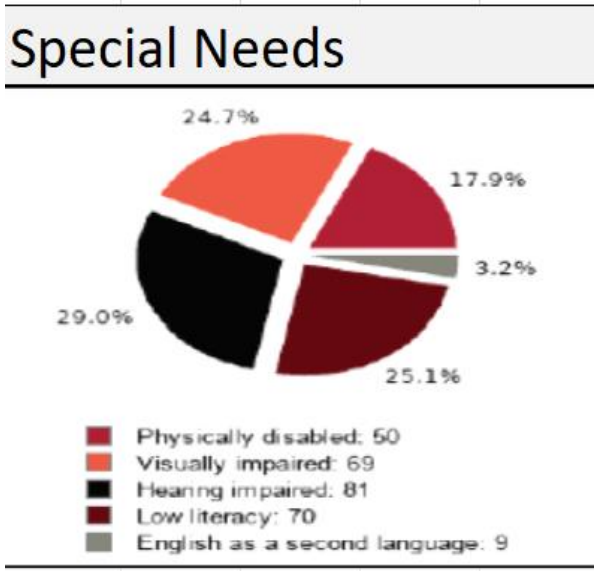
TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

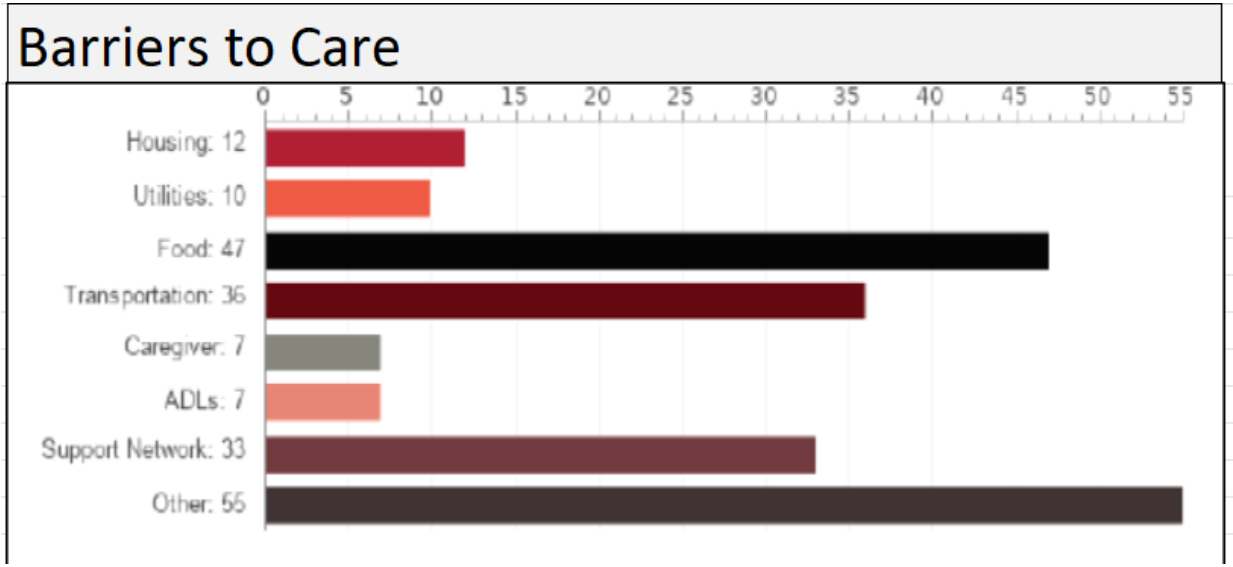
Diabetes Self-Management Education & Support Utilization Data

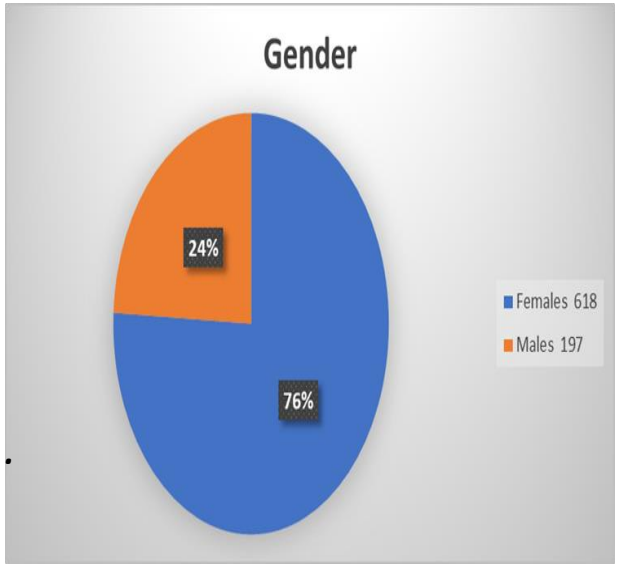


A1c			
#/% Documented	Average Pre-DSMES	Average Post-DSMES	Change Amount
497 / 66.2%	7.7	7	0.7









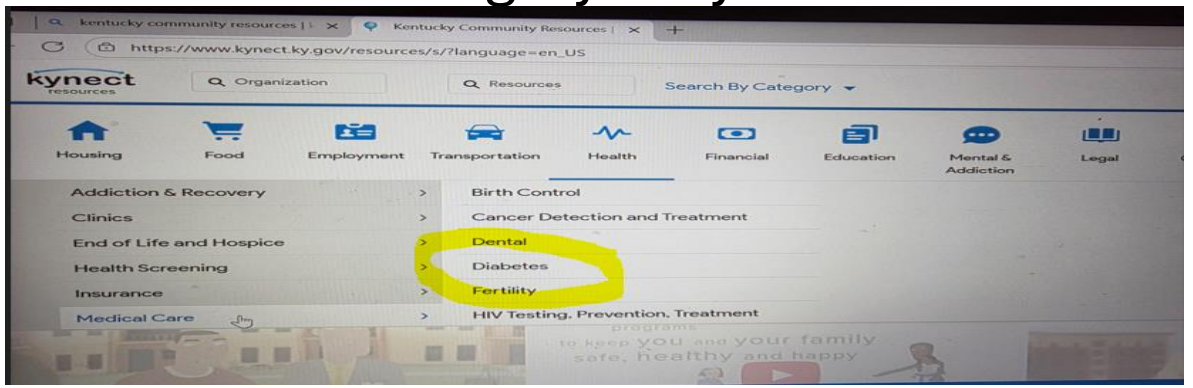
*Public Health Data for January 2023 - December 2024

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Project expansions

- Update to kynect website [Kentucky Community Resources | kynect]
  - In September 2025 Diabetes is now a searchable sub-category in kynect.

  This will make it easier to locate resources across the state.
  - All Health Departments Diabetes programs are listed in kynect.



- CHCS released a Report detailing the project activities on 10/1/25:

[Expanding Access to Continuous Glucose Monitors in Kentucky Through Cross-Agency Partnerships - Center for Health Care Strategies]

- 2025 Kentucky Diabetes Report [2025 Diabetes Report.pdf]

Kentucky Statewide Diabetes Strategic Plan, 2024-2028

VISION: All people in Kentucky are equipped, empowered, and engaged to prevent and manage diabetes.

MISSION: To improve health for people living with, or at risk for, diabetes through community engagement, education, capacity building, policy, advocacy, and collaboration.

GUIDING PRINCIPLES: Focus on health equity • Intentionally engage with communities • Pursue a collaborative approach • Use data to drive decision-making • Choose evidence-based strategies

GOALS (FOCUS ON)	Eliminate disparities among individuals who have systemically experienced greater obstacles to health	Prevent or delay the onset of prediabetes and type 2 diabetes	Improve health outcomes and quality of life among all people with diabetes	Improve quality of care for people with prediabetes and diabetes
OBJECTIVES (MEASURE)	1. Maintain or decrease the percentage of adults living in Eastern Kentucky who have diabetes at 16.2%. 2. Maintain or decrease the percentage of adults with disabilities who have diabetes at 18%. 3. Create or modify at least 5 Diabetes Self-Management Education and Support (DSMES) programs that are tailored to priority populations. 4. Identify at least 3 gaps in health equity data. 5. Increase the average Food Environment Index score in the Appalachian counties from 6.55 to 7.11.	1. Increase percentage of Black/African American adults who are aware they have prediabetes from 15.2% to Y%. 2. Increase the number of participants enrolled in Diabetes Prevention Program (DPP) from 1334 to 3500, with at least X% of participants identifying as Black/African American. 3. Increase the number of CDC-recognized DPP cohorts in Kentucky from X to Y. 4. Adopt at least 2 new statewide policies related to physical activity and nutrition.	1. Increase the statewide average percentage of adults enrolled in a Medicaid MCO plan who have blood pressure control from 57.31% to Y%. 2. Decrease the statewide average percentage of adults enrolled in a Medicaid MCO plan who have poorly controlled A1C scores from 44.6% to Y. 3. Increase the number of DSMES programs provided from 350 to Y. 4. Increase the percentage of adult Medicaid beneficiaries who use DSMES benefit from 0.4% to Y. 5. Increase the number of individuals with diabetes participating in accredited or recognized DSMES programs annually from X to Y, with at least X% of participants identifying as Black/African American.	1. Increase the number of referrals to the DPP among people living in Appalachia from 375 to Y. 2. Increase the number of referrals to DSMES among people living in Appalachia from 630 to Y. 3. Provide diabetes prevention and management training to at least 150 Community Health Workers. 4. Disseminate at least 3 best practice alerts. 5. Develop at least 3 quality improvement recommendations.
STRATEGIES (WORK ON)	A. Review existing sources to identify gaps in health equity-related data B. Promote diabetes programs, services, and resources tailored to underserved populations C. Recruit workers in healthcare and community that represent the populations they serve D. Provide equity and diversity training for healthcare and public health workforce E. Evaluate and advocate for policy, systems, and environmental changes that address social determinants of health impacting diabetes	A. Increase referrals to DPP and other lifestyle change programs B. Expand program offerings for DPP and other lifestyle change programs C. Increase access to nutritious foods and safe accessible physical activity opportunities	A. Increase referrals to DSMES programs B. Expand offerings of diabetes management programs and services C. Equip people with diabetes and their support networks with resources for diabetes self-management	A. Share best and promising practices related to diabetes and prediabetes B. Improve capacity for, and use of, diabetes surveillance systems and Health Information (HIT) systems C. Promote interdisciplinary patient care across community and healthcare sectors D. Expand the diabetes workforce

PRIORITY POPULATIONS: ***People who live in:*** Appalachia/Eastern Kentucky; Rural Areas • ***People who have:*** Lower incomes; Lower education levels; Disabilities • ***People who are:*** Black/African American; Native American; Hispanic/Latino; Asian American; Multiracial; LGBTQ+; Pregnant; Aged 65+; Youth at risk for diabetes

Thank you for allowing DMS to present today

Contact us at dms.dqph.phb@ky.gov

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES