Washington State Health Care Authority

June 13, 2025 Meeting Materials
Health Technology Clinical Committee

Previous meeting business

Contents

Washington State Health Care Authority

Health Technology Clinical Committee

Date: March 21, 2025
Time: 8:00 a.m. – 4:00 p.m.
Location: Webinar
Adopted: Pending

Meeting materials and transcripts are available on the **HTA website.**

HTCC Minutes

Members present: John Bramhall, MD, PhD; Janna Friedly, MD, MPH; Chris Hearne, DNP, MPH; Laurie Mischley, ND, MPH, PhD; Evan Oakes, MD, MPH; Amy Occhino, MD; Jonathan Staloff, MD, MSc; Tony Yen, MD
Clinical experts: Jay Rubinstein, MD & Luke Wander, MD

HTCC Formal Action

1. **Welcome and Chair remarks:** Dr. Friedly, chair, called the meeting to order; members present constituted a quorum.
2. **HTA program updates:** Josh Morse, program director, presented HTCC meeting protocols and guidelines, and an overview of the HTA program.
3. **Previous meeting business:**

   January 31, 2025 meeting minutes: Draft minutes reviewed. Motion made and seconded to approve the minutes as written.

   Action: Eight committee members approved the January 31, 2025 meeting minutes.

   Vote on vertebroplasty, kyphoplasty, and sacroplasty draft findings and decision: Public comments and draft findings reviewed.

   Action: Eight committee members voted to finalize vertebroplasty, kyphoplasty, and sacroplasty draft findings.

4. **Hyperbaric oxygen therapy (HBOT) for sudden sensorineural hearing loss (SSHNL)**

   HTCC discussion and action:

   Discussion

   Based on the deliberations of key health outcomes, the committee decided that it had the most complete information: a comprehensive and current evidence report, public comments, and state agency utilization information. The committee discussed and voted separately on the evidence for the use of hyperbaric oxygen therapy (HBOT) for idiopathic sudden sensorineural hearing loss (SSNHL) and acute acoustic trauma (AAT). The committee decided that the current evidence on SSNHL and AAT is sufficient to determine coverage with conditions. The committee considered the evidence, public comment, and expert input, and gave greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

Based on these findings, the committee voted to cover with conditions on HBOT for SSNHL and AAT.

	Not covered	Covered with conditions	Covered unconditionally
HBOT for SSNHL	0	7	1
HBOT for AAT	3	5	0

Discussion

The committee reviewed and discussed the available studies on HBOT for sensorineural hearing loss and acute acoustic trauma. Details of study design, inclusion criteria, outcomes and other factors affecting study quality were discussed. In addition to consideration of the evidence from the report and evidence shared by public commenters, the committee discussed other payer policies and the relationship to Medicare and HTCC decision process. A majority of committee members present supported the conditions of coverage of HBOT for SSNHL and AAT. Details of study design, inclusion criteria, outcomes, cost, cost-effectiveness, and other factors affecting study quality were discussed as well as clinical application.

Decision

- Covered for idiopathic SSNHL and AAT for individuals with:
    - Moderate to severe hearing loss, AND
    - Treatment must start within 30 days of onset

Action

The committee checked for availability of a Centers for Medicare and Medicaid Services (CMS) national coverage decision (NCD). Based on the information provided in the systematic review, there are no NCDs identified for HBOT that were specific to the SSNHL indication.

The committee discussed clinical guidelines identified from the following organizations:

- American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF): Clinical practice guideline: sudden hearing loss, 2019
- European Committee for Hyperbaric Medicine (ECHM): The Tenth European Conference on Hyperbaric Medicine: recommendations for accepted and non-accepted clinical indications and practice of hyperbaric oxygen treatment, 2017
- National Institute of Health and Care Excellence (NICE): Hearing loss in adults: assessment and management, 2018 (updated 2023)
- The Underseas and Hyperbaric Medical Society (UHMS): Idiopathic SSNHL, 2011

The recommendations of the guidelines vary. The committee's determination is consistent with the noted guidelines.

HTA staff will prepare a findings and decision document on vertebroplasty, kyphoplasty, and sacroplasty for public comment to be followed by consideration for final approval at the next committee meeting.

5. Continuous glucose monitoring

HTCC discussion and action:

Discussion

Based on the deliberations of key health outcomes, the committee decided that it had the most complete information: a comprehensive and current evidence report, public comments, and state agency utilization information. The committee discussed and voted separately on the evidence for the use of continuous glucose monitors (CGM) for adults and children with type 2 diabetes on insulin, pregnant people with type 1, type 2, or gestational diabetes, and adults and children with type 2 diabetes not on insulin. The committee decided that the current evidence on CGM is sufficient to determine coverage with conditions for those on insulin. The committee considered the evidence, public comment, and expert input, and gave greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

Based on these findings, the committee voted to cover with conditions CGM for adults and children with type 2 diabetes on insulin, and cover unconditionally CGM for pregnant people with type 1, type 2, or gestational diabetes.

	Not covered	Covered under certain conditions	Covered unconditionally
Adults and children with type 2 diabetes on insulin	0	7	1
Pregnant people with type 1, type 2, or gestational diabetes	0	0	8
Adults and children with type 2 diabetes not on insulin	8	0	0

Discussion

The committee reviewed and discussed the available studies on CGM for adults and children with type 2 diabetes on and not on insulin, and pregnant people with type 1, type 2, or gestational diabetes. Details of study design, inclusion criteria, outcomes and other factors affecting study quality were discussed. In addition to consideration of the evidence from the report and evidence shared by public commenters, the committee discussed other payer policies and the relationship to Medicare and HTCC decision process. A majority of committee members present supported the conditions of coverage on CGM for adults and children with type 2 diabetes on insulin and to cover unconditionally for pregnant people with type 1, type 2, or gestational diabetes. Details of study design, inclusion criteria, outcomes, cost, cost-effectiveness, and other factors affecting study quality were discussed as well as clinical application.

Decision

CGM is a covered benefit for:

- Individuals with Type 1 diabetes

OR

- Individuals with Type 2 diabetes who are on insulin therapy, AND

  - Are unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan, OR
  - Are suffering from recurrent severe episodes of hypoglycemia (blood glucose < 50 mg/dl or symptomatic), OR
  - Have hypoglycemia unawareness

OR

- Individuals who are pregnant who have:
  - Type 1 diabetes, OR
  - Type 2 diabetes, OR
  - Gestational diabetes

Action

The committee checked for availability of a Centers for Medicare and Medicaid Services (CMS) national coverage decision (NCD). Based on the information provided in the systematic review, adults with type 2 diabetes, continuous glucose monitors are covered if taking insulin of any kind or any amount, or have a history of problematic hypoglycemia. Not applicable to children or pregnant people with type 2 diabetes, or pregnant people with gestational diabetes mellitus.

The committee discussed clinical guidelines identified from the following organizations:

- American Diabetes Association Standards of Care in Diabetes: Chapter 7 Diabetes Technology, 2024
- American Association of Clinical Endocrinology Developing a Diabetes Mellitus Comprehensive Care Plan, 2022
- American Association of Clinical Endocrinology The Use of Advanced Technology in the Management of Persons with Diabetes Mellitus, 2021
- Endocrine Society Management of Individuals with Diabetes at High Risk for Hypoglycemia, 2023
- National Institute for Health and Care Excellence (NICE): Type 2 Diabetes in Adults: Management, 2022
- Ontario Health Quality: Flash Glucose Monitoring System for People with Type 1 or Type 2 Diabetes: Recommendations, 2019
- Veterans Administration/Department of Defense: Management of Type 2 Diabetes Mellitus, 2023

The recommendations of the guidelines vary. The committee's determination is consistent with the noted guidelines.

HTA staff will prepare a findings and decision document on continuous glucose monitoring for public comment to be followed by consideration for final approval at the next committee meeting.

6. Meeting adjourned

Washington State Health Care Authority

Hyperbaric oxygen therapy for sudden sensorineural hearing loss

Draft findings and decision

Timeline, overview and comments

Timeline

Phase	Date	Public Comment Days
Selected technologies published	April 22, 2024	
Public comments	April 22 to May 22, 2024	**31**
Draft key questions published	August 29, 2024	
Public comments	August 29 to September 12, 2024	**15**
Final key questions published	September 26, 2024	
Draft report published	January 7, 2025	
Public comments	January 7 to February 5, 2025	**30**
Final report published	February 21, 2025	
Public meeting	March 21, 2025	
Draft findings & decision published	March 28, 2025	
Public comments	March 28 to April 11, 2025	**15**

Overview

Category	Comment Period *March 28 to April 11, 2025*	Cited Evidence
Patient, relative, and citizen	0	0
Legislator and public official	0	0
Health care professional	0	0
Industry & manufacturer	1	Yes
Professional society & advocacy organization	0	0
Total	**1**	

Comments

- Ty Jones, MD, Regence BlueShield of Washington

Washington State Health Care Authority

Health Technology Clinical Committee
DRAFT Findings and Decision

Topic: Hyperbaric oxygen therapy (HBOT) for sudden sensorineural hearing loss
Meeting date: March 21, 2025
Final adoption: Pending

Number and coverage topic:

20250321A – Hyperbaric oxygen therapy for sensorineural hearing loss and acute acoustic trauma

HTCC coverage determination:

Hyperbaric oxygen therapy (HBOT) for idiopathic sudden sensorineural hearing loss (SSNHL) and acute acoustic trauma (AAT) are **covered benefits with conditions.**

HTCC reimbursement determination:

Limitations of coverage:

- Covered for idiopathic SSNHL and AAT for individuals with:
  - Moderate to severe hearing loss, AND
  - Treatment must start within 30 days of onset

Non-covered indicators:

- N/A

Notes:

- See previous determination (20130322A) for additional HBOT findings and decision.

Related documents:

- Final key questions
- Final evidence report
- Meeting materials and transcript

Agency contact information:

Agency	Phone Number
Labor and Industries	1-800-547-8367
Public and School Employees Health Plan	1-800-200-1004
Washington State Medicaid	1-800-562-3022

HTCC coverage vote and formal action:

Committee decision

Based on the deliberations of key health outcomes, the committee decided that it had the most complete information: a comprehensive and current evidence report, public comments, and state agency utilization information. The committee discussed and voted separately on the evidence for the use of hyperbaric oxygen therapy (HBOT) for idiopathic sudden sensorineural hearing loss (SSNHL) and acute acoustic trauma (AAT). The committee decided that the current evidence on SSNHL and AAT is sufficient to determine coverage with conditions. The committee considered the evidence, public comment, and expert input, and gave greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

Based on these findings, the committee voted to cover with conditions HBOT for SSNHL and AAT.

	Not covered	Covered under certain conditions	Covered unconditionally
Sudden sensorineural hearing loss	0	7	1
Acute acoustic trauma	3	5	0

Discussion

The committee reviewed and discussed the available studies on HBOT for sensorineural hearing loss and acute acoustic trauma. Details of study design, inclusion criteria, outcomes and other factors affecting study quality were discussed. In addition to consideration of the evidence from the report and evidence shared by public commenters, the committee discussed other payer policies and the relationship to Medicare and HTCC decision process. A majority of committee members present supported the conditions of coverage of HBOT for SSNHL and AAT. Details of study design, inclusion criteria, outcomes, cost, cost-effectiveness, and other factors affecting study quality were discussed as well as clinical application.

Action

The committee checked for availability of a Centers for Medicare and Medicaid Services (CMS) national coverage decision (NCD). Based on the information provided in the systematic review, there are no NCD's for HBOT specific to the SSNHL indication.

The committee discussed clinical guidelines identified from the following organizations:

- American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF): Clinical practice guideline: sudden hearing loss (updated), 2019
- European Committee for Hyperbaric Medicine (ECHM): The Tenth European Conference on Hyperbaric Medicine, 2017
- National Institute of Health and Care Excellence (NICE): Hearing loss in adults (updated 2023), 2018
- The Underseas and Hyperbaric Medical Society (UHMS): Idiopathic SSNHL, 2011

The recommendations of the guidelines vary. The committee's determination is consistent with the noted guidelines.

HTA staff will prepare a findings and decision document on HBOT for SSNHL and AAT for public comment to be followed by consideration for final approval at the next committee meeting.

Health Technology Clinical Committee Authority:

Washington State's legislature believes it is important to use a science-based, clinician-centered approach for difficult and important health care benefit decisions. Pursuant to chapter 70.14 RCW, the legislature has directed the Washington State Health Care Authority (HCA), through its Health Technology Assessment (HTA) program, to engage in an evaluation process that gathers and assesses the quality of the latest medical evidence using a scientific research company that takes public input at all stages.

Pursuant to RCW 70.14.110, a Health Technology Clinical Committee (HTCC) composed of eleven independent health care professionals reviews all the information and renders a decision at an open public meeting. The Washington State HTCC determines how selected health technologies are covered by several state agencies (RCW 70.14.080-140). These technologies may include medical or surgical devices and procedures, medical equipment, and diagnostic tests. HTCC bases its decisions on evidence of the technology's safety, efficacy, and cost effectiveness. Participating state agencies are required to comply with the decisions of the HTCC. HTCC decisions may be re-reviewed at the determination of the HCA Director.

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Public Comment re: sudden sensorineural hearing loss and acute acoustic trauma draft findings and decision.
Date: Friday, April 11, 2025 12:34:47 PM

External Email

I notice that this draft proposes creation of a new and discrete HTCC determination specifically for HBOT for SNRI, instead of updating the prior and still active HTCC determination that addresses HBOT for SNRI treatment: *20130322A – Hyperbaric Oxygen Therapy (HBOT) for Tissue damage, Including Wound Care and Treatment of Central Nervous System* Conditions from 2013, which states in the Non-Covered Indicators section:

Non-Covered Indicators 5. Acute and chronic sensorineural hearing loss.

(https://www.hca.wa.gov/assets/program/hbot_final_findings_decision_052013[1]_0.pdf)

Creating this new HTCC determination (20250321A) would result in two active policies with conflicting coverage information. This would create an administrative stalemate and cause confusion for covered members and providers

If moving forward with a discrete HTCC determination, please consider updating the 2013 HTCC Determination (20130322A) by removing "Acute and chronic sensorineural hearing loss" from the Non-Covered Indicators section. This would ensure that the new determination (20250321A) is the single, clear source of truth regarding coverage of HBOT for sensorineural hearing loss.

Thank you,

Ty Jones, MD, FAAFP, CPPS, CPHQ (he/him)
Senior Medical Director, HCA Account
Regence BlueShield WA
[redacted]

[redacted]

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Washington State Health Care Authority

Continuous Glucose Monitors: New Populations

Draft findings and decision

Timeline, overview and comments

Timeline

Phase	Date	Public Comment Days
Selected technologies published	April 22, 2024	
Public comments	April 22 to May 22, 2024	**31**
Draft key questions published	September 3, 2024	
Public comments	September 3 to 16, 2024	**14**
Final key questions published	October 2, 2024	
Draft report published	January 9, 2025	
Public comments	January 9 to February 7, 2025	**30**
Final report published	February 28, 2025	
Public meeting	March 21, 2025	
Draft findings & decision published	March 28, 2025	
Public comments	March 28 to April 11, 2025	**15**

Overview

Category	Comment Period *March 28 to April 11, 2025*	Cited Evidence
Patient, relative, and citizen	1	No
Legislator and public official	0	0
Health care professional	36	Yes
Industry & manufacturer	1	Yes
Professional society & advocacy organization	2	Yes
	Total **40**	

Comments

1. Jennifer Marnik Scalici, DO, Providence
2. Pamela Dick, RD, Samaritan Healthcare
3. Julianne Ramirez-Nadjm, PharmD – Cited evidence
4. Rachel Gibbons, PharmD, Virginia Mason
5. Maureen Chomko, RD, Neighborcare Health
6. Stephanie Yoo, RD
7. Gregor Derupe, PharmD, Virginia Mason
8. Katie Rogers, RD, Virginia Mason
9. Cynthia Beck, ND, Squaxin Island Health Clinic
10. Sarah Faulkerson, RD, Mason General Hospital
11. Susan Wang, RD, EvergreenHealth
12. Kathleen Hargiss, RD, Neighborcare Health
13. Pam Kramer, RDN – MultiCare
14. Rachel Spillane, OD – Cited evidence
15. Liza Lugo – Family Health Centers
16. Lori Gardner, RDN – Kadlec Regional Medical Center
17. Sarah Loebner, PA – University of Washington
18. Melinda Nix, RDN
19. Virginia O'Kelly, RDN – Family Health Centers
20. Melinda Nix, RDN – Providence
21. Liann Sundquist, RDN
22. Alisa Elliott, RN – Family Health Centers
23. Christina Nickell, RN – Family Health Centers
24. Emily Lindsey, ARNP
25. Denelle Martin, RD
26. Brittany Flesher, PharmD – MultiCare
27. Amy Myrtue Nelson, RD – MultiCare
28. Rebecca Tarbert, RDN – Confluence Health
29. Nicole Treanor, RD – Virginia Mason
30. Matt Prokop, American Diabetes Association – Cited Evidence
31. Shirly Matenda, RDN, Virginia Mason – Cited Evidence
32. Matt Prokop, American Diabetes Association – Cited Evidence
33. Christina Burrows, RN – Kadlec Regional Medical Center
34. Hamza Alshannaq, MD, Dexcom – Cited Evidence
35. Carrie Swift, RDN, Kadlec Regional Medical Center – Cited Evidence
36. Jinha Park – Virgina Mason
37. Dylan Tracy, DO
38. Tara Cardinal, ARNP – University of Washington
39. Nicole Ehrhardt, MD, University of Washington – Cited Evidence
40. Leanna Davis, PharmD, MultiCare – Cited Evidence

Summary

- Breakdown of public comments received:
    - 32 requested to update the criteria to state "individuals with diabetes who are on insulin therapy" or "people on insulin therapy" to avoid unintentionally excluding patients with latent autoimmune diabetes in adults, pancreatogenic, or other insulin-dependent forms of diabetes.
    - 32 stated the criteria "Unable to achieve target HbA1C" is too exclusionary and continuous glucose monitors (CGMs) should be available regardless of glycemic

targets to all insulin users, regardless of their current or future HbA1C levels or remove this language
    - 29 requested for CGMs to be added to Medicaid Preferred Drug List and point of sale lookback allowed
    - 11 requested all patients diagnosed with diabetes should receive a CGM and not be limited to insulin
    - 7 requested CGM for patients with a history of Level 2 or 3 Hypoglycemia [per American Diabetes Association (ADA) Criteria], adding coverage for patients experiencing hypoglycemia without insulin therapy, or patients with hypoglycemia unawareness
    - 5 requested CGMs be available to all patients
    - 2 requested coverage for patients with chronic kidney disease
    - 2 requested including continuation of care for those who previously achieved target A1C
    - 1 requested eliminating all 3 sub-categories for patients using insulin for prescriber's to meet 2025 ADA standards of care
    - 1 requested that '4 times per day' for blood glucose checks not be reinstated
    - 1 requested adding an option for short-term us of CGM, such as two weeks prior to appointments 2 to 3 times per year
    - 1 requested that Medicare policy criteria for non-insulin treated individuals be applied:
        - Have a documented history of recurrent level 2 hypoglycemia (blood glucose <54 mg/dL) despite multiple medication adjustments
        - Have experienced a level 3 hypoglycemic event requiring third-party assistance; or
        - Are unable to recognize or communicate symptoms of hypoglycemia.
    - 1 requested a change in language to state "Individuals who are pregnant with any type of diabetes" or "Individuals who are pregnant with any type of hyperglycemia."
    - 1 requested inclusion of less commonly recognized forms of diabetes

- Cited evidence in public comments fell into three categories – included in the evidence report, out of scope for review, or titles cited could not be found.

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM
Date: Thursday, April 3, 2025 1:03:15 PM

External Email

As an OBGYN I fully support coverage for CGM in pregnant patients in WA state

Jennifer Marnik Scalici DO

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Public comments on 20250321B- Continuous Glucose Monitoring
Date: Thursday, April 3, 2025 2:33:07 PM
Attachments: image002.png
image003.png
image004.png

External Email

Hello- My name is Pam Dick and I am a Certified Diabetes Care and Education Specialist and Registered Dietitian here in rural Moses Lake, WA. As a diabetes educator in a rural healthcare, I see a variety of patients every day that live with diabetes. One of the most significant advances in diabetes care I have experienced in my 20+ years working in this field is the advancement of technology and technology availability to all patients. Continuous Glucose Monitoring is a game changer and patients of all ages love it and utilize it.

Times are changing, and we need to keep moving forward with reduction of care burden and complications for patients living with diabetes. Since we started using more continuous glucose monitoring here at Samaritan Healthcare, when Medicare changed their ruling to coverage for anyone using insulin or having documented hypoglycemia, we have seen an overall average decrease in A1c in new patients starting CGM. The average A1c went from **9.1% before CGM to 6.75% in just 6 months**. We were floored by this improvement!

Both educators, providers, and patients all appreciate the increased accessibility to this technology. We are so grateful the state is granting better access for our Gestation Diabetes patients to have more access to CGM use. This is especially important in rural healthcare where the disparities are large. Historically, our Hispanic mothers have less access to this technology during pregnancy, but higher incidence of Gestation diabetes.

Being able to identify true hypoglycemia (unsafe drops in glucose) while using CGM has also been a game changer. I often have had patients not know the symptoms they are feeling and issues they are having are due to these drops in glucose. When they begin wearing CGM and we can identify the drops and patterns we can more adequately pinpoint education and changes in lifestyle and medications that may need to be altered. Continuing to expand coverage for anyone with hypoglycemia is invaluable. We have seen employment productivity and overall health safety improve. Honestly, all truck drivers with diabetes should be required to wear CGM sensor for public safety too! You also don't have to be on insulin to have hypoglycemia. Some people are just more sensitive to their oral diabetes medications, or they can have drops in glucose with or without diabetes as well.

As we continue to see the value of CGM use and application of its benefits, one of the key items is the possible reduction in obesity/weight related issues. Knowing your glucose and being able to see your rises in fall in relation to food choice/portion and activity, can significantly impact how people choose health. CGM really should not be limited by "insulin use only". From pre-diabetes to Type 2

diabetes, all people benefit from CGM use and review of the data.

Please consider ongoing expansion of coverage for Continuous Glucose Monitoring. Thank you!

Pam Dick MS RDN CDCES
Samaritan Healthcare Diabetes Education
[redacted]

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Stay connected:

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: 20250321B – Continuous glucose monitoring
Date: Friday, April 4, 2025 9:38:42 AM

External Email

To: Health Technology Clinical Committee
Washington State Health Care Authority

Subject: 20250321B – Continuous glucose monitoring

Dear Committee Members,

As a clinical pharmacist specialist who has worked side-by-side with individuals living with diabetes in ambulatory care settings for years, I write this letter not only as a healthcare professional but as an advocate for those patients who too often face avoidable obstacles to accessing tools that could prevent suffering, emergency room visits, and even death.

Every week, I work with patients navigating the complexities of diabetes—some newly diagnosed, others decades into their journey. Many of them are on insulin, some are pregnant, and some live with less commonly recognized forms of diabetes, such as Latent Autoimmune Diabetes in Adults (LADA) or pancreatogenic diabetes. Despite differing diagnoses, they share a common need: safe and effective glucose management. Continuous glucose monitoring (CGM) is no longer a luxury—it is a clinically proven standard of care that empowers patients, prevents costly complications, and supports sustainable, data-driven management decisions.

I want to sincerely thank the committee for expanding CGM access to pregnant patients and individuals with type 1 diabetes without additional restrictions. These are crucial and commendable changes. I now ask the committee to consider four additional refinements, each grounded in scientific evidence and informed by lived clinical experience.

Recommended Revisions and Supporting Evidence

1. CGM for Patients with Type 2 Diabetes on Insulin

I've seen firsthand how CGM transforms care for individuals with type 2 diabetes (T2D) on insulin. Patients gain confidence, avoid dangerous lows, and often reduce insulin dosing altogether as their data enables more informed decisions.

Improved Glycemic Control:
Randomized controlled trials consistently show that CGM use significantly reduces HbA1c in patients with T2D on multiple daily injections or basal-only insulin regimens [(Beck et al., 2017); (Martens et al., 2021); (McGill & Ahmann, 2017)].

Prevention of Glycemic Deterioration:
Even patients with well-controlled diabetes benefit by avoiding deterioration—a vital goal for patients who have finally stabilized after years of struggle [(Karter et al., 2022)].

Improved Time in Range and Reduced Variability:
CGM use improves time-in-range (70–180 mg/dL) and reduces time in hyperglycemia without increasing hypoglycemia risk [(Martens et al., 2021)].

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2. CGM for Patients with a History of Level 2 or 3 Hypoglycemia (per ADA Criteria)

I've had patients come into the clinic confused, frightened, and shaken after waking up on the floor or in the ER due to a severe low they didn't even feel coming. Often, they had no access to CGM—until after the event.

Undetected Severe Hypoglycemia:
CGM detects significantly more severe hypoglycemic episodes (≤54 mg/dL or ≤40 mg/dL) than self-monitoring, revealing a blind spot in diabetes care [(Levy et al., 2017); (Hai-yan, 2011)].

Risk Prediction in Tightly Controlled Patients:
In patients with HbA1c <6.5%, CGM identifies nocturnal and asymptomatic lows that otherwise go unnoticed [(Morimoto et al., 2011); (Jiang-pin, 2006)].

Improved Detection in Elderly Populations:
Elderly patients face elevated risks of falls, hospitalization, and mortality due to undetected hypoglycemia—risks significantly mitigated through CGM [(Ishikawa et al., 2017); (Sekhar, 2020)].

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3. CGM for Patients with Hypoglycemia Unawareness

As a clinician, there is little more terrifying than managing a patient with hypoglycemia unawareness—someone whose body no longer warns them of a drop until it's too late. CGM is the safety net they need.

Validated CGM Use for Diagnosis:
CGM identifies prolonged, silent episodes of low glucose that correlate with hypoglycemia unawareness (HUN), providing objective documentation of this dangerous condition [(Streja, 2005)].

High Prevalence and Risk:
Studies show that as many as 42% of hypoglycemic events go unnoticed by patients, increasing the risk for severe outcomes [(Mizoguchi, 2018); (Suzuki, 2023)].

Improved Physiologic Response:
Real-time CGM with alarms improved the counterregulatory response in adolescents with HUN, showing that CGM may even help reverse this condition [(Ly et al., 2010)].

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4. Policy Support: Reducing Prior Authorization Burden

I cannot count the number of peer-to-peer calls I've participated in to overturn CGM denials for patients with LADA or pancreatogenic diabetes. Every single one was approved—eventually. However, the administrative burden delays access and adds unnecessary stress to already overwhelmed clinics.

Timely Access Equals Better Outcomes:
Research shows that frequent CGM users achieve better glycemic control, implying that uninterrupted, streamlined access is key [(Martens et al., 2021); (Karter et al., 2022)]. Using pharmacy point-of-sale data to verify insulin prescriptions could eliminate unnecessary manual PAs while preserving appropriate safeguards.

Additional Recommendations

1. **Inclusive Language:** Update the criteria to say "individuals with diabetes who are on insulin therapy" to avoid unintentionally excluding patients with LADA, pancreatogenic, or other insulin-dependent forms of diabetes.

2. **Unconditional Inclusion for LADA and Pancreatogenic Diabetes:** These patients face identical risks to those with T1D or T2D. Despite eventual approval, their exclusion results in denials, appeals, and delays.

3. **Incorporate 2025 ADA Standards of Care:** The draft relies on outdated guidelines. The 2025 ADA Standards strongly support CGM for all patients on insulin and for many with hypoglycemia risk, regardless of therapy (ADA, 2025).

4. **Hypoglycemia Pathway Independent of Insulin Use:** Sulfonylureas and other agents carry significant hypoglycemia risks. Coverage criteria should reflect this by enabling CGM access for patients experiencing hypoglycemia without insulin.

My patients are resilient, but they should not have to fight for access to evidence-based care. CGM is not just a piece of technology—it is a lifeline, a teacher, and a tool that empowers people with diabetes to live fuller, safer, and healthier lives.

I respectfully urge the committee to strengthen this policy to better reflect the day-to-day realities of clinical practice, the robust and growing body of scientific evidence, and the urgent needs of our most vulnerable patients. In particular, I advocate for removing all sub-criteria for individuals on insulin therapy to ensure alignment with the 2025 ADA Standards of Care and enable clinicians to provide evidence-based care without unnecessary administrative hurdles. One of the most impactful and practical changes would be to designate CGM as a pharmacy benefit across all Medicaid plans. Adjudication varies by payor—with some CGM claims routed through pharmacy and others through durable medical equipment (DME)—creating confusion for providers and patient delays. Standardizing CGM as a pharmacy benefit would streamline prescribing, enable real-time eligibility checks using diagnosis codes at the point of sale, eliminate the need for burdensome manual prior authorizations, and reduce overall administrative costs, all while ensuring timely access to this life-saving technology.

Thank you for the work you do and for considering these recommendations.

With gratitude,

Julianne Ramirez-Nadjm, PharmD, BCPS, BCGP, BCACP, CDCES, BC-ADM, BCACP

Reference Summary

1. Beck RW, Riddlesworth TD, Ruedy K, et al. Continuous Glucose Monitoring Versus Usual Care in Patients With Type 2 Diabetes Receiving Multiple Daily Insulin Injections. *Ann Intern Med.* 2017;167(6):365-374.

2. Martens T, Beck RW, Bailey R, et al. Effect of Continuous Glucose Monitoring on Glycemic Control in Patients With Type 2 Diabetes Treated With Basal Insulin. *JAMA.* 2021;325(22):2262-2272.

3. McGill JB, Ahmann A. Continuous Glucose Monitoring With Multiple Daily Insulin Treatment. *Diabetes Technol Ther.* 2017;19(S3):S3-S12.

4. Karter AJ, Parker MM, Moffet HH, et al. Continuous Glucose Monitor Use Prevents Glycemic Deterioration in Insulin-Treated Patients With Type 2 Diabetes. *Diabetes Technol Ther.* 2022.

5. Levy JC, Davies M, Holman R. Continuous Glucose Monitoring Detected Hypoglycaemia in the 4-T Trial. *Diabetes Res Clin Pract.* 2017;131:161-168.

6. Hai-yan Y. Clinical Significance of the Continuous Glucose Monitoring on Asymptomatic Hypoglycaemia Reaction in T2DM. *2011*.

7. Morimoto A, Nishimura R, Tsujino D, et al. Relationship Among A1C, Hypoglycemia, and Hyperglycemia. *Diabetes Technol Ther.* 2011;13(6):667-670.

8. Jiang-pin J. Bedtime Glucose and Nocturnal Hypoglycemia. *2006*.

9. Ishikawa T, Koshizaka M, Maezawa Y, et al. CGM Reveals Hypoglycemia Risk in Elderly T2D. *J Diabetes Investig.* 2017;9(1):69-74.

10. Sekhar MS. Hypoglycemia in T2DM Using CGM. *J Med Sci Clin Res.* 2020;8(11).

11. Streja D. Objective Detection of Hypoglycemia Unawareness Using CGMS. *Endocr Pract.* 2005;11(2):83-90.

12. Mizoguchi A. Risk Factors for Hypoglycemia Unawareness. *Diabetes.* 2018.

13. Suzuki Y. Factors Associated With Hypoglycemia Unawareness. *Diabetes.* 2023.

14. Ly TT, Hewitt J, Davey R, et al. Improving Epinephrine Responses With Real-Time CGM. *Diabetes Care.* 2010;34(1):50-52.

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Continuous glucose monitors - comment in support of legislation
Date: Monday, April 7, 2025 1:41:32 PM

External Email

I am emailing as a primary care pharmacist who treats patients with diabetes across the state of Washington. Having access to continuous glucose monitors (CGM) has changed the way we practice diabetes management and allows patients to reach their glycemic targets better than fingerstick self monitoring blood glucose.
The reality is fingerstick glucose checks, even when dose 3-4x per day do not give patients the insight into how to best treat the diabetes. Finding a patient who is willing to do a fingerstick 3-4x per day is hard enough, even when they do it doesn't always paint the picture of clear trends in glucose in response to meals, exercise, or throughout the day. Patients with CGM can see in real time how their glucose and diabetes is impacted by their lifestyle choices. This acts to motivate them to make healthier choices. And importantly, it allows their providers to fine tune insulin doses to limit hyperglycemia while also preventing severe hypoglycemia.

I urge that the suggested edits be made to CGM coverage for WA medicaid. All individuals on insulin (little value in specifying type 1 vs type 2 vs gestational, and may actually miss many patients) benefit from this. If their HbA1c reaches the target due to CGM, it should not then be taken away. CGM should remain covered regardless of achieving glycemic targets to ensure people remain at their target and continue to use insulin safely. To reduce barriers of prior authorization, DME billing, and patient confusion CGMs should be added to the Preferred Drug List and POS lookback be allowed. One of the major barriers to CGM is the hurdles patients need to jump through in an already complex medical system. Adding extra delays and non-pharmacy suppliers of CGM prescriptions does NOT improve patient care nor save on cost. Particularly when that delay causes poor outcomes for these patients.

Rachel

--
Rachel Gibbons, PharmD
Clinical Pharmacist
Department of Primary Care and Rheumatology
[redacted]

Virginia Mason Franciscan Health™
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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CHC Healthcare Professional Public Comment on Continuous glucose monitoring
Date: Monday, April 7, 2025 1:55:04 PM

External Email

As a registered dietitian (RDN) and certified diabetes care and education specialist (CDCES) for over ten years in the state of Washington, with the last 9 of those years being spent working at Neighborcare Health, Seattle's largest provider of healthcare for those on state insurance or uninsured, I can speak confidently to CGM use in the state insured population.

I support expanding CGM coverage to all individuals on insulin, but as there are multiple "shades" of diabetes, not just type 1 and type 2, but I have many patients with LADA or type 3c diabetes (pancreatogenic diabetes) so the language should include "people on insulin therapy" instead of categorizing types 1 or 2.

I recommend that the language of "unable to achieve target HbA1C" is too exclusionary. This feels like a punishment for having good blood glucose control and incentivizes poor control in order to obtain this device. Poor control contributes to worse outcomes and increased healthcare expenditures, therefore I would remove this language, again, to include all insulin users despite glycemic or HbA1C targets.

To reduce barriers in this population, CGM technology should be added to the Medicaid Preferred Drug List for pharmacy coverage. POS (Point of Sale) lookback should be allowed by the pharmacy to approve coverage. This simplifies things for all of us in the healthcare field. Our team who helps with prior authorizations is so overloaded, with CGM technology being one of those issues that slows down our team, the patient's positive outcomes.

I cannot speak enough to the benefits of CGM in all people with diabetes. Especially those on insulin therapy, but for all patients, there is a marked improvement in glucose and HbA1c once CGM therapy is started. I have been working with patients for nearly a decade that have seen their best A1c's and glycemic control once we started CGM therapy. Where before we couldn't break past certain barriers to getting their glucose down, once we started CGM, it is truly a game-changer. This is also a huge benefit and time-saver for those with caregivers or those in nursing homes/assisted living/rehabs, etc.

Thank you for your time and attention. Please don't hesitate to reach out to me with any questions.

- Maureen

Maureen Chomko, RD, CDCES
[redacted] Delegate, Rainier Beach Clinic

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Comments in update to WA Medicaid CGM coverage
Date: Monday, April 7, 2025 1:58:26 PM

External Email

To Whom it May Concern,

I am writing as a Registered Dietitian, Certified Diabetes Care and Education Specialist working currently in a hospital based Diabetes Education program in Edmonds, and formally at a FQHC in Seattle. I have been serving folks benefiting from Apple Health coverage for more than a decade, and have seen the tremendous benefit to habitat change and A1c in these individuals who have access to CGM. It is a well known recommendation from the American Diabetes Association that all individuals loving with diabetes have access to CGM at diagnosis or at anytime as determined by their care team.

I have reviewed the draft updates for Apple Health CGM coverage and have the following suggestions to the final language

1. Current draft language limits CGM coverage to only the 3 most common forms of diabetes. I support the expansion of CGM coverage to " All individuals on insulin". However the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA, surgically or drug induced or pancreatogenic diabetes.

2. The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. My concern is that these individuals will lose access to the very device that helped them reach targets while avoiding dangerous hypoglycemic events. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.

3. I suggest that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thanks very much for your consideration of my comments.

Stephanie K Yoo, MS, RD, CDCES
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Health Technology Review: CGM - Public Comment
Date: Monday, April 7, 2025 1:59:58 PM

External Email

To Whom It May Concern,

I am writing to the HTCC to provide comments regarding the recent assessment for Medicaid coverage for continuous glucose monitor devices. I am providing these insights as an Endocrinology and Diabetes specialty clinic pharmacist at Virginia Mason Franciscan health that works with complex Type 1, Type 2, Type3c, and MODY diabetes patients.

I have a personal account of how instrumental the use of CGMs are to improving glycemic control for all patients with diabetes.

There are key components of the draft decision that should be considered.

1) The diagnoses listed (Type 1 and Type 2) are limiting to patients who would greatly benefit from CGM usage. We have completely insulin dependent patients that have undergone pancreatectomy that fall into the category of pancreatogenic diabetes (also known as Type 3c). Some of these patients may be insulin dependent like Type 1 diabetes with even more risk of hypoglycemia due to exocrine pancreatic insufficiency. The current language for diagnostic criteria for coverage should include both patients with Type 3c and LADA (late onset Type 1 diabetes). It would be recommended that the language therefore include "patients on insulin therapy" to include the scope of patients that would benefit from this coverage.

2) The language does not include patients who have restrictive/debilitating disabilities that would make fingerstick glucose monitoring difficult to achieve. Although some of these patients may not be on insulin, lack of coverage for a continuous glucose monitor would make it much harder for patients with manual dexterity issues to monitor their blood sugars. This opens up the question for medical justice and lack of equity for those that may otherwise be considered for accommodations through the American Disabilities Act. Failure to consider these patients would be discriminatory and negligent.

3) The draft decision does not include continuation of care for those who may have previously achieved target A1c because they had access to use of a continuous glucose monitor. I have seen multiple incidences of patients who have previously been well controlled due to being able to adjust their insulin doses based on what their current level is and the trajectory of their glycemic trend per a continuous glucose monitor. Failure to consider continuation of this care poses great risk for harm to the patient.

4) Consideration for coverage for patients with chronic kidney disease. In many circumstances, patients with chronic kidney disease may not be on insulin for therapy. However, there is a high likelihood that the A1c will be underestimated and inaccurately depicts a false adequate control. As a clinician, the best way for us to be able to determine if their current regimen is adequate would be to see the continuous trend of their glucose levels.

5) I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage,

versus having to do a PA.

Thank you in advance for your consideration. The cost consideration for coverage of these devices are likely to provide much greater cost savings in the long run to prevent diabetes related complications compared to the cost of covering CGMs. I implore that you do the right thing for our patients and to widen the access to these life-altering devices.

Best,
Gregor Derupe, PharmD, BC-ADM

--

Gregor Derupe, PharmD, BCADM (*he/him/his*)

Clinical Pharmacist

Endocrinology and Diabetes

[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Recommendation for Clarification and Expansion of Continuous Glucose Monitoring (CGM) Coverage Policy
Date: Monday, April 7, 2025 2:27:33 PM

External Email

Hello,
I am writing to express my **strong support for the expansion of Continuous Glucose Monitoring (CGM) coverage** and to offer some recommendations to ensure the policy is as inclusive and effective as possible for all individuals who could benefit from this technology.

I wholeheartedly support the expansion of CGM coverage to all individuals on insulin therapy. However, I believe the current language specifying "type 1" or "type 2" diabetes is unnecessarily restrictive and excludes individuals with other forms of diabetes requiring insulin, such as Latent Autoimmune Diabetes in Adults (LADA) and pancreatogenic diabetes. To ensure comprehensive coverage, I respectfully request that the language be clarified to encompass **all people on insulin therapy**, regardless of their specific diabetes diagnosis.

Furthermore, the phrase "unable to achieve target HbA1C" introduces ambiguity and potential barriers to access. While CGM is undoubtedly valuable for individuals struggling to reach their glycemic targets, it is also a powerful tool for maintaining stable blood glucose levels and preventing complications in those who are already at target or who achieve target A1C after starting CGM. Therefore, I recommend that CGM be a covered benefit for **all insulin users, regardless of their current or future HbA1C levels.** This will allow individuals to proactively manage their diabetes and prevent future complications.

Finally, I strongly recommend that CGM be added to the Medicaid Preferred Drug List (PDL) for pharmacy coverage and that Point of Sale (POS) lookback be allowed by the pharmacy to approve coverage. Currently, the absence of CGM on the PDL creates uncertainty regarding the appropriate channel for dispensing (pharmacy vs. Durable Medical Equipment - DME) and potentially necessitates prior authorization (PA) if dispensed through DME. This administrative burden, particularly for smaller practices and primary care offices, will likely inhibit the prescription and adoption of CGM.

Implementing POS lookback would streamline the process significantly. By allowing the pharmacy to verify a current insulin prescription, coverage can be approved at the point of sale, eliminating the need for a PA and ensuring timely access to CGM for eligible individuals. This would greatly reduce administrative overhead and improve patient access to this vital technology.

Thank you for considering these recommendations. I believe that these clarifications and additions will significantly improve the effectiveness and accessibility of the CGM

coverage policy, ultimately leading to better health outcomes for individuals on insulin therapy.

Sincerely,

Katie Farrell Rogers, MA, RD, CDCES
Program Manager
Comprehensive Diabetes Care Program SJMC
Certified Diabetes Care & Education Specialist
St. Joseph's Medical Center
Virginia Mason Franciscan Health™
[redacted]

Upcoming Time Away:
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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM benefits in WA
Date: Monday, April 7, 2025 2:42:27 PM
Attachments: Outlook-wek23dcw

External Email

Hello

I am a licensed Naturopathic Physician and Certified Diabetes Care and Education Specialist, working with the Squaxin Island tribe in Shelton WA.

CGMs are one of the most important tools that I have.

CGMs are important for all individuals who have blood sugar issues. It helps everyone - from those who use insulin to keep themselves alive to the those who are struggling to prevent diabetes. The amount of information gathered from CGMs is amazing!

CGM coverage for all individuals who use insulin is the standard of care for Diabetes, and some of our insurance companies are not honoring this standard of care.

I Support the expansion of CGM coverage to all individuals on insulin therapy. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.

It is requested that CGM be added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. I have alot of pts who are on Medicaid who use insulin, who are denied CGM therapy - that is a CRIME!

We are WASHINGTON State!! We are better than this, and all Washingtonians deserve the Best Healthcare!!

In Health,

Cindy Beck, ND, CDCES, DipACLM
Naturopathic Physician & Diabetes Coordinator/Educator
Squaxin Island Health Clinic
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Continuous Glucose Monitor coverage expansion
Date: Monday, April 7, 2025 4:05:18 PM

External Email

Hello,

I'm a Certified Diabetes Care and Education Specialist in Shelton, WA. My team and I meet with people every day for diabetes self-management who benefit from improved glycemic awareness and control because of Continuous Glucose Monitoring technology. That improved glycemic control directly reduces each individual's risk of short-term and long-term complications, as well as expensive hospitalizations. I've personally seen individuals drop their HbA1c levels by well over 1% and improve their "Time In Range" in a matter of weeks to months simply by adding this technology. This technology also dramatically improves an individual's quality of life by decreasing the number of times they have to poke their fingers each day, and allowing them to be alerted before a blood glucose level drops too low or goes too high.

I would encourage the State to consider the liberalization of requirements for individuals receiving these devices. Ideally, they would be available to anyone with a diagnosis of diabetes (Type 1, Type 2 or Gestational) and I strongly feel that this needs to be in our future. An easier next-step would be to make CGMs available to anyone with a diagnosis of diabetes (Type 1, Type 2, or Gestational) who takes at least 1 insulin injection per day ("people on insulin therapy") and/or who have documented hypoglycemia. I also would encourage CGM to be added to the Medicaid Preferred Drug List for pharmacy coverage and that Point Of Sale lookback be allowed by the pharmacy to approve coverage.

Thank you for your consideration on this important matter!

Sarah Fulkerson, RD, CDCES
Diabetes Wellness and Dietitian Supervisor

Mason Health
Mason General Hospital • Mason Clinic
[redacted]

United Community, Empowered People, Exceptional Health

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CMG coverage comment
Date: Monday, April 7, 2025 10:31:56 PM

External Email

I strongly support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes and you request the language be clarified to "people on insulin therapy".

Also, the language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. Prevention of hypoglycemia is still important as well as to look at TIR as an indicator of control rather than just A1c. In addition there is more evidence that a tighter TIR is more beneficial in terms of risk reduction in complications including microvasular complications.

In addition, I request that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

> As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Also, even though people with diabetes do not require insulin, I believe they should be eligible for coverage of CGM at least for a few months with the diagnosis of diabetes, change of diabetes medication, a change of weight of more than 5%, and /or 3 months per year. People with diabetes not requiring insulin can learn a lot about how to manage their diabetes better by seeing how their blood sugar react to foods (certain food, amounts, combinations, etc), exercise, illness, hormonal, menstrual cycles, exercise in the context of changes in diabetes medication, weight or just getting older.

Susan R. Wang, MS, RD, CD, CDCES
MFM EvergreenHealth
Kirkland, WA

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM through state Medicaid
Date: Tuesday, April 8, 2025 8:26:26 AM
Attachments: Outlook-Neighborca.png

External Email

Hello,

I support expansion of CGM coverage to all individuals with diabetes. I have been working in a Federally Qualified Health Center (FQHC) for the past year. I have had the opportunity to place sample CGM on patients with all forms of diabetes and it has been educational for each individual and has supported their lifestyle change in quality of food choices, food timing, exercise, sleep, stress management, and medication adherence. CGM is the most powerful tool I have seen in my 30 years as a Registered Dietitian and 18 years as a certified diabetes care and education specialist! I wish you could experience and share the difference I have seen in the people I work with who are primarily insured through state Medicaid.

Recommended suggestions to draft decision:

1. The language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes and you request the language be clarified to "people on insulin therapy".
2. The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. In my experience, CGM helps all people with diabetes achieve and maintain their glycemic targets.
3. All patients experiencing hypoglycemia <70 should be using a CGM. This low blood sugar puts the person at risk for falls, decreased mental alertness, and for others that may be involved with the individual such as other drivers, pedestrians, etc.
4. I request that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your kind consideration,
Kathleen Hargiss, RD CDCES

Kathleen Hargiss, MS, RD, CDCES
She/Her/Hers Pronouns
Dietitian, Diabetes Care and Education Specialist

Work days: Monday, Tuesday, Wednesday, Thursday 8am to 1:30pm
Neighborcare Health at Meridian
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neighborcare health

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM expansion for Medicaid patients
Date: Tuesday, April 8, 2025 9:29:07 AM

External Email

Good morning.

I am writing to advocate for the expansion of continuous glucose monitor (CGM) coverage to all individuals on insulin therapy. The current language specifying "Type 1" or "Type 2" diabetes excludes individuals with less common forms of diabetes, such as latent autoimmune diabetes in adults (LADA) or pancreatogenic diabetes. To ensure inclusivity, I respectfully request that the language be updated to "people on insulin therapy."

Addressing HbA1C Target Language

The phrase "unable to achieve target HbA1C" is problematic because it leaves room for interpretation. Patients who are already at target A1C levels or those who achieve targets after starting CGM may be excluded from coverage. CGM should be a covered benefit for all insulin users, regardless of whether glycemic targets are achieved.

Medicaid Preferred Drug List and POS Lookback

I also urge that CGM devices be added to the Medicaid Preferred Drug List for pharmacy coverage and that pharmacies be allowed to use Point-of-Sale (POS) lookback functionality to approve coverage. Without inclusion on the preferred drug list, it is unclear whether CGMs can be dispensed through pharmacies or durable medical equipment (DME). If sent via DME, prior authorization will likely be required, creating unnecessary administrative burdens for smaller practices and primary care offices. POS lookback functionality would streamline this process by allowing pharmacies to verify insulin prescriptions and approve coverage without requiring prior authorization.

The Importance of CGM Access

As a diabetes educator with over 30 years of experience, I have witnessed firsthand how technological advancements like CGM have transformed lives—helping millions of people with diabetes (PWD) live more abundantly and with reduced health risks. Access to CGM should not be considered a privilege but rather a standard of care for all individuals with diabetes, irrespective of economic status. Just as glucometers became a standard tool in diabetes management, we must embrace CGM as the next essential step forward.

Thank you for considering these requests to make CGM accessible to all PWD, ensuring equitable and effective diabetes care.

Pam Kramer, RDN, CDCES | Manager of Diabetes and Nutrition Services
Ambulatory Pharmacy Services | MultiCare Health System
[redacted]
Office: Remote
Work hours: Monday-Friday 8:00 AM – 5:00 PM

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Health Care Authority review on Continuous Glucometry (CGM)
Date: Tuesday, April 8, 2025 11:55:55 AM

External Email

Good morning,

I have worked at the Tulalip Health Clinic on the Tulalip Reservation in Snohomish County for the past 10 years. Many of the patients I serve have diabetes. I have witnessed firsthand how transformational Continuous Glucometers (CGM) can be in allowing my patients better control over their diabetes and have been able to see the improvements in the ocular health of my patients along with helping address visual fluctuations which are a common and frustrating problem. My ask is for you to review the problems posed below by our primary care doctors and consider the recommended changes which will allow myself and my colleagues on our diabetes care teams to help our patients optimize their diabetes care and management.

Continuous Glucometer (CGM) coverage language needs to go further than the current draft which limits it to certain types of diabetes and requires certain A1c goals. The current draft is unsafe and frankly unacceptable and I appreciate you taking the time to read and understand this so we can prevent an increase in morbidity and mortality in our diabetic population. In addition to saving and improving lives, it will save an incredible amount of money in lost tax generation for those unable to work and reduce the cost of hospital stays.

The current draft only includes language for diabetes types 1 and 2, though there are many dozens of kinds of diabetes that require insulin which this does not account for. For example, two of the most common other forms of diabetes that require insulin several times a day include the "type 1 diabetes in adulthood" (actual diagnosis is latent autoimmune diabetes in adulthood "LADA", or "diabetes type 1.5") and diabetes related to pancreatic failure to make insulin for non-autoimmune reasons (such as pancreatic cancer, chronic pancreatitis, surgical pancreas removal, etc). In family practice these are commonly seen and treated. For those with LADA, their pancreas does not make sufficient insulin and they require insulin for every meal just the same as those with Type 1 Diabetes because the disease course is the same, but the patient was a different age at onset. If you use language that excludes LADA and type 1.5 diabetes, people who have the same need for continuous glucometers will be at incredibly high risk of life threatening and life shortening complications from diabetes (such as coma, diabetic ketoacidosis "DKA", **permanent vision loss**, amputations, etc) that will be incredibly expensive to treat, will cause a decrease in the productivity and fulfilling lives of patients with diabetes, and will very negatively impact the lives of our community members. For patients with diabetes related to pancreatic failure for non-autoimmune reasons they generally have either no pancreas, partial pancreas, or inflammation of the organ that renders it incapable of making sufficient insulin on a regular basis. Pancreatogenic diabetes is quite dangerous because the pancreas either makes no insulin or sometimes makes no insulin; the changes in pancreatic function make it more challenging to keep blood sugars in a safe range and reduce the morbidity and mortality of the disease and dangerous low sugars and dangerous high sugars are both common. In addition to the moment-by-moment changing insulin production,

with pancreas inflammation or pancreas loss, there is also a loss of function of the part of the pancreas that makes the hormone that protects the body against low blood sugars (which remains intact for those with autoimmune diabetes such as type 1 and LADA). Therefore, these patients are at *incredibly* high risk for life altering and life ending low blood sugars and they need to check their blood sugars many more times a day than the average diabetic and the alarm to alert them of low blood sugars and approaching low blood sugars help them to get to life saving glucose *before* they have a blood sugar so low that they are unable to get help. The language of the current draft does not cover for these diabetics because they are neither type 1 nor type 2 diabetics. ***Please change the language to include "people on insulin therapy" rather than limiting it to diabetes types 1 and 2 which will exclude the people with the many other types of diabetes that require insulin.***

Secondly, the language in the draft that notes it could be covered or type 2 people "on insulin therapy AND are unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan" - this point leaves room for insurance companies to deny coverage at the beginning of each year while getting an updated prior auth for the year for their CGM. Our family practice doctors spend many hours on the phone with prior auth departments wrestling to get life saving technology into the hands of their patients. Our concern is that insurance companies will interpret this section to mean that every year they can withhold CGM till the patient demonstrates elevated HbA1Cs and then may cover it. The HbA1C is drawn every 3 months or so and insurance companies, who feel their obligation is to the shareholder and not to the patient, will certainly keep the CGM from my patient for at least 3 months a year which will, again, increase the morbidity and mortality of our diabetic community members. The fact that they are on insulin demonstrates that their blood sugars are not controlled despite an appropriate glycemic management plan, so this is redundant language that puts the burden of proof yearly on the patient and provider. ***Please change the language to include "people on insulin therapy" rather than limiting it to type 2 diabetes with HbA1C out of range which will a) lead to poorer outcomes for patients forced to have poorly controlled diabetes for several months a year to prove the need for their prior authorization and b) increase unnecessary work for providers in family practice who are already burning out and and leaving their profession at an alarming rate.***

Adding this to the pharmacy to reduce burnout in physicians and prescribers who are burned out and leaving the profession due to hours spent jumping through needlessly complicated and drawn out processes designed to create barriers to care for patients so insurance companies don't have to cover the patients who pay their salaries. ***Please add CGM to the Medicaid Preferred Drug List for pharmacy coverage and allow the point of sale lookback. This will allow the pharmacy to recognize that for a patient on insulin, they meet the criteria for coverage rather than needing to drag the prescribing provider into a drawn out prior authorization process which delays care for patients and increases burnout among physicians and prescribers).***

Thank you,

Rachel Spillane, O.D.

An Optometric Physician, Concerned and Vocal Voter and Community Member

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Health Technology Clinical Committee regarding access to CGM,
Date: Tuesday, April 8, 2025 12:33:25 PM

External Email

Hi Everyone,

I strongly support the expansion of coverage for Continuous Glucose Monitors (CGM) for all individuals on insulin therapy, regardless of their type of diabetes, including those with LADA and pancreatogenic diabetes. This measure will improve equitable access to a crucial tool for diabetes management, allowing for more precise control and the prevention of severe complications such as hypoglycemia. Additionally, removing the restriction based on HbA1C levels and including CGM on Medicaid's Preferred Drug List will simplify access without unnecessary administrative barriers, benefiting both patients and healthcare providers. This expansion is essential to ensure that all insulin users have access to the technology they need to improve their quality of life and prevent diabetes-related risks.

--

Liza Oliver Lugo (Alicia) (she/her/Ella)
Population Health Educator / Community Partner Program Manager
Family Health Centers Okanogan County

[redacted]

[redacted]

Office Hours: Monday - Thursday: 7:30 AM - 6:00 PM
Clinic Days: Monday (Brewster Jay Clinic) Thursday (Bridgeport)

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM
Date: Tuesday, April 8, 2025 5:05:43 PM

External Email

I support the expansion of CGM coverage to all individuals on insulin. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.
Thank you!

Lori Gardner RDN, CDCES
Registered Dietitian Nutritionist and Diabetes Care and Education Specialist
KADLEC REGIONAL MEDICAL CENTER
[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Comment regarding CGM access through Medicaid
Date: Tuesday, April 8, 2025 7:00:36 PM

External Email

Hello,

I am emailing to provide comment regarding the latest draft for CGM access through Medicaid.

I am glad CGM access is being expanded to all insulin users, but hope there will be consideration for covering CGM for all "people on insulin therapy" rather than specifying type 1 and type 2 diabetes for eligible diagnoses. There are many types of diabetes that are treated with insulin, and I don't want any of my patients with those diabetes types to be denied access to CGM based on their diagnosis alone.

Additionally, specifying that a person must be unable to achieve A1c targets prior to accessing CGM leaves potential gaps in coverage for those who are already successfully using CGM (which allows them to meet their A1c goal), those who are "meeting goal A1c" through dangerous means like frequent hypoglycemia (which CGM would help identify and rectify), or those whose customized A1c target is lower than the standard (non-individualized) < 7% used to make these decisions. Access should be based on insulin use and otherwise increased risk of hypoglycemia (like when using sulfonylureas) rather than A1c targets.

Finally, I would also request that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS lookback be allowed by the pharmacy to approve coverage. Without allowing for this, many patients will suffer delays in access due to rerouting their prescription to DME coverage. Lower health literacy and unawareness of additional steps required to receive CGM via DME has caused too many of my patients to miss out on access to CGM, leading to worse safety and health outcomes for them and this is unacceptable when we know sufficient access to CGM can save lives.

Thank you for your consideration and for making CGM access for our most vulnerable people with diabetes a priority!

Sarah Loebner, PA-C, MPH (she/her/hers)
Teaching Associate – Diabetes Institute
Division of Metabolism, Endocrinology and Nutrition
University of Washington

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM coverage
Date: Wednesday, April 9, 2025 9:03:16 AM

External Email

As a diabetes care and education specialist I work with many people living with all types of diabetes daily. I am writing in support of the expansion of CGM coverage to all people who use insulin to manage their diabetes. The language “type 1” or “type 2” diabetes does not encompass of those with other types of diabetes such as LADA, MODY, pancreatogenic, and many others. Changing the language to read “people on insulin therapy” is more accurate and safer.

The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. CGM provides safe guards for alerting uses to high and low blood sugars that prevent hospitalizations.

I recommend that CGM be added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your thoughtful consideration for those who must use insulin to manage their diabetes.

Melinda Nix, RDN, CD, CDCES, CPT

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM coverage for Medicaid
Date: Wednesday, April 9, 2025 9:54:46 AM
Attachments: image001.png

External Email

As a diabetes care and education specialist I work with many people living with all types of diabetes daily. I am writing in support of the expansion of CGM coverage to all people who use insulin to manage their diabetes. The language “type 1” or “type 2” diabetes does not encompass of those with other types of diabetes such as LADA, MODY, pancreatogenic, and many others. Changing the language to read “people on insulin therapy” is more accurate and safer.

The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. CGM provides safe guards for alerting uses to high and low blood sugars that prevent hospitalizations.

I recommend that CGM be added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your thoughtful consideration for those who must use insulin to manage their diabetes.
Melinda Nix, RDN, CDCES, CPT

Melinda Nix, RDN CDCES
Diabetes Care and Education Specialist
Insulin Pump Trainer

Providence Adult Endocrinology
[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: HTCC Reimbursement Determination
Date: Wednesday, April 9, 2025 2:18:03 PM

External Email

To Whom it May Concern,

As an RDN and CDCES who worked at a community clinic for 31 years, I personally witnessed what a positive difference the use of CGM's can make for people with diabetes.

I support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes. I request the language be clarified to "people on insulin therapy".

I believe that CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.

I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

Thank you for your consideration.

Liann Sundquist, MS, RDN, CDCES

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM through state Medicaid
Date: Wednesday, April 9, 2025 2:27:07 PM

External Email

To Whom It May Concern,

Please, let it be known, as a nurse in a small rural clinic, I thoroughly support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes. Please, clarify the language to read "people on insulin therapy". Additionally, the language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.

Please, add CGM to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, like the one I work in, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your time and consideration on this topic,

Alisa Elliott
Staff RN

Family Health Centers
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: PUBLIC COMMENT FOR CONTINUOUS GLUCOSE MONITORING
Date: Wednesday, April 9, 2025 4:10:26 PM

External Email

1. I support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes. I request the language be clarified to "people on insulin therapy".
2. The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.
3. I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.

As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

*CGM IS SO IMPORTANT FOR DIABETES OUTCOMES!

As a nurse, I see the positive effect having a CGM has on patients. It ensures patients understand how their bodies react to carbohydrates and insulin by measuring as often as every minute. PLEASE PROVIDE COVERAGE WITHOUT RESTRICTIONS. IT WILL REDUCE HOSPITAL ADMISSIONS FROM COMPLICATIONS AND POOR HEALTH OUTCOMES THAT ULTIMATELY RESULT IN HIGHER COSTS TO WASHINGTON STATE. The elderly often have trouble poking their fingers and standard glucose monitors are cumbersome for those with poor vision and unsteady hands.

Thank you for your consideration,

--
Christina Nickell, RN
Family Health Center
Remote RN Case Manager
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM coverage comments
Date: Wednesday, April 9, 2025 9:41:25 PM

External Email

Hello,

I am a registered nurse practitioner and Certified Diabetes Care and Education Specialist with more than 5 years of experience working directly with patients with diabetes. In my clinical practice I continue to see that CGM is a crucial technology for insulin dependent patients with diabetes, helping to improve glycemic control while decreasing the risks of hypoglycemia. Unfortunately, access to CGM continues to be limited by insurance coverage and the frustrating red tape of prior authorizations. I urge you to help expand CGM coverage and access for our patients, via the following recommendations:

1. I strongly support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes. I request the language be clarified to "people on insulin therapy".
2. The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.
3. CGM should be added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback should be allowed by the pharmacy to approve coverage.

    As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your time. I hope these changes will be implemented to improve diabetes care for our patients.

Sincerely,
Emily Lindsay, ARNP, CDCES
Tacoma, WA

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Letter of support for CGM coverage in Washington State
Date: Thursday, April 10, 2025 1:24:24 PM
Attachments: Denelle page 2 (002).tiff
Denelle (002).tiff

External Email

Good afternoon,
My name is Denelle Martin and I am a Registered Dietitian and Certified Diabetes Care and Education Specialist here in Washington State. I would like to lend my support for improved access to continuous glucose monitoring technology for our Medicaid patients. I respectfully submit this letter for your consideration.
Thank you,
D. Martin, RD, LD CDCES

April 10, 2025

HCA HEALTH TECHNOLOGY CLINICAL COMMITTEE

CHERRY STREET PLAZA
628 8TH AVENUE SE
OLYMPIA, WA 98501

I am sending this letter today to provide the committee a perspective from a Certified Diabetes Education and Care specialist who has "boots on the ground" experience with people with diabetes.

I currently work for a tribally run diabetes program here in Washington State but have worked for 25 years in Arizona Tribal Communities as a diabetes educator. I would like to respectfully present my thoughts about the use of continuous glucose monitoring (CGM) in the treatment of diabetes.

Simply put, a continuous glucose monitor is an integral, essential part of caring for one's diabetes. This is true regardless of the type of diabetes, duration of the disease or medication treatment modalities. Using a CGM allows a person to see blood sugar data in real time, assess blood sugar patterns and target areas for improving the level of control. An individual can assess the effects of insulin/medications, foods and physical activity in a way that is vastly superior to fingerstick blood sugar testing alone. Monitoring blood sugar with this technology prevents complications from high or low blood sugar and prevents hospitalizations and emergency room use.

This technology should be available to any person with diabetes regardless of their "type" of diabetes or age. High blood sugar is high blood sugar-whether a person is dealing with Type 1, Type 2, MODY, LADA, pregnancy or any other condition which brings about diabetes.

In addition, individuals should enjoy continued coverage for CGM devices even if blood sugars are technically "in control". Diabetes is a life-long, progressive disease and people should not be penalized for being in control! That is the goal for all stakeholders involved in the care and management of people with diabetes.

Please consider language in your decision that removes barriers and recognizes people with diabetes struggle daily with decisions to control diabetes and keep themselves healthy. The availability of a CGM is a powerful tool in this endeavor.

RESPECFULLY,

Denelle Martin

DENELLE MARTIN, RD CDCES
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Recommendations to Strengthen CGM Access for Medicaid Patients
Date: Thursday, April 10, 2025 1:48:27 PM

External Email

Dear Committee Members,

I am a clinical pharmacist that specializes in diabetes. I work alongside other health care providers in a family practice clinic.

I am writing you today to encourage the support of the expansion of CGM coverage to all individuals on insulin. The language "unable to achieve target HbA1c" leaves room for interpretation for patients who are already at target A1c or who start on CGM and later achieve target. CGMs should be a covered benefit for insulin users, regardless of achieving glycemic targets.

I highly recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Patients that use insulin are a highly vulnerable population and in almost every case they are not testing their blood sugar correctly and highly benefit from CGM data. It is also safer as a provider to adjust their insulin with all the data CGM produce. I have seen numerous cases where this data proves to keep the patient safe and the provider adjusting correctly.

Please consider strengthening CGM access.

Thank you,

Brittany Flesher, PharmD, BCACP

Ambulatory Pharmacy | **MultiCare Health System**

[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM Coverage
Date: Friday, April 11, 2025 10:18:01 AM

External Email

I would like to state my support for expanding the coverage of Continuous Glucose Monitors (CGM) in the diabetic population.

I worked as a Registered Dietitian in dialysis for 21 years. Many of my patients were diabetic and the disease directly lead them to stage 5 chronic kidney disease requiring dialysis. Many of my patients could not get their insurance to pay for a CGM. They had given up on poking themselves to check blood sugars four times a day. I had more than one patient with needle phobia who struggled with glucose checks as well as administering insulin. I also had an insured patient get a CGM device after being hospitalized for diabetic ketoacidosis. Then his insurance would not pay for the replacement sensors. He had limited finances because he needed to decrease his working hours due to the time required for dialysis treatment. I was not able to find an assistance program to help with the sensors. The need for dialysis is an end result for diabetes that is not optimally managed. The CGM is a tool that allows patients to see their glucose in real time. They can make adjustments to their next meal. It was only my most medically compliant patients who were able to obtain CGMs. They all stated that they had to fight/ advocate for themselves quite hard to get insurance to pay for them. I left dialysis before Medicare lowered the requirements to get a CGM. However, the CGM should be available to all patients with diabetes who require insulin regardless of their hemoglobin A1C values. It is the use of the CGM that helps patients keep glucose in range. It should not be taken away once they reach the goal.

Now I work in an acute care hospital an many patients end up hospitalized due to diabetic ketoacidosis due to issues surrounding getting insulin and diabetic supplies like a glucometer and strips or a continuous glucose monitor. Diabetes is a difficult disease to manage and those on insulin have to make adjustment from meal to meal both on what they eat and how much medication. Medicaid or Insurance should attempt to make it as easy as possible for these patients to manage the condition. The CGM is a tool that makes a very big difference in the quality of life for managing diabetes. I do not have any research articles to back up what I have said above. However, my suspicion is the cost of one CGM for two or even five years is far less than the cost of one year on dialysis.

Sincerely,

Amy Myrtue Nelson, MPH, RD, CSR, CD | Clinical Dietitian
MultiCare Capital Medical Center | MultiCare Health System
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Testimony for the expansion of CGM coverage
Date: Friday, April 11, 2025 12:29:25 PM

External Email

Hello, I am a Registered Dietitian Nutritionist and Diabetes Educator and am writing to provide testimony for the expansion of CGM coverage.

1. I support the expansion of CGM coverage to all individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes and I request that the language be clarified to "people on insulin therapy".
2. The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets.
3. I request that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage.
4. I have seen amazing results for hemoglobin A1c reduction in patients using CGMs and would like to see this highly valuable tool be available to all patients with diabetes and prediabetes regardless of medication status.

In health,

Rebecca Tarbert, MS, RDN

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Public comments for CGM access
Date: Friday, April 11, 2025 1:34:41 PM

External Email

To the HTCC,

Thank you for allowing public comments and testimony on the issue of CGM access for people with diabetes in our state. I watched the meeting on March 21st and was happy to see some progress toward more universal coverage for those with insulin, but also had some concerns.

1. The language in the document specified type 1 and type 2 diabetes, but does not distinguish other types of diabetes such as LADA, pancreatogenic diabetes, and MODY which may also be treated with insulin. To avoid potential denials to these individuals, I would recommend to change the language in your document to "individuals with diabetes on insulin therapy" and not distinguish the type of diabetes.

2. I am also concerned with the language that designates CGM approval for those who are "unable to achieve target A1C". This may potentially lead to denials for those who have in-target A1C levels, yet may still be at risk for hypoglycemia or need CGM to help operate their insulin pump technology. It also puts people at risk of losing current therapy, if they are initially approved for CGM and then demonstrate an improvement in glucose control, their CGM could later be denied.

3. Finally, during the public meeting on 3/21/25, much of the discussion around use of CGM in those on non-insulin therapies seemed to lack the first-hand experience of working with people with diabetes and therefore the benefits did not seem apparent. I have worked with patients with diabetes for 10 years as a diabetes care and education specialist, and in this role I have seen numerous times the benefits of patients being able to monitor glucose patterns and make behavioral changes from this knowledge. The evidence in the form of journal articles on this topic may not yet be robust, grade A level, and may be expert opinion. But expert opinion should count for something. We are the people who follow and guide these patients and know best what they need. CGM will expand to the standard of care with all people with diabetes in the future, and it would be wonderful for Washington to take the lead in increasing access.

And to an issue not specified in the HTCC report, I would like to ask that CGM be added to the preferred drug list to ensure pharmacy coverage, not just DME coverage. Additionally pharmacies should be able to use point of sale lookback to see if patients are on qualifying medications to approve CGM. This helps limit the extreme burden of prior authorizations, and delay of care. Many offices are not staffed to do a high volume of PAs, and this leads to providers withholding CGM orders because they cannot manage the PAs.

Again, I thank you for all the work you have put into this issue.

Nicole Treanor, MS, RD, CD, CDCES

Virginia Mason Franciscan Health
Diabetes Education Program Coordinator

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Comment Letter on Draft Findings and Decision For HTTC Continuous Glucose Monitoring Review
Date: Friday, April 11, 2025 3:12:18 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png
image007.png
HTCC Comment Letter April 11.pdf

External Email

Good afternoon,

Attached is our letter with comments on the draft findings and decision for HTCC's review of continuous glucose monitors. Can you please confirm that you received our letter? Thanks.

Matt Prokop

Director, State Government Affairs
(Northwest and North Central: AK, ID, KS, MN, MT, ND, NE, OR, SD, WA, and WY)

Central Time Zone

[redacted]

American Diabetes Association.

April 11, 2025

Health Technology Clinical Committee (HTCC)
Washington Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Re: Comments on draft findings and decision related to review of coverage for continuous glucose monitors

Dear Health Technology Clinical Committee Members:

On behalf of the American Diabetes Association (ADA), we appreciate the opportunity to provide comments on the release of your draft findings and decision. After reviewing the language, we wanted to highlight the positive changes the committee proposed and ask the committee to consider making additional revisions in the final coverage criteria guidelines.

We thank the committee for making the following changes:

- Removing the requirement that an individual living with type 2 diabetes must be on intensive insulin therapy, so all types of insulin users are included in the new coverage criteria

- Allowing all pregnant women with diabetes to qualify for coverage

The inclusion of these populations in the final guidelines is an important step forward in helping more Washingtonians better manage their diabetes. We strongly recommend keeping these proposed changes in the final coverage criteria.

In addition to providing feedback on the positive changes, we wanted to share additional recommendations for the committee to consider in developing a final policy that fits with current clinical evidence and prevents barriers for patients and providers. We recommend removing the requirement that patients with type 2 diabetes on any insulin therapy meet certain additional criteria. For example, those criteria preclude coverage for someone who is currently achieving target HbA1C unless they have recurrent hypoglycemia or hypoglycemia unawareness. This criterion is subjective, burdensome for the provider, and should be eliminated. The fact that someone is currently achieving target HbA1C does not mean that they will continue to do so.

Additionally, we ask that the final guidelines do not reinstate a “4 times per day” blood glucose checking requirement in the coverage criteria. Providers have shared that such a requirement is not clinically relevant, administratively burdensome, and delays access to CGMs. The ADA’s Standards of Care also does not include this as necessary clinical criteria. Having consistent criteria among people with diabetes will allow for equitable access and provide clear guidance to providers in determining if their patients qualify to access continuous glucose monitors.

We thank the committee for your work and respectfully ask that the final guidelines include the committee's broadened coverage, and the recommendations shared in this letter.

Sincerely,

Matt Prokop

Matt Prokop
Director of State Government Affairs
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Public Comments for Increased State Medicaid CGM Access
Date: Friday, April 11, 2025 3:05:54 PM

External Email

I have been a Diabetes Care and Education Specialist (DCES) FOR ~ 5 years during the diabetes tech explosion of more hybrid closed loop insulin pumps and increasing patient access to CGM among the commercially insured. I also have a background as a Registered Dietitian Nutritionist for 15 years. In my time as a DCES I have seen first hand how real time CGM feedback has the power to quickly inform and motivate patients of ALL backgrounds along their diabetes journey. The CGM allows the patient to learn surprising factors (https://www.webmd.com/diabetes/facts-about-sugar-spikes) that spike their blood sugars past 180 mg/dL immediately, and in the same instant are motivated to effect change. Long durations of blood sugar spikes like this whether due to these surprising factors or wide blood sugar variation due certain medications like insulin or medications that impact glucose absorption or insulin production lead to diseases of the kidney, eyes, heart, brain and nervous system (https://www.webmd.com/diabetes/facts-about-sugar-spikes). Yet adherence to self monitoring of blood glucose (SMBG) remains low. One large international study found among adults with T1DM the rate is 44% and among adults with T2DM the rate is a dismal 24%. In practice, I find that by the time patients get to my office after a new T2DM diagnosis it is a common occurrence that they are not clear on how often they should check, how to use their glucometer, and many are afraid to prick their finger in the first place. Among adult patients with T1DM only 21% report using a CGM, and multiple studies demonstrate improvements in patients' glycemic control if CGM is worn consistently (at least 60% of the time). As a DCES I have had the honor of helping patients navigate and solve the common barriers to learning and adapting to both glucometers and newer technologies like CGMs such as pain associated with wrong sensor placement, sensor insertion issues, sensor adhesives, sensor connections, nuisance alarms, understanding device accuracy, incorporating CGM use into daily activities and sports, and skin reactions due to the sensor adhesive. However, one barrier I cannot fix is the cost of CGM supplies if my patient's insurance will not cover it (https://pmc.ncbi.nlm.nih.gov/articles/PMC4604539/pdf/10.1177_1932296814567709.pdf). Some of my patients have resorted to paying out of pocket because intermittently yet they live well below the poverty line, because of the quality of life they feel from controlled blood sugars via CGM compared to SMBG.

I support the expansion of CGM coverage to ALL individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes and you request the language be clarified to "people on insulin therapy".

The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve their target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. As you can see above, the reason why many achieve their targets in the first place is because they are using the CGM as a motivational/educational tool. It's like taking someone's medicine away once their symptoms have improved for a chronic disease.

I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your time and consideration.

Best,
Shirley~

Shirley Matenda, MS RDN CD CDCES
Certified Diabetes Care and Education Specialist
Registered Dietitian Nutritionist
Insulin Pump & CGM Specialist

Virginia Mason Franciscan Health™
Franciscan Endocrine Associates
[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Medicaid coverage of CGM
Date: Friday, April 11, 2025 3:31:28 PM

External Email

I am a diabetes educator who has seen patients for 6 years. One of the best tools that I have seen/used for controlling diabetes has been the CGM. Most patients come back to me after using and tell me that they learned so much about their diabetes and how to keep it controlled. They would like to continue to use CGM as a tool for this. In my experience, this has helped lower A1C levels, increased the desire to control their diabetes, enabled people to reduce the need for other medications, and to reduce the number and severity of chronic diabetes problems.
All patients who are diagnosed with diabetes should have access to a CGM to manage their diabetes.

Christina Burrows, RN

Christina Burrows, RN, CDCES
Certified Diabetes Care and Education Specialist
Nutrition and Diabetes Learning Center - Kadlec Health Plex
Inpatient Diabetes Care - Kadlec Regional Medical Center
[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Medicaid coverage of CGM
Date: Friday, April 11, 2025 3:31:28 PM

External Email

I am a diabetes educator who has seen patients for 6 years. One of the best tools that I have seen/used for controlling diabetes has been the CGM. Most patients come back to me after using and tell me that they learned so much about their diabetes and how to keep it controlled. They would like to continue to use CGM as a tool for this. In my experience, this has helped lower A1C levels, increased the desire to control their diabetes, enabled people to reduce the need for other medications, and to reduce the number and severity of chronic diabetes problems.
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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Public Comments on HTCC DRAFT Findings and Decision - Continuous Glucose Monitoring
Date: Friday, April 11, 2025 4:18:08 PM
Attachments: Dexcom Comments on Washington HTCC Decision and Findings April 10__Public1.pdf

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External Email

Dear Washington State Health Care Authority,

Please find attached Dexcom's public comments on the draft findings and decision regarding Continuous Glucose Monitoring (CGM) coverage.

We appreciate the opportunity to provide feedback and commend the committee for its commitment to evidence-based policymaking.

Thank you!

Best regards,

Hamza Alshannaq, MD, MPH:: DEXCOM
Senior Manager-Health Economics & Outcomes Research | Global Access
[redacted]

dexcom

[redacted]

April 10, 2025

RE: Public Comments on Health Technology Clinical Committee DRAFT Findings and Decision - Continuous Glucose Monitoring

To the Washington State Health Care Authority,

We commend the Washington State Health Care Authority for its positive recommendation to expand CGM access to all individuals with diabetes using insulin, regardless of insulin regimen or diabetes type. The Washington State Health Care Authority, which provides health coverage to over 2.5 million residents through Medicaid and public employee health plans, plays a critical role in shaping access to care across the state. As part of the Health Technology Assessment (HTA) Program, the committee's CGM coverage decision not only impacts access and outcomes within Washington but may also influence other states that view Washington's HTA as a national model for evidence-based coverage policy. The decision aligns with the American Diabetes Association (ADA) 2025 Standards of Care, which assign a Grade A recommendation for CGM use in all youth and adults on any insulin therapy (Recommendation 7.15). Importantly, when recommending CGM for insulin users, the ADA does not impose clinical restrictions—such as requiring failure to meet glycemic targets. This reflects both the strength of the evidence and the recognition that CGM should be a standard part of care for all people using insulin.

We also appreciate the committee's decision to provide CGM coverage for individuals with gestational diabetes, regardless of insulin use, which reflects growing recognition of CGM's value in improving maternal and neonatal outcomes and aligns with the expanding coverage trends among state Medicaid programs.

While we support these expansions, we are concerned that the current recommendation does not extend to individuals with type 2 diabetes who are not on insulin therapy. A significant proportion of individuals in this population are at increased risk of hypoglycemia, particularly older adults and those using glucose-lowering agents associated with hypoglycemia or managing multiple comorbidities. Importantly, Medicare's Local Coverage Determination (LCD) provides CGM access to individuals with a documented history of problematic hypoglycemia, regardless of insulin use, reflecting a risk-based approach rather than one tied to therapy type.

In parallel, the ADA 2025 Standards of Care recommend using CGM in adults with type 2 diabetes treated with non-insulin glucose-lowering agents (Recommendation 7.16, Grade B) to support individualized glycemic management. Additionally, Recommendation 6.14 gives a Grade A endorsement for the use of CGM in individuals at high risk of hypoglycemia, further reinforcing the rationale for expanding access beyond insulin use. Accordingly, the current Washington HTA position on excluding this population does not fully align with established national coverage policies or the broader clinical consensus supporting CGM use based on individual patient risk and clinical need.

dexcom

[redacted]

Recent real-world evidence further underscores the value of CGM in this population. Garg et al. (2024) analyzed data from over 74,000 adults with T2D and found that CGM use was associated with a 1.1% reduction in HbA1c among non-insulin users—comparable to or greater than reductions seen in insulin-treated individuals. Furthermore, non-insulin users experienced a 31% reduction in acute diabetes-related hospitalizations and a 30.7% reduction in emergency room visits, including those due to hypoglycemia. These results demonstrate that CGM offers meaningful clinical benefits for this group, particularly in preventing acute complications. Notably, many of these improvements occurred without changes in medication, underscoring the value of CGM as a tool that enhances self-management and glycemic control independently.

While the current recommendation expands access for insulin users, the continued exclusion of non-insulin-treated individuals—even those at high risk—may disproportionately impact underserved populations. According to the CMS Framework for Health Equity, one of the central priorities is to "assess causes of disparities within CMS programs, and address inequities in policies and operations to close gaps" (Priority 2). The CMS Framework explicitly calls attention to addressing chronic diseases like diabetes, which disproportionately affect racial and ethnic minorities, individuals with lower socioeconomic status, and those with limited access to care. By not providing CGM access to non-insulin users at high risk of hypoglycemia, the policy may inadvertently create structural barriers to equitable care, particularly for those unable to safely self-monitor or manage their diabetes due to comorbidities, low health literacy, or limited access to technology. As CMS notes, underserved communities are often more likely to experience avoidable hospitalizations and poorer outcomes due to inadequate management of chronic conditions such as diabetes. We recommend that the Washington HTA align its coverage policy with CMS's coverage policy, which includes individuals with a history of problematic hypoglycemia regardless of insulin use. Doing so would help reduce disparities and support Washington State's alignment with national equity priorities.

To support a risk-based and evidence-informed coverage expansion, access for non-insulin-treated individuals could be guided by clear clinical criteria, similar to those used in Medicare policy. For example, CGM could be made accessible to individuals who:

- Have a documented history of recurrent level 2 hypoglycemia (blood glucose <54 mg/dL) despite multiple medication adjustments
- Have experienced a level 3 hypoglycemic event requiring third-party assistance; or
- Are unable to recognize or communicate symptoms of hypoglycemia.

Applying such criteria would help ensure that CGM is directed to those at greatest clinical risk, consistent with established federal policy and ADA guidelines. It would also provide a structured framework for decision-making that balances access, safety, and appropriate utilization in a large and diverse population.

dexcom

[redacted]

We appreciate the opportunity to comment on the draft findings and commend the committee for its thoughtful deliberation and commitment to evidence-based policymaking. We urge the Washington Health Technology Clinical Committee to consider expanding CGM coverage to include individuals with type 2 diabetes who are not on insulin but are at risk of hypoglycemia, in alignment with national clinical guidelines, federal coverage policy, and equity priorities. We welcome continued dialogue and remain committed to supporting efforts that promote access to high-quality, equitable care for all individuals with diabetes.
Sincerely,

Sincerely,

Hamza Alshannaq, MD, MPH
Senior Manager of Health Economics & Outcomes Research
Dexcom, Inc.
[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Comments for CGM coverage
Date: Friday, April 11, 2025 4:35:12 PM
Importance: High

External Email

Please see my comments on the draft decision for CGM coverage highlighted below.

HTCC reimbursement determination:
CGM is a covered benefit for:

- Individuals with Type 1 diabetes OR
- Individuals with Type 2 diabetes who are on insulin therapy, Any type of insulin requiring diabetes OR
  - o Are unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan, OR
  - o Are suffering from recurrent severe episodes of hypoglycemia (blood glucose < 50 mg/dl OR symptomatic), OR – this should not be limited to people on insulin as many oral diabetes medications may also contribute to hypoglycemia
  - o Have hypoglycemia unawareness

- Individuals who are pregnant who have:
  - o Type 1 diabetes, OR
  - o Type 2 diabetes, OR
  - Gestational diabetes Even gestational diabetes not on oral medication or insulin therapy.

Non-covered indicators:

- CGM for adults and children with type 2 diabetes not on insulin is not a covered benefit. I think CGM should be covered for all children with type 1 or type 2 diabetes whether or not they are using insulin. I saw a teenager with type 2 diabetes today who is on oral diabetes medication. Having the CGM data for our diabetes education visit today was valuable in helping discuss behavior change and food choices. This helped emphasize the need for physical activity and how beneficial it is in keeping blood glucose in target.

CGMs should be a pharmacy benefit on the preferred medication/formulary list for easier access.

Thank you,
Carrie Swift

Carrie Swift, MS, RDN, BC-ADM, CDCES, FADCES
Registered Dietitian Nutritionist
Certified Diabetes Care and Education Specialist
Kadlec Healthplex
[redacted]
[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM Public Comment
Date: Friday, April 11, 2025 4:57:47 PM

External Email

To Whom It May Concern,

I am writing to the HTCC to provide comments regarding the recent assessment for Medicaid coverage for continuous glucose monitor devices. I am providing these insights as a primary care pharmacist at Virginia Mason Medication Center.

I manage diabetes for my patients, and I am a huge advocate of expanding the CGM access to all patients with diabetes (type 1, type 2, type 3c, etc.). CGM allows patients to not only manage their medication regimen but also see how different diet and exercise patterns affect their glucose levels.

Below is copied from the letter sent by our endocrinology pharmacist Gregor Derupe, PharmD, BC-ADM, and I echo all the statements.

There are key components of the draft decision that should be considered.

1) The diagnoses listed (Type 1 and Type 2) are limiting to patients who would greatly benefit from CGM usage. We have completely insulin dependent patients that have undergone pancreatectomy that fall into the category of pancreatogenic diabetes (also known as Type 3c). Some of these patients may be insulin dependent like Type 1 diabetes with even more risk of hypoglycemia due to exocrine pancreatic insufficiency. The current language for diagnostic criteria for coverage should include both patients with Type 3c and LADA (late onset Type 1 diabetes). It would be recommended that the language therefore include "patients on insulin therapy" to include the scope of patients that would benefit from this coverage.

2) The language does not include patients who have restrictive/debilitating disabilities that would make fingerstick glucose monitoring difficult to achieve. Although some of these patients may not be on insulin, lack of coverage for a continuous glucose monitor would make it much harder for patients with manual dexterity issues to monitor their blood sugars. This opens up the question for medical justice and lack of equity for those that may otherwise be considered for accommodations through the American Disabilities Act. Failure to consider these patients would be discriminatory and negligent.

3) The draft decision does not include continuation of care for those who may have previously achieved target A1c because they had access to use of a continuous glucose monitor. I have seen multiple incidences of patients who have previously

been well controlled due to being able to adjust their insulin doses based on what their current level is and the trajectory of their glycemic trend per a continuous glucose monitor. Failure to consider continuation of this care poses great risk for harm to the patient.

4) Consideration for coverage for patients with chronic kidney disease. In many circumstances, patients with chronic kidney disease may not be on insulin for therapy. However, there is a high likelihood that the A1c will be underestimated and inaccurately depicts a false adequate control. As a clinician, the best way for us to be able to determine if their current regimen is adequate would be to see the continuous trend of their glucose levels.

5) I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you in advance for your consideration. Please understand that having a CGM is often a life-changing experience for patients with diabetes and leads to better diabetes management. I can confidently say that the cost of expanding CGM coverage will be offset by the healthcare cost savings for things like hospitalization and diabetes complication management (e.g., ASCVD, neuropathy, etc.).

Best regards,

Jinha Park

Clinical Pharmacist

Department of Primary Care

She/her/hers

Virginia Mason Franciscan Health™

[redacted]

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: CGM support and expansion
Date: Friday, April 11, 2025 4:58:21 PM

External Email

To whom it may concern,

I am a physician practicing as an attending now for nearly 7 years. I have seen how much continuous glucose monitoring helps patients identify healthy foods for their diabetes, often improving their A1c by 2-3 whole numbers (more than what 2 oral diabetes medications could do) just by the feedback from their CGM.

I support the expansion of CGM coverage to ALL individuals on insulin, however the language specifying "type 1" or "type 2" diabetes is not inclusive of those with LADA or pancreatogenic diabetes and you request the language be clarified to "people on insulin therapy".

The language "unable to achieve target HbA1C" leaves room for interpretation for patients who are already at target A1C, or who start on CGM and later achieve their target. CGM should be a covered benefit for insulin users, regardless of achieving glycemic targets. As you can see above, the reason why many achieve their targets in the first place is because they are using the CGM as a motivational/educational tool. It's like taking someone's medicine away once their symptoms have improved for a chronic disease.

I recommend that CGM is added to the Medicaid Preferred Drug List for pharmacy coverage and that POS (Point of Sale) lookback be allowed by the pharmacy to approve coverage. As it stands, if CGM is not on the preferred drug list, then it is unclear whether it can be sent via pharmacy or DME, and if sent by DME it will likely require prior authorization. This is a burden, especially to smaller practices and primary care offices, and will inhibit prescription of the device. POS lookback allows the pharmacy to see if the patient has a current prescription for insulin (i.e. meets the above criteria) and allow for coverage, versus having to do a PA.

Thank you for your time and consideration.

--
Respectfully,

Dylan

Dylan Tracy D.O.
FMC Seahurst
[redacted]

[redacted]

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From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: Final comments CGM Draft
Date: Friday, April 11, 2025 5:00:45 PM

External Email

From: [redacted]
Sent: Friday, April 11, 2025 4:59 PM
To: shtap@hca.wa.gov <shtap@hca.wa.gov>
Subject:

Dear HCA Health Technology Clinical Committee,

I am writing to thank you for your recognition of the importance of CGM being a covered benefit for all pregnant people with Type 1, Type 2 and Gestational Diabetes, regardless of whether they have started insulin therapy or medication management.

This will dramatically improve our ability to identify, counsel and manage hyperglycemia in pregnancy and exponentially reduce risks in pregnancy, birth and beyond for the dyad.

However, I am concerned about additional types of diabetes that are not specifically mentioned: LADA, MODY and pancreatogenic diabetes, or Type 3c diabetes. For these individuals, not specifically mentioning their conditions in your final decision could lead to delays and barriers in appropriate counseling, management and treatment. Alternative wording that could include these individuals might be "Individuals who are pregnant with any type of diabetes" or "Individuals who are pregnant with any type of hyperglycemia."

I am also curious if there is a way to reduce the burdensome need for administrative work and prior authorizations by making it so if pharmacies see covered diagnosis or medication management, if a prior authorization can be bypassed?

Lastly, a cost savings measure may be receivers/readers only being given to those individuals who need them. In my practice, less than 1 in 40 people have a phone that is not compatible with the CGM apps. These are the only individuals who need a receiver or reader in order to use their CGM. However, I often see these prescribed and dispensed by the pharmacies regardless of whether they are needed or not.

Thank you for this opportunity to contribute to your final decision making!

Sending my best,
Tara Cardinal, CNM, ARNP

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: FW: IMMEDIATE ATTENTION REQUIRED: Final chance to make public comments for CGM
Date: Saturday, April 12, 2025 6:09:31 AM
Attachments: 11UWLetter to Washington Health AuthorityCGMletterfinalcomments.docx

External Email

Hello I am so sorry and I hope you can add these comments as the day on Friday slipped away from me

Nicole Ehrhardt

Send Comments To: shtap@hca.wa.gov

All information and draft findings can be found at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/glucose-monitoring

Assessment timeline (2025)

- **Draft key questions published:** September 3, 2024
  - **Public comment period:** September 3 to 16, 2024
- **Final key questions:** October 2, 2024
- **Draft report published:** January 9, 2025
  - **Public comment period:** January 9 to February 7, 2025
- **Final report published:** February 28, 2025
- **HTCC public meeting:** March 21, 2025
- **Draft findings and decision published:** March 28, 2025
  - **Public comment period:** March 28 to April 11, 2025
- **Final findings and decision published:** June 19, 2025

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Letter to Washington Health Technology Clinical Committee

Date: 4/8/2025

Subject: Increasing Access to Continuous Glucose Monitoring for Type 2 Diabetes Patients and Gestational Diabetes

Dear Members of the Washington State Health Technology Clinical Committee,

I am writing to provide additional comments on the CGM 2025 report and draft decision. **Please reduce the administrative workload on providers and clinics to ensure that their primary focus remains on supporting patients living with diabetes.**

Draft Decision:

HTCC reimbursement determination:

CGM is a covered benefit for:

- Individuals with Type 1 diabetes OR
- Individuals with Type 2 diabetes who are on insulin therapy AND
    - Are unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan OR
    - Are suffering from recurrent severe episodes of hypoglycemia (blood glucose < 50 mg/dl or symptomatic) OR
    - Have hypoglycemia unawareness OR
- Individuals who are pregnant and have:
    - Type 1 diabetes OR
    - Type 2 diabetes OR
    - Gestational diabetes

Non-covered indicators:

- CGM for adults and children with type 2 diabetes not on insulin is **not a covered benefit.**

Recommended Suggestions:

- Please change the language to CGM **is covered for all individuals on insulin**. Please remove the language specifying "type 1" or "type 2"
- The phrase "unable to achieve target HbA1C" can have different meanings for patients who are already at target A1C or who start using CGM and later achieve the target. CGM should be available as a benefit for insulin users, regardless of glycemic targets. This additional language will require extra paperwork and documentation, placing a burden on clinics and providers. **Please remove this language.**

- CGM needs to be **added to the Medicaid Preferred Drug List for pharmacy coverage**. If CGM is not listed, it may be unclear whether it can be dispensed through a pharmacy or DME; prior authorization might be required via DME. This could pose difficulties for smaller practices and primary care offices, restricting prescriptions. POS lookback lets pharmacies verify active insulin prescriptions and approve coverage without prior authorization.

Thank you for considering these suggestions.

Thank you for your attention to this important matter. I look forward to your favorable response and the positive impact it will have on our community.

Sincerely,

Nicole Ehrhardt, MD
Assistant Professor of Medicine

Arthi Thirumalai, MBBS
Associate Professor of Medicine

Irl B. Hirsch, MD MACP
Professor of Medicine

University of Washington Diabetes Institute and Harborview Medical Center
Division of Metabolism, Endocrinology and Nutrition | UW Medicine

With support from:

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Director UW Medicine LatinX Diabetes Clinic

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Stephanie Kim, MD
Clinical Assistant Professor

Amy Eby, MD
Clinical Assistant Professor

Savitha Subramanian, MD
Professor of Medicine

Roini Wadhwani, ARNP
Sarah Loebner, PA-C, MPH

Subbulaxmi Trikudanathan, MD
Clinical Professor of Medicine

Mayumi Endo, MD
Clinical Assistant Professor

Kate Weaver, MD
Clinical Associate Professor

Anthony Desantis, MD
Clinical Professor of Medicine

University of Washington Diabetes Institute and Harborview Medical Center

From: [redacted]
To: HCA ST Health Tech Assessment Prog
Subject: 20250321B – Continuous glucose monitoring
Date: Monday, April 14, 2025 1:07:31 PM

External Email

To the P&T Committee:

As a clinical pharmacist practicing in primary care, I am writing to advocate for my patients who rely on WA HCA Medicaid benefits. Ensuring comprehensive health coverage is crucial for improving community health outcomes and saving healthcare dollars with targeted preventive care.

First, I am thrilled to see the update to coverage for pregnant patients and strongly support the draft decision to extend CGM coverage to pregnant patients of all diabetes types regardless of their pharmacologic treatment. This change is very likely to help reduce C-section rates and NICU admissions, improving outcomes and reducing cost of care.

Second, I thank the committee and endorse the draft decision to provide CGM for patients with type 1 diabetes with no secondary criteria. Access to this technology is essential for meeting the standard of care and improving patient management, and removing barriers to access for CGM in this population improves outcomes and reduces emergency department visits and hospital admissions by empowering patients to prevent hypoglycemia and DKA using real-time continuous glucose monitoring.

In addition, I write to advocate for a few key changes to the draft decision:

1) A significant change that would remove barriers to care for patients and prescribers would be placing CGM on the pharmacy formulary as a strictly pharmacy benefit. Right now, our five Medicaid payors differ in how they adjudicate their CGM claims, some going to the pharmacy and some going to DME through the medical benefit. Having all five of our Medicaid payors on the same pathway for claim adjudication would streamline the prescription process and reduce confusion among healthcare providers. This change would also simplify coverage restrictions allowing qualification for coverage to be determined using associated diagnosis codes at the pharmacy point of sale, minimizing manual prior authorizations and reducing costs.

2) Inclusive Language: Revising the drafted criteria to eliminate the diagnosis of type 2 diabetes on insulin and instead use the language, "Individuals with diabetes who are on

insulin therapy" would ensure coverage for all insulin-dependent diabetes conditions. The language as it exists has the unintended consequence of excluding patients with insulin dependence from disease states other than type 1 or type 2 diabetes. This approach recognizes the similar risks of hypoglycemia and need for CGM across all insulin users of different diabetes diagnoses.

3) Eliminate all three of the sub-criteria for patients using insulin in order to allow prescribers to meet the 2025 ADA Standards of Care for their patients using insulin.
- The first sub-criteria would mean that patients would need to fail their glycemic management plan annually in order to continue on their CGM therapy. This unintended consequence would cause unnecessary disruptions in therapy and require patients to lose access to a therapy that had been working for them.
- The second and third sub-criteria could be eliminated and replaced with a separate hypoglycemia coverage pathway. See next point.

4) Hypoglycemia Coverage: Adding coverage for patients experiencing hypoglycemia without insulin therapy is essential. Many patients on sulfonylureas or similar medications face significant hypoglycemia risks, and adding a separate coverage pathway for patients who experience hypoglycemia on therapies other than insulin would allow prescribers to meet the ADA Standards of Care for our patients. Language such as "Individuals on therapy for diabetes that causes hypoglycemia." This language would limit coverage to patients with a diabetes diagnosis but expand coverage to patients with risk for problematic hypoglycemia. This change would also allow a pharmacy point of sale look-back and allow for elimination of manual prior authorizations while still upholding the desired coverage restrictions.

There is ample research that supports these changes. Studies show that CGM access reduces emergency department visits and hospitalizations for patients with type 2 diabetes, even those not on insulin therapy. This highlights the need for broader CGM coverage to improve outcomes and reduce healthcare costs. Additionally, patients who use CGM as part of their diabetes therapy have significantly improved outcomes including reduced hypoglycemia, improved A1C, and improved time spent in goal glucose range. This research has already guided the ADA Standards of Care, and I encourage WA HCA to align their coverage with these Standards of Care to allow your providers to meet those standards for our patients.

https://diabetesjournals.org/care/article/48/Supplement_1/S146/157557/7-Diabetes-Technology-Standards-of-Care-in
(Specifically 7.15 - 7.18 for the Standards of Care for CGM use in diabetes)

https://dom-pubs.pericles-prod.literatumonline.com/doi/10.1111/dom.15866
https://orbi.uliege.be/handle/2268/316103
https://pmc.ncbi.nlm.nih.gov/articles/PMC11686249/

Thank you for considering these recommendations. Expanding CGM coverage will enhance patient care and yield long-term savings by preventing complications and hospitalizations.

Best regards,

Leanna Davis, PharmD, BCACP, CDCES (she/her)
Faculty Pharmacist, Tacoma Family Medicine Residency
Program Director, MultiCare PGY2 Ambulatory Care Pharmacy Residency
MultiCare Health System
[redacted]

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Washington State Health Care Authority

Health Technology Clinical Committee
DRAFT Findings and Decision

Topic: Continuous glucose monitoring
Meeting date: March 21, 2025
Final adoption: Pending

Number and coverage topic:

20250321B – Continuous glucose monitoring

HTCC coverage determination:

Continuous glucose monitoring (CGM) is a **covered benefit with conditions.**

HTCC reimbursement determination:

Limitations of coverage:
CGM is a covered benefit for:

- Individuals with Type 1 diabetes

OR

- Individuals with Type 2 diabetes who are on insulin therapy, AND
  - Are unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan, OR
  - Are suffering from recurrent severe episodes of hypoglycemia (blood glucose < 50 mg/dl or symptomatic), OR
  - Have hypoglycemia unawareness

OR

- Individuals who are pregnant who have:
  - Type 1 diabetes, OR
  - Type 2 diabetes, OR
  - Gestational diabetes

Non-covered indicators:

- CGM for adults and children with type 2 diabetes not on insulin is **not a covered benefit.**

Notes:

- See final key questions for populations and treatments within the scope of this determination.

Related documents:

- Final key questions
- Final evidence report
- Meeting materials and transcript

Agency contact information:

Agency	Phone Number
Labor and Industries	1-800-547-8367
Public and School Employees Health Plan	1-800-200-1004
Washington State Medicaid	1-800-562-3022

HTCC coverage vote and formal action:

Committee decision

Based on the deliberations of key health outcomes, the committee decided that it had the most complete information: a comprehensive and current evidence report, public comments, and state agency utilization information. The committee discussed and voted separately on the evidence for the use of continuous glucose monitors (CGM) for adults and children with type 2 diabetes on insulin, pregnant people with type 1, type 2, or gestational diabetes, and adults and children with type 2 diabetes not on insulin. The committee decided that the current evidence on CGM is sufficient to determine coverage with conditions for those on insulin. The committee considered the evidence, public comment, and expert input, and gave greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

Based on these findings, the committee voted to cover with conditions CGM for adults and children with type 2 diabetes on insulin, and cover unconditionally CGM for pregnant people with type 1, type 2, or gestational diabetes.

	Not covered	Covered under certain conditions	Covered unconditionally
Adults and children with type 2 diabetes on insulin	0	7	1
Pregnant people with type 1, type 2, or gestational diabetes	0	0	8
Adults and children with type 2 diabetes not on insulin	8	0	0

Discussion

The committee reviewed and discussed the available studies on CGM for adults and children with type 2 diabetes on and not on insulin, and pregnant people with type 1, type 2, or gestational diabetes. Details of study design, inclusion criteria, outcomes and other factors affecting study quality were discussed. In addition to consideration of the evidence from the report and evidence shared by public commenters, the committee discussed other payer policies and the relationship to Medicare and HTCC decision process. A majority of committee members present supported the conditions of coverage on CGM for adults and children with type 2 diabetes on insulin and to cover unconditionally for pregnant people with type 1, type 2, or gestational diabetes. Details of study design, inclusion criteria, outcomes, cost, cost-effectiveness, and other factors affecting study quality were discussed as well as clinical application.

Action

The committee checked for availability of a Centers for Medicare and Medicaid Services (CMS) national coverage decision (NCD). For adults with type 2 diabetes, continuous glucose monitors are covered if taking insulin of any kind or any amount, or have a history of problematic hypoglycemia. Not applicable to children or pregnant people with type 2 diabetes, or pregnant people with gestational diabetes mellitus.

The committee discussed clinical guidelines identified from the following organizations:

- American Diabetes Association Standards of Care in Diabetes: Chapter 7 Diabetes Technology, 2024
- American Association of Clinical Endocrinology Developing a Diabetes Mellitus Comprehensive Care Plan, 2022
- National Institute of Health and Care Excellence (NICE): Hearing loss in adults (updated 2023), 2018
- American Association of Clinical Endocrinology The Use of Advanced Technology in the Management of Persons with Diabetes Mellitus, 2021
- Endocrine Society Management of Individuals with Diabetes at High Risk for Hypoglycemia, 2023
- National Institute of Health and Care Excellence (NICE): Type 2 Diabetes in Adults: Management, 2022
- Ontario Health Quality, Flash Glucose Monitoring System for People with Type 1 or Type 2 Diabetes: Recommendations, 2019
- Veterans Administration/Department of Defense: Management of Type 2 Diabetes Mellitus, 2023

The recommendations of the guidelines vary. The committee's determination is consistent with the noted guidelines.

HTA staff will prepare a findings and decision document on HBOT for SSNHL and AAT for public comment to be followed by consideration for final approval at the next committee meeting.

Health Technology Clinical Committee Authority:

Washington State's legislature believes it is important to use a science-based, clinician-centered approach for difficult and important health care benefit decisions. Pursuant to chapter 70.14 RCW, the legislature has directed the Washington State Health Care Authority (HCA), through its Health Technology Assessment (HTA) program, to engage in an evaluation process that gathers and assesses the quality of the latest medical evidence using a scientific research company that takes public input at all stages.

Pursuant to RCW 70.14.110, a Health Technology Clinical Committee (HTCC) composed of eleven independent health care professionals reviews all the information and renders a decision at an open public meeting. The Washington State HTCC determines how selected health technologies are covered by several state agencies (RCW 70.14.080-140). These technologies may include medical or surgical devices and procedures, medical equipment, and diagnostic tests. HTCC bases its decisions on evidence of the technology's safety, efficacy, and cost effectiveness. Participating state agencies are required to comply with the decisions of the HTCC. HTCC decisions may be re-reviewed at the determination of the HCA Director.