TIRC Submission to National Committee for Quality Assurance (NCQA) Proposed New Measure: CGM Utilization for Patients with Diabetes (CGD-E)

Question 1: Do you support the inclusion of the CGD-E measure in HEDIS MY 2027?

Support with Modifications

The Time in Range Coalition (TIRC) strongly supports, with modifications, the addition of the CGD-E measure to HEDIS MY 2027 and applauds NCQA for recognizing the clinical value of CGMs. However, we urge NCQA to include people with diabetes not on insulin, in alignment with the latest evidence and clinical guidelines.

About TIRC

Spearheaded by The diaTribe Foundation, the TIRC is a diverse group of global diabetes stakeholders, including nonprofit organizations, professional societies, industry, and patient advocates working to drive awareness and adoption of time in range (TIR). Reliable measurement of TIR, which is the percentage of time a person spends within a target glucose range and is reported alongside time above range and time below range, is now possible through advancements in continuous glucose monitoring (CGM). CGM empowers individuals living with diabetes to be aware of their real-time glucose levels and patterns, empowering adjustments to their diet, activity, and medication dosing to improve health outcomes.

The CGD-E Measure

CGM provides clinically meaningful data. Studies have shown that as TIR increases, health complications from the disease–and associated healthcare costs—decrease (Yapanis et al., 2022; De Meulemeester et al., 2024; Shah et al., 2024; Alkhuzam et al., 2025). As such, facilitating utilization of CGMs is a core focus for us. NCQA's proposal to monitor utilization of CGMs is aligned with our goals and we support the proposal with a strengthening modification.

As NCQA notes in its clinical recommendation statement and rationale, the American Diabetes Association's (ADA) 2026 Standards of Care, which contain changes from the 2025 Standards, recommend CGM initiation and use at diabetes onset for anyone on insulin therapy or a treatment where CGM helps in management, as determined by an individual's needs (ADA, 2025b). CGM has been widely established as a cost-effective intervention for people with type 1 diabetes (T1D) and those with type 2 (T2D) on insulin. Further, CGM is a key component of automated insulin delivery systems, which are widely used in T1D and now approved for T2D. Major payors like Medicare have recognized the value of CGM and expanded coverage in response.

However, newer evidence demonstrates CGM use should be incentivized for all people with diabetes—including those not on insulin, as it is associated with improvement in both health outcomes and healthcare resource utilization. In a 2024 real-world study that included over 25,000 adults on non-insulin therapy, health outcomes improved and healthcare resource utilization fell among all sub-groups with T2D after starting CGM, regardless of treatment regimen. CGM led to an average -1.1% reduction in A1C, -10.1% in all-cause hospitalizations, -31.0% in diabetes-related hospitalizations, and -30.7% in diabetes-related ED visits among those on non-insulin therapy (Garg et al., 2024). Similarly, a 2026 study of over 20,000 adults with diabetes exclusively treated with noninsulin therapies found significant reductions in all-causes hospitalizations (-25%), emergency department visits (-7%), hyperglycemic events (-7%), and diabetic ketoacidosis (-86%) in the 12 months after CGM acquisition compared to 12

months prior (Sharma et al., 2026). In addition to these cost and complication benefits, research shows CGM use is associated with clinically significant improvements in A1C, TIR, and other CGM metrics, improved treatment satisfaction, and positive health behavior changes (Ferreira et al., 2024; Martens et al., 2025).

Additionally, CGM has benefits beyond those noted in the Measure Workup, including providing consistent assessment of diabetes management and preventing over- or under-treatment in cases where A1C is known to be less accurate (A1C does not reflect the same average glucose in all individuals, as red blood cell glycation rates vary greatly across individuals, including in association with race and ethnicity, co-occurring conditions, medication use, age, and other factors) (ADA, 2025a; Karter et al., 2023; Nayak et al., 2019).

More generally, we encourage NCQA to consider the inclusion of TIR in the Glycemic Status Assessment for Patients with Diabetes. According to the 2026 ADA Standards of Care in Diabetes, CGM metrics such as TIR should be used in place of or in addition to A1C to assess glycemic status (ADA, 2025). This reflects the value of TIR to provide nuanced information such as glycemic variability or hypoglycemia to guide medication adjustments, health behavior strategies, and more. As noted above, TIR is associated with meaningful outcomes for both the individual and the health system (Yapanis et al., 2022; De Meulemeester et al., 2024; Shah et al., 2024; Alkhuzam et al., 2025). TIR provides a more complete, actionable picture of diabetes management than can be seen in an average such as A1C or glucose management indicator and therefore serves as an essential indicator to guide high-quality diabetes care.

Conclusion

By expanding this measure to include all people with diabetes, not just those on insulin, NCQA can better align with the latest evidence and maximize CGM's potential to improve outcomes. The TIRC supports this measure for inclusion with appropriate modifications that reflect the full clinical and public health benefits of CGM and to ensure alignment with the most current evidence and clinical guidelines.

References

Aleppo et al. (2026). *Diabetes Technology & Therapeutics*. https://doi.org/10.1177/15209156251414980

Alkhuzam et al. (2025). *Diabetes, Obesity & Metabolism*, 27(3), 1564–1571. https://doi.org/10.1111/dom.16168

ADA Professional Practice Committee. (2025a). *Diabetes Care*, 49(S1), S132–S149. https://doi.org/10.2337/dc26-S006

ADA Professional Practice Committee. (2025b). *Diabetes Care*, 49(S1), S150–S165. https://doi.org/10.2337/dc26-S007

Aronson et al. (2025). *Diabetes, Obesity and Metabolism*, 27(11), 6220–6242. https://doi.org/10.1111/dom.70008

De Meulemeester et al. (2024). *Diabetologia*, 67(8), 1527–1535. https://doi.org/10.1007/s00125-024-06171-y

Ferreira et al. (2024). *Diabetes Technology & Therapeutics*, 26(4), 252–262. https://doi.org/10.1089/dia.2023.0390

Garg et al. (2024). *Diabetes, Obesity and Metabolism*, 26(11), 5202–5210. https://doi.org/10.1111/dom.15866

Karter et al. (2023). *Diabetes Technology & Therapeutics*, 25(10), 697–704. https://doi.org/10.1089/dia.2023.0153
Layne et al. (2024). *Diabetes Technology & Therapeutics*, 26(12), 925–931. https://doi.org/10.1089/dia.2024.0197
Martens et al. (2025). *Diabetes Technology & Therapeutics*, 27(4), 261–270. https://doi.org/10.1089/dia.2024.0579
Nayak et al. (2019). *Endocrine Reviews*, 40(4), 988–999. https://doi.org/10.1210/er.2018-00284
Nemlekar et al. (2025). *Endocrinology, Diabetes & Metabolism*, 8(5), e70089. https://doi.org/10.1002/edm2.70089
Shah et al. (2024). *Diabetes Technology & Therapeutics*, 26(4), 246–251. https://doi.org/10.1089/dia.2023.0486
Sharma et al. (2026). *Diabetes Technology & Therapeutics*. https://doi.org/10.1177/15209156261423934
Soriano et al. (2026). *Diabetes, Obesity, and Cardiometabolic CARE*, 1(1), 118–127. https://doi.org/10.2337/doc25-0053
Yapanis et al. (2022). *Journal of Clinical Endocrinology and Metabolism*, 107(6), e2221–e2236. https://doi.org/10.1210/clinem/dgac034

Question 2: Do you support the proposed age stratification (18-64; 65-75)? Is it meaningful given the proposed diabetes type stratification?

Yes

TIRC supports the proposed age stratification to monitor and assess demographic discrepancies in CGM use. There are documented demographic discrepancies in who is offered CGM (Alkabbani et al., 2025; Milosavljevic et al., 2026). In a cohort of adults with insulin-treated type 2 diabetes, researchers found CGM was 21% less likely to be prescribed for patients older vs. younger than 65 years (Milosavljevic et al., 2026). Among Medicare beneficiaries (age 65+) with type 2 diabetes using insulin, CGM use remains <10%, with use even lower among Black and Hispanic individuals, those ≥85 years old, and beneficiaries living in lower socioeconomic areas, despite the unique benefits CGM offers older adults (Alkabbani et al., 2025). By measuring and monitoring use by age stratification, clinicians likely will be prompted and incentivized to offer CGM in a broader and more equitable manner.

Many factors impact whether an individual is offered CGM. For example, older adults may not be offered CGMs because of bias or a presumption that they may not know how or be able to learn how to use them; yet we understand from published research and patient lived-experience not only that older individuals can successfully use CGMs, but that they offer additional benefits unique from those observed in other sub-groups. CGMs help reduce risk for hypoglycemia, which is particularly valuable given that older individuals with diabetes are more susceptible to recurring hypoglycemia, and may also be more likely to experience hypoglycemia unawareness (Bao et al., 2022; Maltese et al., 2024; Miller et al., 2022; Munshi et al., 2024; Pratley et al., 2020). Reducing hypoglycemia is a key focus of care for older adults with diabetes, as it can exacerbate declining cognitive function and frailty (Maltese et al., 2024). Further, CGMs remove the need for regular testing in those struggling with memory, offer flexibility for individuals struggling with dexterity needed for finger-stick testing, and enable remote monitoring, which

may be particularly supportive for older individuals living alone and/or needing additional assistance (Maltese et al., 2024; Munshi, 2023).

We know that "what's measured gets done" and, as such, measuring CGM utilization among individuals age 65-75 years would help prompt clinicians who have patients with diabetes in this age group to increase their offering of CGM to this patient cohort, particularly since Medicare coverage is available. By incentivizing clinicians to consider CGM for their older patients with diabetes, those patients will benefit from improved TIR and, in turn, gain all the accompanying acute and longer-term health benefits that come from fewer highs and lows in their glucose levels.

Importantly with respect to systems change, age stratification can help identify patterns and pinpoint certain demographic trends to guide where outreach, education, and quality improvement efforts related to CGM access and prescribing should be focused.

References

Alkabbani et al. (2025). *Diabetes Care, 48*(8), 1377–1385. https://doi.org/10.2337/dca25-0006

Bao et al. (2022). *Diabetes Technology & Therapeutics, 24*(5), 299–306. https://doi.org/10.1089/dia.2021.0494

Maltese et al. (2024). *Diabetologia, 67*(10), 2085–2102. https://doi.org/10.1007/s00125-024-06240-2

Miller et al. (2022). *Diabetes Technology & Therapeutics, 24*(6), 424–434. https://doi.org/10.1089/dia.2021.0503

Milosavljevic et al. (2026). *Journal of General Internal Medicine.* https://doi.org/10.1007/s11606-025-09923-7

Munshi (2023). *Diabetes Technology & Therapeutics, 25*(3_suppl), S-56. https://doi.org/10.1089/dia.2023.0111

Munshi et al. (2024). *Diabetes Care,* dc241069. https://doi.org/10.2337/dc24-1069

Pratley et al. (2020). *JAMA, 323*(23), 2397–2406. https://doi.org/10.1001/jama.2020.6928

Question 3: What data sources does your organization use to identify CGM (medical claims/DME, pharmacy claims, EHR fields, vendor feeds), and can these be mapped to the value sets as specified?

Our organization does not use patient data directly.