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RE: Local Coverage Determination L33822, Glucose Monitors

On behalf of the [Time in Range Coalition](#) (TIRC), the diaTribe Foundation (diaTribe), we write to respectfully request that in your respective roles as DME Medicare Administrative Contractors (DME MAC) you work together to modify the coverage criteria for Continuous Glucose Monitors (CGMs) to expand access for Medicare beneficiaries. We appreciate your collective past recognition of the need to periodically update Medicare coverage and payment policy for CGMs and ask that you do so again now. Improving Medicare payment policy for CGMs will help expand access to care, strengthen disease management efforts, reduce preventable expensive complications, and improve health outcomes.

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 CGM. This clear, consistent, and immediately actionable information empowers individuals living with diabetes to be aware of their glucose levels and patterns, and to make adjustments to their diet, activity, and medication dosing to improve health outcomes.

Background

Approximately 12% of the U.S. population has diabetes – a staggering 40.1 million people.¹ The latest data from the Centers for Medicare & Medicaid Services (CMS), meanwhile, show 32% of beneficiaries having been diagnosed with diabetes at some point.²

Under the current local coverage determination (LCD), beneficiaries with insulin-treated diabetes or problematic hypoglycemia have access to CGM. We applaud the DME MAC for recognizing the body of evidence demonstrating CGM's significant impact in these groups and offering access accordingly.³⁻⁶ However, research has quickly evolved to demonstrate significant benefits from CGM use among broader populations of people with diabetes, including those not using insulin. Therefore, we echo the request submitted by a broad coalition of diabetes patient and provider groups, leading clinicians and manufacturers in early 2025 that Medicare's CGM coverage criteria be updated to include all beneficiaries with diabetes, in line with current clinical standards of care. We believe this will empower better-informed diabetes care, improved management and outcomes, and ultimately a reduction in costly complications and related healthcare utilization.

CGM Effectiveness and Need for Expanded Coverage

CGM provides detailed, actionable data that can help individuals fine-tune management strategies such as medication timing and health behaviors, and inform clinicians' treatment plans.⁷⁻¹⁰ These adjustments can be particularly valuable in the earlier stages of type 2 diabetes, before exogenous insulin is needed.¹¹ The American Diabetes Association's Standards of Care now endorse the use of CGM for all people with diabetes, starting at diagnosis.^{12,13}

This inclusive recommendation reflects strong research demonstrating that CGM use among individuals on noninsulin diabetes treatment plans is associated with sustained and clinically-significant reductions in A1C, increases in TIR and benefits to patient experience.¹⁴⁻²¹ Accordingly, many commercial insurance plans now cover CGM for people with non-insulin-treated diabetes—meaning some beneficiaries with diabetes would experience a loss of access to a trusted and relied-upon tool after enrolling in Medicare.²²

Multiple analyses, including of large real-world datasets, have demonstrated that these clinical improvements lead to reductions in common short- and long-term complications of diabetes that often result in costly emergency room visits and hospitalizations.^{15,23,24} In fact, a recent projection calculates that expanding coverage to Medicare beneficiaries with type 2 diabetes not on insulin would reduce overall costs by \$562 million in year 1, \$1.3 billion in year 2, and \$1.6 billion in year 3, by reducing healthcare utilization associated with acute hypoglycemic and diabetic ketoacidosis events and diabetes-related complications.²⁵

Conclusion

Given that less than half of beneficiaries with diabetes use insulin, there is potential to leverage CGM to delay or prevent significantly more acute and long-term complications and costs for the Medicare population.¹² We urge you to move as quickly as possible to align Medicare's CGM coverage policy with the latest evidence and standards of care.

We stand ready to partner with you, CMS leadership, and other stakeholders to expand CGM coverage. Should you have any questions, please do not hesitate to contact us, via julie.heverly@diaTribe.org, at any time.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim Carroll". The signature is fluid and cursive, with a large initial "J" and "C".

Jim Carroll
CEO, The diaTribe Foundation

A handwritten signature in black ink, appearing to read "Julie K. Heverly". The signature is cursive, with a large initial "J" and "H".

Julie K. Heverly
Vice President, Time in Range Coalition

CC: Office of the Administrator
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