

September 9, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Submitted via Regulations.gov

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the [Time in Range Coalition](#) (TIRC), we appreciate the opportunity to comment on the Calendar Year (CY) 2027 Payment Policies Under the Physician Fee Schedule Proposed Rule [CMS-1848-P]. The TIRC applauds CMS' development of a Merit-Based Incentive Payment System (MIPS) Value Pathway (MVP) for diabetic disease. We thank you and your staff for recognizing the importance of a dedicated MVP focused on quality of care and health outcomes for beneficiaries with diabetes. We write to respectfully urge you to expand the MVP to reflect current clinical practice guidelines and the utilization of diabetes technologies, as discussed below. Thank you in advance for your consideration of our views and recommendations. We welcome the opportunity to work with you and your staff on this and other pressing diabetes care issues.

About TIRC & Time in Range (TIR)

Spearheaded by The diaTribe Foundation, the TIRC is a diverse group of diabetes stakeholders, including nonprofit organizations, professional societies, industry, and patient advocates working to drive awareness and adoption of time in range (TIR), as measured by continuous glucose monitors (CGMs). Given the broad array of perspectives, collective reach, lived experience of people with diabetes, and deep expertise in influencing the adoption of diabetes technology, the TIRC can offer CMS valuable insights with respect to policies related to diabetes care and management.

Research continues to demonstrate that CGMs provide reliable, actionable data and can improve outcomes among people with diabetes while reducing other healthcare utilization costs. As CGMs, and the data they provide, become increasingly utilized and recommended by leading clinical practice guidelines, we believe CMS should incorporate and reflect this data into its quality measures.

The CGM metric TIR, which is the percentage of time a person spends within a target glucose range and is reported alongside time above range (TAR) and time below range (TBR), empowers individuals living

with diabetes to be aware of their glucose levels every few minutes, such that they can make real-time adjustments to their diet, activity, and medication dosing to improve health outcomes.^{1,2}

Background

Approximately 12% of the U.S. population has diabetes – a staggering 40.1 million people.³ The latest CMS data, meanwhile, show 32% of beneficiaries having been diagnosed with diabetes at some point.⁴ According to the Centers for Disease Control and Prevention (CDC), the annual cost of complications related to type 2 diabetes among Medicare beneficiaries 65 and older is more than \$37 billion with an estimated half of the total costs due to kidney disease, congestive heart failure, and stroke.⁵ Complications associated with diabetes and all-cause mortality can be reduced and prevented through improved disease management.⁶⁻⁹

CGM Use and Metrics Help Improve Outcomes, Reduce Costs

Over the past decade, Food and Drug Administration (FDA) approvals of safe and effective drugs and devices have transformed diabetes care. People with diabetes now have access to therapies and devices that not only improve glucose levels, but also support weight management, reduce hypoglycemia, and prevent some of the costly complications associated with diabetes, including cardiovascular and renal disease. One important tool that contributes to improved diabetes management and helps prevent complications is CGM technology, which allows for easy, reliable measurement of CGM metrics, like TIR. Advances in the accuracy and ease of use of CGM technology have increased the acceptability by clinicians and people with diabetes who are increasingly reliant on CGM metrics like TIR for daily diabetes management.

Importantly the American Diabetes Association's 2026 Standards of Care 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.¹⁰ Studies have shown that CGM use supports greater TIR and reduces risk for diabetes-related complications.¹⁰⁻¹⁹

CGM has been widely established as a cost-effective intervention for people with type 1 diabetes and those with type 2 diabetes on insulin, with newer evidence suggesting CGM may provide cost savings among individuals on other medications, as well.²⁰⁻²³ CGM also is a key component of automated insulin delivery systems, which are now approved for use in both type 1 and type 2 diabetes. CMS has recognized the value of CGM and expanded coverage in response and is further encouraged to ensure all beneficiaries living with diabetes can access CGM should they wish.

CGMs may have unique additional benefits for the older population of Medicare beneficiaries. 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.²⁴⁻²⁸ Reducing hypoglycemia is a key focus of care for older adults with diabetes, as it can exacerbate declining cognitive function and frailty.²⁵ 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.^{25,27}

Given the significant positive impact of improved TIR on the health and well-being of beneficiaries living with diabetes and CMS' desire to ensure that digital technologies are being leveraged to the maximum extent to address chronic disease among beneficiaries, we strongly urge CMS to begin to incorporate TIR metrics into quality measurement related to diabetes care.

Diabetic Disease MVP

The TIRC is grateful that CMS has developed a diabetes MVP as part of the Quality Payment Program (QPP) and strongly endorses the assessment of meaningful outcomes in caring for people with diabetes. The TIRC commends the agency for creating and announcing the addition of this MVP before the planned sunset of the traditional MIPS reporting option.

The TIRC believes one of the quality measures that will form part of this MVP could be strengthened to better align with current clinical practice guidelines and patient lived experience: Specifically the measure "Q001: Diabetes: Glycemic Status Assessment Greater Than 9%." As written, Q001 references glycemic status assessments of over 9.0% as measured by hemoglobin A1C (HbA1c) or glucose management indicator (GMI), but it makes no reference to TIR despite the extensive body of evidence that shows that TIR has added value in clinical and research settings, as well as in regulatory considerations as an important secondary endpoint.^{27–30} We encourage CMS to consider including TIR (TAR/TBR) in the Glycemic Status Assessment measure by specifying that, for patients with sufficient CGM data, TIR within the enumerated thresholds be accepted alongside HbA1c and GMI metrics.

According to the 2026 American Diabetes Association 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.¹⁰

This reflects the value of TIR in providing nuanced information such as glycemic variability or hypoglycemia to inform medication adjustments, support health behavior strategies, and reduce complication risks. TIR is associated with meaningful outcomes for both the individual and the health system, as risk for diabetes-related complications and costs both fall as someone's TIR increases.^{10–19,29} Research in type 1 diabetes suggests each 10 percentage point increase in TIR reduces complication costs by 7.5–9.9%.^{30,31} Studies in type 2 diabetes demonstrate similar patterns, with increased TIR accompanied by increases in quality-adjusted life years and reduction in cardiovascular risk.²⁹

Further, TIR provides a more complete, actionable picture of diabetes management than can be seen in an average such as A1C or GMI, and therefore serves as an essential indicator to guide high-quality diabetes care. We respectfully note that there are many confounding factors known to undermine the accuracy of A1C, which do not affect TIR, making it a more consistent indicator of glycemia. A1C, for instance is known to overestimate glycemia in older individuals and those of African American heritage, while TIR as measured by a CGM has detected undiagnosed hyperglycemia in patients with end-stage renal disease.^{32–36} Adding TIR could therefore improve the accuracy of the Q001 measure. Moreover, as CMS strives to expand deployment of digital health technologies and leverage remote patient monitoring to improve chronic disease management, incorporating CGM metrics and TIR into the MVP quality measure would be a complementary addition and contribute to this broader agency initiative.

Conclusion

TIRC respectfully encourages CMS to add TIR (and/or TAR and TBR) to the Q001 measure, if possible; if not feasible at this time, we ask the agency to work with the measure's steward, the National Committee for Quality Assurance, to amend the measure to include TIR (and/or TAR and TBR) during the next quality measure pre-rulemaking process. In that process, CMS, NCQA, clinical experts, and stakeholders could determine and validate the TIR threshold that corresponds to the level of glycemic control Q001 is designed to identify.

Including TIR in the definition of the Q001: Diabetes: Glycemic Status Assessment measure would be a straightforward step that would strengthen the measure's utility, reflect current clinical practice guidelines, and help reduce complications of diabetes, which in turn will improve health outcomes and decrease preventable Medicare spending.

Thank you again for your consideration of our request. We stand ready to partner with CMS to improve quality measurement for care provided to beneficiaries living with diabetes. Should you have any questions, please do not hesitate to contact us, via julie.heverly@diaTribe.org, at any time.

Sincerely,



Jim Carroll
CEO, The diaTribe Foundation



Julie K. Heverly
Vice President, Time in Range Coalition

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