



Maryland  
Hospital Association

November 21, 2022

Katie Wunderlich  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we offer an alternative population health measure for hospital accountability and convey the field's serious concerns with the current direction HSCRC staff is pursuing. HSCRC should adopt performance on hemoglobin A1C control in hospitals' affiliated practices as the population health metric in hospital payment policy instead of screening for diabetes in the emergency department (ED). Coordination between hospitals and ambulatory practices is an integral part of the Maryland Total Cost of Care Model. Aligning with the Maryland Primary Care Program's (MDPCP) metric, hemoglobin A1C control, incentivizes coordination between the hospital and its practices on diabetes management.

### **Bolster existing workflows at hospitals and practices**

Hospitals want to build on existing workflows and strengthen alignment with affiliated ambulatory practices in MDPCP. Practices already have systems to identify and support patients whose diabetes is not under optimal control. Hospital care navigators help patients at increased risk for suboptimal diabetes control get to appointments with primary care practices. Controlling diabetes is critical to reduce downstream morbidity and improve outcomes for patients.

### **EDs are already overburdened**

The emergency department is not the place to persuade patients to make lifestyle changes. Maryland's EDs are overflowing with patients who are waiting to be seen for urgent and emerging medical problems. Doctors, nurses, and other staff are barely keeping up with taking care of the most life-threatening conditions. EDs do not have the structures and resources in place to effectively counsel patients on the importance of diabetes follow-up when the patient and staff are focused on immediately urgent medical conditions.

### **Diabetes screening in ED is avoidable utilization**

The field is moving low-value care and low acuity care out of the hospital and ED into lower-cost settings. Screening is better suited to community outreach and ambulatory practices.

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Further, without the ability to know whether a person has recently been tested at another hospital or clinic, individuals will likely be retested several times within the three-year span recommended by the American Diabetes Association.<sup>1</sup> While additional screening is valuable to identify previously undiagnosed diabetes, there is significant potential for increased total cost of care without the additional benefit of getting individuals into a regular system of care and diabetes management.

We look forward to continuing to work with the Commission on this and future policies.

Sincerely,



Traci La Valle  
Senior Vice President, Quality & Health Improvement

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<sup>1</sup> Classification and Diagnosis of Diabetes: Standards of Medical Care in Diabetes—2022, Diabetes Care, Vol 45, Issue Supplement 1. [diabetesjournals.org/care/article/45/Supplement\\_1/S17/138925/2-Classification-and-Diagnosis-of-Diabetes](https://diabetesjournals.org/care/article/45/Supplement_1/S17/138925/2-Classification-and-Diagnosis-of-Diabetes)