December 1, 2023

William Henderson
Principal Deputy Director, Medical Economics & Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we offer comments on the draft Medicare Performance Adjustment (MPA) Policy for calendar year (CY) 2024.

Inpatient Diabetes Measure

The Maryland Model helps hospitals move utilization to lower cost settings by working closely with community partners who can address patients' health-related social needs[1]. MHA recognizes the direction from CMMI staff to increase hospital accountability for population health measures. This requires careful consideration of the potential benefits and a departure from the historic structure of the U.S. health care system. Earlier diagnosis and treatment for all people who have diabetes or pre-diabetes can slow the progression of diabetes' consequences, yet hospitals' staffing, reimbursement, and cost structures are designed to address serious and urgent health crises. Screening accompanied by referrals to coordinated medical and lifestyle management are better suited to the primary care setting. The U.S. Preventive Services Task Force (USPSTF) Recommendation Statement on Screening for Diabetes and Pre-Diabetes limits the population to non-pregnant people 35-70 *who are overweight or obese and are seen in primary care.*[2] **As an alternative, the hospital field supports holding hospitals accountable for diabetes screening and referral in their related primary care practices.** In November 2022, MHA offered this alternative and it has received no discussion. Therefore, we offer additional guidance on the latest proposal.

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1 Evaluation of the Maryland Total Cost of Care Model: Quantitative Only Report for the Model's First Three Years (2019 to 2021) Mathematica. Available at [Evaluating Accountability for Statewide Health Cost and Quality Outcomes: The Maryland Total Cost of Care Model (mathematica.org)]

[2] US Preventive Services Task Force. Screening for Prediabetes and Type 2 Diabetes: US Preventive Services Task Force Recommendation Statement. *JAMA.* 2021;326(8):736–743. doi:10.1001/jama.2021.12531 Available at [Screening for Prediabetes and Type 2 Diabetes: US Preventive Services Task Force Recommendation Statement | Diabetes | JAMA | JAMA Network]

MHA's Council on Clinical & Quality Issues, a governance council which includes senior clinical leaders from nearly all Maryland health systems and hospitals, are unanimous in calling for changes to this recommendation. Even though screening all adults over 35 every three years is a recommendation of the American Diabetes Association, it is not well-supported in peer reviewed literature and has the potential to add low value care and increase costs.[3,4,5] While it will likely reveal previously undiagnosed diabetes in some patients, it is not clear whether the benefits will outweigh the cost or result in measurable differences in future hospital readmissions, intensive care stays, or the need for other interventions.[6]

For screening to have an impact on patients' health, it is critical that patients are able to follow up with primary care, lifestyle changes, and in some cases, endocrinology specialists.[7,8] At the same time, it's been widely noted that getting a doctor's appointment in Maryland has become a monumental task for patients, who say they have hit barrier after barrier in the search for care.[9]

To improve the likelihood of benefit from inpatient screening, we recommend narrowing the screening population and bolstering resources to ensure patients with newly identified diabetes are able to access primary care, and the recommended lifestyle and medication therapies. Specifically, we recommend the following:

- Screen only non-pregnant people 35-70 who are overweight or obese in alignment with USPSTF primary care screening recommendations

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[3] Karakonstantis S, Kassotaki I, Korela D, Arna D, Milaki K, Tsigaridaki M, Lydakis C, Pappas A. In-hospital screening for diabetes mellitus with HbA1c in an internal medicine department was not useful; a prospective pilot study. Rom J Intern Med. 2019 Dec 1;57(4):315-321. doi: 10.2478/rjim-2019-0015. PMID: 31256067.

[4] Farmer AJ, Shine B, Armitage LC, Murphy N, James T, Guha N, Rea R. The potential for utilising in-hospital glucose measurements to detect individuals at high risk of previously undiagnosed diabetes: Retrospective cohort study. Diabet Med. 2022 Oct;39(10):e14918. doi: 10.1111/dme.14918. Epub 2022 Jul 26. PMID: 35839301; PMCID: PMC9543037.

[5] Thornton-Swan TD, Armitage LC, Curtis AM, Farmer AJ. Assessment of glycaemic status in adult hospital patients for the detection of undiagnosed diabetes mellitus: A systematic review. Diabet Med. 2022 Apr;39(4):e14777. doi: 10.1111/dme.14777. Epub 2022 Jan 5. PMID: 34951710; PMCID: PMC9302131.

[6] Nanayakkara N, Nguyen H, Churilov L, Kong A, Pang N, Hart GK, Owen-Jones E, White J, Ross J, Stevenson V, Bellomo R, Lam Q, Crinis N, Robbins R, Johnson D, Baker ST, Zajac JD, Ekinci EI. Inpatient HbA1c testing: a prospective observational study. BMJ Open Diabetes Res Care. 2015 Sep 7;3(1):e000113. doi: 10.1136/bmjdrc-2015-000113. PMID: 26380095; PMCID: PMC4567658. Available at Inpatient HbA1c testing: A prospective observational study — Charles Darwin University (cdu.edu.au)

[7] Hare MJ, Shaw JE. Inpatient diabetes care requires adequate support, not just HbA1c screening. Med J Aust. 2019 Nov;211(10):452-453. doi: 10.5694/mja2.50391. Epub 2019 Oct 31. PMID: 31674035

[8] Cheung NW, Campbell LV, Fulcher GR, McElduff P, Depczynski B, Acharya S, Carter J, Champion B, Chen R, Chipps D, Flack J, Kinsella J, Layton M, McLean M, Moses RG, Park K, Poynten AM, Pollock C, Scadden D, Tonks KT, Webber M, White C, Wong V, Middleton S. Routine glucose assessment in the emergency department for detecting unrecognised diabetes: a cluster randomised trial. Med J Aust. 2019 Nov;211(10):454-459. doi: 10.5694/mja2.50394. Epub 2019 Nov 3. PMID: 31680269

[9] *Struggling to Make Health Care Appointments in Maryland? You're Not Alone,* Baltimore Banner 2023/27/3 Available at Why it's hard to find a doctor in Maryland right now - The Baltimore Banner

- Screen only medical patients
- In the initial phase, exclude people whose primary diagnosis is behavioral health as connection with primary care is more challenging in that population
- Invest the time to build the connections that will identify at the bedside patients who have been screened within the last three years or are otherwise outside the screening guidelines
- Add resources to expand access to primary care for patients who do not have a usual source of primary care and have other social needs such as financial or housing insecurity, and lack of transportation

Support Care Transformation Initiatives (CTI) Buy Out

Maryland hospitals bear financial risk for total cost of care (TCOC) growth through the MPA, CTIs and efficiency policies. As staff noted in their Nov. 29 TCOC Work Group materials, the results from CTI performance year one were material—culminating in a $130-million statewide savings offset that shifted $56 million in revenue between low and top performing hospitals.

In previous years, HSCRC instituted an attribution methodology designed to capture hospital relationships with primary care providers. The field understands the methodology was complex, with many technical challenges, but supports its underlying intent. CTIs are complimentary to MPA in this manner—going beyond the traditional provider attribution to capture initiatives that produce savings. Examples of such activities include:

- Real-time data sharing with skilled nursing facilities to prevent readmissions
- Transitional care staff to address unmanaged chronic conditions
- Warm hand offs with community partners after discharge for health-related social needs
- Palliative care programs for end-of-life patients
- Delivery of preventative services in community settings
- Mobile integrated health programs to divert lower acuity patients from emergency departments

The CTI buyout mitigates duplication of financial penalties to the extent such initiatives overlap with MPA attributed beneficiaries in their geographic service areas. Because penalties from CTIs exceeded traditional MPA penalties in performance year one, the field believes the buyout is appropriate.

If CMMI does not accept the buyout, MHA encourages HSCRC to evaluate reducing hospitals' total amount of financial risk by modifying existing policies.

Support CTI Downside Risk Threshold

MHA appreciates staff's willingness to refine the CTI policy over time and supports instituting a 2.5% downside risk cap.

Attribution & Hospital Ability to Impact Performance

Although the CTI buy out mitigates downside risk, we remain concerned that strict geographic attribution is not the best mechanism to promote clinician engagement. A more intricate

methodology may be necessary to expand opportunities to influence total cost of care performance across care settings.

MHA also recommends HSCRC continue to evaluate all payment policies measuring hospital TCOC performance and determine whether policies should continue, sunset, or be modified based on hospitals' ability to meaningfully impact performance.

Thank you again for engaging the hospital field on the draft CY 2024 MPA policy. Please contact me if you would like to discuss these recommendations.

Sincerely,

Traci La Valle
Senior Vice President, Quality & Health Improvement

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