Maryland
Hospital Association

June 29, 2023

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, and in response to your recent policy memo about screening adult inpatients for diabetes, we again recommend a different approach to hospital accountability for population health. Creating a reward and penalty system for hospitals to test all adult inpatients for elevated Hemoglobin A1C incentivizes low-value testing in an environment that is not conducive to ensuring needed follow-up—risking increased health care spending with no additional value.

In November 2022, the Health Services Cost Review Commission (HSCRC) proposed holding hospitals accountable for screening adults for elevated Hemoglobin A1C in the emergency department (ED). MHA recommended aligning hospital accountability with their affiliated ambulatory practices' performance on Hemoglobin A1C control. Alignment with the Maryland Primary Care Program's (MDPCP) metric incentivizes coordination between the hospital and its practices on diabetes management. We continue to recommend that alternative approach as screening inpatients has many of the same drawbacks as screening in the ED.

Hospital inpatient capacity is high, and resources are stretched

During an acute episode of inpatient care is not the time to introduce patients to the management of a new chronic condition that is different from their reason for admission. Hospitals are already connecting high-risk, high-needs patients with primary and specialty care at discharge to continue management in the community. This type of care navigation is very resource intensive, and hospitals carefully select patients most likely to benefit from the limited resource. Without the resources to support a large number of patients newly diagnosed with diabetes, the additional testing will have no benefit.

Diabetes screening for all adult inpatients is avoidable utilization

The field is moving low-value care and low-acuity care out of the hospital into lower-cost settings. Screening is better suited to community outreach and ambulatory practices. 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.[1] 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

CC: Adam Kane, Chairman
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[1] 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