

DMPC

Disease Management

Purchasing Consortium International, Inc.

August 6, 2012

Office of the Secretary
The Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Dear Secretary Sebelius:

I have been asked to opine on the methodology of the Health Status Monitoring data used by CMS to measure the impact of the DME competitive bidding program on the health outcomes, including deaths, hospitalizations, emergency room visits, physician visits, admissions to skilled nursing facilities, and average days of stay for beneficiaries with certain chronic diseases.

By way of background, I am the person most often identified as the inventor of disease management. I was the founder and first president of what is now the Care Continuum Alliance. I provide the field's only methodological/outcomes certification <http://dismgmt.com/certs/cora/honor-roll>, and I "wrote the book" on population-based outcomes measurement, *Why Nobody Believes the Numbers: Distinguishing Fact from Fiction in Population Health Management* (John Wiley & Sons, 2012). I would encourage you to peruse, if not the book itself, then the [advance praise and early reviews](#), which reflect the fact that *Why Nobody Believes* is already established as the authoritative source in the field of population-based outcomes measurement.

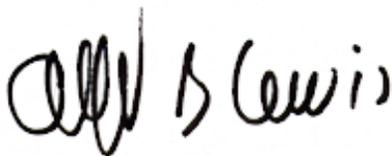
My upcoming August commentary "Questioning the Widely Publicized Savings for North Carolina Medicaid," in the *American Journal of Managed Care* presents a classic vignette of valid vs. invalid population outcomes measurement, as it turns out that two teams of outside actuaries miscalculated savings by hundreds of millions of dollars, and by doing so caused CMS to massively mis-allocate resources (a 9-to-1 match) to encourage North Carolina-type Medicaid "medical home" models in other states to (among other things) generate cost savings

My concern is that CMS is doing something in its Health Status Monitoring similar to the examples in my book, which could also lead to an incorrect evaluation that would negatively affect the health status of our seniors. Specifically, many chronic disease members can't be identified from claims data, for at least nine reasons, listed on Page 8. Leaving out what is likely to be a large percentage of members will skew the results to a significant degree.

For instance, the observed hospitalization rate for diabetics in Access Group 1 is (with geographic variation) about 600-800 admissions per 1000 previously identified people per year. However, both the denominator and the numerator for this calculation are strictly limited to observing only those beneficiaries with a claim in the last 120 days to qualify as the "Access Group" or "Utilizers." This skews the results by omitting those who become non-compliant, or are omitted for other reasons. This creates inaccurate and unreliable data as the excluded beneficiaries may be at risk for worse outcomes due to their non-compliance.

As further evidence that the observed admission rates are not accurate, these rates are quite different from my knowledge of what occurs in other Medicare populations (such as Medicare Advantage plans, from which my extensive data is drawn), which I would be pleased to discuss with you. Therefore, it is clear that a large number of beneficiaries with chronic disease are not being tracked in this analysis. Given that beneficiaries with chronic disease account for the majority of Medicare costs, it is critical for the entire population to be tracked in any health outcomes analysis. (My observation does not affect the comparative results for the observed cohorts, but rather notes that the observed cohorts are an unknown fraction of the entire population with the conditions in question.)

One recommendation would be -- just as with the forthcoming North Carolina Medicaid commentary noted above and everything else in the area of population health -- not to have a claims-based algorithm drive the identified patient pool but rather have the entire population be the pool. Comparators would then be areas of similar demographics, and all events would be tracked, including events by people who did not self-identify prior to their inclusion in the access group. This should ensure that your outcomes evaluation process is valid.

Handwritten signature in black ink, appearing to read "A. Lewis".

c: Marilyn Tavenner, Acting Administrator
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