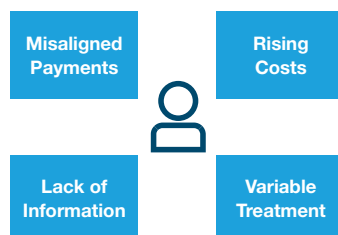


Rheumatoid Arthritis Quality: Current and Future Status

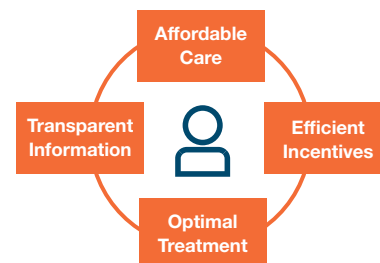
WHY IS QUALITY IMPORTANT?

- The U.S. healthcare system has been evolving toward a value-based model. Value in healthcare is commonly defined as the health outcomes achieved per dollar spent.¹
- This ongoing shift has led payers to use quality measures to assess health outcomes and incentivize high-value care

Current Fragmented System



System Driving by Value



RHEUMATOID ARTHRITIS IS RECOGNIZED AS A NATIONAL PRIORITY FOR QUALITY IMPROVEMENT

- Rheumatoid arthritis (RA) is a systemic autoimmune disease with substantial healthcare costs and patient quality of life burdens.

Examples of Stakeholders Involved in Addressing Quality of RA Care	American College of Rheumatology (ACR)	<ul style="list-style-type: none"> • ACR is a leading organization in the development of RA quality measures² • The ACR sponsors a rheumatology patient registry, the Rheumatology Clinical Registry. ACR also recently launched an enhanced version of this registry, the RISE (Rheumatology Informatics System for Effectiveness) Registry, which allows seamless integration with electronic health records • RISE is a Qualified Clinical Data Registry (QCDR) for the Physician Quality Reporting System (PQRS)³
	Arthritis Foundation (AF)	<ul style="list-style-type: none"> • The AF focuses on advocacy and research to advance arthritis care • The AF recently launched the Arthritis Internet Registry (AIR) to help facilitate AF research to develop personalized treatment plans for peoples with RA⁴
	Centers for Medicare & Medicaid Services (CMS)	<ul style="list-style-type: none"> • RA is one of the top 20 high-impact Medicare conditions identified by CMS based on cost, prevalence, improvability, variability in treatment, and disparities⁵ • RA is ranked 14th among 20 Medicare conditions⁵
	National Quality Forum (NQF)	<ul style="list-style-type: none"> • NQF has endorsed RA-related measures and recently reviewed and updated RA quality measures as a part of its Musculoskeletal Project⁶

RA MEASUREMENT IS FOCUSED ON PROCESSES OF CARE

- Avalere identified 53 RA quality measures through the Avalere Quality Measures Navigator^{®*}
- RA quality measures primarily address medication use, diagnosis and disease assessment, and patient education/counseling
- 100 percent (53) of identified quality measures in this space address processes of care, which assess the provision of healthcare services. No measures are outcome measures, which measure the results of healthcare, including functional status or patient satisfaction.
- 11 percent (6/53) have received endorsement from the National Quality Forum (NQF); these measures address assessment of disease activity or functional status, medication use, and tuberculosis screening
- 37 measures address medication use directly

Distribution of Measures by Measure Type** (n=53***)



- Process, 53
- Access, 0
- Cost/Resource Use, 0
- Efficiency, 0
- Outcome—Clinical, 0
- Outcome—Patient Reported, 0
- Structure, 0

^{*}**Quality Measures Navigator** is a repository of quality measures obtained from publicly available sources, including: Quality measure databases such as the NQF Quality Positioning System; U.S. professional societies, including the American Medical Association's Physician Consortium for Performance Improvement; CMS quality programs, including the Physician Quality Reporting System; and Provider-level quality recognition and accreditation programs sponsored by organizations such as URAC, the Joint Commission and the National Committee for Quality Assurance (NCQA)

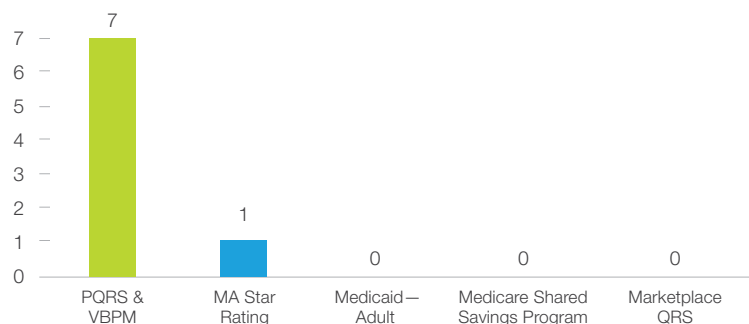
^{**}Process measure example: Assessment and Classification of Disease Activity

^{***}Current as of August, 2016

RA MEASURES ARE IN PQRS, VBPM, AND MA STAR RATINGS

- 13 percent (13/53) of RA measures are included in the PQRS and Value-Based Payment Modifier (VBPM) programs, which focus on eligible professionals including physicians
- 1 measure, which is in the PQRS and VBPM programs, is also included in the Medicare Advantage (MA) Star Rating program
- RA measures are not used in any additional CMS programs

Number of RA Quality Measures Included in CMS Programs



Programs with no measures are included here as examples of programs that might include RA measures in the future

ALTHOUGH SEVERAL RA MEASURES ARE DEVELOPED AND IN USE, GAPS STILL EXIST

- While several RA measures address the *assessment* of important outcome measures, there is still a need for measures that measure actual outcomes (e.g., change in functional status over time), including patient-reported outcomes
- Additional measures are needed to address patient engagement, education, and shared decision making to better help patients be engaged in the care that they receive
- Few measures have focused on costs of RA care or efficiency

FUTURE OF RA QUALITY MEASURES

- CMS has proposed 6 of the 7 current PQRS and VM program measures for the Merit-Based Incentive Payment System (MIPS), which will replace PQRS and the VM starting in 2019 (2017 reporting). *The Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy* (PQRS #108) measure is not proposed for MIPS, as CMS views it as a “low-bar” (e.g., providers are easily able to meet the measure). A new measure assessing costs across an episode of care for RA episode is proposed for the MIPS program
- Additional RA measures may be developed through the ACR RISE registry
- Additional patient-centric measures may be developed in the future given the demand for these types of measures.
- RA measures were not included in the recently released CMS/America’s Health Insurance Plans (AHIP) Core Quality Measure Collaborative Sets, which indicates the topic may not be an area of focus for quality improvement for private health plans

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MEASURE TYPE DEFINITIONS: **Access:** Measures that focus on barriers to care, such as lack of insurance, financial barriers to care experienced by the population with health insurance, and usual source of care; **Clinical Outcome:** Physiologic or biochemical values that precede and may lead to clinical outcomes, those that represent an end result, and those that are proxies used to indicate an outcome; **Cost/Resource Use:** Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters); **Efficiency:** The cost of care associated with a specified level of health; **Patient-Reported Outcome:** Measures that provide information into the impact of illness and disease directly from the patient and without interpretation by clinicians or others; **Process:** A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to evidence based recommendations for clinical practice; **Structure:** Features of a healthcare organization or clinician relevant to the capacity to provide healthcare such as measures that address health IT infrastructure, provider capacity, systems, and other healthcare infrastructure supports

CMS PROGRAM DESCRIPTIONS: **Marketplace QRS (Quality Rating System):** public reporting program for Qualified Health Plans in the Insurance Marketplace; **MA (Medicare Advantage) Star Rating Program:** pay-for-performance program for health plans; **Medicaid—Adult Core Set:** voluntary reporting program focusing on state Medicaid programs; **MSSP (Medicare Shared Savings Program):** shared savings program for accountable care organizations; **PQRS (Physician Quality Reporting System):** pay-for-reporting program targeted to physicians; **VBPM (Value-Based Payment Modifier):** pay-for-performance program targeted to physicians

Note: A pay-for-reporting program refers to a program which ties some portion of payment to reporting on quality measures, whereas a pay-for-performance program considers performance on quality measures when determining payment

