Arthritis Care to Undergo Quality Assessment

A new measure seeks to encourage wider utilization of disease-modifying antirheumatic drugs.

BY MARY ELLEN SCHNEIDER
Senior Writer

This year, health plans will start collecting data on the utilization of disease-modifying antirheumatic drugs in rheumatoid arthritis patients as part of a new arthritis-focused endeavor by the National Committee for Quality Assurance.

The measurement of disease-modifying antirheumatic drug (DMARD) usage is being added to the list of more than 60 quality measures that comprise the Health Plan Employer Data and Information Set (HEDIS)—a quality assessment and reporting system used by most U.S. health plans.

Under the new HEDIS measure, health plans will be asked to assess whether rheumatoid arthritis (RA) patients have had at least one ambulatory prescription dispensed for a DMARD during the calendar year.

Allowable DMARDs include methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, infliximab, cyclophosphamide, penicillamine, etanercept, anakinra, gold (oral or intramuscular), cyclosporine, azathioprine, adalimumab, minocycline, and staphylococcal protein A.

In September 2006, NCQA will report aggregate data on the performance of plans at the regional and national level. Starting in 2007, the organization will provide annual reports on performance at the individual health plan level. Such information can then inform the decisions of health plan purchasers when making their contact decisions.

Despite strong evidence that backs their effectiveness, DMARDs are underutilized, which is why NCQA officials created the measure, explained Phil Renner, assistant vice president for quality measurement at NCQA.

Health plans will be asked to assess if rheumatoid arthritis patients received at least one ambulatory prescription for a DMARD during the calendar year.

NCQA officials expect the use of DMARDs in rheumatoid arthritis patients will rise sharply within the first few years as health plans and physicians begin to conduct quality improvement programs, Mr. Renner said. And they expect to see steady improvement over time.

"This is incredibly good news for patients," said Patience White, M.D., a rheumatologist and chief public health officer for the Arthritis Foundation.

Physicians already know that DMARDs have a huge impact on RA prognosis, Dr. White said, but the high cost of the drugs has been a significant barrier to their use.

The development of a HEDIS measure puts this information in the hands of patients, physicians, insurers and—most importantly—health plan purchasers. And it gives physicians more leverage to make the case to insurance companies that expensive biologics ought to be covered, she said.

"It is another way to get the marketplace to do the right thing," Dr. White said.

Similarly, plans at the Centers for Medicare and Medicaid Services to cover injectable drugs as part of the new Medicare prescription drug benefit will probably have an even greater impact on what gets covered in the marketplace, Dr. White predicted.

At the same time, evidence is now available for professional associations such as the American College of Rheumatology to issue guidelines on how to prescribe DMARDs in these patients.

The combination of these forces is likely to increase the availability of DMARDs for RA patients, Dr. White said.

Although the DMARD measure is the first arthritis-related HEDIS measure, Mr. Renner said, it's unlikely to be the last. "We're very interested in developing measures for arthritis," he said.

Previous attempts by NCQA to measure arthritis care quality have been encumbered by difficulty in capturing this information through health plan databases, he said. As a result, NCQA is considering ways to gather this information at the provider level.

Already established NCQA programs that measure quality at the provider level include the Diabetes Physician Recognition Program and the Heart/Stroke Physician Recognition Program, which recognize physicians who voluntarily comply with their standards.

This is a nonpunitive program, Mr. Renner said. If a physician does not achieve recognition, that status is not published. But for physicians who do meet the qualifications, it can be an opportunity to be recognized by health plans, he said.

Some health plans are already using these programs as part of their pay for performance efforts. They highlight recognized physicians in their directories or encourage other physicians to use the recognition as a basis for referrals, he said. ■

Industry Expert: HSAs Can Promote Healthful Behaviors

BY MARY ELLEN SCHNEIDER
Senior Writer

Health savings accounts and other consumer-directed insurance products can help lower health care utilization and encourage better health behaviors, according to an industry expert.

Consumers "begin to recognize that the behaviors that they have can lead to a health outcome that can actually cost them money in the long run," said Doug Kronenberg, chief strategy officer for Lumenos, a company that sells health savings accounts. Lumenos is based in Alexandria, Va.

"And therefore they begin to think about changes in their behavior that can impact that health care," he said.

When an employer or insurer combines their insurance product with a program that shows consumers the financial benefits of changing their behavior and offers support tools, consumers really become engaged in their health care, Mr. Kronenberg said during a teleconference sponsored by the Kaiser Family Foundation.

For example, employers can create financial incentives for consumers to encourage them to complete a health risk assessment.

Health savings accounts (HSAs) were authorized under the Medicare Modernization Act of 2003 and are portable accounts that consumers can use to pay for certain qualified medical expenses. The accounts are generally offered in conjunction with a high-deductible insurance plan, and both consumers and employers can contribute to the accounts.

HSAs and similar accounts, such as health reimbursement accounts, also are capable of creating big savings for employers, Mr. Kronenberg said.

With these types of plans, consumers tend to see the money as their own, and utilization of health care services typically drops.

"That's not a bad thing, when you take a look at the environment we're in today, as long as you're getting the right kind of utilization reduction," Mr. Kronenberg said.

But Mila Kofman, J.D., assistant research professor at the Health Policy Institute at Georgetown University, Washington, said that HSAs coupled with high deductible plans are just shifting the cost burden for health care from the insurer and the employer to the consumer.

And one of the possible pitfalls of the plans is that consumers who are facing deductibles of $1,000 or more each year will simply forego needed medical care because they can't afford to pay for it. This could actually raise the cost of health care in general if consumers skip or delay screenings and other preventive care that can identify problems early. ■

Medical Schools Should Help Students With Debt, AAMC Says

BY JENNIFER SILVERMAN
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U.S. medical schools need to improve their tuition- and fee-setting processes to help students pay off their debts, the Association of American Medical Colleges concluded in a new study.

The future affordability of a U.S. medical education may be in jeopardy unless significant changes are made, particularly for lower-income applicants and applicants from racial and ethnic groups underrepresented in medicine, said the study, conducted by an AAMC working group.

The median indebtedness of medical school graduates has increased dramatically during the last 20 years—from $20,000 for both public and private schools in 1984, to almost $140,000 and $100,000 for private and public schools, respectively, last year. Although medical school tuition and fees have increased at rates far in excess of inflation, physician income at the same time has remained relatively flat, the study said.

To address rising tuition costs and student debt, the AAMC recommended that medical schools offer:

► Greater predictability about the student costs of a medical education.

► Ongoing financial education for medical students.

► More financial aid, with an emphasis on need-based scholarships and on programs offering loan repayment and forgiveness in exchange for service in the military or to underserved populations.

► Periodic self-reviews of their attendance costs.

Medical schools should also reevaluate their funding of medical education and develop innovative methods to generate financial support at the local, state, and national levels for financial aid programs that would address the nation's current health care needs, the AAMC recommended.

"It's essential that we find more creative ways for students to pay off their educational debt by providing health care services to our uninsured and underserved citizens," said AAMC President Jordan J. Cohen, M.D.

The American Medical Association has offered some assistance in this area by awarding a total of $40,000 in grants to five medical schools to help medical students and patients care for patients in underserved communities.

The grants, part of the AMA's Reaching Equitable Access to Care for Health Program, will support health promotion and disease prevention projects in free clinics led by medical students. Grant recipients included schools in New York, Texas, Pennsylvania, and Chicago. ■