



WHITE PAPER



Rheumatoid Arthritis: Transforming Care Delivery to a Value-Based Model

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INTRODUCTION: RHEUMATOID ARTHRITIS AND THE IMPORTANCE OF EVIDENCE-BASED CARE

Rheumatoid arthritis (RA) is a chronic, progressive, inflammatory condition that imposes a high burden on individual patients and on the health care system. Approximately 1.5 million people in the United States have RA, which is more prevalent in women, who account for about 75% of cases.¹ RA affects individuals across a wide range of ages, with onset generally occurring between the ages of 30 and 60 in women and later in men. RA results in an estimated \$8.4 billion annually in direct medical costs and another \$10.9 billion in indirect costs.² RA also exacts a significant human toll and can adversely impact a patient's health-related quality of life.³ A recent global survey of patients found that more than half (51%) of patient respondents discontinued participation in some activities due to RA, nearly a third (30%) reported changing jobs due to the condition and 5% delayed having children.

The pathogenesis of RA results in symptoms such as pain, fatigue, stiffness and swelling of the joints;^{4,5} left untreated, RA leads to destruction of cartilage and bone.⁶ Patients with RA have an average of five comorbidities, making treatment of RA complex. Among the most common comorbidities are hypertension, back problems, osteoarthritis, chronic obstructive pulmonary disease (COPD) and depression.⁷ RA also places patients at higher risk of infection, including infections requiring hospitalization, compared with individuals without RA.⁸

In recent years, treatment of RA has evolved to be more aggressive in an effort to achieve low disease activity or remission and to prevent inflammatory joint disease and disability.^{9,10} Although research suggests RA treatment may be more aggressive and in line with recommendations from the American College of Rheumatology, opportunities still exist for greater adherence to evidence-based guidelines (e.g., therapy with anti-TNF agents and appropriate use of opioids).^{11,12} Coupled with the high cost of care, these variations make RA an attractive focal point to incentivize quality improvement and promote evidence-based care.

Alternative payment models (APM) are designed to foster quality by rewarding efficient, value-based care through the use of incentives and penalties. In recent years, APMs have sparked interest from both public and commercial payers and APMs constitute one of two tracks in the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP). APMs present an opportunity to promote patient-centred care and flexibility to meet the patient's needs and preferences by rewarding and supporting care coordination and evidence-based care.¹³ APMs can apply to a specific population or therapeutic area, raising the possibility that an APM can be developed and deployed to support the delivery of value-based care for patients living with RA.

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PURPOSE OF THIS PAPER

The purpose of this paper is to summarize the input, ideas and recommendations from key opinion leaders representing diverse stakeholders during two NCQA-facilitated meetings held in November 2018. The issues addressed include:

- Underutilization of disease activity assessment tools and development of RA-specific outcome measures to optimize patient-centered treatment, evidence-based care and outcomes for individuals living with RA.
- Technological challenges associated with measuring and reporting outcomes.
- Development and implementation of APMs that support patient-centered, value-based care.

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METHODOLOGY

Recognizing that the successful implementation of quality improvement programs involves input and alignment from clinical, professional society, practice management, information technology, patient advocacy and payer stakeholders, NCQA organized an RA-focused roundtable to coincide with its annual Digital Quality Summit (DQS), cohosted with Health Level 7 International (HL7®).

The combined meetings presented a unique opportunity to assemble and leverage diverse expertise in a creative three-day forum to identify and address challenges with data capture, performance measurement and rational incentivization of evidence-based, patient-centered care. Both meetings included many of the same clinical, quality and information system experts. We wish to note that during the DQS, dozens of quality, data and practice management experts contributed guidance on the development of an RA outcome quality measure construct that was developed during these meetings by a core group of experts affiliated with the American College of Rheumatology, United Rheumatology, Arthritis Northwest and others.

Unless otherwise noted, content in the Roundtable Findings section of this report represents a synthesis of conversations and work done during the meetings described in this section.

THE IMPORTANCE OF MEASURING DISEASE ACTIVITY AND TREATING TO TARGET

“Treat-to-target” is the approach recommended by the ACR for managing RA, which includes defining a treatment target (specifically, remission or at least low disease activity), periodically assessing disease activity and regularly adjusting therapy if the target is not achieved within a given time frame.¹⁴ Treat-to-target also considers variations in risk and other characteristics of individual patients and involves shared decision making between patient and physician.

Multiple clinical tools* are used to assess disease activity and ACR recommends that disease activity be measured using an endorsed clinical tool in a majority of encounters for RA patients.¹⁵ Table 1 shows those tools endorsed by the ACR (each of which may include patient- and/or provider-reported outcomes) that are considered an effective surrogate measure to support clinical decision making in RA.¹⁶ Clinical tools generally score disease activity on a scale, with defined ranges to indicate whether the patient is in remission or experiencing high, medium or low disease activity. The Clinical Disease Activity Index (CDAI) and the RAPID3 are commonly used measurement tools. The CDAI includes both patient- and clinician-reported outcomes in the form of a tender and swollen joint count and global assessment of disease activity, as well as a patient-reported global assessment.¹⁷ The RAPID3 uses patient-reported outcomes and includes patient global assessments for both pain and overall health, as well as assessments of specific physical functions such as dressing, walking and getting in and out of bed.¹⁸ RAPID3 does not include a clinician-reported component. Some tools, such as the DAS28, include the tender and swollen joint count as assessed by a clinician, as well as lab results such as C-reactive protein levels.¹⁹

Table 1: ACR-Endorsed Clinical Tools for Assessing Disease Activity in RA

CLINICAL TOOL	PROVIDER-REPORTED COMPONENTS	PATIENT-REPORTED COMPONENTS
CDAI	✓	✓
RAPID3		✓
DAS28	✓	✓
PAS		✓
PAS-II		✓
SDAI	✓	✓

*In this paper, the term “clinical tools” refers to assessment instruments used to evaluate disease activity in RA.

Clinicians also use clinical tools for quality reporting. For example, the QPP includes five RA-specific quality measures for which ACR serves as the steward. Each of these is a process measure, rather than an outcome measure. Although a process measure assesses practices (e.g., whether a clinical tool is used or tests are performed); outcome measures assess results (e.g., whether the clinical tool indicates that a patient is experiencing higher, lower or stable disease activity). For example, the process measure for periodic assessment of disease activity assesses whether the clinician uses an ACR-endorsed tool to evaluate the level of disease activity for each patient in at least 50% of outpatient RA encounters. The use of process measures is an important step toward evidence-based care in RA, but outcome measures are needed to demonstrate whether care is effective.

ROUNDTABLE FINDINGS

CLINICAL PRACTICE

Table 2: Clinical Practice Barriers to Evidence-Based Care and Potential Solutions

BARRIER	POTENTIAL SOLUTION
1A. Clinical tools to assess RA disease activity appear to be underutilized in clinical practice, presenting a barrier to evidence-based care.	1B. Practice transformation activities will be required to drive uptake of clinical tools, which may be accelerated by financial incentives, more effective communications, integrating disease activity measurement into the clinical workflow and a shift from process measures to outcome measures.
2A. Patients and clinicians may define treatment success differently, complicating the treat-to-target paradigm.	2B. Align treatment goals by further integrating the patient voice into assessment and care planning, which includes the use of clinical tools that capture patient-reported outcomes in real time.
3A. Patients may not see the value in routine assessments via clinical tools, and rheumatologists noted that without visibility into how results are being used, patients may become disengaged and grow reluctant to participate in these assessments.	3B. Increase the use of tools that capture results in real time and regularly share results so that patients can visually track treatment progress and understand the value of assessments.
4A. Most rheumatology practices use basic electronic medical record (EMR) systems with limited ability to capture and process data from clinical tools, which may ultimately hinder quality reporting and APM implementation.	4B. Continue industry pressure for inclusion of clinical tools in EMR systems and support regulatory incentives for inclusion.

➤ Barrier: Underutilization of Clinical Tools

1A. Clinical tools to assess RA disease activity appear to be underutilized in clinical practice, presenting a barrier to evidence-based care.

WHO IS AFFECTED?

Clinicians 

Patients 

Payers 

Although the ACR has recommended a list of clinical tools to measure disease progression in RA, many clinicians do not apply tools in clinical practice; roundtable participants estimated that only 10% to 40% of rheumatologists do so. The use of tools may not fit well within the current clinical workflow. Even choosing a tool can present challenges, as various clinical tools measure different clinical or patient-reported outcomes, and some tools, such as CDAI, capture elements of each. When standardized tools are not used, clinicians, patients and payers may miss opportunities to improve patient health and minimize disease progression.

Clinicians sometimes lack evidence-based data to facilitate treat-to-target. Patients may also be affected when standardized tools are not used during follow-up visits if symptoms are missed and treatment is not accelerated to reduce their level of disease activity or achieve remission. Without standardized assessment, payers lose the opportunity to gauge the effectiveness of interventions at both the individual and population levels.

➤ Potential Solutions

1B. Practice transformation activities will be required to drive uptake of clinical tools, which may be accelerated by financial incentives, more effective communications, integrating disease activity measurement into the clinical workflow and a shift from process measures to outcome measures.

Changes in how clinical care is provided and funded will need to occur to increase the use of clinical tools to assess RA activity. Clinical tools are a critical aspect of evidence-based care in RA, but utilization of these tools is a complex issue. Because of the variety of tools available, potential disruption to the clinician's workflow and the resources required to measure and report clinical tool results, it is unlikely that any single solution would be sufficient to drive clinical tool adoption. Practice transformation comprises many components and will be driven not only by clinicians and their teams, but also by payers and health systems.

At a high level, shifting the emphasis from episodic care to a population health model could help drive practice transformation. Financial incentives for clinical tool utilization are expected to be a key driver, but professional societies and clinical leaders will need to expand their communication, education and research efforts to accelerate the use of standardized tools to promote evidence-based care. Rheumatologists described ways that disease activity measurement had been successfully implemented within clinical workflows and could potentially serve as best-practice models. Rheumatologists and APM developers will have to demonstrate the value of clinical tool data to improve outcomes for patients in order to gain greater support from payers. Rheumatologists and payers also want to be confident that they are measuring the outcomes that matter most, underscoring the need for developing and adopting outcome measures. Rheumatologists discussed the potential positive impact of financial incentives linked to patient disease activity outcomes to:

- Drive an increase in regular use of standardized tools to assess disease activity (a process measure).
- Develop and adopt an outcome measure assessing changes in a patient's disease activity over time (as measured through standardized tools).
- Accelerate treatment to targets determined by clinicians and their patients.

To this end, the Rheumatology Working Group at the DQS hosted by NCQA and HL7 discussed a digital outcomes-based draft quality measure concept prior to the roundtable in November 2018. The outcome measure concept was designed to facilitate treat-to-target. In developing the measure, the Working Group desired to create an easy-to-use measure that accounted for certain comorbidities while focusing on outcomes instead of process. Rheumatologists would be able to use either CDAI or RAPID3 to report results for the outcome measure. Most Rheumatology Working Group participants expressed a preference for CDAI. Like other clinical tools, CDAI assesses disease activity, but not outcomes such as bone erosion; however, rheumatologists noted that CDAI measures what matters, with CDAI results available to discuss with the patient at time of consult. The roundtable participants gravitated toward the CDAI as perhaps the best tool because it includes clinician and patient input and engagement over time.

➤ **Barrier: Varying Definitions of Treatment Success**

2A. Patients and clinicians may define treatment success differently, complicating the treat-to-target paradigm.

WHO IS AFFECTED?

Clinicians 

Patients 

Outcomes considered meaningful by rheumatologists may not hold the same value for patients. For example, achieving remission may be the gold standard in the eyes of the rheumatologist, but patients are unlikely to consider themselves in remission if fatigue persists despite low disease activity. From the patient's perspective, a clinical tool will likely be considered incomplete if its results do not align with the patient's perception of treatment progress.

“ *If value-based payments rest on whether outcomes are achieved and if clinicians have an outcome that doesn't speak to patient outcomes, then it will never work. Can't pay clinicians for an outcome that doesn't matter to patients. You'll lose.* **”**
—Patient Advocate

➤ **Potential Solutions**

2B. Align treatment goals by further integrating the patient voice into assessment and care planning, which includes the use of clinical tools that capture patient-reported outcomes in real time.

Greater alignment of treatment goals will require the use of clinical tools that capture both the patient and clinician perspective, as well as effective patient-clinician communication to determine how patients and clinicians perceive clinical outcomes.

Rheumatologists expressed a preference for CDAI, generally considering it the most valuable tool for periodic assessment of disease activity to facilitate treat-to-target. While not perfect, the inclusion of both patient- and clinician-reported outcomes in CDAI may help to better incorporate the patient perspective into treatment. It was noted that future iterations of CDAI could be improved by addressing more refined patient input (e.g., fatigue levels). Indeed, rheumatologists note that when using CDAI, even small negative changes to the patient's self-assessment portion potentially reflect that the patient is no longer experiencing remission of symptoms. This sensitivity to the patient's view of disease activity may facilitate closer alignment between clinician and patient perceptions of treat-to-target.

Some rheumatologists acknowledge using RAPID3—which only captures patient-reported outcomes—either alone or as a complement to CDAI. However, RAPID3 is not a continuous measurement and thus may not reflect patients' feelings and perceptions in the areas of pain, fatigue and physical function. To capture a well-rounded picture of disease activity, some rheumatologists use both CDAI and RAPID3, while supplementing

with an additional questionnaire about patient fatigue levels. A patient advocate agreed with this approach and suggested the use of fatigue assessments in addition to CDAI (or potentially incorporated into future CDAI versions), given that some patients may view CDAI as a clinician-centered tool, despite the inclusion of patient-reported outcomes.

To support shared decision making in RA, a prominent rheumatologist explained that for the last 9 years, his delivery system has collected CDAI (95%) and RAPID3 (85%) data from most returning patients. These tools were chosen because they capture data in real time and offer a window into the perspectives of both clinician and patient. Depending on how the patient and rheumatologist view treatment progress, patients are segmented into one of four quadrants in a two-by-two matrix, with action steps depending on where the patient lands.



GAINING ACTIONABLE INSIGHT FROM CLINICIAN-AND PATIENT-REPORTED OUTCOMES

The matrix below is an example used by one delivery system to integrate the patient voice into clinical decision making in real time.

		PATIENT VIEW OF TREATMENT PROGRESS (RAPID3)	
		Negative	Positive
CLINICIAN VIEW OF TREATMENT PROGRESS (CDAI)	Positive	Consider the possibility of secondary conditions (e.g., osteoarthritis)	Discuss de-escalation of therapy
	Negative	Escalate or change therapy	Patient might be "stoic" and require a different approach to engagement

➤ Barrier: Patient Reluctance to Record Routine Assessments

3A. Patients may not see the value in routine assessments via clinical tools and rheumatologists noted that without visibility into how results are being used, patients may become disengaged and grow reluctant to participate in these assessments.

WHO IS AFFECTED?

Clinicians 

Patients 

From both the rheumatologist's and the patient's perspectives, more than two assessments are needed to accurately reflect the patient's journey, because disease activity in RA does not necessarily follow a straight line. Flares may diminish quality of life for patients between routine assessments; the pain and fatigue the patient experienced when they booked their appointment may have waned by the time the assessment is performed. Furthermore, a clinician's accurate understanding of a patient's disease activity may sometimes be impeded by

patient reluctance to report outcomes such as fatigue, due to a sense of resignation and doubts that available therapies can effectively address their symptoms, not wanting to be seen as "complaining" or lack of perceived value of routine assessment.

“ *If you collect information from patients and don't use it, they're only altruistic to three or four visits. You need to show the patient you're using it, show the team that you're using it; it will keep collection rates high.* **”**
—Rheumatologist

➤ Potential Solutions

3B. Increase the use of tools that capture results in real time and regularly share results so that patients can visually track treatment progress and understand the value of assessments.

Stakeholders across the health care spectrum recognize a need to motivate patients to drive participation in assessments and treatment. To this end, sharing and discussing clinical tool data with the patient should be a key tenet of treatment and should ideally occur in real time, while recognizing that patients' preferences and needs will vary with regard to how many assessments are required for meaningful engagement. This approach engages the patient by offering a clear sign that the clinician is providing active and responsive care. Having the patient's disease activity results available for discussion with the patient at time of consult was viewed by the roundtable participants as vital to patient-centered care and was a factor influencing their use of the CDAI, an ACR-endorsed, standardized tool providing real-time results assessing a patient's level of disease activity.

Understanding the period between assessments is also important. If patients are afforded a mechanism to report outcomes outside of the encounter, rheumatologists could develop a clearer picture of disease activity over time. Both rheumatologists and patients see the value in engaging one another with this information, and rheumatologists recognize that patient-centered care is better served when they can spend an appointment interacting with the patient, rather than reading the patient's disease activity history. Ideally, rheumatologists would be armed with information about the patient's disease activity trends prior to the appointment, enabling them to begin by discussing the patient's progress, rather than spending the first 15 minutes questioning the patient. This could require mechanisms to capture data both between and immediately prior to sessions. Several of the participants referenced the roles of their treatment teams to facilitate care continuity between visits and to facilitate patient participation and education to help with symptom reduction or remission. A key step would be determining whether practices that adopt these approaches achieve better outcomes, including a more optimal patient care experience, for their patients living with RA.

Systemic change will ultimately be required to drive this shift to use of tools and data collected outside the encounter to assess and discuss with patients their disease activity experience. Participants observed that it will be imperative for professional societies and key opinion leaders to promote research and best practices to emphasize the importance of transparency and shared decision making to expand patient-centered, evidence-based care for patients with RA. It is also vitally important that patients and their advocates continue to amplify the patient voice regarding participatory communication when deciding on patient-centered treatment targets.

Some participants observed that financial incentives may be needed from payers to support clinicians' efforts to modify their systems for real-time data collection and discussion with patients. The prioritization of readmission reduction through CMS value-based reimbursement programs was offered during the discussion as one analog. Catalyzed by CMS, this emphasis on readmission reduction saw clinicians, health systems and health plans collaborate to address what was once considered an intractable problem, by establishing systems and processes to track, intervene and prevent readmissions. There could also be a role for professional societies and major payers to facilitate this change by assigning Current Procedural Terminology (CPT) codes to the assessment of patient-reported outcomes and reimbursing clinicians billing for those procedures. By offering practices an avenue for reimbursement, this move would support the infrastructure and facilitate the performance of routine, patient-reported clinical assessments using ACR-endorsed standardized tools.

➤ **Barrier: Capture of Clinical Tool Data**

4A. Most rheumatology practices use basic EMR systems with limited ability to capture and process data from clinical tools, which may ultimately hinder quality reporting and APM implementation.

WHO IS AFFECTED?

Clinicians 

Patients 

Payers 

“ *We have 50 to 60 EMR platforms and can reliably extract from maybe 10. We can do transactional extractions, such as admissions and discharge... but the routine extraction of population-level data from an EMR is still really hard.* **”**

-Executive, Clinical Pathways

Because many EMR systems were designed principally for primary care, even the simplest and most common systems have structured data fields for entries such as blood test results. However, capturing specialized entries such as RA disease activity assessments and patient-reported outcomes can be challenging. Most EMR platforms have a native capacity to build forms for multiple disease-assessment tools, including the ability to track changes in scores over time and share data with clinicians and payers in a standardized format. However, these capabilities are typically offered as costly add-ons, rather than a standard feature. For rheumatologists who want to customize their EMR systems to include these data, the process can be slow, cumbersome and often expensive.

Entering data into the EMR based on these specialty-specific clinical tools is only a first step. At this time, only quality process measures exist in RA (primarily to verify that a clinical tool was used or an evaluation occurred at certain intervals) but not the clinical tool scoring results. Cementing alignment on what constitutes low, medium and high disease activity (based on the type of clinical tool used) and appropriate clinical follow-up based on these scores is an important next step. During the DQS, the RA working group was able to reach a consensus on an initial digital quality outcome measure construct based on low/medium/high scoring on the selected clinical tool, performed within certain time frames, with rules regarding patient age, conditions, and so on. Furthermore, this construct was written and defined as an electronic clinical quality measure (eCQM) that enables scoring to be tracked and reported in an automated way, including severity and change over time (see the Appendix for details on the construct created at the DQS).

With periodic tracking of patient disease activity levels, payers will be able to better evaluate if clinical scores and therapies are resulting in better outcomes for patients. Not having the capability to electronically track these data may hinder payers from deploying a viable value-based reimbursement model for RA. This may in turn result in lower utilization of disease activity assessment tools in clinical practice and could limit patients from having a clear view of treatment progress. For clinicians, it may also cause missed opportunities for additional compensation from APMs.

➤ Potential Solution

4B. Continue industry pressure for inclusion of clinical tools in EMR systems and support regulatory incentives for inclusion.

Because RA is one chronic disease among many, the business case may not exist for EMR vendors to prioritize the inclusion of clinical tools such as CDAI or RAPID3. Regulatory pressure may be the most direct path to updating EMR systems to include clinical tools.

A potential first step might be to strengthen the coalition of clinicians, advocacy organizations and professional societies to demonstrate the need for EMR vendors to support this approach and align on a set of clinical tools for inclusion in EMR systems. The coalition would advocate use of clinician and patient-reported outcome measurement tools endorsed by the ACR. The group also believed that CMS and the Office of the National Coordinator for Health Information Technology (ONC) could potentially play a significant role in driving adoption by EMR vendors.

Policymakers would also need to support standardization to share data between payers and clinicians. Third parties, such as CMS and private payers, must be able to extract and analyze EMR data to assess quality performance for various purposes, including determining reimbursement under APMs.

Finally, in order for clinical tools to support improved quality of care, quality measures should inform and drive decision support tools that suggest actionable next steps for clinicians. Although an eCQM can produce a score, it cannot offer an array of tools to enhance decision making within a clinical workflow. Tools such as care alerts, patient and clinician reminders, clinical guidelines and order sets can help guide the clinician and patient on what to do with that score. To support clinical decision making, the RA community must translate scores into a set of evidence-based action steps, potentially in the form of "if/then" rules, to guide next steps.

APMs AND THE TRIPLE AIM

CMS developed APMs with the purpose of incentivizing clinicians for the provision of high-quality, high-value care in pursuit of the Triple Aim: better care, smarter spending and healthier people. APMS can focus on specific clinical conditions, care episodes or populations. The models include payment structures to encourage transformation of health care delivery systems to provide person-centered care, prioritizing value over volume,^{20,21} and offer clinicians and delivery systems greater flexibility to provide patients the right care, in the right place, at the right time.²²

ACR is currently developing an APM to encourage better care for people with RA. Elements of the potential model address reducing barriers to care, paying for high-value services, flexible care delivery and team-based care consistent with ACR guidelines, including assessment of patient disease activity using an ACR-endorsed tool. The model acknowledges that RA is a lifelong condition and that care should vary depending on the stage of the disease the patient is experiencing.²³ In that regard, key features of the model under development include:²⁴

- Diagnosis and treatment planning for patients with RA.
- Support for primary care practices in evaluating joint symptoms.
- Initial treatment of patients with RA.
- Continued care for patients with RA.

The draft APM is intended to reduce current variations in treatment and facilitate treat-to-target. ACR expects the APM to help meet the Triple Aim by improving patient satisfaction and providing ready access to the rheumatologist. This would be achieved through financial incentives for high-value services like care management, which would facilitate the use of efficient resources such as follow-up and telephonic care coordination.

Table 3: Barriers to Driving Evidence-Based Care via APM and Potential Solutions

BARRIER	POTENTIAL SOLUTION
5A. The financial cost of practice transformation was identified as a key challenge to rheumatologists' participation in an APM.	5B. Compensate practices for the infrastructure, staff and routine systems required to coordinate care to optimize clinical outcomes and the care experience of patients with RA.
6A. The administrative investment required for practice transformation poses challenges, particularly for small practices.	6B. Ensure simplicity of APM-reporting requirements and administrative tasks for practices, integrating as much as possible with an EMR.
7A. A heterogeneous patient population could complicate APM payments.	7B. Segmentation of patients by response to therapy for the purposes of APM reimbursement should contain risk adjustments to account for patient heterogeneity.

➤ **Barrier: Cost to Participate**

5A. The financial cost of practice transformation was identified as a key challenge to rheumatologists' participation in an APM.

WHO IS AFFECTED?



Clinicians



Payers



Transforming a traditional practice to one focused on value-based care is costly for health care clinicians. The process often requires upgrades to infrastructure, including analytics and segmentation tools and the introduction of systems for pre-visit planning, targeted follow-up and coordination with primary care. Practices may also need to hire additional full-time staff, such as care coordinators, to handle these and administrative tasks. One respondent estimated the cost of practice transformation at 5% of annual revenue, on an ongoing basis. In addition to startup costs, the prospect of bearing risk for outcomes may be daunting for small or solo practices.

If it costs 5%, you need at least a 10% to 15% increase in revenue.

-Executive, EMR

”

➤ **Potential Solution**

5B. Compensate practices for the infrastructure, staff and routine systems required to coordinate care to optimize clinical outcomes and the care experience of patients with RA.

A key question related to the implementation of any APM is the level of reimbursement, particularly for activities related to the quality of care for patients. Approval of the APM by CMS could facilitate participation, potentially attracting rheumatologists with the promise of higher long-term base Medicare payment rates.

To offset the initial cost of infrastructure, APM developers could consider a monthly enhanced services payment for practices that are new to value-based reimbursement. Payments could also be provided to compensate practices for activities aimed at improving the patient experience of care. Payments could potentially cover activities such as care management, including coordinating with primary care physicians and specialists to manage comorbidities. A precedent is the Oncology Care Model, which offers such a payment (called a Monthly Enhanced Oncology Services payment) for the duration of an episode of care.

Clinicians and payers will need to align on appropriate reimbursement to defray the financial cost of participation. This alignment may require a dialogue to highlight the value of rheumatology, particularly for patients who remain in remission or who experience low disease activity. Some roundtable participants commented that although some payers prioritize value-based reimbursement for high-prevalence chronic conditions such as diabetes and cardiovascular disease, they might not regard inflammatory conditions with the same urgency, due to smaller population sizes. Understanding the outcomes that matter to patients—particularly in terms of function and fatigue—will also help payers align on appropriate incentives to encourage achievement of these outcomes.

A member of the ACR APM Work Group described a conversation in which the value of rheumatology was successfully clarified for a regional payer. Because rheumatologists manage inflammation throughout the body, they play an important role in reducing health care resource utilization by preventing avoidable hospitalizations and ER visits. This is particularly true for patients with complex comorbidities and medication histories, for which hospitalization is a significantly greater risk. Illustrating these benefits for public and commercial payers could elevate the profile of rheumatology as clinicians and payers align on appropriate reimbursement.

➤ **Barrier: Administrative Workload**

6A. The administrative investment required for practice transformation poses challenges, particularly for small practices.

WHO IS AFFECTED?

Clinicians 

Patients 

Payers 

APM participation is likely to lead to an increase in administrative and reporting workload for clinicians. Several roundtable participants believe that the administrative burden on practices has already become untenable, pointing to the systems and staff required to comply with current utilization management tactics, such as prior authorization and step therapy. The time required for administrative workload could potentially impact patient care as clinicians spend more time dealing with paperwork and have less availability for face-to-face interactions to ensure a positive care experience for patients. Because practices are not reimbursed for these administrative services, each additional requirement associated with an APM imposes a financial burden as well.

Practices at full risk for Medicare Advantage patients may already possess the data tools and processes necessary to ensure a smooth transition to value-based reimbursement in RA. However, several participants voiced doubts that solo practitioners could effectively participate.

“ *It’s not appreciated how hard the administrative burden is and the pressure on the doc to do just one more thing. Many of these programs come out as making us eat the stick and get beaten by the carrot. Adding one more thing without taking something else away will be a real struggle and could implode the specialty.* **”**
—Rheumatologist

➤ **Potential Solution**

6B. Ensure simplicity of APM-reporting requirements and administrative tasks for practices, integrating as much as possible with an EMR.

Multiple roundtable participants commented that an APM for RA should initially be based on simple, objective measurements that minimize the reporting burden on the rheumatologist. Some participants commented on the use of tools and registries and on the need for closer integration of tools (e.g., CDAI) and registries with a practice’s EMR, thereby helping to automate the reporting process and free the rheumatologist to devote more time to patient care.

A roundtable member also affiliated with the ACR APM Work Group recognized that simplicity is one key to adoption of an APM by rheumatologists, indicating that the more complex an APM is, the less likely it will be to gain traction. For the draft APM reviewed by the group, participants considered the pathway compliance requirements to be straightforward, as the rheumatologists in attendance were already following guidelines. The requirement for visits every 6 months could be a challenge, as an estimated 20% of patients are seen outside the 6-month window. Inefficient scheduling systems are partly to blame and some patients may consider 6-month intervals to be too frequent.

➤ **Barrier: Reimbursement for Difficult-to-Treat Patients**

7A. A heterogeneous patient population could complicate APM payments.

WHO IS AFFECTED?

Clinicians 

Patients 

Payers 

Clinicians voiced concern that factors over which they have limited or no control may result in lower reimbursement under a value-based APM. As examples, social determinants of health, such as financial status, may influence treatment success, and rheumatologists with a heavier mix of bio-experienced to bio-naïve patients may see lower rates of patients with low disease activity or in remission. Comorbidities may further complicate a patient's ability to adhere to medication and may impact a patient's quality of life and clinical outcomes. One participant pointed out that one unintended consequence of tying reimbursement to outcomes could be comparatively higher reimbursement rates for younger rheumatologists, who may disproportionately treat newly diagnosed patients. Outcomes can also depend on when patients are diagnosed, a process that may take years and may be outside the rheumatologist's control. Patients with a long history of RA may also be more difficult to treat and require more time and resources than newly diagnosed patients, which can be challenging under an APM. Roundtable participants indicated that there is significant value to patients and payers when clinicians and patients successfully address complex problems impacting a patient's care and outcomes and clinicians are able to support patients in reaching mutually agreed-upon and realistic goals. Participants expressed concern that payment models should not overlook the impact of these factors on disease activity.

“ RA may come not only with other rheumatologic considerations, such as coronary artery disease. We can manage our patient, but we need to know that COPD or something like that won’t penalize us. ”

-Professional Society Panelist

“ If a patient is seen for 20 years and they went through 4 or 5 lines of biologics, they might not ever get to low disease activity, but if they’re staying out of the hospital, it’s good. ”

-Physician Executive

➤ Potential Solution

7B. Segmentation of patients by response to therapy for the purposes of APM reimbursement should contain risk adjustments to account for patient heterogeneity.

The draft ACR APM under consideration as of October 2018 initially stratified patient disease activity levels into three categories (high, moderate and low disease activity), and it is this draft stratification to which roundtable participants responded. Concerned that three categories may be too restrictive, participants suggested a higher number of categories. A member of the ACR APM Work Group acknowledged that the APM could potentially launch with more granular categories, but noted that simplicity was a priority.

Participants suggested that a patient's disease activity level could be risk-adjusted to account for comorbidities, social determinants of health, time since diagnosis and treatment history, including previous biologic treatment. Any APM should have realistic expectations for these patients and their clinicians, understanding that patients on their third trial of a biologic may never experience low disease activity, but if the patient is staying out of the hospital or ER, the rheumatologist is providing value by avoiding unnecessary health care resource utilization and offering patients a better quality of life due to fewer flare-ups requiring hospital visits.

Alternatively, complex patients could choose a target together with their rheumatologist, since patients may value different outcomes and these patients may have different treatment goals from those who are bio-naïve, or who have few or no comorbidities. For some patients, being able to perform simple activities of daily living without pain may be sufficient.

6

CONCLUSION

Roundtable participants from across the health care spectrum were clear that a transformation to value-based reimbursement in support of the Triple Aim must be the product of collaboration among multiple stakeholders and institutions. Likewise, no single issue is sufficient to drive the transformation. It is noteworthy that participants had robust discussions about appropriate reimbursement and clinical tool uptake to promote standardized measurement of disease activity and evidence-based treatment, with treatment targets determined by the clinician and the patient. Participating rheumatologists commented that rheumatology teams play an important role in reducing avoidable health care resource utilization and that a model to demonstrate successful cost avoidance to payers could potentially build on experiences voiced by participants.

To summarize, the shift to value-based RA care will require practice transformation that is:

- Aligned with practice standards adopted and promoted by the rheumatology profession in the service of patients.
- Evaluated through measures that leverage existing or new, nonburdensome workflows and information collected as a by-product of providing patient care.
- Supported by technology, including the EMR capable of capturing and reporting high-value RA data.
- Advanced by training, research, best practices and models that produce better outcomes (e.g., NCQA Patient-Centered Specialty Practice Recognition).
- Funded through appropriate payment models adjusted to support the care of patients throughout the wide range of complexity associated with conditions such as RA.

APPENDIX

Outcome measure construct developed by the Rheumatology Working Group at the DQS:

The percentage of patients 18 years and older with a diagnosis of RA, at least two in-person encounters and two disease activity assessments (CDAI or RAPID3) during the measurement period, who improved or remained in low disease activity/remission according to the first and last disease activity assessments during the measurement period.

Numerator:

- Patients who improved or remained in low disease activity/remission according to the first and last disease activity assessments during the measurement period.
- The disease activity assessment tool must be the CDAI or RAPID3; the same assessment tool must be completed for both assessments.
- The assessments must be at least 90 days apart and must occur during an in-person encounter.

Denominator:

- Patients age 18+ with RA (excludes those in hospice and those who died).
- ≥ 2 in-person encounters.
- ≥ 2 disease activity assessments (CDAI or RAPID3) during measurement period.

Human-readable measure construct:

POPULATION CRITERIA

▲ Initial Population

exists ["Patient Characteristic Birthdate"] BirthDate
where Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 18
and exists "Has Rheumatoid Arthritis"
and exists "Patient Had At Least Two Encounters with a CDAL Performed at Least 90 Days Apart"

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

None

▲ Numerator

("First CDAL Result of High Disease Activity" is not null
and ("Last CDAL Result of Moderate Disease Activity" is not null
or "Last CDAL Result of Low Disease Activity or In Remission" is not null
)
)
or ("First CDAL Result of Moderate Disease Activity" is not null
and "Last CDAL Result of Low Disease Activity or In Remission" is not null
)
or ("First CDAL Result of Low Disease Activity or In Remission" is not null
and "Last CDAL Result of Low Disease Activity or In Remission" is not null
)

▲ Numerator Exclusions

None

▲ Denominator Exceptions

None

▲ Stratification

None

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Table 4: Roundtable Participants

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Eric Newman, MD	Geisinger
Tarun Sharma, MD	Allegheny Health Network
David Sikes, MD	Florida Medical Clinic
Lisa Suter, MD	Yale School of Medicine, CMS Technical Expert Panelist (ACR)
Shilpa Venkatachalam	Creaky Joints, Global Healthy Living Foundation

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*As of November 2018.

†Member of American College of Rheumatology APM Work Group.



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