

Wide variation exists in receipt of recommended medications for Medicare managed care RA patients

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An analysis of data from more than 90,000 Medicare managed care enrollees who received care for rheumatoid arthritis finds that more than one-third did not receive the recommended treatment with a disease-modifying antirheumatic drug, and that receipt varied by demographic factors, socioeconomic status, geographic location and health plan, according to a study in the February 2 issue of *JAMA*.

Despite evidence-based guidelines recommending early and [aggressive treatment](#) of active rheumatoid arthritis (RA), recent population-based studies of disease-modifying antirheumatic drug (DMARD) receipt in patients with RA report low rates of use, although these data may not be broadly generalizable because of several limitations. In 2005, the Healthcare Effectiveness Data and Information Set (HEDIS) introduced a quality measure to assess the receipt of DMARDs among patients with [rheumatoid arthritis](#), according to background information in the article. HEDIS data from [Medicare](#) managed care plans provide a nationally representative sample of the managed care population older than 65 years.

Gabriela Schmajuk, M.D., M.S., of Stanford University, Stanford, Calif., and colleagues examined sociodemographic, community, and health plan factors associated with DMARD receipt among Medicare managed care enrollees. The researchers analyzed HEDIS data for 93,143 patients who were at least 65 years old with at least 2 diagnoses

of RA within a year (during 2005-2008). The average age of patients was 74 years; 75 percent were women and 82 percent were white.

Overall performance on the HEDIS measure for RA in the study sample was 63 percent. In 2005, 59 percent of the sample received a DMARD, increasing to 67 percent in 2008. The largest difference in performance on the HEDIS RA measure was based on age: participants 85 years and older had a 30 percentage point lower rate of DMARD receipt compared with patients 65 to 69 years old. Other participant categories less likely to receive a DMARD were men, individuals identified by race as black or other, individuals with low personal income, participants in lower socioeconomic status zip codes, and individuals in the Middle and South Atlantic regions.

"Patients living in a health professional shortage area had slightly lower performance (-3 percentage points). In addition, patients enrolled in a for-profit health plan had a 4 percentage point lower rate of DMARD receipt compared with patients enrolled in a not-for-profit health plan," the authors write. Performance varied widely by health plan, with rates ranging from 16 percent to 87 percent.

The researchers write that although RA was once an inevitably deforming and disabling condition, the development of new DMARDs and support for their early use has dramatically improved clinical outcomes for many patients. "This study suggests that 1 mechanism for the sociodemographic disparities in RA outcomes in the United States may relate to differences in DMARD receipt."

"Given the enormous individual and societal costs associated with RA, and increasing substantial evidence that DMARDs can reduce these costs, variations in DMARD receipt based on demographics, [socioeconomic status](#), and geography are unacceptable. Because optimizing DMARD use is the primary mechanism for decreasing the

significant public health impact of RA in the United States, targeting educational and quality improvement interventions to patients who are underusing DMARDs and their clinicians will be important to eliminate these disparities. Additional studies of population-wide cohorts that include clinical data and disease activity measures are needed to validate our findings."

More information: *JAMA*. 2011;305[5]:480-486.

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