Colin C. Edgerton, MD, FACP, FACR, RhMSUS

Testimony – Committee on Energy and Commerce

Subcommittee on Health

Wednesday, November 8, 2017

Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished members of the Health Subcommittee, thank you for opportunity to speak before you today. My name is Dr. Colin Edgerton, and I am a rheumatologist in a small private practice at Low Country Rheumatology in Charleston, South Carolina, where I am one of seven rheumatologists in a single-specialty group.

Our practice is a typical rheumatology practice, with around 50 percent of our patients being in Medicare, along with a significant number of Tri-care patients and a smaller group of Medicaid patients. The remaining group of commercial patients makes up approximately 40 percent of our patient population. As rheumatologists, many of the diseases we treat affect the Medicare population, although autoimmune diseases do also strike younger Americans as well.

Because South Carolina, like most areas of the country, suffers from a shortage of rheumatologists, our patients may travel long distances (commonly 1.5 to 2 hours) to see us and receive treatment. As a result, we see a mix of urban, suburban, and rural populations in our practice. In addition to my work as a rheumatologist caring for patients with rheumatic disease in our small private practice, I am also privileged to be involved as a volunteer with the American College of Rheumatology (ACR), where I currently chair the Committee on Rheumatologic Care. The ACR represents approximately 9,500 rheumatologists and rheumatology health professionals.

Community physicians including rheumatologists are keenly aware of the opportunities created by the Medicare Access and CHIP Reauthorization Act (MACRA) for developing models to promote

value-based care. Before MACRA there really was no meaningful way for small specialties or small practices to participate in alternative payment models (APMs). As rheumatologists we did not have the opportunity to engage in early APMs because our specialty did not fit into the previously existing value-based projects. Looking back just a few years, I recognize that, coming from a community practice setting, I would not have considered myself someone who could get involved in an APM. But with the repeal of sustainable growth formula (SGR) and institution of MACRA, rheumatologists saw for the first time a structured opportunity to participate in value-based medicine.

There are several reasons that I and also the ACR have been excited to get involved in creating APMs under MACRA. Most notably, we immediately saw the benefits of APMs, recognizing that certain aspects of care provided by rheumatologists as cognitive specialists are undervalued in the current system. We are trained to recognize and diagnose rheumatologic diseases and other illnesses that complicate treatment, and to communicate with patients, their family and their doctors to maximize the treatment plan. Yet in many instances, the value of the training and expertise provided by rheumatologists is not always recognized in payment outside of innovative models. Services such as non-face-to-face care and chronic disease care coordination with other providers are examples of critically important but non-reimbursed services provided by rheumatologists every day. And, like other specialists that are developing APMs, rheumatologists know that these valuable services prevent costly or unnecessary procedures and lower overall costs.

My early foray into value-based medicine involved reaching out to leaders in the AMA who had experience with value-based projects at the Centers for Medicare and Medicaid Services (CMS). This led me to the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, whose members have been generous with their time listening to my ideas and guiding my progress. The ACR simultaneously began developing an APM and I have been fortunate to participate in this process as a

representative of community rheumatologists. The ACR's APM is approaching its testing phase, and back home my partners and I are eager to be a pilot site and to help "work out the kinks."

The ACR's APM addresses the treatment of rheumatoid arthritis (RA), a life-long condition whose care depends on the stage of the disease. The ACR's APM reflects the varied involvement of the rheumatologist during these distinct stages of care, splitting payment into an initial stage for diagnosis (including, for example, communication with primary care physicians), followed by ongoing care stratified by the disease severity and the other illnesses that complicate treatment. This model aligns payment with physician work and reimburses for services that have traditionally been undervalued. Quality measures are built into the APM to ensure treatment adheres to best practices.

One of the most important components of MACRA is its emphasis on physician-generated value-based initiatives. In support of that emphasis, the PTAC has been created and it is obvious that it is made up of people who are committed to "beating the bushes" around the country to engage physicians at the grass-roots level, and providing guidance even before an APM is formally submitted. The feedback that PTAC provides to organizations developing and submitting APMs has been enormously helpful.

Rheumatologists as a specialty are energized by the opportunity to provide our patients value-based care through this framework, and we look forward to more physician participation in APMs. Smaller practices are eager to participate in APMs, and allowing some of the downside risk to be covered could help those practices get involved. Regarding timelines, as soon as MACRA was codified many specialties developed APMs, and I am hearing that a reduction of the qualification thresholds could allow these eager physicians to utilize the APM framework.

We appreciate the Committee's work to get us to this point and we look forward to continuing to develop and implement innovative new payment models that offer the opportunity to provide better patient care-- aligning payment with highly value services. Thank you again for accepting this testimony and I am happy to address any questions the Committee may have.