The Sage Group Highlights P.A.D. Costs and Consequences for National PAD Awareness Month

According to The Sage Group, an organization that conducts research and consulting around peripheral artery and venous disease, peripheral artery disease (PAD) is one of the most widespread chronic diseases. The organization chose to highlight some of their research for national PAD Awareness Month this September.

In fact, PAD affects almost 20 million U.S. citizens, costing an estimated $212 to $319 billion, exceeding the costs of diabetes, coronary disease, and all cancers combined. Mary Yost, President of The Sage Group, elaborated on the reasons for high costs, saying, “The majority of costs are inpatient (62%-87%) with PAD-specific treatments only one factor driving up spending. Cardiovascular events, such as heart attacks and strokes, and related treatments account for over 40% costs, adding significantly to total costs.”

PAD can easily be diagnosed with a simple, noninvasive test. However, Medicare only offers testing for patients with symptoms, while approximately 75% of PAD is most commonly asymptomatic.

“However, if the disease is not diagnosed until critical limb ischemia (CLI) occurs, interventional therapy is more costly. If gangrene is so severe that the limb cannot be salvaged, the patient must undergo amputation, the most costly procedure,” Yost explained. “Amputation is not only extremely undesirable from the patient’s viewpoint, it is socially undesirable in terms of costs. According to our estimates, CLI amputations cost $25 billion.”

To read the full article, click here.
Morning Consult Publishes Column on PAD Intervention

On September 8, Morning Consult published a column by Dr. Jeffrey Carr highlighting the lack of understanding among decision makers about peripheral arterial disease (PAD), the value of clinically appropriate interventions and opportunities for improving health and lowering costs by increasing understanding and access to care.

Carr also characterizes the July Medicare Evidence Development & Coverage Advisory Committee (MedCAC) meeting as a “positive step toward federal regulators more fully understanding vascular disease, its patient populations, effective treatments, costs and the ramifications – both clinical and fiscal – of inaction.”

To read the column, click here.

CVC Submits Comments to CMS on Medicare Physician Fee Schedule for 2016

On September 8, the CardioVascular Coalition (CVC) submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Medicare Physician Fee Schedule Proposed Rule for 2016.

The CVC comment letter addresses the following issues:

- Overview of Freestanding Cardio/Vascular Centers
- Overview of the CY 2016 Physician Fee Schedule Proposed Rule
- Alternative Payment Models and Prevention of Amputations in PAD Patients

The letter addresses a forthcoming request for information relating to alternative payment model provisions in the Medicare Access and CHIP Reauthorization Act of 2015. Specifically, it highlights the CVC’s key focus of appropriate vascular interventions to prevent non-traumatic amputations in patients.

Although a recent study of more than 1 million Medicare patients with critical limb ischemia (CLI) found that proper interventions reduced the odds of amputation by 90%, the letter explains that vascular diagnostics are underutilized, resulting in 43,000 Medicare patients receiving non-traumatic amputations annually. Further, Avalere Health has found that policies encouraging revascularization instead of major amputation for Medicare patients could reduce Medicare spending by nearly $2 billion over 10 years.

To read the CVC comment letter, click here.
AMA Recommends Approach to SGR Reform Implementation

In its comment letter to CMS on the 2016 proposed Medicare Physician Fee Schedule changes, the American Medical Association (AMA) offers several suggestions for crafting regulations that implement the alternative payment models (APM) that replace the Sustainable Growth Rate (SGR) formula for setting Medicare physician reimbursement.

The AMA comment letter covers a variety of issues related to APMs, including the definition of financial risk, eligible alternative pay entities, thresholds of participation, evaluation of alternative pay models and the application of SGR-replacement law to electronic health records.

AMA also emphasizes that doctors have administrative costs, they pay for services that are not billable, and they lose income by reducing or changing the types of services they deliver, none of which are accounted for in the Medicare payments they receive. AMA offers CMS several examples of costs physicians incur, which AMA states APMs should consider as financial risk:

- The initial cost of forming alternative payment entities, including equipment and training.
- Operating costs that enable doctors to deliver services that are not directly reimbursable under alternative pay models, such as hiring care managers.
- Lost revenues from reducing the number of services for which doctors otherwise would bill.
- Loans or bonds to pay for forming alternative pay entities or to deliver services in alternative pay models that would require repayment regardless of the success of alternative pay entities.
- Equity capital for forming alternative payment entities or for supporting the costs of delivering services in alternative pay models that would be lost if the alternative pay entity were to fail.

The AMA writes that well-designed APMs should provide adequate financial support for appropriate care and ask physicians to take accountability for avoiding both overuse and underuse of appropriate treatment. Specifically, the AMA offers this table to outline problems with current shared savings programs and suggestions on how “more desirable” APMs should operate:
CMS Announces New Program to Address Health Equity in Medicare

In September, the Centers for Medicare & Medicaid Services (CMS) Office of Minority Health (CMS OMH), announced the first action program to address health equity in Medicare, which could offer potential opportunities for underserved communities with peripheral artery disease (PAD). The CMS Equity Plan for Improving Quality in Medicare (CMS Equity Plan for Medicare) will focus on six key areas with the goal of reducing health disparities across four years.

The priorities were released by CMS as:

1. Expand the Collection, Reporting, and Analysis of Standardized Data
2. Evaluate Disparities Impacts and Integrate Equity Solutions Across CMS Programs
3. Develop and Disseminate Promising Approaches to Reduce Health Disparities
4. Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations
5. Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities
6. Increase Physical Accessibility of Health Care Facilities

CMS also named three fundamental principles for guiding the program for Medicare:

1. Increasing understanding and awareness of disparities;
2. Developing and disseminating solutions; and
3. Taking sustainable action and evaluating progress.

African Americans face a high prevalence of asymptotic PAD, resulting in delays in care and high-risk behaviors, and are 2.7 times more likely to have lower limb amputations compared to Caucasians.

To read the CMS announcement, click here.

**CRFP Releases Sequester Offset Solutions Plan**

On September 16, 2015, the Committee for a Responsible Federal Budget released a Sequester Offset Solutions Plan (SOS) that would provide $300 billion of total sequester relief by restoring half of the sequester cuts to discretionary spending over the next two years and then indexing discretionary caps to inflation through 2025.

The SOS is a four-part plan to replace a portion of the discretionary cap reductions under the sequester with more long-term savings. Specifically, the SOS lays out four points as the foundation of the plan:

1. Establishing new spending caps above sequester levels;
2. Offsetting two-year sequester relief with targeted mandatory savings and receipts;
3. Offsetting continued sequester relief by adopting the chained CPI; and
4. Strengthening enforcement of budget caps

While the SOS would be deficit-neutral over ten years, it would generate deficit and debt reductions over time, including $1.3 to $1.8 trillion saved over the next twenty years. The plan promises to grow the economy by 0.2-0.3 percent each year and pay for itself within ten years while closing 15 percent of Social Security’s gap.

To read the full plan, click here.
Lawmakers Call Hearings to Examine Healthcare Consolidations

**House Judiciary Committee**

On September 10, the House Judiciary Committee hosted a hearing, “The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition,” to examine competition and consolidation among healthcare insurers, which according to Chairman Bob Goodlatte (R-VA) was the first in a series of hearings on competition in the health care marketplace.

Expert panelists from both the provider and insurance sectors addressed current trends in healthcare, including an increase in acquisitions across the marketplace and the impact on physician-based practices.

To view the hearing and access all witness testimony, [click here](#).

**Senate Committee on the Judiciary**

The Senate Committee on the Judiciary held a hearing of the Subcommittee on Antitrust, Competition Policy and Consumer Rights on September 22, “Examining Consolidation in the Health Insurance Industry and its Impact on Consumers.”

Senate lawmakers called the hearing to examine the proposed mergers in the health insurance industry and discuss the enforcement of our antitrust laws as these transactions take place.

To view the hearing and access all witness testimony, [click here](#).

The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers and manufacturers.

The mission of the CVC is to advance patient access to community-based cardiovascular and endovascular care. Recognizing that cardiovascular disease is a leading – and preventable – cause of death in the United States, the physicians, care providers, advocates, and manufacturers who comprise the Coalition are dedicated to community-based solutions designed to improve awareness and prevention of cardiovascular disease and peripheral artery disease, reduce geographic disparities in access to care, and secure patient access to high-quality, cost-effective, community-based interventional treatment across America.