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ABC MISSION:

To promote the prevention and treatment of cardiovascular disease including stroke, in Blacks and other minorities and to achieve health equity for all through the elimination of disparities.

February 26, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201

Dear Secretary Becerra,

On behalf of the Association of Black Cardiologists (ABC), I wish to draw attention to the pressing impact of peripheral artery disease (PAD) affecting over 12 million adult Americans, especially for those in marginalized communities such as communities of color, rural areas, and those facing economic challenges. PAD, an atherosclerotic cardiovascular condition recognized for restriction of blood flow to the legs, poses significant risks of heart attack, stroke, amputation, and death. Despite its high prevalence, PAD remains underestimated, underdiagnosed, and under-treated. Indeed, it is likely that 75% of the patients with PAD remain undiagnosed thereby needlessly forgoing life and limb-saving treatments. Many individuals are unaware of their PAD status and lack access to essential guideline-directed medications and limb-preserving interventions. The total economic burden of PAD exceeds \$30 billion annually, a cost primarily borne by taxpayers.

Alarming, Black Americans are disproportionately affected by adverse consequences of PAD, facing twice the likelihood of developing the condition compared to their White counterparts; yet only 8 in 10 Black people have been told about PAD by their primary care providers. Moreover, Hispanic Americans often experience aggressive cases of PAD, with a similarly heightened risk of major amputation and death within a year of diagnosis. This national epidemic results in approximately 400 daily amputations, predominantly affecting those with diabetes, hypertension, and nicotine use, burdening taxpayers, and devastating underserved patients, families, and communities. One in five Hispanic adults suffers from PAD, yet a staggering eight out of ten are oblivious to this condition, resulting in chronic disability and higher rates of amputations compared to their non-Hispanic white peers. People who require amputations have a mortality as high as 33% by one year after the procedure.

As a Blackheart and vascular specialist in Mississippi's Congressional District 2, which holds the dubious distinction of having the highest amputation rate nationally at 170 per 100,000 persons compared to the American Heart Association's Amputation Heat Map's national average of 45 per 100,000 persons, I am deeply troubled by the prevalence of PAD-related amputations among Black individuals that I see here in my site of service and across the country. Over the past decade, my team and I have tackled this issue head-on by actively engaging with communities in Mississippi, including places of worship, schools, civic organizations, and medical institutions, to raise awareness about PAD. Our proactive efforts, including aggressive screening and

intervention strategies, have yielded remarkable results, with an 88 percent decrease in amputation rates over four years in the Delta region, as documented in a peer reviewed cardiovascular CathLab Digest journal. Having grown up and trained in the Northeast before moving to the Delta region out of a profound sense of duty to serve this marginalized region, I view myself as a voice for justice, and I am committed to collaborating with the Department of Health and Human Services (HHS) and through Congressman Thompson's office to amplify the concerns of those who lack a platform.

Despite the clear urgency, the US Preventive Services Task Force (USPSTF) has been reticent to recommend a one-time screening for PAD, despite evidence suggesting its potential to reduce mortality within four years. For the past 15 years, the reluctance to revise their recommendation has fostered a sense of complacency regarding screening, testing, and diagnosing those at the highest risk, thereby perpetuating the disparities in the amputation epidemic. This epidemic not only disrupts lives but also undermines the livelihoods of individuals who could otherwise contribute positively to our workforce. Upon investigation, it appears the lack of involvement from panel members in creating the evidence base and instead relying on a single Evidence-based Practice Center (EPC) over more than a decade with entrenched opinions may have contributed to this reluctance.

To address these systemic inequities and concerns and to ensure more informed health care provider decision-making to prevent non-traumatic limb amputations, all major heart and vascular societies recommend the following actions by HHS

1. Support congressional passage of **H.R. 4261, the *Amputation Reduction and Compassion (ARC) Act***. This legislation would reduce amputations by requiring Medicare and Medicaid to cover preventive screenings for high-risk individuals so that PAD can be diagnosed and treated early, well before it leads to amputation. This bill would also establish a PAD education program at HHS so health professionals and the public are more aware of PAD symptoms and would require HHS to implement quality payment measures to reduce unnecessary amputations.
2. Review the PAD screening recommendation by the USPSTF and consider the engagement of a new EPC to offer a renewed viewpoint and rotating EPC authors regularly to diminish entrenched preferences. Develop clear and objective criteria for evaluating benefits and risks to enhance impartiality and incorporate diverse topic expertise to ensure recommendations align with the best available evidence, clinical expertise, and patient values.
3. Funding and grants: HHS should allocate funding and provide grants to specific healthcare organizations, community-based organizations, and local governments in rural Mississippi and other communities with high rates of limb amputations to implement SDoH interventions. These funds would support initiatives such as improving access to quality healthcare services, addressing food insecurity/food is medicine campaigns, providing transportation assistance, and promoting affordable housing. We would welcome a demonstration program through the CMS Innovation Center.
4. Research and data analysis: HHS conducts community-level-based research and data analysis to understand the specific social determinants affecting rural communities in Mississippi and other communities with high rates of limb amputations. This research helps identify areas of need and informs the development of targeted interventions to address these determinants effectively.

5. Technical assistance and capacity building: HHS should offer technical assistance and capacity-building support to healthcare providers and organizations in rural Mississippi and other communities with high rates of limb amputations to help them integrate SDoH into their clinical practice and service delivery models. This may include training on screening for social needs, implementing referral pathways to social services, and developing partnerships with community resources.

6. Collaboration and partnerships: HHS should collaborate with state and local agencies, community organizations, healthcare providers, and other stakeholders in rural Mississippi and other communities with high rates of limb amputations to develop comprehensive approaches to addressing SDoH. By leveraging partnerships and resources, they can maximize impact and reach underserved populations more effectively.

7. Telehealth: HHS should advocate for an inclusive telehealth model in the Mississippi Delta and other similar specialty deserts, prioritizing value-based care and addressing biases in telemedicine and artificial intelligence. By overcoming technical and patient-related barriers, we ensure equitable access to telehealth services for all. While telehealth can complement in-person cardiologist visits, we must reserve face-to-face appointments for high-level decisions, incentivizing team-based telehealth through streamlined coding and fixed, per-patient payments.

8. Mississippi has the lowest number of physicians per capita and has become a medical-specialty desert. Abolishing Certificate-of-Need (CON) regulations is imperative to foster a competitive healthcare landscape, improve access to quality care, and lower healthcare costs for patients. To understand the necessity of abolishing CON regulations in Mississippi, it's vital to revisit their origins. Initially enacted in the 1960s and 1970s to address rising healthcare costs and disparities, CON laws aimed to ensure quality care and equitable access. However, evidence suggests they have failed to achieve these goals. States with CON laws experience reduced access to healthcare facilities, higher costs for patients, and exacerbated disparities for minority populations, particularly in rural areas like Mississippi. Abolishing CON regulations would promote competition, attract new, young talented physicians, and spur economic growth, ultimately improving access to care, lowering costs, and addressing healthcare disparities. It's time for a critical reassessment of CON laws to ensure our healthcare system meets the needs of all our communities.

9. The Centers for Medicare & Medicaid Services (CMS) can play a pivotal role in addressing concerns raised by the American College of Cardiology (ACC) and American Medical Association (AMA) regarding yearly proposed and implemented Medicare physician payment schedule. This system is antiquated. By leveraging its authority and resources, HHS can advocate for policy changes within CMS to mitigate the adverse effects of proposed payment cuts. HHS can collaborate with CMS to explore alternative strategies that prioritize maintaining access to care for patients while also ensuring fair compensation for healthcare providers. It would also be challenging to recruit or retain physicians under such model. We encourage a dialogue between CMS and physician stakeholders to develop solutions that address the challenges faced by physicians, safeguard patient access to healthcare services, and promote the sustainability of healthcare practices nationwide. Through strategic advocacy and collaborative efforts, CMS has the authority to adopt policies that better support both healthcare providers and patients.

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10. Only 6 percent of US doctors are Black, and 1-2 percent of heart and vascular experts are Black - this should send alarms and warn of the shortage that ultimately harms public health. It is vitally important for federal and state governments to partner with Historically Black Colleges and Universities (HBCUs) to invest in rural areas and build trust in the healthcare system while promoting healthcare-seeking behavior. By intentionally collaborating with HBCUs, HHS can leverage the expertise, resources, and community connections of these institutions to address healthcare disparities and improve access to care in underserved rural communities. Through initiatives focused on rural workforce development, training programs, and community outreach, HHS and HBCUs can work together to cultivate a rural healthcare workforce that reflects the diversity of the communities it serves, thus fostering cultural concordance and enhancing patient-provider relationships. This collaborative approach not only strengthens the healthcare infrastructure in rural areas but also empowers individuals to actively engage in their healthcare, ultimately leading to better health outcomes and reduced disparities.

The Mississippi region and similar areas outside the state share common contributors and root causes to this epidemic that demand attention. Residents often reside in food swamps and food deserts, economically distressed communities, and experience physician shortages, particularly of their own race, who comprehend the culture and dietary habits. These challenges are pervasive across America, particularly affecting communities of color. The root causes of unnecessary amputations stem from a failure to raise awareness, address social determinants of health, provide screening (USPSTF) and optimal treatment to at-risk patients, ensure access to the best pharmacological treatments or supervised exercise, and implement a multidisciplinary team-based approach. Challenges such as specialty deserts, CON law inconsistencies, lack of physician-patient racial-ethnic concordance in the healthcare sector, and physician payment cut disparities further exacerbate the problem. It is imperative to incentivize doctors to practice within underserved areas and address discrepancies in policies to ensure equitable access to quality care and prevent unnecessary amputations.

Implementing and supporting these aforementioned policies will lead to equitable-based recommendations that better serve the needs of all Americans to have a fair and just opportunity to attain their highest level of health to attain, particularly those affected by PAD and devastating amputations.

Thank you for your attention to this critical matter.

Sincerely,



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