It is the intent of the Nevada Podiatric Medical Association to present to the Health and Human Services Committee our opinion that inclusion of a Podiatrist for Medicaid in the State of Nevada will provide immediate and significant cost savings. We have conducted an exhaustive search in preparing this presentation and have been unable to locate any evidence that a negative budgetary impact would be incurred if the state of Nevada would again allow podiatrists the opportunity to treat foot conditions for the state’s full Medicaid population.

It is our understanding that in the 1990’s the state of Nevada elected to discontinue providing foot care through podiatrists for Medicaid recipients. The rationale for this decision seems to be based upon two premises, first, there would be a cost savings associated with eliminating the line items of the budget associated with podiatry, and second, these podiatric services are elective in nature and could easily be performed by other physicians.

Unfortunately, the exclusion of podiatrists has been shown to significantly increase cost, overburdened physicians and other specialties including primary care physicians, and reduce the standard of care for those who are most unable to provide for themselves. By not allowing primary care physicians to refer their Medicaid patients to podiatrists the system has become confusing, necessary treatment has been delayed, and Medicaid beneficiaries have been unable to enjoy the same standard of care afforded to other Nevadans.

This assessment of this impact on Nevada is based on careful review of research performed by Thomson Reuters, Duke University, and the University of Arizona, College of Medicine. Each of these studies provide us with valuable information regarding the costs associated by failing to include podiatrists as part of a patient’s treatment plan.

The following studies are presented for your review as evidence that podiatrists prevent complications while providing significant savings.
Access to a Podiatrist Can Lead to Savings for US Health-Care Delivery Systems

According to a study conducted by Thomson Reuters Healthcare that compared outcomes of care for patients with diabetes treated by podiatrists versus care provided by other health-care professionals and physicians published in the *Journal of the American Podiatric Medical Association*:

- Among patients with commercial insurance, a savings of $19,686 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding a diabetic ulceration. Diabetic ulcerations are the primary factor leading to lower extremity amputations. Among patients with commercial insurance, each $1 invested in care by a podiatrist results in $27 to $51 of savings for the health-care delivery system.
- Among Medicare-eligible patients, a savings of $4,271 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding ulceration. Among Medicare eligible patients, each $1 invested in care by a podiatrist results in $9 to $13 of savings.
- Conservatively projected, these per-patient numbers support an estimated $10.5 billion in savings over three years if every at-risk patient with diabetes sees a podiatrist at least one time in the year preceding the onset of an ulceration.

Care by a Podiatrist Can Reduce the Risks of and Prevent Complications from Diabetes

According to an independent study conducted by Duke University published in *Health Services Research*:

- Medicare-eligible patients with diabetes were less likely to experience a lower extremity amputation if a podiatrist was a member of the patient-care team.
- Patients with severe lower extremity complications who only saw a podiatrist experienced a lower risk of amputation compared with patients who did not see a podiatrist.
- A multidisciplinary team approach that includes podiatrists most effectively prevents complications from diabetes and reduces the risk of amputations.

A recent Arizona Medicaid Study Found That after Excluding Podiatric Physicians from the State’s Medicaid Plan, Costs Increase and Patient Outcomes Worsen

In 2009, the nearby state of Arizona chose to exclude podiatrists from its Medicaid program. This prompted a group of world renowned researchers to follow the results. Their peer-reviewed findings were presented at the 73rd Scientific Sessions of the American Diabetes Association and published in *Diabetes Care*:

The study found a significant decline in quality outcomes and higher program expenditures among those diagnosed with a diabetic foot infection, including:
• 37.5-percent increase in diabetic foot infection hospital admissions;
• 28.9-percent longer lengths of patient stay;
• 45.2-percent higher charges, and
• a nearly 50-percent increase in severe aggregate outcomes (e.g., death, amputation, sepsis, or surgical complications).

Importantly, the data reveal that the vast majority of the worsening of diabetic foot infection patient health outcomes and increased costs occurred during the 2009—2010 time window, coinciding with Arizona’s policy change to exclude patient access to foot and ankle care provided by DPMs. Arizona ultimately restored podiatry as a covered benefit in its Medicaid Plan.

**Policy Implications for Modernizing Medicaid Arizona’s Medicaid**

Arizona’s Medicaid experience underscores the compelling policy rationale for removing patient access barriers to podiatric physicians and surgeons. The Arizona study complements two additional, separate studies that found that when podiatrists are administering medical and surgical foot and ankle care, outcomes are better, hospitalizations are fewer and shorter, and the health-care system saves billions of dollars annually.5

The unfortunate counterproductive experience that embroiled Arizona is also happening in other states around the country. The core problem persists because podiatrists are not defined as “physicians” under Medicaid, even though they have been defined as such under Medicare for more than 40 years and are recognized as such throughout most of the US health-care system.

Doctors of Podiatric Medicine prescribe medication, perform surgeries, and are licensed by Nevada state boards to deliver independent medical and surgical care without any supervision or collaboration requirement.

Ironically, Medicaid only ensures coverage of necessary foot and ankle care if provided by a medical doctor (MD) or a Doctor of Osteopathy (DO). But Medicaid coverage for foot and ankle care provided by DPMs is optional for states, meaning “podiatry services” are teased out and classified as an “optional” benefit.

Under current law, states are under constant pressures to curtail “optional services” like patient access to podiatrists in a “penny wise/pound foolish” attempt to trim Medicaid budgets. But as this Arizona Medicaid study indicates, doing away with “podiatry services” is a classic demonstration of the law of unintended consequences.
As Arizona Medicaid has shown, maintaining a separate optional podiatry benefit has had significant negative health effects on patients with diabetes. State (and by extension, federal) Medicaid spending is not reduced, but merely redistributed to another setting or provider, often with adverse consequences for patient health and with increased cost. The current ever-changing patchwork of Medicaid patient access has the effect of limiting access to timely and appropriate foot and ankle care, at a time when the US is already facing a growing physician shortage.

So long as we continue to exclude Podiatrists from providing necessary foot and ankle care, preventable chronic conditions will continue to become an even greater cost burden for Medicaid.


3 Foot-In-Wallet Disease: Tripped Up By ‘Cost Saving’ Reductions, Grant H. Skrepnek, Joseph L. Mills, and David G. Armstrong, abstract presented 73rd Scientific Sessions of the American Diabetes Association


5 The Economic Value of Specialized Lower Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers”, *Journal of the American Podiatric Medical Association*, Vol. 101, No 2, March/April, 2011; and