



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

September 30, 2022

Office of Regulations and Reports Clearance
Social Security Administration
3100 West High Rise
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted via Regulations.gov

RE: NPRM on Revised Medical Criteria for Evaluating Cardiovascular Disorders (Docket No. SSA-2019-0013)

The undersigned co-chairs of the Consortium of Constituents with Disabilities' (CCD) Social Security Task Force thank you for the opportunity to comment on the notice of proposed rulemaking (NPRM) on Revised Medical Criteria for Evaluating Cardiovascular Disorders. CCD is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance.

The CCD Social Security Task Force co-chairs are concerned that the updates proposed in the NPRM are based on outdated science, specifically regarding the settings in which people with cardiovascular disorders receive care and the need for hospitalization. We are concerned that this proposal will have a disparate impact on rural cardiovascular claimants. Moreover, the updates, as proposed, might exclude some people with disabilities who should be found eligible at step 3 of the sequential evaluation process and will ultimately be found eligible but will need to wait longer for a decision while SSA completes step 4 and 5 of the process if the rule is finalized as proposed. The medical listings are an important tool for SSA to save time and money by identifying eligible individuals as early in the sequential evaluation process as possible. People with disabilities are often in dire financial situations when they apply for benefits and any delay in awarding their benefits could be devastating. The CCD Social Security Task Force co-chairs urge SSA to reconsider the changes proposed to the listings as outlined in these comments to ensure that individuals who should be found eligible by meeting the cardiovascular listing continue to do so.

The undersigned co-chairs support SSA's efforts to make periodic updates to the medical listings to ensure that the criteria are consistent with current science, terminology, and clinical practice. We also support SSA's practice of engaging outside experts through respected institutions such as the Institute of

Medicine (now the National Academy of Medicine) to provide recommendations to SSA to inform these listing updates. With the rapid pace of advancement in cardiovascular treatment, however, we are concerned that SSA is relying on a report entitled “Cardiovascular Disability: Updating the Social Security Listings (2010)” from 2010 as the basis for many of the changes contained in this NPRM.

The proposed rule also includes a requirement that hospitalizations be at least 30 days apart to be considered separate events for listing eligibility. Changes made to Medicare by the Affordable Care Act might mean rehospitalization within 30 days of discharge might actually be a more accurate indicator of severity in some cases than a separate hospitalization after more than 30 days, as we will explain later. This would have the opposite effect intended by the rule and we urge SSA to reconsider this proposal.

Much of our concern regarding the changes in the NPRM comes from reading the report of the SSA expert panel that examined the use of health care utilization as a proxy in disability.¹

As noted in the report: “[t]here have been many changes in the health-care system, for example, movement away from hospitalizations, movement toward outpatient settings or ambulatory care centers, and discouragement of rehospitalizations; thus, utilization might be a poor marker of disease severity and disability.”²

I. THE NPRM MAY CAUSE GEOGRAPHIC DISPARITIES IN DISABILITY ADJUDICATIONS

There are significant disparities in access to cardiovascular care between urban and rural areas. People who live in rural areas are less likely to have access to cardiac specialists and even primary care physicians in some cases. There is also a lack of infrastructure in rural areas. Outpatient clinics and ambulatory surgery centers, especially those focused on cardiovascular issues, are often rare in rural locations in the United States. We raise the following points based on consultation with a cardiologist who practices in an urban area:

- Rural cardiac patients might need to travel a significant distance to get access to the care they need, which means they often go without care.
- Rural patients who came to see him are often extremely decompensated because they did not get preventative care and require hospitalization as a result.
- Rural patients often lack a cardiac specialist to treat them.
- Rural patients often lack health insurance (or money for required co-payments or co-insurance) so they don’t get timely treatment or interventions.

¹ National Academies of Sciences, Engineering, and Medicine, HEALTH-CARE UTILIZATION AS A PROXY FOR DISABILITY DETERMINATION [hereinafter Health-Care Utilization Report] (The National Academies Press, 2018). <https://doi.org/10.17226/24969>.

² Id. at 10.

- He indicated that his urban patients, who might have the same condition and severity, with equivalent severity of impairment and resulting inability to work, might never need to be hospitalized for more than 48 hours but a rural patient who would be referred to him might require repeated hospitalizations because of the patient’s decompensated state when referred and the lack of care available in rural areas.

As the Health Care Utilization report summarized, “[m]any factors affect health-care utilization, including need. . . . [t]he ability to access care – including whether it is available, timely and convenient, and affordable – affects health care utilization.”³ These factors, combined with the fact that many rural hospitals have closed since the 2010 IOM report was written,⁴ mean that the reliance on hospitalizations as an indication of severity of impairment and the corresponding inability to work, may be misplaced and lead to geographic disparities in access to benefits through the listings. We urge SSA not to increase the hospitalization requirements as outlined in the NPRM to ensure equal access to disability benefits through the cardiovascular listings to people regardless of where they live.

II. HOSPITALIZATION AS A PROXY FOR SEVERITY

In addition to the conclusions of the Health Care Utilization report, a cardiologist we spoke with indicated that many of the procedures and treatments for cardiovascular disease that would require hospitalization in 2010 could be handled as outpatient procedures in 2022. We are not clear that the hospitalization requirements proposed or expanded in the NPRM are appropriate or reflect current medical practice as a result.

Access to health care is a major factor in the utilization of health care services. Access to care, including the ability and propensity to use services, as well as insurance and ability to pay for services, will affect an individual’s utilization of health care services.⁵ The Health-Care Utilization Report indicated that its review of the science regarding cardiovascular impairments failed to find any study of adults under 65 that provided any direct evidence regarding health care utilization for determining the inability to work.⁶ In fact, the report found that whether the individual had any additional medical conditions and the person’s socioeconomic status might be more predictive of severity and inability to work than hospitalization. These included psychological distress and depression, concomitant cardiovascular diseases (such as hypertension or diabetes) and non cardiovascular diseases (such as asthma, COPD, arthritis, or renal disease).⁷ Socioeconomic factors such as low income, as well as race, were also

³ Id. at 33.

⁴ The GAO report found that between 2012 and 2018, the median distance in miles that someone had to travel to reach a cardiac care unit increased almost 8 times from 4.5 miles to 35.1 miles. U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-21-93, RURAL HOSPITAL CLOSURES: AFFECTED RESIDENTS HAD REDUCED ACCESS TO HEALTH CARE SERVICES (Jan. 21, 2021), <https://www.gao.gov/products/gao-21-93#:~:text=GAO%20found%20that%20when%20rural,access%20certain%20health%20care%20services> (see chart and data re Coronary Care unit under “What GAO Found”). One hundred and thirty-nine rural hospitals have closed since 2010. UNC, *Rural Hospital Closures*, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures>.

⁵ Health-Care Utilization Report at 23.

⁶ Id. at 66-67.

⁷ Id. at 67.

mentioned as possible predictors of cardiovascular outcomes when health care utilization was not found to be a predictor.⁸

We are surprised that SSA chose to continue to use and expand hospitalization requirements as a proxy for severity given the Health-Care Utilization Report's clear conclusions that:

"The committee's extensive literature review found no studies that addressed the usefulness of health-care utilizations in determining disability or impairment severity and few that addressed the association of health-care utilization with disability."⁹

"The committee found no evidence that health-care utilizations alone can predict disability, impairment severity, or disease severity. For several medical conditions, including chronic obstructive pulmonary disease COPD and chronic kidney disease, there is some evidence that increased hospitalizations, ED visits, and outpatient physician visits might predict disease severity for some specific diagnoses. However, their relevance to the committee's task is limited in that *disease* severity does not fit SSA's definition of *impairment* severity and statistical modeling in the supporting papers involved more factors than health-care utilization, such as individual and societal factors that influence the use of health care."¹⁰

"Another intervening factor that complicates the picture is the presence of comorbid conditions. Many of the studies that the committee reviewed discussed the influence of comorbidities in predicting health-care utilizations and health outcomes."¹¹

"The committee's review of HCUP data corroborated its literature findings that numbers and rates of hospitalizations and ED visits alone do not indicate severity of a condition; they only suggest that a hospitalization or ED visit appeared necessary. Event-level data tell little about the continuing severity of a condition. The committee did not find the data useful in determining how types of utilizations are more or less probable for particular medical conditions, but it found that utilization is more related to sets of conditions, and analysis of which specific conditions should be grouped is extremely complex and faces many data limitations."¹²

The undersigned co-chairs encourage SSA to reconsider including the stricter hospitalization criteria in the finalized rule given the lack of data and scientific basis for these requirements.

⁸ Id.

⁹ Id. at 8.

¹⁰ Id. at 9; *see also id.* at 78.

¹¹ Id. at 78.

¹² Id.

III. THE 30-DAY REQUIREMENT AND THE READMISSION PENALTY

Finally, the undersigned co-chairs urge SSA to reconsider including the requirement that there are thirty days between hospital stays to consider each stay a separate event for the purposes of meeting the listing criteria. The Affordable Care Act made changes to Medicare that created billing penalties for hospital readmissions shortly after discharge for people with certain conditions, including cardiovascular disorders.¹³ It is our understanding from a cardiologist we consulted with that doctors work very hard not to readmit patients during the readmission penalty window because they and the hospital they work for will get “dinged” if they do. Ironically, given these strong financial incentives, a readmission within 30 days might actually be a better indicator of severity in some cases since a doctor will only do so when the patient is quite ill and decompensating again despite the treatment they received, according to this cardiologist. Another doctor indicated that sometimes the reason for readmission within 30 days might be an additional condition that is identified that SSA should probably count as a separate event for the purposes of determining eligibility for disability benefits. We therefore urge SSA to reconsider adding the requirement that hospitalizations be thirty days apart to be considered separate events for the purposes of meeting the medical criteria.

CONCLUSION

Ensuring that the cardiovascular listings represent the state of current science and medical practice is important to people with disabilities. As outlined above, the settings in which cardiovascular care takes place, the need for hospitalization, and incentives regarding short-term hospital readmissions have all changed significantly since 2010. The undersigned co-chairs urge SSA to consider these changes and make changes to the proposed updates to the medical criteria for evaluating cardiovascular disorders as outlined in these comments.

Thank you for the opportunity to comment on this proposed rule.

Sincerely,

Jennifer Burdick, Community Legal Services of Philadelphia
David Goldfarb, The Arc of the United States
Tracey Gronniger, Justice in Aging
Jeanne Morin, National Association of Disability Representatives

¹³ See Center for Medicare & Medicaid Services, Hospital Readmission Reduction Program, *available* <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program>; Rich Daly, *Medicare Readmissions Reduction Program Penalizes Hospitals Inaccurately, Study Finds*, hfma (Oct. 22, 2020), <https://www.hfma.org/topics/news/2020/10/medicare-readmissions-program-penalizes-hospitals-inaccurately--.html>; Jordan Rau, *Medicare Punishes 2,499 Hospitals for High Readmissions* KHN (Oct. 28, 2021), <https://khn.org/news/article/hospital-readmission-rates-medicare-penalties/>.