



NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS'
REPRESENTATIVES
ESTABLISHED 1979

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

September 30, 2022

Submitted via Regulations.gov

RE: Notice of Proposed Rulemaking on Revised Medical Criteria for Evaluating Cardiovascular Disorders (Docket No. SSA-2019-0013)

Dear Director Lipsky:

Thank you for the opportunity to comment on these proposed changes to update the medical criteria for evaluating cardiovascular disorders. I am submitting these comments on behalf of the thousands of members of the National Organization of Social Security Claimants' Representatives (NOSSCR). NOSSCR supports the Social Security Administration's (SSA) efforts to ensure that the criteria for qualifying for Social Security disability benefits are up to date and reflect the current science and clinical practice for claimants with cardiovascular conditions. The National Organization of Social Security Claimants' Representatives (NOSSCR) is a specialized bar association for attorneys and advocates who represent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claimants throughout the adjudication process and in federal court. Founded in 1979, NOSSCR is a national organization with a current membership of more than 3,000 members from the private and nonprofit sectors and is committed to the highest quality representation for claimants and beneficiaries. NOSSCR's mission is to advocate for improvements in Social Security disability programs and to ensure that individuals with disabilities applying for SSDI and SSI benefits have access to highly qualified representation and receive fair decisions.

The listings are very important to NOSSCR members, our clients, and the Social Security Administration as they affect the ability of eligible individuals to access benefits to which they are entitled. The medical listings also save valuable time and money for SSA by ensuring that individuals with the most severe impairments with evidence of that severity established by objective testing and criteria are awarded benefits as early as possible during the disability determination process. Unfortunately, NOSSCR is concerned the proposed updates to the cardiovascular listings might not make the listings more scientifically accurate. Rather, the changes might result in some individuals no longer qualifying for benefits through the listings despite having impairments just as severe (and corresponding inability to work) as other individuals who do qualify.

RELIANCE ON THE 2010 IOM REPORT

The proposed updates to the medical criteria for cardiovascular conditions are mostly based on recommendations made by the Institute of Medicine expert panel report entitled “Cardiovascular Disability: Updating the Social Security Listings (2010).” NOSSCR fully supports SSA consulting with medical experts when developing recommendations to update its medical criteria. NOSSCR believes that the Institute of Medicine (now called the National Academy of Medicine) assembled a well regarded and top in the field of cardiology expert panel to make consensus recommendations based on the latest science in 2010.

NOSSCR appreciates that it is not possible to update listings contemporaneously with getting consensus recommendations from an expert panel, but NOSSCR is concerned that the recommendations upon which most of these listing updates are based are over a decade old. This is most concerning regarding the use of hospitalizations as a proxy for severity. It is my understanding based on conversations with several cardiologists that many procedures that required inpatient hospital stays in 2010 can be completed on an outpatient basis in 2022. The availability of specialty clinics and outpatient facilities in urban areas can make hospitalizations less likely for the urban population with cardiovascular disorders despite the same level of functional impairment as their rural counterparts. In addition, changes in insurance practices since the implementation of the Affordable Care Act might paradoxically mean rehospitalization within 30 days of discharge is more likely to be an indicator of severity in some cases than a separate hospitalization after more than 30 days.

As noted in the report *Health-Care Utilization as a Proxy in Disability Determination* (referred to as the National Academies of Sciences report hereinafter), “There 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.”¹

HOSPITALIZATION AS A PROXY FOR SEVERITY

Many of the updates proposed in the NPRM increase the requirements for hospitalizations and/or require 30 days in between hospitalizations to meet listings and be eligible for benefits. NOSSCR doesn't question whether these were appropriate when the IOM panel recommended these changes as proxies for the severity of the claimant's cardiovascular condition and therefore the corresponding inability to work. However, as noted in the National Academy of Sciences report, 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.² NOSSCR is particularly concerned that the changes proposed in the NPRM will lead to a significant geographic disparity between urban and rural Americans in their ability to meet the newly proposed cardiovascular hospitalization requirements.

The National Academies of Sciences report on utilization 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 utilization for determining the inability to work.³ The report concluded that “...utilizations or functionality metrics were occasionally included, but none provided direct evidence for

¹ National Academies of Sciences, Engineering, and Medicine 2018. *Health Care Utilization as a Proxy for Disability Determination*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24969>

² *Id.* at 23.

³ *Id.* at 66.

determining inability to work. Information that might provide guidance for addressing the SSA Listings, however, was not covered.”⁴ The section in the National Academy of Sciences report regarding cardiovascular impairments did find some factors in epidemiologic investigations that could be used to predict utilization or functionality outcomes. That finding was the “adverse effect of comorbidities on health.” These included psychological distress and depression, concomitant cardiovascular diseases (such as hypertension or diabetes) and noncardiovascular diseases (such as asthma, COPD, arthritis, or renal disease).⁵ Socioeconomic factors such as low income, as well as race, were also mentioned as possible predictors of cardiovascular outcomes when health care utilization was not found to be a predictor.

The National Academies of Sciences utilization report conclusion summed up its findings:

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.

The committee found no evidence that health-care utilizations alone can predict disability, impairment severity, or disease severity. For several medical conditions, including COPD and CKD, 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. The other factors could be social factors, insurance, hospital factors, geographic factors, and personal factors. Those factors, many of which are discussed in Chapter 2, limit the classifying power of health-care utilizations in determining disability and impairment severity.

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.

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.⁶

The conclusions of the panel seem to clearly say that there is not science to support increasing the requirements for hospitalizations in the medical criteria. Given that, NOSSCR urges SSA not to move forward with these changes to the medical criteria for cardiovascular disorders.

⁴ *Id.* at 66.

⁵ *Id.* at 67.

⁶ *Id.* at 8-9.

GEOGRAPHIC DISPARITIES

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.⁷ 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. Cardiac patients might need to travel a significant distance to get access to the care they need, which according to an urban cardiologist NOSSCR consulted with, means they go without care. This same cardiologist indicated that rural patients who came to see him are often extremely decompensated because they did not get preventative care and require hospitalization as a result. The same cardiologist said that his rural patients often lack a cardiac specialist to treat them and lack health insurance (or money for required co-payments or co-insurance) so they don't get timely treatment or interventions. He indicated that one of 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 National Academy of Sciences report summarized, "Many factors affect health-care utilization, including need....The ability to access care – including whether it is available, timely, convenient, and affordable – affects health care utilization."⁸

These factors, combined with the fact that many rural hospitals have closed since the 2010 IOM report was written⁹, 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. NOSSCR urges SSA not to increase the hospitalization requirements as outlined in the NPRM.

The 30-Day Requirement and the Readmission Penalty

Finally, NOSSCR is concerned that the proposed change to require 30 days between hospitalizations to consider the hospitalization a separate event for the purposes of meeting the listing criteria will result in claimants not meeting the listing who should be found disabled using the medical criteria. Due to changes made to Medicare by the Affordable Care Act, doctors and hospitals face significant financial and reputational incentives designed to ensure that cardiovascular patients who leave the hospital do not get readmitted within 30 days.¹⁰ One cardiologist NOSSCR spoke with indicated 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. This doctor said that a readmission within 30 days might paradoxically be

⁷ *Id.* at 30.; see also Jaqueline Mitchell, Rural Patients Less Likely to Receive Cardiovascular Care, More Likely to Die from Certain Heart Conditions, Researchers Find," January 18, 2022; <https://www.bidmc.org/about-bidmc/news/2022/01/researchers-find-rural-patients-less-likely-to-receive-cardiovascular-care>.

⁸ National Academies of Sciences, Engineering, and Medicine, *supra* note 1 at 33.

⁹ See e.g. Government Accountability Office, Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services, December 202, Washington DC; What GAO found section. 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. See also <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (indicating that one hundred and thirty-nine rural hospitals have closed since 2010).

¹⁰ See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program>; <https://www.crainsdetroit.com/health-care/hospital-readmissions-penalties-2023-lower-expected>; <https://www.hfma.org/topics/news/2020/10/medicare-readmissions-program-penalizes-hospitals-inaccurately--.html>; <https://khn.org/news/article/hospital-readmission-rates-medicare-penalties/>

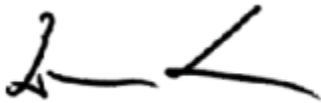
a better indicator of severity in some cases because a doctor will only do so when the patient is quite ill and decompensating again despite the treatment they received. Another doctor indicated that sometimes the reason for readmission within 30 days might be an additional condition that is identified that SSA should probably count as a separate event for the purposes of determining eligibility for disability benefits. NOSSCR urges 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

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. NOSSCR urges 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,

A handwritten signature in black ink, appearing to be 'David Camp', written in a cursive style.

David Camp
President