
**COMMITTEE ON WAYS AND MEANS**

**SUBCOMMITTEE ON SOCIAL SECURITY**

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# STATEMENT FOR THE RECORD

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**FOR THE OFFICE OF ANALYTICS, REVIEW AND OVERSIGHT**
**SOCIAL SECURITY ADMINISTRATION**

Chairman Johnson, Ranking Member Larson, and Members of the Subcommittee:

## Introduction

Thank you for inviting me to discuss the Social Security Administration (SSA) disability adjudication process. My name is Patricia Jonas. I am the Deputy Commissioner for the Office of Analytics, Review, and Oversight (OARO) at SSA. Before I came to work at SSA, I was a private practice attorney and I would occasionally represent claimants before the agency. Thirty-five years ago, I joined SSA as a hearing office attorney, later becoming a manager before transitioning to headquarters where I was involved in implementing several initiatives while serving as a senior executive in our policy component. From that role, I became the Executive Director and Chair of the Appeals Council, managing the Administrative Appeals Judges who adjudicate cases at the final level of administrative review. After a brief time as the agency's acting General Counsel, I agreed to lead the newly created Office of Analytics, Review and Oversight. [1]

Today, I will provide an overview of our disability adjudication process, including the return to a uniform process in nine States and part of one State that have not had the second level of appeal since 1999, and our efforts to improve service at the hearings level.

## Background

I chose to dedicate my career to SSA because the link between our work and helping others is so clear. Social Security touches the lives of nearly every person in the Nation, whether after the loss of a loved one, at the onset of disability, or at the transition from work to retirement. Our programs provide a safety net for the public and contribute to increased financial security for the elderly and disabled. SSA pays benefits to an average of over 70 million Social Security beneficiaries and Supplemental Security Income (SSI) recipients each month. During fiscal year (FY) 2018, we expect to pay over $1 trillion to Social Security and SSI beneficiaries. I certainly appreciate that how well we deliver our services truly matters.

## Adjudicating Disability Claims

*Statutory Definition of Disability*

The Social Security Act (Act) defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months. In making this determination, the Act requires us to consider how a claimant's condition affects his or her ability to perform previous work and, considering his or her age, education, and work experience, other work that exists in significant numbers in the national economy.

[1] The nine States are Alabama, Alaska, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. In most of California, claimants receive the second level of appeal (the reconsideration step), but a portion of claimants in that State would proceed from the initial determination level to an ALJ hearing.

Claimants must also meet non-disability factors including having enough covered earnings to be insured for Title II (Social Security) benefits and meeting resource and income criteria for Title XVI (SSI) benefits.

*Overview of the Administrative Review Process*

In order to frame our conversation, I will briefly explain the steps in the disability process. Initial applications for disability benefits may be filed online, by telephone, or in person at a Social Security field office. After receiving an application, we send the case to a State Disability Determination Service (DDS), which makes the initial determination of disability. If an applicant is dissatisfied with an initial denial of disability benefits by the DDS, our rules provide for three additional levels of administrative review – reconsideration (also handled by the DDS), a hearing before an administrative law judge, and review by our Appeals Council. In nine States, and part of one State, we have been running a prototype project that eliminated the reconsideration step. Our goal is to award benefits that meet the requirements of the Act as early in the process as possible. Indeed, of all the claims that we allow, about 75 percent are approved at the initial or reconsideration level.

*Initial Determination Level*

The State DDSs handle initial disability determinations. The DDSs develop medical evidence and determine whether a claimant meets the statutory definition of disability. Nationwide, in FY 2017, we received over 2.4 million initial disability applications.

A State DDS disability examiner works with a medical or psychological consultant, or both, to determine whether the claimant is disabled under our rules. When deciding the claim, the disability examiner and medical or psychological consultant must consider all of the evidence in the file, both medical and vocational, to make a determination.

We are using data analytics to improve service. We implemented the Compassionate Allowance (CAL) process, an automation that quickly identifies and prioritizes 228 medical conditions that invariably qualify for disability under our rules.

Our Quick Disability Determination (QDD) process uses a computer-based predictive model in the earliest stages of the disability process to identify and fast-track claims where a favorable disability determination is highly likely and medical evidence is readily available. Both QDD and CAL have helped us serve people who are severely disabled more timely.

We require our DDS examiners to use the Electronic Claims Analysis Tool (eCAT), a web-based application that helps the user through the complex disability adjudication process. The tool aids in policy compliance; documenting, analyzing, and adjudicating the disability claim according to our regulations. eCAT has led to improvements in our ability to collect and analyze data relating to the disability process. With this data, we now can study and revise policy based on evidence and develop more advanced models and analytics to improve our efficiency and ensure policy compliance.

In FY 2005, we replaced our paper disability claims files with electronic records, which increased our efficiency. We continue to modernize other parts of our process, including the ability to receive electronic medical evidence, which not only helps us more efficiently obtain the medical information we need to make a timely and accurate decision but also provides additional opportunities for data analytics. Currently, nearly 50 percent of initial disability claims contain some electronic medical evidence. We have other technology advances underway. For example, software called Intelligent Medical-language Analysis Generation, or IMAGEN, converts images of medical information to readable text, which allows us to apply data analytics to the information to improve policy compliance. In addition, using state-of-the-art Natural Language Processing (NLP) techniques, we are developing and will begin implementing by the end of the year, a new NLP application to provide decision support and enhanced quality control assistance in our disability claims process.

Policy compliance is essential and we provide oversight to ensure decisions are accurate. As required by the Act, we review at least 50 percent of all initial allowances before effectuating payment. To help ensure we are using our resources most effectively, we implemented a predictive model to identify the 50 percent most error prone cases for selection and review. These pre-effectuation reviews allow us to correct errors we find before we issue a final decision, and to provide instructional policy compliance feedback to DDS adjudicators. We also have a regulatory quality assurance program where we randomly select a certain number of favorable and unfavorable medical determinations made by each State DDS per calendar quarter. We return cases to the DDS for corrective action if the evidence in file does not support the proposed determination or does not contain all of the information needed to support the final determination.

*Reconsideration Level*

In most States, a claimant who is dissatisfied with our initial disability determination may request a reconsideration. At the reconsideration level, a different State DDS examiner reviews all evidence from the initial determination. The reconsideration step gives the claimant an opportunity to submit additional medical evidence. The claimant's case is also reviewed by a different medical or psychological consultant. In 2017, we allowed about 75,000 claims at the reconsideration level.

As with the initial determination level, we review policy compliance. Federal reviewers perform quality reviews of randomly selected favorable and unfavorable reconsideration State DDS determinations and provide feedback to the DDS to correct any errors before adjudication while also calculating accuracy.

We also use a predictive model to conduct targeted denial reviews (TDRs) of reconsideration determinations.[2] Our TDRs originated from a review the agency initiated called the Random Denial Study, which began in FY 2008. Historically, per the statutorily required pre-effectuation review, quality oversight had focused on allowances. The Random Denial Study collected and analyzed data points from cases denied by the DDSs. In FY 2010, this analysis enabled us to rollout the TDR, which identifies the most error-prone DDS denials that are likely to be

[2] In the Prototype States, these targeted denial review are of initial disability decisions.

allowances. This model allows us to catch allowances, preventing those cases from escalating to the hearing level. It also provides us with information that we can build into our IT planning and improve DDS adjudicator training to prevent errors in the future.

*Hearing Review Level*

A claimant who is dissatisfied with our reconsideration determination may request a hearing with an ALJ who performs a *de novo* review including evaluating evidence that may not have been available to prior adjudicators. The ALJ may call vocational and medical experts to offer opinion evidence, and the claimant or the claimant's representative may question these witnesses. Once the record is complete, the ALJ considers all of the evidence in the record and makes a decision. In FY 2017, approximately 47 percent of decisions at the ALJ were allowances.[3]

Claimants' wait for a hearing decision is a longstanding challenge. In January 2016, the Office of Hearings Operations introduced its Plan for Compassionate and REsponsive Service (CARES) to help the more than 1 million people who were waiting for a hearing with us. CARES, which we updated in August 2017, outlines a multipronged plan including modeling and data analytics, hiring and performance management and policy clarification and streamlining to improve wait times while ensuring decisional accuracy. Our complete CARES plan is available on SSA's website.[4]

The anomaly funding that Congress provided to us in FY 2017, as well as the dedicated funding we received as part of the Consolidated Appropriations Act of 2018, is helping us improve service. In March 2018, we reduced pending hearings to below 1 million cases for the first time since October 2014, and we have reduced the number of people waiting for a hearing in each of the last 19 months and expect to end FY 2018 with approximately 900,000 pending hearings. Based on our current plans, including the implementation of reconsideration in the prototypes States, we expect to reduce the average wait for a hearings decision to 270 days by the end of FY 2021.

Consistency helps with accuracy and efficiency. In December 2016, we published final rules that create nationally uniform hearing and Appeals Council procedures. Under the rules, we provide claimants with a 75-day advance notice of the hearing, which provides claimants more time to obtain updated medical and other records before the date of the hearing. We coupled that 75-day advance notice requirement with a policy that, generally, claimants must submit or inform us of written evidence at least five business days before a hearing. The changes we made

[3] According to an internal quality study from 2016, there are several reasons why an ALJ may allow a case after it has been denied at the reconsideration (or initial determination) level. The study was a one-time, post-effectuation quality review of a certain number of claims denied by the DDS but subsequently allowed as fully favorable at the hearing level. According to the study, key factors why claims are reversed are: claimants move into a higher age bracket while waiting for a hearing; impairments worsen (nearly 60 percent of the claims reviewed included worsening at the hearing level); subsequent treatment provides a fuller record; ALJs may gain additional perspective by observing the claimants; and claimants are more likely to be represented at the hearing level (while 65 percent of the claims reviewed were represented at the DDS level, 95 percent were represented at the hearing level).

[4] Our CARES plan can be found at https://www.ssa.gov/appeals/documents/2017_Updated_CARES_Anomaly_Plan.pdf.

in these rules, coupled with rules changes we made in 2015 that require claimants to inform us about or submit all evidence known to the claimant that relates to his or her disability claim, make our hearings process more effective.

A quality decision is one that is both timely and accurate. We created better tools to provide individualized feedback to our adjudicators. For example, "How MI Doing?" not only gives ALJs information about their AC remands including the reason for remand but also information on their performance in relation to other ALJs in their office, their region, and the nation. We have developed training modules related to the most common reasons for remand that are linked to the "How MI Doing?" tool. ALJs are able to receive immediate training at their desks that is targeted to the specific reasons for the remand. We are also expanding the use of "Insight," a software tool that helps with policy compliance.

Regarding the hearings level, I also wanted to note the agency is evaluating the implications of the Supreme Court's decision in Lucia v. Securities and Exchange Commission, which concerned ALJs of the Securities and Exchange Commission, and the President's recent Executive Order that would prospectively require agencies to hire ALJs through the excepted service and not the competitive service.

*Appeals Council Review Level*

Furthermore, the Appeals Council (AC), which is a part of OARO, uses several methods to ensure the quality of ALJ decisions. In addition to handling the final level of the agency's appeals process, it conducts pre-effectuation reviews on a random sample of ALJ allowances and post-effectuation reviews that look at specific issues to help inform our training needs and potential policy changes.

**Keeping Disability Policy Current**

Our efforts to become more timely and policy-compliant with our disability decisions also depend on keeping our disability policy current. We strive to keep our rules and policies aligned with contemporary medicine, healthcare, and new technology, and to ensure policy decisions are evidence-based. We develop, in consultation with medical and other experts, new medical policies for the administration of the SSDI and SSI programs. These policy revisions reflect our adjudicative experience, advances in medical knowledge and treatment of disorders, recommendations from medical experts, and comments we receive.

*Updated Listings*

The Listings of Impairment describe for each major body system the impairments considered severe enough to prevent an adult from working, or for children, impairments that cause marked and severe functional limitations. We have been comprehensively updating our Listing of Impairments for nearly all body systems. For instance, in 2016, we updated the listings for Neurological Disorders (prior comprehensive update, 1986), Mental Disorders (prior comprehensive update, 1985), and Respiratory Disorders (prior comprehensive update, 1993). Earlier this year, we issued a Notice of Proposed Rulemaking on the last body system that

requires a comprehensive listing update, the Musculoskeletal System (prior comprehensive update, 1985 and minor updates, 2001). Our objective is to revise the listings' criteria on an ongoing basis, using a three to five-year update cycle.

*Occupational Information System*

Disability claims reaching the last two steps of the five step sequential process rely not only on an assessment of a person's functional abilities, but also on consideration of jobs that exist in the national economy and the vocational requirements and physical, cognitive, mental demands of those jobs. To make accurate decisions, we must have information that reflects current occupations and their requirements. The Department of Labor last updated the information we use to determine the availability of jobs, the Dictionary of Occupational Titles (DOT), in 1991. Our program needs to reflect changes that have occurred in the workforce since the last update. In addition, the DOT does not contain information about the mental and cognitive demands of occupations we need to make many determinations, so we rely on vocational experts. Working closely with the Department of Labor's Bureau of Labor Statistics, we are developing a new Occupational Information System that will be the primary source of occupational information used in our disability adjudication process.

## Restoring a Uniform, National Process

The notion that the disability process is complex is not new. Over the years, we have made several attempts to improve the process. In the 1990s, we began testing a series of models under what was known as Disability Redesign. There were many initiatives considered at this time, including the Single Decision Maker (SDM) model, the Adjudication Officer model, introduction of a claims manager, eliminating the reconsideration level of appeal, and the incorporation of a pre-decision interview into the process. One of the models, Disability Redesign Prototype, tested the elimination of the reconsideration level, SDM and a pre-decision interview in one state in each of our 10 regions.

The redesign models had mixed results. We discontinued some initiatives very early on while others, like the Single Decision Maker continued for nearly 20 years before Congress ended it with the *Bipartisan Budget Act of 2015*.[5] The remaining piece of the prototype model – elimination of the reconsideration – was developed as an element of a larger overhaul and was not designed to stand on its own, nor did we intend to continue to run a different appellate process in 9 States, plus part of one State.

Over the next three years, we will end this Disability Redesign artifact and restore a uniform administrative review process. The timing is good: pending claims at the DDSs are at the lowest they have been in some time and the receipt of initial claims continues to be flat or decline, and we will soon be current with our continuing disability reviews. We may have taken this action

[5] Under section 832 of the *Bipartisan Budget Act of 2015* (BBA), we are required to end the single decisionmaker test. In light of this recent legislation, we are in the process of requiring that an MC or PC review the medical portion of a DDS-level disability claim. We have phased in this requirement in over half of the States that used single decisionmakers, and we expect to complete this requirement by the end of FY 2018.

sooner but for other circumstances including the Disability Service Improvement initiative, which planned for changes that would have addressed the appellate process. Reinstating reconsideration will restore uniformity to our national programs. It will also provide claimants the opportunity to receive a favorable decision more quickly and will aid in alleviating the hearings backlog. Further, as we improve our disability process, we are developing new systems and evolving our use of data analytics – for example, refining CAL at the initial level or the targeted denial reviews at the reconsideration level. Under a uniform, national process, we will make these systems and analytics updates more efficiently by writing policy and notices for, and training our employees on, a single process.

We are making this change now because it allows us to return to a uniform disability process for all claimants across the country; it is the most efficient and effective way to help disabled claimants get their benefits sooner; and with flat or declining disability applications and our ability to become current on working our continuing disability reviews, we can most efficiently return to a national process while maintaining service at the initial and reconsideration level and improving our service for people requesting a hearing. As mentioned above, serving Americans who have waited the longest for a hearing remains our biggest challenge. This decision supports our ability to achieve our wait time goals nearly a full year earlier, which is significant to the claimants waiting in line.

As part of our plan, we have had discussions with the State DDSs affected by the change, and there is significant consensus across the State DDSs that there is a need to create a uniform disability appeals process. Our staff worked directly with the State DDS Administrators and staff, and the State DDSs' parent agencies, to identify and address each State's needs including human capital and other resources to smoothly reinstate the reconsideration level of review. Throughout this process, our leadership will continue to work with State leadership to ensure a smooth transition.

We have contacted Subcommittee staff and the staffs of those Members from a prototype State, and we thank you for your interest and thoughtful questions. Our communication plan will also include notification to advocates and the public.

**Conclusion**

I am proud to say that we are an agency that is sincere about public service. Our employees understand what's at stake for our claimants and we strive to thoughtfully evolve our policies and processes. We look forward to continuing to work with you and your subcommittee.