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# EXAMINING WAYS THE SOCIAL SECURITY ADMINISTRATION CAN IMPROVE THE DISABILITY REVIEW PROCESS

## HEARING

BEFORE THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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# EXAMINING WAYS THE SOCIAL SECURITY ADMINISTRATION CAN IMPROVE THE DISABILITY REVIEW PROCESS

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**Wednesday, April 9, 2014,**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE & ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
*Washington, D.C.*

The subcommittee met, pursuant to call, at 1:37 p.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the subcommittee] presiding.

Present: Representatives Lankford, Walberg, Massie, Speier, Cartwright, Duckworth, Lujan Grisham, Horsford, Cummings, and Woodall.

Staff Present: Melissa Beaumont, Majority Assistant Clerk; Brian Blase, Majority Senior Professional Staff Member; Will L. Boyington, Majority Deputy Press Secretary; John Cuaderes, Majority Deputy Staff Director; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Linda Good, Majority Chief Clerk; Mitchell S. Kominsky, Majority Counsel; Mark D. Marin, Majority Deputy Staff Director for Oversight; Emily Martin, Majority Counsel; Ashok M. Pinto, Majority Chief Counsel, Investigations; Jessica Seale, Majority Digital Director; Katy Summerlin, Majority Press Assistant; Sharon Meredith Utz, Majority Professional Staff Member; Jaron Bourke, Minority Director of Administration; Courtney Cochran, Minority Press Secretary; Devon Hill, Minority Research Assistant; Suzanne Owen, Minority Senior Policy Advisor; and Brian Quinn, Minority Counsel.

Mr. LANKFORD. Good afternoon. The committee will come to order.

I would like to begin this hearing by stating the Oversight Committee mission statement.

We exist to secure two fundamental principles: first, that Americans have the right to know what Washington takes from them is well spent; second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights.

Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have the right to know what they will get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people

and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

I will do a quick opening statement.

The Social Security Administration oversees two large Federal disability programs: the Social Security Disability Insurance Program and the Supplemental Security Income Program. Both have grown rapidly over the last 25 years. The growth is unsustainable. It also poses a threat to the truly disabled, who are often pushed to the back of the line and face large benefit cuts in the future.

In the vast majority of cases, a decision to allow benefits is an irrevocable commitment of taxpayer funds since favorable decisions are not usually appealed. Unfortunately, the growth in these programs has limited some people from reaching their full potential, and in many cases a program that was intended to fight poverty is perpetuating poverty.

According to a 2010 paper published jointly by the liberal Center for American Progress and the left-of-center Brookings Institution said SSDI is ineffective in assisting workers with disabilities to reach their employment potential or to maintain economic self-sufficiency. Instead, the program provides a strong incentive to applicants and beneficiaries to remain permanently out of the labor force.

I welcome the testimony of Jennifer Lockhart today—thank you for being here—a fellow Oklahoman, who has both personal and professional experience assisting children and young adults with both physical and intellectual disabilities. Ms. Lockhart will provide perspective today on how the Federal disabilities programs, while seemingly very well intentioned, can have devastating consequences on individuals and communities if not handled correctly. Tragically, many children are languishing on SSI programs, rather than being encouraged to pursue vocational and educational opportunities.

In June of last year, the subcommittee heard testimony from two former and two current Social Security administrative law judges. One of the themes of the testimony was the agency's plan to reduce the backlog of initial claims, resulting in AJLs inappropriately putting people onto these programs. We also learned that the agency policy allows claimants and their attorneys to submit biased and incomplete evidence.

While we have serious questions for the agency about its policies and management of these programs, I thank the agency for providing timely information to the committee requests. Agency personnel have conducted numerous briefings and transcribed interviews with the committee. During one of these interviews, Regional Chief Administrative Law Judge Jasper Bead testified that it raises a red flag for a judge when they allow 75 to 80 percent of their decisions. It is stunning that between 2005 and 2012 more than 930,000 individuals were approved for benefits by an ALJ who approved more than 80 percent of the claimants for benefits. During the same time period, more than 350,000 people were awarded disability by an ALJ with an allowance rate in excess of 90 percent.

I appreciate, by the way, the bipartisan manner which the subcommittee has been able to approach this oversight. Ranking Member Speier and I both recognize there are significant problems with

these programs and that reform is needed. I thank her very much for the work and the partnership in this issue.

Yesterday, Ms. Speier and I sent Acting Commissioner Colvin a letter outlining 11 common sense recommendations for the agency in order to improve the integrity of the disability determination process. One of the recommendations is for the agency to conduct timely continuing disability reviews. The agency is currently out of compliance with its legal requirement to conduct timely CDRs and has allowed a backlog of 1.3 million CDRs to develop.

As Ms. Speier and I explained in our letter, an increase in CDRs must be coupled with a change to the medical improvement standard, because this standard does not allow the agency to remove claimants who were wrongfully awarded benefits in the first place. Under the current standard, the claimant's record must show that the claimant made significant medical improvement in order to end benefits. If the claimant was not disabled and wrongly received benefits initially, the standard of review will not remove them.

Today the agency must address this question: Are the vast majority of people who the agency expects to improve failing to do so or is it just extremely difficult for the agency to cease benefits? The question highlights a significant problem that needs to be addressed and needs to be addressed quickly. Today's testimony will show that the state of disability determination offices that conduct CDRs suffer from a lack of clear guidance about the medical improvement standards.

It will also reveal GAO made recommendations to the agency to correct problems with the CDR process, and made that recommendation years ago, yet the agency has failed to implement fully the GAO's recommendations to address these problems. It is in the works, but we have to be able to get it finished. Failure is not an option at this point. The agency must take steps to improve the disability review process and modify the review standards so that only individuals with genuine disabilities and who are unable to work continue to get benefits from these programs.

This is a program designed to protect those most vulnerable. Through our inattention, if we don't protect the most vulnerable, it is our gross error, and this committee intends to stay on top of that.

With that, I recognize the ranking member, Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you.

At the outset, let me say this. There aren't a lot of cameras in this room today, but this is precisely the kind of work that the Oversight and Government Reform Committee should be doing; in a bipartisan fashion, in a constructive fashion, with a number of experts who are here who are, in many respects, civil servants doing remarkable work. And I think we both know that part of our effort in making sure that this system is improved upon is making sure they have the resources to do the job.

So I want to thank you, at the outset, for your commitment and the great work that you have shown, and the way we have collaborated and worked together and had meetings outside of hearings to try and come up with some solutions to this situation.

The committee has been conducting oversight of the Federal disabilities program at the Social Security Administration. Just yes-

terday, as the chairman pointed out, together we sent a bipartisan letter to Social Security laying out a number of reforms and recommendations we believe the agency can implement to enhance the efficiency and effectiveness of disability adjudications and improve the integrity of Federal disability programs.

Now, I believe that and I said that, but I also recognize part of what we are asking for is going to require more resources in order to do it well.

Social Security disability and supplemental security income are important lifelines for millions of Americans with disabilities. Recent estimates project disability insurance benefits of about $145 billion to approximately 11 million SSDI beneficiaries and $59 billion to almost 8.5 million SSI recipients.

In previous testimony before this committee, Social Security Administration recited a motto repeated at the agency: The right check to the right person at the right time. Making sure that only those who meet the eligibility guidelines receive benefits is important so the American public can have confidence in their Government's efficient and effective operation.

The primary tool at SSA's disposal is the CDRs, the Continuing Disability Reviews. These reviews are critical to the integrity of the Social Security disability program. CDRs are a highly cost-effective measure, saving the Federal Government, on average, $9 for every $1 spent on CDRs. So it makes all the sense in the world that we invest in providing the resources so that more CDRs can be done so that we can be confident in knowing that those who are receiving SSDI and SSI are receiving it appropriately.

SSA's most recent report on CDRs estimates present value savings of $5.4 billion in lifetime program benefits. These numbers speak for themselves as to why CDRs are so critical. Unfortunately, as the chairman mentioned, there is a backlog of 1.3 million uncompleted CDRs. This is just unacceptable. We all get an F for not properly funding you and for not reducing that backlog in an appropriate fashion. We have had a backlog at the Veterans Administration on disability claims and we have thrown a whole lot of money at that agency to get them to reduce that backlog, and I am afraid we are going to have to do it here, but I think it is going to be cost-effective in the long run.

An IG's report found that 79 percent of childhood CDRs were not conducted in a timely fashion. Additionally, GAO has found thousands of cases of child recipients who were expected to medically improve within 18 months, exceeded their scheduled review date by as much as six years or more. You know, this is unacceptable as well.

Another IG found that even when a CDR is conducted and determines benefits are no longer medically justified, those benefits are not always terminated in a timely manner. That results in an estimated $83.6 million in improper payments. That is unacceptable.

President Kennedy once said we can do better, and I really do believe we can. But so must Congress. Annual appropriations of funds for CDRs have fallen short of the levels authorized in the last few years, and that is unacceptable. This is not the first time Congress has allowed a backlog of CDRs to develop. Again, we have to take some responsibility here. In the 1980s, the mid-1990s, Con-

gress also failed to provide adequate funds. Finally, in 1996, Congress acted by increasing funds for CDRs. The backlog was eliminated by 2002, but, again, it took six years to do it, even with the resources being put in place.

We should once again recognize the importance of CDRs and this year finally provide the agency with the funds it needs. CDRs help protect taxpayer funds and the public's interest. Congress must dependably provide adequate funds so that backlogs and the improper payments that result from them never return.

Today we will also hear from a representative of disability examiners who are well positioned to help detect and prevent fraud at the initial determination level and while conducting CDRs. It is important that disability examiners have the training and resources to perform their jobs effectively. It is also important that we support the work and achievements of the inspector general on initiatives like CDIs that allow coordination and collaboration on efforts to prevent, detect, and investigate fraud in Federal disability programs.

Mr. Chairman, it is a pleasure to work with you on this issue, and I look forward to the testimony.

Mr. LANKFORD. Members will have seven days to submit opening statements for the record.

We will now recognize the panel.

Mr. Daniel Bertoni is the Director of Education, Workforce and Income Security at the U.S. Government Accountability Officer.

Ms. Jennifer Nottingham is the President of the National Association of Disability Examiners and a supervisor within the Ohio Disability Determination Service. We will have DDS thrown around a lot today.

Ms. Marianna LaCanfora is the Acting Deputy Commissioner for Retirement and Disability Policy at the Social Security Administration.

Ms. Jennifer Shaw Lockhart is the State Director for Sooner SUCCESS at the University of Oklahoma Health Sciences Center, a fellow Oklahoman.

Mr. Patrick O'Carroll is the Inspector General for the Social Security Administration.

Pursuant to committee rules, all witnesses are sworn in before they testify. If you would please stand and raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you, God?

[Witnesses respond in the affirmative.]

Mr. LANKFORD. Thank you. You may be seated.

Let the record reflect that all the witnesses answered in the affirmative.

We will have time for discussion and questions after your opening statements. We have assigned five minutes for each of your opening statements.

Mr. Bertoni, you are first up.

## WITNESS STATEMENTS

### STATEMENT OF DANIEL BERTONI

Mr. BERTONI. Thank you. Chairman Lankford, Ranking Member Speier, members of the subcommittee, good afternoon. I am pleased to discuss our work on the Social Security Administration's efforts to assess DI and SSI program recipients' continued eligibility for benefits.

Last year, SSA provided nearly $200 billion in benefits to about 11 million DI and 8 million SSI recipients. Both the numbers of recipients as well as program costs have grown in recent years, and are poised to grow further due to economic and population changes.

To ensure that only eligible individuals receive disability benefits, accurate determinations at the time of application and follow-up reviews after benefits are granted provide an important check on growth and are key to ensuring program integrity.

Federal law requires that SSA conduct periodic Continuing Disability Reviews, or CDRs, of recipients and requires SSA to find substantial evidence of medical improvement before ceasing benefits, known as the medical improvement standard. My remarks today are based on our prior work and discuss SSA's efforts to assess recipients' continued benefit eligibility and aspects of the review standard that affect these efforts.

In summary, SSA reported in January 2014 that it is behind schedule in conducting CDRs and has a backlog of 1.3 million reviews. The agency is also conducting fewer CDRs in general. From fiscal year 2000 to 2011, adult CDRs fell from over 580,000 to 100,000, and child CDRs dropped from over 150,000 to 45,000.

For those children with mental impairments, CDRs declined 80 percent, from 84,000 to just 16,000. Thus, in 2012, we reported that over 400,000 child SSI cases with mental impairments were overdue a CDR, with more than 24,000 overdue by six years or more, including thousands who were deemed likely to medically improve.

When CDRs are not conducted as scheduled, especially for those children whose conditions are likely to improve, improper payments may occur. And although child benefits are more likely to be ceased after review, SSA has historically placed a higher priority on conducting adult CDRs, which generally result in a cessation rate of around 12 percent.

Of the child CDRs SSA does conduct, we found that the average benefit cessation rate was 32 percent; and for those with mental impairments, such as personality disorder and speech and language delay, cessation rates were 39 and 38 percent, respectively.

In our report, we recommended that SSA work smarter to better target its limited resources and eliminate the backlog of child CDRs, with a specific focus on those likely to medically improve. SSA generally agreed with our recommendation, but cited resource limitations and competing workloads as a barrier going forward.

Beyond the issue of SSA CDR prioritization, factors associated with the medical improvement standard pose a challenge to assessing recipients. During CDRs, individuals that SSA determines to have improved medically may have their benefits ceased. However, we reported in 2006 that only 1.4 percent of recipients who left the rolls did so because they had medically improved.

We also noted several factors that hindered us the ability to make this determination, including the limitations in SSA's guidance for determining what level of improvement would constitute a cessation and how to apply key exceptions; inadequate documentation of prior disability decisions, especially for cases decided at the appeals level; and the judgmental nature of the process, especially for those cases involving psychological impairments.

In our report, we noted that these factors had implications for the consistency and fairness of decision-making and recommended that SSA clarify its policies for assessing medical improvement. Since then, SSA has taken some steps that may help address the issue, but has not fully implemented our recommendations. Thus, its guidance is likely to continue to be problematic for staff in their efforts to make sound and consistent decisions.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other members of the subcommittee may have. Thank you.

[Prepared statement of Mr. Bertoni follows:]

United States Government Accountability Office

Testimony Before the Subcommittee on Energy Policy, Health Care, and Entitlements, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
1:30 p.m. EDT
Wednesday, April 9, 2014

# SOCIAL SECURITY DISABILITY PROGRAMS

## SSA Could Take Steps to Improve Its Assessment of Continued Eligibility

Statement of Daniel Bertoni, Director
Education, Workforce, and Income Security Issues

GAO-14-492T

# GAO Highlights

Highlights of GAO-14-492T, testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

## Why GAO Did This Study

SSA administers DI and SSI, two disability programs that provided $189 billion in cash benefits to eligible adults and children in 2012. Both the numbers of DI and SSI recipients, as well as program costs, have grown in recent years and are poised to grow further in the future. Both the initial determination of an individual's medical eligibility at the time of application and CDRs after benefits have been granted are key to ensuring the integrity of these programs. CDRs also provide a check on program growth in a time of constrained federal resources. Since 1984, federal law has generally required SSA to find substantial evidence demonstrating medical improvement during a CDR before ceasing a recipient's benefits—known as the medical improvement standard.

In this statement, GAO describes (1) SSA's efforts to monitor DI and SSI beneficiaries' continued eligibility, and (2) factors associated with the medical improvement standard that affect these efforts. This testimony is primarily based on GAO products related to these issues from 2006 and 2012. GAO also updated selected information related to SSA's CDR backlog, budget requests, and guidance for assessing medical improvement as of 2014.

## What GAO Recommends

GAO is not making any new recommendations at this time.

View GAO-14-492T. For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov.

April 2014

# SOCIAL SECURITY DISABILITY PROGRAMS

## SSA Could Take Steps to Improve Its Assessment of Continued Eligibility

## What GAO Found

The Social Security Administration (SSA) reported in January 2014 that it is behind schedule in assessing the continued eligibility of recipients in its two disability programs, Disability Insurance (DI) and Supplemental Security Income (SSI),and has accumulated a backlog of 1.3 million continuing disability reviews (CDRs). From fiscal years 2000 to 2011, the numbers of adult and child CDRs conducted fell about 70 percent. Children make up about one fifth of all SSI recipients, and GAO reported in 2012 that many of their CDRs were overdue. For example, more than 24,000 CDRs for children with mental impairments were overdue by 6 or more years, including over 6,000 CDRs for children who were expected to medically improve within 6 to 18 months of their initial determination. GAO also identified several cases which exceeded their scheduled review date by 13 years or more. When CDRs are not conducted as scheduled, the potential for improper payments increases as some recipients receive benefits for which they are no longer eligible. In September 2011, SSA's Office of the Inspector General estimated that SSA had paid about $1.4 billion in SSI benefits to children who should have not received them. SSA attributes delays in performing CDRs to resource limitations and other factors; SSA also generally gives lower priority to conducting CDRs for children receiving SSI. In 2012, GAO recommended that SSA eliminate the existing CDR backlog for children with impairments who are likely to improve, and regularly conduct reviews for this group. While SSA generally agreed with GAO's recommendation, the CDR backlog remains.

During CDRs, disability recipients that SSA determines to have improved medically may be removed from the program; however, several factors may hinder SSA's ability to make this determination. In 2006, GAO reported that 1.4 percent of people who left the disability programs did so because SSA found that they had improved medically. At that time, GAO identified several factors that hindered SSA's ability to assess whether DI and SSI recipients met the medical improvement standard. These included: (1) limitations in SSA guidance for applying the standard; (2) inadequate documentation of prior disability determinations; (3) failure to abide with the requirement that CDR decisions be made on a neutral basis—without a presumption that the recipient remained disabled; and (4) the judgmental nature of the process for assessing medical improvement. Since 2006, SSA has taken some steps to address these issues; however, the agency has not fully clarified policies for assessing medical improvement, as GAO recommended.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to discuss our prior work on the Social Security Administration's (SSA) efforts to assess Disability Insurance (DI) and Supplemental Security Income (SSI) recipients' continued medical eligibility for benefits. In 2012, these disability programs provided $189 billion in cash benefits to 10.9 million DI recipients and 8 million SSI recipients, including adults and children. Both the numbers of DI and SSI recipients, as well as program costs, have grown in recent years, and both are poised to grow further in the future because of economic and population changes. Federal law, as well as SSA's regulations and guidance, prescribe policies and procedures intended to ensure that only those eligible to receive benefits do so. Both the initial determination of an individual's medical eligibility at the time of application and assessments conducted after benefits have been granted are key to ensuring the integrity of these programs. Assessments of continued eligibility provide an important check on program growth by removing ineligible recipients from the rolls, even while new applicants are added. If these reviews are not conducted in sufficient numbers, the agency will continue to struggle to contain growth in benefit payments, placing added burden on already strained federal resources. Over the years, the Congress has taken actions to add requirements related to SSA's review of recipients' continued medical eligibility for benefits. For example, beginning in 1982, federal law required SSA to conduct certain continuing disability reviews (CDRs) for this purpose, and since 1984, federal law has generally required SSA to find substantial evidence demonstrating medical improvement before ceasing a recipient's benefits—known as the medical improvement standard.

My remarks today are based on our prior work that found several factors hindered SSA's efforts to assess disability program recipients' continued medical eligibility for benefits. I will discuss (1) SSA's efforts to monitor DI and SSI recipients' continued eligibility, and (2) factors associated with the medical improvement standard that affect these efforts. This information was drawn primarily from two reports we issued in 2006 and 2012, as well as a review of SSA's current related data we performed in March and April 2014. Specifically, we updated selected information related to SSA's CDR backlog, budget requests, and guidance for

assessing medical improvement as of 2014.[1] For our prior reports, we reviewed relevant federal law, regulations, and guidance; interviewed SSA officials; and also relied on a variety of additional methodologies. For example, for our 2006 report on the medical improvement standard,[2] we surveyed all 55 state directors responsible for disability determination services (DDS), and for our 2012 report on children receiving SSI benefits,[3] we conducted site visits to 9 SSA field offices and 11 state DDS offices and reviewed SSA's data on CDRs conducted from fiscal years 2000 to 2011. We conducted our work in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## Background

SSA administers two disability programs that provide monthly cash benefits to eligible individuals: DI, enacted in 1956, and SSI, enacted in 1972. DI provides monthly cash benefits to eligible workers unable to work because of a long-term disability and who have paid into the Social Security Trust Fund, whereas SSI provides monthly cash benefits to people with disabilities on the basis of need, regardless of whether they have paid into the Social Security Trust Fund. In order to be eligible for DI or SSI benefits based on a disability, an individual must meet the definition of disability for these programs—that is, they must have a medically determinable physical or mental impairment that (1) prevents

[1]Beyond this review, we did not update our analyses from our prior reports.

[2]GAO, *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, GAO-07-8 (Washington, D.C.: October 3, 2006).

[3]GAO, *Supplemental Security Income: Better Management Oversight Needed for Children's Benefits*, GAO-12-497 (Washington, D.C.: June 26, 2012).

the individual from engaging in any substantial gainful activity and (2) has lasted or is expected to last at least 1 year or result in death.[4]

The disability determination process is the same for DI and SSI applicants. An SSA field office determines that an applicant has met SSA's nonmedical eligibility requirements for disability benefits,[5] and then the applicant's claim is sent to the state DDS for an initial review of the claimant's medical eligibility.[6] After assembling all medical and vocational information for the claim, a DDS examiner, in consultation with appropriate medical staff, determines whether the claimant meets the requirements of the law for having a disability. Claimants who are dissatisfied with the initial DDS determination may choose to pursue several levels of appeal, including: a "reconsideration" of the claim, conducted by DDS personnel who were not involved in the original decision; a hearing before an administrative law judge (ALJ); and a review of the claim by the Appeals Council, which is comprised of administrative appeals judges and appeals officers. Final SSA decisions are also subject to review in federal district court.

If SSA determines that an individual is disabled, the agency is required to conduct periodic CDRs to ensure that only recipients who remain disabled continue to receive benefits.[7] These reviews assess whether individuals are still eligible for benefits based on several criteria, including their current medical condition and ability to work.[8] DDS staff generally

[4]42 U.S.C. §§ 423(d)(1)(A) and 1382c(a)(3)(A). Substantial gainful activity is generally work activity involving significant physical or mental activities that is done for pay or profit, whether or not a profit is realized. 20 C.F.R. §§ 404.1572 and 416.972. In 2012, the substantial gainful activity threshold was $1,690 per month for blind recipients and $1,010 per month for individuals with other disabilities.

[5]For example, field office staff are to ensure that an SSI applicant meets income and resource requirements and determine if a DI applicant has a sufficient work history.

[6]Although SSA is responsible for administering these programs, the law allows for initial determinations of disability to be made by state agencies, known as DDS offices. See 42 U.S.C. § 421(a)(1).The work performed at DDS offices is federally funded and is carried out in accordance with applicable federal laws, as well as SSA regulations, policies, and guidelines.

[7]SSA's regulations pertaining to CDRs for DI and SSI can be found at 20 C.F.R. §§ 404.1589 and 416.989, respectively.

[8]In addition to medical CDRs, SSA also conducts "work CDRs" in which it assesses if an individual's earnings exceeded program limits. This testimony focuses on medical CDRs.

establish the timeframe for when SSA should conduct a CDR on the basis of the expected likelihood of a recipient's medical improvement. However, SSA also uses a profiling model to score and prioritize CDRs if funding is not available to conduct all scheduled CDRs.

In response to prior concerns that some recipients were being arbitrarily removed from the disability programs via the CDR process, Congress passed the Social Security Disability Benefits Reform Act of 1984,[9] which, among other things, established a medical improvement standard. Under this standard, SSA may only discontinue benefits for an individual if it finds substantial evidence demonstrating both that a beneficiary's medical condition has improved[10] and that the individual is able to engage in substantial gainful activity.[11] If SSA determines that these conditions have not been met in the course of conducting a CDR, the recipient may continue to receive benefits until the individual receives a subsequent CDR (which potentially could result in a discontinuation of benefits), dies, or transitions to Social Security retirement benefits.

[9]Pub. L. No. 98-460 § 2, 98 Stat. 1794.

[10]The regulations implementing the act define improvement as any decrease in the medical severity of the recipient's impairment(s) since the last time SSA reviewed his or her disability, based on improvements in symptoms, signs, or laboratory findings.

[11]42 U.S.C. §§ 423(f)(1) and 1382c(a)(4)(A)(i). The medical improvement standard for individuals under the age of 18 who receive SSI benefits is different. *See* 42 U.S.C. § 1382c(a)(4)(B). The law also identifies certain other limited circumstances under which benefits may be discontinued, besides the medical improvement standard. *See* 42 U.S.C. § 423(f) and § 1382c(a)(4)(A) and (C).

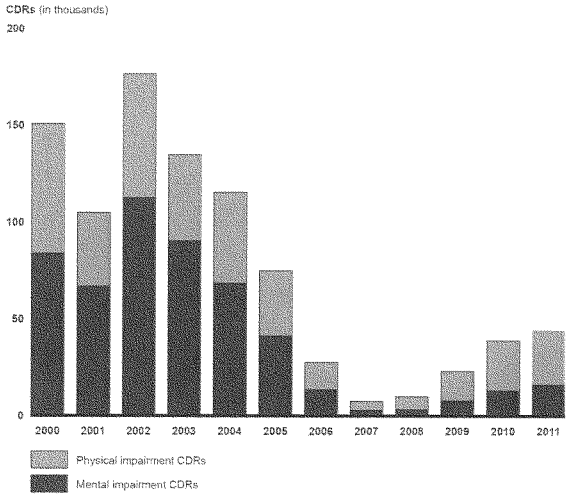
## SSA Has a Backlog of More Than 1 Million DI and SSI Benefit Eligibility Reviews

SSA reported in January 2014 that it is behind schedule in assessing the continued eligibility of DI and SSI recipients and has accumulated a backlog of 1.3 million CDRs. In recent years, SSA has cited resource limitations and a greater emphasis on processing initial claims and requests for hearings appeals as reasons for the decrease in the number of CDRs conducted. From fiscal years 2000 to 2011, the number of adult CDRs fell from more than 580,000 to about 180,000 (69 percent)[12] and the number of childhood CDRs fell from more than 150,000 to about 45,000 (70 percent), according to our analysis of SSA data (see fig. 1).[13] More specifically, CDRs for children under age 18 with mental impairments—a group that comprises a growing majority of all child SSI recipients—declined from more than 84,000 to about 16,000 (an 80 percent decrease).

[12]In general, DDS staff consider the likelihood of a recipient's medical improvement when establishing the timeframe for when SSA should conduct a CDR. Improvement categories and general time frames used are (1) "medical improvement expected," 6 to 18 months; (2) "medical improvement possible," 3 years; and (3) "medical improvement not expected," 5 to 7 years. For adults receiving SSI, SSA conducts CDRs using two methods: (1) SSA headquarters sends some cases to the DDS for a full medical review, and (2) SSA mails a questionnaire to other recipients and reviews their responses to determine continued eligibility. At this time, SSA does not use the mailer process for SSI child recipients. For comparability in the number of CDRs for adults and children, the CDR data in this section apply to full medical reviews only.

[13]With respect to children receiving SSI benefits, under Title XVI of the Social Security Act, SSA is generally required to (1) conduct a CDR at least every 3 years on all child recipients under age 18 whose impairments are likely to improve (or, at the Commissioner's option, recipients whose impairments are unlikely to improve) (42 U.S.C. § 1382c(a)(3)(H)(ii)(I)); (2) conduct a CDR within 12 months after the birth of a child who was granted benefits in part because of low birth weight (42 U.S.C. § 1382c(a)(3)(H)(iv)); and (3) redetermine, within 1 year of the individual's 18th birthday (or whenever the Commissioner determines the individual is subject to a redetermination), the eligibility of any individual who was eligible for SSI childhood payments in the month before attaining age 18, by applying the criteria used in determining initial eligibility for adults (42 U.S.C. § 1382c(a)(3)(H)(iii)). For children under the age of 18—except for the initial CDR for low birth weight babies—DDS offices are directed by SSA policy to determine when recipients will be due for CDRs on the basis of their potential for medical improvement, and select and schedule a review date—otherwise known as a "diary date"—for each recipient's CDR.

**Figure 1: Number of Childhood CDRs Conducted for SSI Recipients under Age 18, by Primary Impairment, Fiscal Years 2000 through 2011**



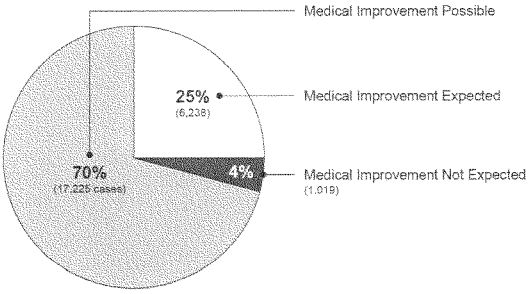

Source: GAO analysis of Social Security Administration data from the Continuing Disability Review (CDR) Waterfall Files.

Children make up about one fifth of all SSI recipients, and we reported in 2012 that a large proportion of their CDRs were overdue. For example, CDRs for about one half of all child recipients with mental impairments (435,000) were overdue, according to our analysis of SSA data in 2012.[14] Of these recipients, about 344,000 (79 percent) had exceeded the scheduled date by at least a year, with about 205,000 (47 percent) exceeding their date by 3 years, and about 24,000 (6 percent) exceeding the scheduled date by 6 years. We also identified several cases which

[14]A total of about 861,000 child recipients with mental impairments were receiving SSI benefits as of December 2011.

exceeded their scheduled date by 13 years or more. Of the 24,000 childhood CDRs pending 6 years or more, we found that about 70 percent (over 17,000) were for children who had been categorized as "medical improvement possible" at initial determination, while 25 percent (over 6,000) of these pending CDRs were for those children deemed medically expected to improve within 6 to 18 months of their initial determination (see fig. 2). Of these cases, we identified nine recipients who were expected to medically improve, but whose CDR had been pending for 13 years or more. Reviews of children who are expected to medically improve are more productive than reviews of children who are not expected to medically improve because they have a greater likelihood of benefit cessation and thus yield higher cost savings over time.

**Figure 2: Childhood CDRs Pending for at Least 6 Years, by Anticipated Medical Improvement Category, for Children with Mental Impairments**




Source: GAO analysis of Social Security Administration data from the Continuing Disability Review (CDR) Waterfall Files.

Note: Percentages do not equal 100 percent due to rounding.

When CDRs are not conducted as scheduled, the potential for improper payments may increase as some recipients can receive benefits for which they are no longer eligible. In September 2011, SSA's Office of the Inspector General estimated that SSA had paid about $1.4 billion in SSI benefits to approximately 513,000 recipients under age 18 who should

have not received them—some of whom were pending reviews for 5 or more years.[15] The Inspector General estimated that SSA will continue to make improper payments of approximately $461.6 million annually until these reviews are completed. Furthermore, in its May 2012 CDR report, SSA estimated a program savings of $9.30 for every $1 invested in conducting CDRs and projected that those CDRs conducted for adult DI and SSI recipients and for child SSI recipients combined in fiscal year 2010 would have saved federal programs the present value of estimated lifetime benefits of $3.5 billion.[16]

For several reasons, SSA has placed a higher priority on conducting CDRs for DI recipients, although children's SSI benefits are more likely to be ceased after review. According to SSA officials, when CDR funding is less than what is needed to conduct all CDRs at the scheduled intervals, the agency has historically given priority to performing reviews considered to be the most cost-effective, as well as staying current with DI CDRs and performing two specific statutorily required SSI reviews.[17] SSA officials told us that it is more cost effective to conduct adult DI CDRs than childhood SSI CDRs, because ceasing benefits for a young adult DI recipient may potentially represent decades of saved benefits. For SSI, statutorily required age 18 redeterminations are cost effective for the

[15]The SSA Inspector General estimated that SSA did not complete 79 percent of childhood CDRs and 10 percent of age 18 redeterminations on the basis of the results of 275 cases of physical and mental impairments they reviewed. To estimate the amount of SSI payments made because SSA had not completed a timely childhood CDR, the Inspector General calculated the amount of SSI payments made between the 1-year anniversary of the scheduled CDR date and the earlier of the month of cessation or April 2011 (the date the Inspector General reviewed the cases).

[16]This represents the combined savings to the SSI, DI, Medicare, and Medicaid programs from CDRs conducted for the SSI and DI programs, from cessations and terminations due to failure to cooperate with a CDR in fiscal year 2010. The estimate includes savings to Medicare and Medicaid, as in some cases eligibility for SSI and SSDI confers eligibility for certain Medicare or Medicaid benefits, as well. SSA noted that the savings-to-cost ratio for fiscal year 2010 represents a significant drop from the average ratio for fiscal years 1996 through 2009 of $10.60 to $1, attributing the drop largely to the Medicaid estimates, which now reflect the effects of a Patient Protection and Affordable Care Act provision that allows most disabled SSI recipients terminated due to a CDR to retain their Medicaid coverage beginning January 1, 2014. *Annual Report of Continuing Disability Reviews, Fiscal Year 2010.*

[17]In particular, SSA officials identified the following two reviews: age 18 redeterminations, which are required within 1 year after a child turns age 18, and reviews required within 12 months after birth for recipients whose low birth weight was a contributing factor material to the determination of their disability. 42 U.S.C. § 1382c(a)(3)(H)(iii) and (iv), respectively.

same reason. Additionally, because DI benefit payments are, on average, almost twice as much as SSI childhood payments, CDRs of adult DI cases generally produce greater lifetime savings, according to SSA officials. However, SSA reported that it ceased about 12 percent of all adult DI claims that received a CDR. In comparison, our analysis of SSA's data showed that 32 percent of child SSI claims that received a CDR were ceased in fiscal year 2011. For example, of those childhood CDRs conducted for children under age 18 with mental impairments, SSA ceased benefits for about 28 percent on average in fiscal year 2011, with personality disorders and speech and language delay having the highest cessation rates, 39 and 38 percent, respectively.[18] Despite these high cessation rates, SSA and state DDS officials have acknowledged that the agency has not conducted reviews for child recipients in a timely manner, and in some cases, they have not conducted childhood CDRs prior to a child's age 18 redetermination.

In our 2012 report, we recommended that SSA eliminate the existing CDR backlog of cases for children with impairments who are likely to improve and, on an ongoing basis, conduct CDRs at least every 3 years for all children with impairments who are likely to improve, as resources are made available for these purposes. SSA generally agreed that it should complete more CDRs for SSI children but emphasized that it is constrained by limited funding and competing DI and SSI workloads. Moving forward, one of the major objectives in SSA's Fiscal Year 2013-2016 Strategic Plan[19] is to "increase efforts to accurately pay benefits," and the Plan indicates that SSA intends to conduct more CDRs, as funding is available. In addition, as part of the President's fiscal year 2014 budget request, SSA asked for $1.227 billion to create a new Program Integrity Administrative Expenses account that the agency says would

[18]The cessation rates cited in this paragraph reflect "initial cessations," meaning that the agency concluded at the end of the CDR that the claimant involved no longer met the eligibility standards to continue receiving benefits, and therefore started the process to cease benefits. Claimants may subsequently avail themselves of an appeals process, which can result in a reversal of the initial cessation.

[19]SSA, *Strategic Plan: Security Value for America, Fiscal Years 2013-2016* (Feb. 2012).

establish a more reliable stream of mandatory program integrity funding.[20] While additional funding may help address the CDR backlog, we continue to have concerns about the agency's ability to manage limited funds in a manner that adequately balances its public service priorities with its stewardship responsibility. Because SSA has noted that it considers SSI childhood CDRs to be a lower priority than other CDRs, it is unclear whether the agency will use new increases in funding to review children most likely to medically improve—reviews that could yield a high return on investment.

## Several Factors Associated with the Medical Improvement Standard Have Challenged the Assessment of Recipients' Continued Eligibility

During CDRs, disability recipients that SSA determines have improved medically may cease receiving benefits; however, several factors may hinder SSA's ability to make this determination. In 2006,[21] our analysis of SSA data showed that 1.4 percent of all the people who left DI and SSI between fiscal years 1999 and 2005 did so because SSA found that they had improved medically; however, more recipients left for other reasons, including conversion to regular Social Security retirement benefits or death. At that time, we identified a number of factors that challenged SSA's ability to assess DI and SSI recipients using the medical improvement standard.[22]

- *Guidance limitations*—Limitations in the SSA guidance then in effect for applying the medical improvement standard may have resulted in inconsistent disability decisions. Specifically, in 2006, SSA guidance on CDRs instructed examiners to disregard "minor" changes in a recipient's condition without defining what constituted a minor change.

[20]This proposal was also included in the President's fiscal year 2015 budget request. According to a statement by Acting Commissioner Carolyn Colvin, the Program Integrity Administrative Expenses account, as proposed, would be separate, and in addition to, SSA's Limitation on Administrative Expenses account. Under the proposal, the funds would be available for 2 years, providing SSA with the flexibility to hire and train staff to support the processing of more program integrity work. See Carolyn W. Colvin, Acting Commissioner, SSA, *Statement for the Record*, testimony before Subcommittee on Social Security, Committee on Ways and Means, United States House of Representatives, January 16, 2014.

[21]See GAO, *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, GAO-07-8 (Washington, D.C.: October 3, 2006).

[22]As previously noted, beyond our review of currently available data, we did not update our 2006 analyses.

In addition, when assessing whether improvements in recipients' medical conditions were related to their ability to work, the SSA guidance instructed examiners to ensure a "reasonable relationship" between the amount of improvement and the increase in the ability to perform basic work activities. However, at that time, the guidance did not require a specific amount of increase in functioning to better guide examiners in their decision making.

- *Inadequate documentation*—If a prior disability determination was inadequately documented, it can be challenging for the disability examiner to demonstrate medical improvement in a CDR. Because the prior decision is the starting point for conducting a CDR and examiners are required to find evidence of medical improvement since that last decision in order to cease benefits, inadequate documentation of evidence in prior decisions may make it difficult to assess medical improvement. In our 2006 survey, some DDS directors commented that cases decided on appeal were the most likely to lack adequate documentation. Several officials reported that guidance in effect at that time instructed ALJs to include enough information to make their decisions legally sufficient, but there was no specific instruction to include all of the evidence that would be needed to assess medical improvement as part of a future CDR.
- *Presumed disability*—According to our 2006 survey,[23] a majority of DDSs incorrectly presumed that a recipient had a disability when the CDR was being conducted, which may have made it more difficult for examiners to determine if a recipient had improved medically. We reported that this practice is contrary to the law as well as SSA

[23]We conducted a national Web-based survey of all 55 Disability Determination Services (DDS) directors in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, the Western Pacific Islands, and the federal DDS. We received 54 completed surveys for a response rate of 98 percent. The purpose of this survey was to assess the extent to which the medical improvement standard impacts outcomes of CDRs and determine if the standard poses any special challenges for SSA when determining whether recipients continue to be eligible for benefits. The results of this survey are available in GAO-07-4SP, *Social Security Disability Programs: Survey of Disability Determination Services Directors, an E-supplement to GAO-07-8.*

regulations and policy, which require that CDR decisions be made on a "neutral basis."[24]

- *Reliance on judgment*—The judgmental nature of the process for assessing medical improvement likely hinders its reliability. For example, one examiner may determine that a recipient has improved medically and discontinue benefits, while another examiner may determine that medical improvement has not been shown and will continue the individual's benefits.[25] Furthermore, we previously found that the amount of judgment involved in the decision-making process increases when the process involves certain types of impairments, such as psychological impairments, which are more difficult to assess than other impairments, such as physical impairments.

These issues have implications for the consistency and fairness of SSA's medical improvement decision-making process, and in 2006, we recommended that SSA clarify policies for assessing medical improvement. Since then, SSA has taken some steps that may help address the issues we raised but has not fully implemented the actions we recommended. In 2009, SSA began implementing an electronic claims analysis tool for use during initial disability determinations to (a) document a disability adjudicator's detailed analysis and rationale for either allowing or denying a claim, and (b) ensure that all relevant SSA policies are considered during the disability adjudication process. In

[24]At the time our 2006 report was issued, SSA defined neutral basis as a review that neither presumes that a recipient (1) is still disabled because he or she was previously found disabled and (2) is no longer disabled because he or she was selected for a CDR. *See also* 42 U.S.C. § 423(f), 42 U.S.C. § 1382c(a)(4), 20 C.F.R. § 404.1594(b)(6), and 20 C.F.R. §§ 416.994(b)(1)(vi) and 416.994a(a)(2).

[25]In one of the CDR cases that we reviewed for our 2006 report, the examiner conducting the initial CDR determined that medical improvement was shown and discontinued the individual's benefits. The recipient was initially awarded disability benefits for a back injury with limited range of motion in the recipient's back. When the CDR was conducted, the examiner evaluated all of the relevant evidence and concluded that the individual's range of motion had improved. The examiner also noted that the individual's allegations of pain did not correlate with the findings from both the physical exam and the laboratory findings. As a result, the examiner concluded that medical improvement had occurred. On appeal to reconsideration 6 months later, a different DDS examiner conducted a review using the same medical evidence as the original examiner, but determined that medical improvement had not occurred, and continued benefits. The examiner conducting the appeal concluded that the recipient continued to experience pain consistent with the back condition, and thus medical improvement was not shown. However, we had no basis for determining which decision was correct.

addition, SSA reported in February 2013 that it was developing a tool to help hearing offices standardize and document the hearing decision process and outcome. However, SSA's guidance for assessing medical improvement may continue to present challenges when applying the standard. As of April 2014, the guidance does not provide any specific measures for what constitutes a "minor" change in medical improvement,[26] and it instructs examiners to exercise judgment in deciding how much of a change justifies an increase in the ability to work.[27]

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

## Contacts and Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-7215. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony include James Bennett, Holly Dye, Rachel Frisk, Isabella Johnson, Kristen Jones, Sheila McCoy, and Walter Vance.

[26]See SSA Program Operations Manual System (POMS) section DI 28010.015. The standards state that "although the decrease in severity may be of any quantity or degree, we will disregard minor changes in your signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that your disability has ended."

[27]See POMS section DI 28015.320.

Mr. LANKFORD. Thank you.
Ms. Nottingham.

**STATEMENT OF JENNIFER NOTTINGHAM**

Ms. NOTTINGHAM. Chairman Lankford, Ranking Member Speier, and other members of the committee, thank you for inviting NADE to share the perspective of the frontline disability determination employee. After several years of high attrition rates and hiring freezes, combined with an increased number of people applying for disability, the DDS's caseload grew, particularly CDRs. With this year's budget, SSA was able to hire a DDS staff and is dramatically increasing the number of CDRs sent for review.

NADE believes it is critical to invest and train for all staff. Employees at all levels of the disability adjudication process should receive more training opportunities and updates. This includes disability hearing officers and ALJs. It would be counterproductive to remind examiners of a policy, only to have it be not known by a hearing officer or ALJ.

Medical improvement review standards shifts the burden of proof from the claimant to the DDS. SSA has a strict definition of disability, and to be found disabled the individual must prove that they meet the criteria. However, at the CDR the definition is removed. The medical improvement review standard policy dictates that benefit continue unless the beneficiary's disabling condition has shown to have demonstrated medical improvement related to the ability to work. This standard is very stringent and, as a result, few claims are actually ceased. It is important to note that, through appeals, a DDS cessation may end up being continued by the disability hearing officer or ALJ.

In processing a CDR claim, the DDSs are required to compare a beneficiary's current condition to their condition at the time of the most recent medical decision. Because of MIRS, the DDS cannot fix what may be perceived as a mistake or wrong decision, as the DDS is not allowed to substitute judgment. There are many times during the processing of a CDR claim where the disability examiner would not currently find the beneficiary disabled, but must continue benefits because medical improvement has not been demonstrated. If an individual is allowed and had minimal or normal findings at the Comparison Point Decision, as long as they still have similar findings, they will be continued.

There are exceptions to MIRS; most notably the fraud and error exception. These exceptions only apply in a small portion of CDRs. The error exception policy states that it cannot be used to substitute judgment, and it can only be used when a previous claim shows evidence that there was a clear objective error. An example would be a decision based off of records for the wrong patient. So even though the CDR examiner may consider the previous decision wrong, it is very difficult to prove an error, particularly if there is minimal rationale. The exceptions are underutilized and additional training is needed; however, the exception would still only apply to a small portion of CDRs.

There has been significant attention on the allowance rate of ALJs. It is likely that fraud or error would not be found in most cases. The difference in the high allowance rate is more likely due

to a difference in subjective conclusions or decisions based on limited information. Where this is often seen is in the assessment of credibility and the weight of medical source statements. The totality of the evidence needs to be considered. Factors such as objective medical evidence, medical history, consistency of the record, and activities of daily living should be considered when assessing the credibility and medical source opinions. If a statement is not well supported or inconsistent with the record, it should be given less weight. The credibility and medical source opinions can have a large impact on the outcome of a claim. They are subjective conclusions and the DDS is directed to not substitute judgment.

In the adjudicative process, if a conclusion is not supported, poorly documented, or inconsistent with the available evidence, this would not be considered an error that can be cited, and if there is no clear objective error found, then MIRS directs us to determine if benefits continue. NADE recommends changing the CDR process and would support a discussion on a de novo decision at CDR.

It is important to make sure the correct decision is made initially and only appropriate claims are allowed. NADE applauds SSA's recent focus on policy and medical training with ALJs. Many examiners complain of ALJ decisions where the medical source statements are not supported with evidence, yet given great weight. NADE feels it would be beneficial if the DDSs were able to be represented at the ALJ to help ensure policy compliance where display examiners receive more training.

More review and oversight may be needed at all levels of the adjudication process. Currently, there is minimal review of ALJ in disability hearing officer decisions. Although most claims are now electronic, there are still paper claims and some end up lost. CDRs with lost folders end up being continued most often. If the DDS cannot reconstruct the prior decision in order to make a comparison, it will be continued. Steps should be taken to decrease the number of paper claims processed and to prevent lost folders.

NADE continues to support the expansion of CDI units to help combat fraud. More emphasis on referrals to CDIU of CDR claims may be needed, along with additional fraud or similar fault training. At CDR, many beneficiaries do not have treatment, despite many having access to treatment. That means the examiner rely upon a decision from a consultative examination that they are only seen one time. It is hard to make a decision without longitudinal evidence, and it is discouraging to see beneficiaries that don't take advantage of medical treatment to improve their condition.

That is all I have. Thank you for allowing me the opportunity to share NADE's views on CDRs.

[Prepared statement of Ms. Nottingham follows:]

**Statement**

**Presented by**

**The National Association of Disability Examiners**

**Jennifer Nottingham, President**

**Presented to the**

**Committee on Oversight and Government Reform**

**Subcommittee on Energy Policy, Health Care and Entitlements**

**United States House of Representatives**

**April 9, 2014**

Mr. Chairman, Members of the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform. My name is Jennifer Nottingham and I am the current President of NADE, the National Association of Disability Examiners. I am also a Supervisor in the Ohio Disability Determination Service, or DDS. The members of NADE thank you for this opportunity to offer our comment and insight regarding the Social Security Administration's management of the federal disability programs. This hearing will examine the effectiveness of SSA's current process to medically review beneficiaries to determine if they should continue to receive federal disability benefits.

**Who We Are**

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members work in the state Disability Determination Service (DDS) agencies where 15,000+ employees adjudicate claims for Social Security and/or Supplemental Security Income (SSI) disability benefits. As such, our members constitute the "front lines" of disability evaluation. Our membership also includes many SSA Central and Regional Office personnel, attorneys, physicians, non-attorney claimant representatives, and claimant advocates. The diversity of our membership, combined with our extensive program knowledge and "hands on" experience, enables NADE to offer a perspective on disability issues that is unique and which reflects a programmatic realism, which we believe, is a critical factor for Members of this Subcommittee to consider.

NADE members are deeply concerned about the integrity and efficiency of the Social Security and the SSI disability programs. Simply stated, we believe those who are entitled to disability benefits under the law should receive them; those who are not, should not.

**The CDR Claims Process and Impact of MIRS**

When a claim is approved for disability benefits, a diary is established for that claim to be reviewed again after a certain period, usually three (3) to seven (7) years, to determine if the disabling condition continues. After the diary expires, the claim is sent to the DDS for a Continuing Disability Review (CDR). The Medical Improvement Review Standard (MIRS) is used to evaluate CDR claims. MIRS was established in 1984 after a mandate from Congress. The MIRS policy dictates that benefits continue unless the beneficiary's disabling condition has shown medical improvement and the medical improvement is related to the ability to work. In effect, MIRS turns the tables on the federal disability program. During the initial application process, the burden is on the claimant to prove they are disabled. For initial and reconsideration claims, SSA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted for a continuous period of not less than 12 months. At the CDR level, the necessity to apply MIRS shifts the burden to SSA and the Disability Determination Service (DDS) to prove there has been significant medical improvement related to the ability to work. The MIRS standard is very stringent and, as a result, few claims are actually ceased. It must be noted, when the DDS proposes a cessation of benefits for CDRs or Age 18 redeterminations, the decision is not always upheld on subsequent appeal by Disability Hearing Officers (DHO) or Administrative Law Judges (ALJ). The majority of cessations processed by the DDSs are the age 18 redeterminations. These are claims processed for adults who have recently attained the age of 18 and were allowed benefits as children. These claims are re-examined by the DDS using adult criteria to determine if disability continues. MIRS does not apply to age 18 redeterminations. Instead, the DDS makes a new initial determination whether the claimant has an impairment that continues to be disabling based on adult criteria.

To process a CDR claim, the disability examiners are required to compare a beneficiary's current condition to the beneficiary's condition at the time of the most recent medical decision, whether that is the initial allowance decision or the most recent CDR continuance decision. This most recent favorable decision is called the Comparison Point Decision (CPD). Because of MIRS, the DDS can only fix a mistake on a prior allowance decision if there is a clear objective error on the previous decision, as the DDS is not allowed to substitute judgment. It is not unusual to find a CDR claim where the disability examiner would not currently find the beneficiary disabled, but must continue benefits because significant medical improvement cannot be shown. If an individual is allowed and had minimal abnormal findings at the CPD, as long as the findings are similar, the beneficiary will remain on the disability rolls.

**Fraud or Similar Fault**

A finding of fraud or similar fault would be an exception to the use of the MIRS. When fraud or similar fault is suspected on a claim, it can be referred to the Cooperative Disability Investigation Unit (CDIU), if it is available in the state. After screening by CDIU, the claim can then be sent to the Office of Inspector General (OIG). Once a Report of Investigation (ROI) is

completed, the DDS is able to make a decision with additional information to address the concerns with fraud or similar fault. Unfortunately, not all DDSs have access to a CDIU. In those states, a screening process involves multiple levels of management reviewing the claims where fraud is suspected to make a decision whether to refer the claim to OIG. Significantly fewer claims are referred to OIG from states without a CDIU. The majority of CDIU referrals are for initial or reconsideration claims. Only a small number of CDR claims are referred to OIG.

NADE believes it would be beneficial to the disability trust fund if there were an increased emphasis on referring CDR claims where fraud or similar fault is suspected, to CDIU. NADE supports the continued expansion of CDIUs and recommends each state have access to a CDIU. There are currently only 25 CDIUs in 22 states. To help with fraud detection, DDS employees should have access to more current employment information for claimants. NADE also supports a revision of the policies regarding fraud and similar fault. The current policies contain limited detail and direction on handling complex fraud or similar fault cases. NADE believes additional training in detecting and handling claims with suspicions of fraud or similar fault cases is always beneficial.

While any amount of fraud or similar fault is too much, fraud and similar fault is only involved in a small portion of the claims processed. Most claims where an individual may be inappropriately receiving disability benefits are due to judgments not supported by the evidence at the previous decision. In these cases, the CDR review of the CPD file shows too much weight was given to an unsupported medical source statement or the claimant's statements were found fully credible even though the statement was inconsistent with other evidence. It is important to distinguish these claims that seemingly are "mistakes" with judgments that are not supported by the evidence from claims where there was fraud or similar fault or a clear objective error made. In claims where judgments are not supported by the evidence, neither the fraud and similar fault nor the error exceptions to MIRS would apply and the examiner would need to make a determination if there was significant medical improvement related to the ability to work.

**Exceptions to MIRS**

There are exceptions to MIRS; the exceptions policy explains the limited situations where disability may be ceased without consideration of whether there is medical improvement. The intent of the exceptions policy is only to address situations where an individual clearly should never have been found disabled at CPD. There are two types of exceptions, Group I and Group II. These are defined for the DDSs in POMS DI 28020.001 through DI 28020.900. The Group II exceptions are fraud or similar fault, failure to cooperate, whereabouts unknown and failure to follow prescribed treatment. The Group II exceptions are commonly used in the DDS, particularly failure to cooperate. The Group I exceptions include vocational therapy; new or improved diagnostic or evaluative techniques; and error exceptions. The Group I exceptions are not generally well understood and, as a result, are rarely utilized in the DDS. Most disability examiners receive minimal, if any, training on the Group I exceptions to MIRS. It is important to note, the policy regarding the exceptions to MIRS is explicit that the exceptions should not be

used to substitute judgment. Disability Examiners aware of the policy on exceptions are often reluctant to utilize it due to an expectation of additional scrutiny by quality assurance reviewers either in the DDS or in the federal reviewing components. If the rationale for using an exception is not well documented, any attempt to apply an exception will be reversed on appeal.

The error exception is appropriate when the CPD evidence shows there was a clear error based upon the record. The only evidence that can be considered to determine if this exception applies is evidence on record at the time of the CPD decision. An error would have to be a clear objective finding that was incorrect. Examples would be the use of a vocational rule that did not apply or using medical records for the wrong patient. It would not be appropriate to use the error exception because the CDR decision maker came to a different conclusion than the CPD decision maker. Generally, disability allowances that are considered "inappropriate" or "in error" are actually not errors but rather, differences in the subjective findings of credibility and weighing of medical source statements. Indicating there was an error on a subjective finding would be substituting judgment, which is not allowed by the policy. While there would be some benefit to increased training on the exceptions to MIRS, using these exceptions would be rare as the policy applies to a limited number of claims.

**Subjective Conclusions**

The high allowance rates of some Administrative Law Judges (ALJs) have received significant attention. While fraud and error may be assumed to be the reason for high allowance rates, it is possible that fraud or error is not the cause in most claims. The higher allowance rate is more likely due to a difference in subjective judgments or decisions based on limited information. Subjective judgments are completed in the assessment of credibility and the weighing of medical source statements. In reviewing disability claims, there is the assumption that the claimant's statements are fully credible. Even so, the totality of the evidence needs to be considered to determine if the statements are consistent with the rest of the evidence in file, functioning and the claimant's medically determinable impairment. Similarly, if a treating source give a medical source opinion, it should be given controlling weight, but only if the statements are supported, consistent with other findings and would reasonably result from the impairment. If not, then the medical statements should be given less weight. The assessment of credibility and weighing of medical source opinions can have a large impact on the outcome of a claim. It would not be appropriate to use the error exception to MIRS on a claim just because the findings were not supported.

**Case Scenarios**

It may be best to illustrate the difference in fraud or similar fault, errors and a subjective conclusion through examples. Below are three examples of a claim being considered for an intellectual disability. When evaluating for this condition, a critical aspect is the adaptive functioning. While the IQ score is required, the individual's adaptive functioning should be consistent.

In one scenario, school records were not available and a consultative examination was completed. The claimant knowingly provided inaccurate answers so that the test scores underestimated their true intellectual abilities. The individual gave statements to the examiner, indicating they had many challenges completing activities of daily living independently. The claimant was awarded benefits because the IQ scores were in the mental retardation range and the claimant's report of functioning was consistent with a diagnosis of mental retardation. At CDR, if evidence was found that proved the individual knowingly provided inaccurate information, a finding of fraud or similar fault can be found. The MIRS exception for fraud or similar fault would apply.

In a second scenario, an individual provides information about their activities of daily living and reports that he attended special education classes in school. The examiner contacts the school and receives records with IQ testing in the mental retardation range; however, the records were for a different student. The examiner approved disability benefits based mainly upon the IQ scores. At CDR, the error exception would apply because the decision was clearly made based upon incorrect evidence. This would not be a case of fraud or similar fault because the individual did not provide inaccurate information.

In a third scenario, the individual received special education services while in school. The school records included an abbreviated intelligence test, which cannot be accepted by SSA for a measure of intelligence. The school testing indicated the student performed in the Borderline Intellectual Functioning range. The clmt attended a consultative exam and completed IQ testing, with scores that ranged from the Borderline Intellectual Functioning range to the Mental Retardation range. The CE examiner gave a diagnosis of Mental Retardation. Activities of daily living showed the claimant was able to drive and shop independently, complete household chores but had problems reading and needed help completing applications and forms. The examiner allowed the claim. On CDR, the current examiner finds that the school records and high level of functioning established in the activities of daily living are more consistent with a diagnosis of Borderline Intellectual Functioning rather than Mental Retardation and felt the initial decision should have been a denial. The MIRS exception would not apply as no clear error is shown at the initial decision. Instead, the difference is due to a difference in subjective conclusions. The initial examiner gave great weight to the diagnosis of the CE examiner, while the CDR examiner considered the diagnosis not consistent with the school records and the high level of functioning. It would be a substitution of judgment to conclude that the initial decision was wrong. MIRS would apply and disability benefits would continue if the beneficiary's activities of daily living were similar to the time of the initial decision.

**Increased Efforts for Consistency Between DDSs and ALJs**

NADE applauds SSA's recent efforts to bring consistency between the DDS and ALJ determinations. There has been improvement in documentation of rationales at the DDS level with the eCAT tool. SSA has recently focused on providing additional policy and medical training for ALJs. The result has been a decrease in the overall allowance rates by ALJs. While

the focus of this hearing is CDRs and MIRS, the ultimate goal is to have only the appropriate people receiving disability benefits. When the initial decision is correctly documented with a well-supported rationale, there is no "mistake" to address in the CDR.

When a claimant appeals a denial decision to the ALJ, they have the right to be represented at the hearing. NADE concurs with the right of claimants to be represented, as this is a privilege granted under our country's system of justice. However, that system of justice is also predicated on the concept that both parties to a dispute are represented at a hearing before an impartial third party. Such is not the case in disability hearing. Once the DDS makes its decision, it is left to stand on its own and can be interpreted by the ALJ in whatever manner they wish to interpret that decision. While a claimant is usually represented by counsel at a hearing, there is no one present to explain the DDS decision to the ALJ. The ALJ must review the claim file without benefit of talking to the decision maker or the DDS who can explain the basis for the decision. NADE believes it would be beneficial to have the DDS represented at the ALJ level.

Likewise, NADE believes there should be equal quality review for decisions made at all levels in the adjudicative process. Currently, 50% of DDS initial and reconsideration allowance decisions are subject to quality reviews by the federal reviewing component (DQBs). There are limited quality reviews for denial and CDR decisions and even fewer quality reviews of decisions made by Disability Hearing Officers and Administrative Law Judges. For the DDS examiners, because of the higher likelihood of initial allowance claims to be reviewed for quality assurance, there is a tendency to better document and rationalize allowance claims. An ALJ decision is typically only reviewed and questioned if there is an appeal of a denial decision. Consequently, it is more often found that ALJ denial decisions have more detailed rationales than allowance decisions. NADE believes it is critical for consistency of decision-making that more of the decisions made by DHOs and ALJs are subject to some type of quality review that will provide feedback to the decision maker.

**Impact of Reductions in Workforce**

In recent years, Congress has significantly reduced the budget for most federal agencies. SSA was not immune to these cutbacks, but the impact may have been particularly acute for SSA because the budget reductions coincided with heavy attrition due to massive retirements. The DDSs experienced attrition rates as high as 15% annually prior to the downturn in the economy and 10% after the downturn.

With a high attrition rate and hiring freezes, many states have experienced significant challenges in maintaining sufficient staff to process their workload. Unfortunately, the reduction in workforce coincided with an increase in initial claim filings of 15% annually following the economic downturn. SSA and the DDSs prioritized the initial claim workload and delayed the processing of CDRs until a time when adequate staff and resources were available. This delay in processing CDRs resulted in 1.3 million CDRs with overdue diaries.

SSA is attempting to correct this problem with the new budget funds. DDSs have been authorized to hire 2600 new personnel. New staff will help fill many of the positions in the DDSs that have been vacant, but it is necessary to stress that these 2600 new hires will not replace all vacant positions. In addition, while the new hiring authorization is welcome in the DDS community, obtaining clearance from state governments and other required personnel actions will make it challenging, if not impossible, for all new hires to be in place before the end of the fiscal year. In effect, some DDSs will not be able to hire for all positions they are authorized to hire for, as they will not be able to act as quickly as needed to fill all positions before funding authorization expires.

NADE wants to point out that SSA has done an excellent job sending age 18 redeterminations to the DDSs in a timely manner. There is a much higher likelihood of benefits ceasing with an age 18 redetermination since MIRS is not used. While the redeterminations were prioritized to be sent for review, other types of CDRs have been significantly delayed. Many childhood disabilities can improve during the developmental years or with appropriate intervention. There is a higher likelihood to find medical improvement in a childhood claim as opposed to adult CDRs. Many childhood CDRs continue to be sent to the DDSs years past their scheduled diary date. The delays in reviewing a childhood CDR may mean benefits are ceased much later than necessary.

Having well trained, experienced staff with a manageable workload is the best way to prevent incorrect decisions. NADE believes that additional training of new examiners, as well as experienced staff, should be a priority. In recent years, many DDSs elected to reduce the training opportunities available for their limited staff to allow their personnel to devote as much time as possible to the processing of disability claims. With recent approval to hire a large number of employees at the DDSs, some states may provide inadequate training for these new hires to learn the basics of this complicated program. There should be increased efforts to provide training opportunities for all staff as policies change, may be misinterpreted or forgotten. NADE reminds Members of this Committee that the Inspector General has commented on numerous occasions that SSA's best defense against fraud is the well-trained disability examiner. NADE would add the caveat that the well-trained disability examiner must also have a manageable caseload. The Inspector General has previously pointed out that the majority of fraud in the disability program, to date, has been detected by the front line disability examiner in the DDS.

While inadequate staffing levels plague nearly every DDS, some states continue to assign every new claim receipted into the agency to a disability examiner. Other DDSs "stage" new case receipts. The impact of the former practice is that disability examiners are often overwhelmed by the number of claims they have pending at any given time, while the latter practice can result in delays in processing new claims. Work pressures for disability examiners to produce a high number of decisions can create opportunities for mistakes that can be critical in making the correct determination or making judgment that are not fully supported by the evidence. The impact of a high caseload may affect the quality at the initial, reconsideration and CDR level. If an examiner misses details or does not take the time to take additional steps to clarify

an issue, an initial claim may be inappropriately allowed or denied. In the case of an allowance, the claim will likely become a continuance on CDR because MIRS will preclude the DDS from ceasing benefits. CDR workload pressures may affect the thoroughness of review of the CPD evidence. If there is an oversight in the review of CPD evidence, an incorrect determination that a medical condition has not improved may be made. Remember, there is a higher burden of proof for processing CDR claims and the disability examiner must show significant medical improvement has occurred. Because of this, more documentation and rationalization may be needed to prove a cessation is appropriate. When a disability examiner with a high caseload is processing a CDR, the extra effort needed for a cessation may be replaced by the need to spend the available time processing other CDR claims.

**Lost Folders**

Initial and reconsideration claims completed in the past six to eight years are usually in an electronic format. When the CPD claim file is electronic, the evidence is readily available for review on CDR. Older decisions are likely to be paper cases. If the CPD paper folder is lost, the CDR decision is likely to be a continuance. For a lost folder, the examiner starts by developing the beneficiary's condition to see if they are a current allowance. If the claimant cannot be found disabled currently, then the disability examiner must attempt to recreate the CPD file. This is often a challenging and time-consuming process as it can be difficult to obtain older records. Many medical records are destroyed after seven years. The disability examiner must often rely upon the memory of the beneficiary to provide information about their condition and treatment at the last decision. The beneficiary has no incentive to provide this information. If the CPD claim file cannot be reconstructed, then the DDS must process a continuance decision (POMS DI 28035.001ff). It is rare when a lost folder can be reconstructed fully and the DDS can make a decision that significant medical improvement has occurred. Due to the difficulty and time that it takes to reconstruct a file and the fact that a continuance is usually the result, some examiners will not put forth the effort to attempt the reconstruction, instead utilizing their time to process other claims.

Lost folder decisions are a small percentage of CDRs. However, this still results in great cost to the trust fund. DDS examiners are expected to assign a specific list code for CDR claims that involve a lost CPD claim folder. Unfortunately, not every DDS personnel ensure this list code is properly used. Consequently, there are likely more lost folder continuance decisions than SSA is aware.

The policy regarding exceptions to MIRS does not apply with a lost folder. This becomes difficult in a case where there is clear fraud or similar fault found only at CDR, and not at CPD. If the DDS and CDIU are unable to reconstruct the CPD file, then the claim is treated as a lost folder and benefits would continue, regardless of the current finding of fraud or similar fault. This is very concerning because the current CDR decision will be the CPD for the next CDR, since the CDR evaluates only if medical improvement from the last decision can be established. To cease benefits at a future CDR in these types of claims, medical improvement would need to be established from the current decision where fraud or similar fault was found.

There are multiple reasons for lost folders. For example, there was a flood at one storage facility, which destroyed some folders. Since the majority of claims are now processed electronically, the business process for handling paper folders may be forgotten or overlooked. Because of this, folders may not be appropriately documented when transferred to the appropriate storage facility.

As mentioned above, the transition to electronic files significantly reduced the number of lost folders for subsequent CDRs. Even so, there are still system limitations that require a claim to be processed as a paper file. SSA has been reluctant to scan in paper files due to cost. It may be worth studying the possibility of scanning in prior allowances that are scheduled to be reviewed for CDR prior to retirement. Additionally, there may be benefit to reviewing the business processes for handling paper claims.

**Impact of Lack of Current Treatment**

When there is a lack of current medical evidence from a qualified treating source in CDR claims, the DDS must purchase a consultative examination (CE). This "one-shot" exam, for better or worse, becomes the primary evidence used by the DDS in making a decision on the CDR. That decision can be based on how well, or how poorly, the claimant was feeling on the day of their CE. This scenario can lead to an incorrect decision. For conditions that rely upon more subjective information, longitudinal evidence increases the likelihood of making the appropriate decision. Many beneficiaries do not have current or ongoing medical treatment for the impairment for which they were allowed. The majority of disability beneficiaries have access to medical care, although many do not take advantage of this access. Some beneficiaries only seek treatment when they receive notice of the CDR. This behavior may lead a disability examiner to question the motivation for seeking medical treatment only when their benefits are up for review. NADE continues to advocate for the removal of the two-year waiting period for Medicare. This would allow all disability beneficiaries to have access to treatment. NADE would also recommend a study regarding the possibility of requiring treatment for certain conditions that may improve.

**Summary**

The current CDR backlog of 1.3 million is the result of an agency with inadequate staff and resources to address all needs. SSA and DDSs had a high attrition rate and were not able to replace all staff. The decreased workforce combined with an increase in initial claim filings, resulted in the prioritization of initial claims. SSA has announced its intention of addressing the backlog by increasing the number of CDRs sent to the DDSs for processing in the next few years. Additional personnel and funding will be needed from Congress if this effort is to be successful and sustained.

Due to the MIRS policy, few claims are actually ceased at CDR. An examiner is not able to fix a seeming "mistake" in a previous decision with this policy if there is no clear, objective error. Distinctions must be made between objective errors versus subjective conclusions in considering the error exception. They are called "exceptions" for a reason and their utilization

in the DDSs will be infrequent as they are appropriate for a small percentage of claims. Additional training and emphasis on this policy may improve its utilization but the exceptions will not save the trust fund. There will not be a dramatic increase in the rate of cessations through the proper use of the exceptions rule. Perhaps it is time to explore options to MIRS.

New hires in the DDS are welcome but it takes an average of two to four years for a disability examiner to become proficient at their job. It is critical that SSA and the DDSs be allowed to replace personnel lost to attrition. An increase in training opportunities to ensure the success of new personnel, as well as the continued success of current staff, is necessary.

Even though claims are processed electronically now, on CDR there are many claims where the CPD was a paper file. Lost folders continue to be a problem.

CDIUs are an effective tool in the campaign against fraud or similar fault in the disability program. CDIUs have been shown to be very cost effective with savings of $16 for every $1 spent.

Training at all levels of adjudication is important to ensure that the decision maker is current on program policies.

**Recommendations**

- NADE supports the continued expansion of CDIU.
- Revisions to the fraud or similar fault policy are needed.
- Revision of the MIRS process for CDRs should be considered. NADE would support a de novo review on CDR.
- Additional training and clarification on the exceptions to MIRS policy would be beneficial.
- Quality review at all levels of adjudication is needed.
- Electronic claim exceptions should be eliminated to prevent any future claims being processed in paper format.
- Improved documentation of the location of paper files is needed to prevent additional lost folders.
- The lost folder policy should not apply to cases of fraud or similar fault.

- Eliminating the two-year waiting period for Medicare, to allow increased access to medical coverage.
- There should be consideration of the possibility of requiring treatment for conditions that may improve.

- Continued training opportunities are needed at all levels of adjudication, with an emphasis on policy.
- Appropriate funding for staffing is needed to ensure there are well-trained, experienced examiners with manageable caseloads.
- To ensure policy compliance, the DDS should be represented at the ALJ review.

SSA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted for a continuous period of not less than 12 months. To be found disabled, the individual must prove that they meet the strict definition of disability; however at CDR, the definition is removed. When completing CDR claims, MIRS is used to determine if beneficiaries still meet the requirements for disability. The change in definitions from the initial to CDR level is important because a decision can rarely be "fixed" at the CDR level. However, if a "mistake" does occur and a decision is not clearly an error, MIRS precludes the DDS from correcting the "mistake" at CDR. Consequently, many beneficiaries who no longer meet SSA's definition of disability are continued at the CDR level. Perhaps it is time to reconsider the options.
NADE appreciates this opportunity to present our views on the effectiveness of SSA's current process to medically review beneficiaries to determine if they should continue to receive federal disability benefits.

Mr. LANKFORD. Thank you.
Ms. LaCanfora.

**STATEMENT OF MARIANNA LACANFORA**

Ms. LACANFORA. Chairman Lankford, Ranking Member Speier, members of the subcommittee, thank you for this opportunity to continue the conversation on Social Security's disability programs. My name is Marianna LaCanfora and I am the agency's Acting Deputy Commissioner for Retirement and Disability Policy.

Today, my testimony focuses on medical continuing disability reviews, or CDRs. These program integrity reviews, which cover both the Disability Insurance and Supplemental Security Income disability programs ensure that only those beneficiaries who remain disabled continue to receive benefits. While CDRs are essential, it bears acknowledging that they are only one of many critical workloads that millions of Americans depend on us to complete each year. Absent sufficient funding, we must make difficult tradeoffs as we balance our service and stewardship responsibilities.

I would like to highlight a few important points regarding our CDRs. First, we have proven that our CDRs are an excellent investment and, when we receive adequate resources, we deliver. For example, we received a seven year commitment of special funding from Congress in fiscal year 1996 so that we could eliminate our backlog of CDRs. By the time the funding had expired, in 2002, we had eliminated the backlog and saved about $36 billion in taxpayer money.

The second point I would like to make about our CDRs is that we strictly adhere to legal requirements and we consistently achieve high quality. Our adherence to the medical improvement review standard perhaps best illustrates this point. Congress enacted the medical improvement review standard in 1984 to address widespread concern that disability adjudicators were substituting their judgment to overturn the judgment of a prior adjudicator.

In 1984, the law remedied this by generally requiring that we terminate benefits only if a beneficiary's condition medically improves and that improvement is related to the ability to work. This standard has remained unchanged for 30 years. We continuously train our adjudicators on its correct application and our quality review of CDRs shows a high rate of decisional accuracy, 97.2 percent last year.

My third point is that absent adequate funding, we are forced to make difficult tradeoffs and prioritize CDRs. We focus our limited funding on the CDRs most likely to produce the highest return on investment or the highest amount of taxpayer savings. Our highest priority CDRs are age 18 re-determinations and low birth weight baby cases because they are statutorily required. We prioritize other CDRs using a statistical model that gathers data from our records to identify a high likelihood of medical improvement and a high return on investment. We complete of these cases as our funding permits.

We began using our model in 1993 and we have been continuously validating and updating it in collaboration with the best outside experts. The model allows us to conduct some CDRs in an ex-

pedited manner, without the need for expensive medical development when the likelihood of cessation is remote.

Despite our efforts to keep pace with the CDR workload, chronic under-funding has led to a backlog of 1.3 million cases. We did not receive the full funding for CDRs authorized by the Budget Control Act in each of the last two years, but I am pleased to say we did receive the full amount this year, and thank you to the committee. With the additional funding, we plan to complete 510 full medical CDRs this year, and we will also hire and train more employees. The President's budget for fiscal year 2015 also requests the full BCA level for Social Security. With this funding we plan to complete 888,000 full medical CDRs.

Starting in fiscal year 2016, the President's budget proposes a dedicated dependable source of mandatory funding for our agency to conduct CDRs. The mandatory funding will enable us to eliminate the CDR backlog. We need your support of the President's budget to ensure that only those beneficiaries who remain disabled continue to receive benefits. Timely, sustained, and adequate funding is the single most important way to eliminate the CDR backlog.

Thank you, and I am happy to answer any questions you may have.

[Prepared statement of Ms. LaCanfora follows:]

**COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM**

**SUBCOMMITTEE ON ENERGY POLICY, HEALTHCARE AND ENTITLEMENTS**

**UNITED STATES HOUSE OF REPRESENTATIVES**

**APRIL 9, 2014**

**STATEMENT FOR THE RECORD**

**MARIANNA LACANFORA**
**ACTING DEPUTY COMMISSIONER**
**OFFICE OF RETIREMENT AND DISABILITY POLICY**
**SOCIAL SECURITY ADMINISTRATION**

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

Thank you for this opportunity to continue the conversation from last November's hearing and the follow-up discussion in December on the disability programs we administer at the Social Security Administration (SSA). We share your commitment to effective oversight of Federal benefit programs, so that they remain strong for those who need them.

The responsibilities with which we have been entrusted are immense in scope. To illustrate, in fiscal year (FY) 2013 we performed the following for Social Security and Supplemental Security Income (SSI) beneficiaries:

- Paid over $850 billion to more than 62 million beneficiaries, of whom about 15 million received approximately $175 billion in benefits under our disability programs (About 3 million of our beneficiaries receive benefits under more than one program);
- Handled over 53 million transactions on our National 800 Number Network;
- Received over 68 million calls to field offices nationwide;
- Served more than 43 million visitors in over 1,200 field offices nationwide;
- Completed nearly 8 million claims for benefits and nearly 794,000 hearing dispositions; and
- Completed 429,000 full medical continuing disability reviews (CDR).

Today, my testimony focuses on medical CDRs and age 18 redeterminations. We conduct medical CDRs and age 18 redeterminations to ensure that only those beneficiaries who remain disabled continue to receive monthly benefits.

I begin with a very brief overview of our disability programs and the legislative history of CDRs and age 18 redeterminations. I'll then discuss where we stand today in conducting these critical program integrity reviews, including our plans for processing them under the President's FY 2015 Budget Request.

**The Disability Programs We Administer**

Under the Social Security Act (Act), we administer two major programs that provide cash benefits to persons with disabling physical and mental disorders: the Social Security Disability Insurance (SSDI) program and the SSI program.

The SSDI program provides benefits to disabled workers and their dependents. Workers become insured under the SSDI program based on contributions to the Social Security trust funds through taxes on their wages and self-employment income. Thus, SSDI benefits are commonly called "earned benefits." Under the Act, most SSDI beneficiaries are eligible for Medicare after being entitled to cash benefits for 24 months.

SSI is a Federal means-tested program funded by general tax revenues and designed to provide cash assistance to aged, blind, or disabled persons with little or no income or resources to meet their basic needs for food, clothing, and shelter. In addition to cash payments, most SSI beneficiaries are eligible for Medicaid health insurance coverage from the States.

**Definition of Disability**

For adults under both the SSDI and SSI disability programs, the Act generally defines disability as the inability to engage in any substantial gainful activity[1] due to a severe, medically determinable physical or mental impairment that has lasted or is expected to last for at least one year or to result in death.[2] This is a very strict definition of disability when compared to definitions in many commercially available long-term disability policies.

**Legislative History of CDRs and Age 18 Redeterminations**

When Congress created the SSDI program under the "Social Security Amendments of 1956,"[3] it included a mechanism for SSA to monitor a disability beneficiary's continued eligibility by adding section 225 to the Act.[4] This section authorized SSA to suspend the benefits and review the medical conditions of those beneficiaries believed by SSA to no longer have a disabling condition. Such reviews are generally conducted by examiners in the Federally-funded State Disability Determination Services (DDS), which also are responsible for making initial determinations of disability.

In its report accompanying the "Social Security Amendments of 1965,"[5] the House Committee on Ways and Means articulated its expectation that "procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical reexaminations obtained" so that benefits would be "promptly" terminated if a worker's disability ceased.[6]

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[1] Substantial gainful activity, or SGA, refers to the performance of significant physical or mental activities in work activity of a type generally performed for pay or profit. SGA is a test for determining initial eligibility for both the SSDI and SSI disability programs, as well as a test for determining continuing eligibility under SSDI. Generally, countable earnings averaging over $1,070 a month (in 2014) demonstrate the ability to perform SGA. For blind persons, countable earnings averaging over $1,800 a month (in 2014) demonstrate SGA for SSDI. These amounts, however, are subject to modifications and exceptions based on very complex statutory incentives designed to encourage work.

[2] We also have an SSI disability program for children under age 18. To qualify for SSI benefits based on a disability, a child must have a physical or mental condition that results in marked and severe functional limitations. This condition must have lasted, or be expected to last, at least one year or result in death.

[3] P.L. 84-880.

[4] U.S. Senate. Committee on Finance. "Staff Data and Materials Related to the Social Security Disability Insurance Program." (S. Prt. 97-16). Washington: Government Printing Office, 1982, at 48.

[5] P.L. 89-97.

[6] U.S. House. Committee on Ways and Means. "Report on H.R. 6675." (H. Rpt. 89-213). Washington: Government

Under SSA policy from 1969 until 1976, medical improvement had to be shown before an adjudicator could cease a beneficiary's benefits.[7] According to a 1975 House Subcommittee on Social Security staff survey, almost all DDSs cited this requirement as a problem; they believed it allowed some beneficiaries to continue receiving disability benefits they should not have received in the first place.[8] In July 1976, SSA eliminated this requirement; instead, an adjudicator could treat the case as if it were an initial decision.[9]

By 1978, SSA's monitoring activities had significantly dropped due to an increase in the size and complexity of its other workloads. The number of CDRs per 1,000 beneficiaries fell from approximately 111.8 in 1970 to a low of 29 in 1978.[10] Consequently, there were fewer disability cessations. These circumstances raised congressional concerns that SSA was not properly monitoring the ongoing medical condition of its disability beneficiaries.

To address this problem, the "Social Security Disability Amendments of 1980" added section 221(i) to the Act.[11] This provision required SSA to review the cases of SSDI beneficiaries with nonpermanent disabilities at least once every three years, and those with permanent disabilities at less frequent intervals to be determined by SSA. Although the law required these reviews to begin in January 1982, SSA began the periodic review process in March 1981. From FYs 1981 to 1983, SSA—mainly through the DDSs—conducted nearly 1.3 million CDRs.[12]

Shortly thereafter, media reports began to surface of people dying after their SSDI and SSI benefits had been discontinued. There was also great concern about the large number of disabled beneficiaries whose benefits had been terminated due to CDRs.[13] In 1983, governors or Federal courts ordered 18 DDSs to provide evidence of medical improvement before terminating disability benefits. Eight more governors ordered DDSs to discontinue processing benefit terminations. As the year progressed, this situation worsened and, on December 7, 1983, SSA

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Printing Office, 1965, at 89.

[7] U.S. House. Committee on Ways and Means. "Report to Accompany H.R. 3755." (H. Rpt. 98-618). Washington: Government Printing Office, 1984, at 9.

[8] U.S. House. Committee on Ways and Means. "Status of the Disability Insurance Program." (H. Prt. 97-3). Washington: Government Printing Office, 1981, at 10-11.

[9] Ibid.

[10] U.S. Senate. Committee on Finance. "Staff Data and Materials Related to the Social Security Disability Insurance Program." (S. Prt. 97-16). Washington: Government Printing Office, 1982, at 49.

[11] P.L. 96-265, section 311.

[12] "Timeline History of Continuing Disability Reviews," SSA/Office of Disability and Income Security Programs Archival Document, circa 1995.

[13] For example, see Engel, Margaret. "Eligible Recipients Losing Out; U.S. Gets Tough With Disabled." *The Washington Post* 7 Sept. 1982: A1. Print.

advised all DDSs to temporarily stop processing benefit terminations. As a result of this moratorium, a backlog of pending CDRs began to develop.[14]

Concerned about the erosion of public confidence in the disability program, Congress passed the "Social Security Disability Benefits Reform Act of 1984."[15] Section 2 of this law amended sections 223(f) and 1614(a) of the Act by establishing a Medical Improvement Review Standard (MIRS) for CDR cases.[16] SSA issued final MIRS regulations on December 6, 1985. These regulations define "medical improvement" as any decrease in the medical severity of the beneficiary's impairment(s), which was present at the time of the most recent favorable medical decision that he or she was disabled or continued to be disabled. In addition, the statute and SSA's rules generally require that, even if the beneficiary's condition has medically improved, the improvement must be related to his or her ability to work before benefits may be terminated. CDRs were resumed at a diminished pace in 1986.

By the early 1990s, Congress was again taking notice of the CDR backlog and the difficulty the agency was having with balancing initial claims processing and program integrity reviews in an environment of increased workload pressures.[17] In response to these concerns, Congress passed several laws aimed at increasing the number of CDRs SSA conducted.

First, the "Social Security Independence and Program Improvements Act of 1994" directed SSA to conduct CDRs on at least 100,000 SSI recipients during each of FYs 1996, 1997, and 1998.[18] It also required SSA to redetermine the eligibility of at least one-third of all childhood SSI recipients who reached age 18 during FYs 1996-1998 within one year after they turned 18.[19]

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[14] U.S. General Accounting Office. "Social Security Disability: Implementation of the Medical Improvement Review Standard." December 1986, at 8.

[15] U.S. House. Committee on Ways and Means. "Report to Accompany H.R. 3755." (H. Rpt. 98-618). Washington: Government Printing Office, 1984, at 2.

[16] P.L. 98-460, section 2.

[17] For example, see the written statement of Jane L. Ross, Associate Director, Income Security Issues, Human Resources Division, General Accounting Office, submitted to the House Committee on Ways and Means Subcommittee on Social Security, March 25, 1993.

[18] P.L. 103-296, section 208.

[19] P.L. 103-296, section 207.

The "Contract with America Advancement Act of 1996" followed and included a provision authorizing the appropriation of special funds to be used exclusively to conduct additional CDRs over a seven-year period.[20] That same year, "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996," required SSA to:

- Conduct CDRs at least once every 3 years for SSI disability recipients under age 18 whose conditions were likely to improve;
- Redetermine the eligibility of an SSI recipient using the adult criteria for initial eligibility during the one-year period beginning on the individual's 18th birthday; and
- Conduct CDRs no later than 12 months after birth for recipients whose low birth weight is a contributing factor material to the agency's finding of disability.[21]

The "Balanced Budget Act of 1997" fine-tuned these changes. It permitted SSA to schedule CDRs for low birth-weight babies at a date after the first birthday if the agency determined the impairment is not expected to improve within 12 months of the child's birth. It also allowed SSA to make redeterminations of disabled childhood recipients who attain age 18, using the adult eligibility criteria for initial claims, either during the one-year period beginning on the individual's 18th birthday, or in lieu of a CDR, whenever SSA determines that an individual's case is subject to such a redetermination.[22]

The "Ticket to Work and Work Incentives Improvement Act of 1999" included several modifications to the CDR process. Among them, it prohibited the initiation of a CDR for disability beneficiaries who were participating in the Ticket to Work and Self-Sufficiency Program.[23]

Most recently, the "Budget Control Act of 2011" (BCA) authorized additional funding over a 10-year period so that the agency could essentially eliminate the backlog of CDRs, as well as increase the volume of SSI non-medical redeterminations.[24] As the chart (below) shows, the current backlog of CDRs developed due to lower volumes of CDR processing over most of the last decade, which occurred because of budgetary shortfalls.

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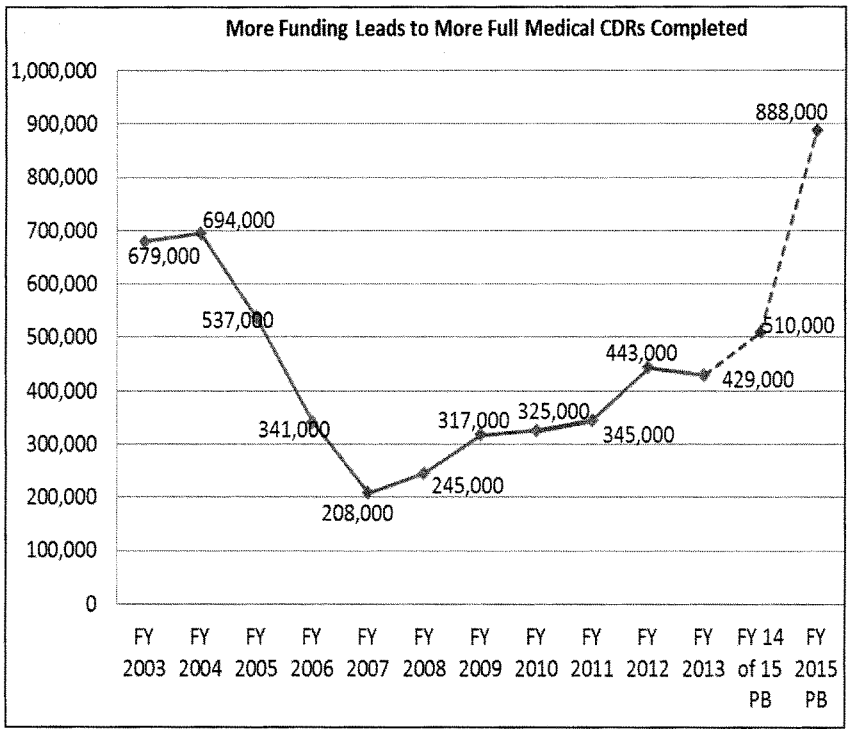
[20] P.L. 104-121, section 103.

[21] P.L. 104-193, section 212.

[22] P.L. 105-33, section 5522.

[23] P.L. 106-170, section 101. In addition, under section 111, it prohibited scheduling a CDR based on work activity for disability beneficiaries who received at least 24 months of benefits, or using the work activity of those beneficiaries as evidence that the individual is no longer disabled. These individuals would still be subject to a regularly scheduled CDR that is not triggered by work and termination of benefits if the individuals' earnings exceeded the SGA level.

[24] P.L. 112-25, section 101.




Regrettably, Congress did not fully fund the additional program integrity spending it authorized for appropriation during the first two years of the BCA's 10-year period. For FY 2014, it did fully fund the additional resources it had authorized.

**The CDR Process and How We Ensure Quality**

As mentioned earlier, we periodically conduct medical CDRs to evaluate whether SSDI and SSI beneficiaries continue to meet the medical criteria for disability. We also conduct medical CDRs when we receive a report of medical improvement from a beneficiary or third party.

We complete medical CDRs in two ways, which together ensure that we are targeting our resources to the most problematic areas in the most cost-effective way. To ensure that we are focusing our efforts on the cases with the highest likelihood of medical improvement, we employ a statistical modeling system that uses data from our records to determine the likelihood that a disabled beneficiary has improved medically. We began using models to focus our efforts in 1993 and have been continuously reviewing, validating, and updating them in collaboration with

the best outside experts in this field. If the statistical modeling system indicates that the beneficiary has a higher likelihood of medical improvement, we send the case to the State DDS for a full medical review.[25]

The remaining beneficiaries who are due for review but have a lower likelihood of medical improvement receive a questionnaire requesting updates on their impairments, medical treatment, and work activities. If the completed mailer indicates that there has been potential medical improvement, we send the case to the DDS for a full medical review. Otherwise, we reschedule the case for a future review.[26] Since 1996, we estimate that, on average, medical CDRs yield at least $10 in net Federal lifetime program savings per dollar spent, including savings accruing to Medicare and Medicaid.

As history has shown, we produce results when we receive adequate funding for CDRs. For example, by the time the seven-year commitment of special funding we received in FY 1996 expired at the end of FY 2002, we had completed approximately 9.4 million CDRs (including 4.7 million full medical reviews) and were current on all CDRs that were due. For all the medical CDRs completed during the period of FYs 1996 through 2002, we spent roughly $3.4 billion, with an estimated associated lifetime savings from this activity of approximately $36 billion.

We go to great lengths to ensure that CDRs are done right and that their outcomes flow from consistent application of policy. We require all of the DDSs to have an internal quality assurance (QA) function. In addition, we conduct QA reviews of DDS CDR determinations. These reviews show that the DDSs have maintained a high CDR decisional accuracy rate—approximately 97.2 percent in FY 2013.[27]

In addition to our QA reviews of CDRs, the Act requires that we review at least 50 percent of all DDS initial and reconsideration allowances for SSDI and SSI disability for adults. These pre-effectuation reviews allow us to correct errors we find before we issue a final decision. The reviews of allowances and continuances done in FY 2011 resulted in an estimated $751 million in lifetime net Federal program savings, including savings accruing to Medicare and Medicaid. Based on our estimates for the reviews done in FY 2011, the return on investment is an average of roughly $13 in net Federal savings per $1 of the total cost of the reviews.[28]

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[25] Once we determine which CDRs are eligible for full medical reviews, we prioritize statutorily mandated reviews for release, which include age 18 redeterminations and low birth-weight baby cases.

[26] Each year, we validate the mailer process by performing full medical reviews of cases in which we otherwise would have used the mailer process to ensure that the mailer process is properly identifying individuals who continue to be disabled. These cases and the hundreds of thousands of other similar cases we reviewed in prior years confirm that the mailer process is a sound, efficient way to conduct CDRs for most individuals.

[27] The percent is based upon a statistically valid sample of case reviews. It reflects the percent of cases reviewed where we agree with the decision made by the DDS.

[28] Details can be found in the "Annual Report on Social Security Pre-effectuation Reviews of Favorable State Disability Determinations" at http://ssa.gov/legislation/PER%20fy11.pdf.

**CDRs in the FY 2015 President's Budget**

Earlier, I touched upon Congress not appropriating the full program integrity amounts it authorized for us in the BCA in each of the first two years following enactment. For this reason, we were not able to increase our CDR levels during that period. This fiscal year, however, we will be able to expand our capacity to complete more of our cost-effective CDRs, because Congress appropriated the full BCA level. We plan to aggressively hire and train employees in FY 2014, allowing us to complete more CDRs and set the stage for handling even more in FY 2015.

In FY 2015, the President's Budget is once again requesting the full BCA level of program integrity funding for SSA, or $1.396 billion. With this funding, we plan to complete 888,000 full medical CDRs. For comparison, we completed 429,000 full medical CDRs in FY 2013, and we plan to complete 510,000 full medical CDRs in FY 2014.

Starting in FY 2016, the budget proposes to repeal the discretionary cap adjustments enacted in the "Balanced Budget and Emergency Deficit Control Act of 1985,"[29] as amended by the BCA, for SSA and instead provide a dedicated, dependable source of mandatory funding for SSA to conduct CDRs, as well as SSI non-medical redeterminations. The proposal includes the creation of a new account called Program Integrity Administrative Expenses, which will reflect mandatory funding for SSA's program integrity activities. The mandatory funding will enable us to work down a backlog of 1.3 million medical CDRs.

As a result of the discretionary funding in 2015 and the mandatory funding in 2016 through 2024, we will recoup a net savings of nearly $35 billion in the 10-year window and additional savings in the out-years.[30]

**Conclusion**

We need your support of the President's FY 2015 Budget Request for our agency to continue ensuring that only those beneficiaries who remain disabled continue to receive benefits. As history has shown, the provision (or availability) of timely, sustained, and adequate resources is the single most important way to ensure that backlogs do not develop in program integrity reviews. We welcome continued collaboration with the Subcommittee to identify new opportunities that may further strengthen our program integrity review process.

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[29] P.L. 99-177.

[30] Office of Management and Budget. "Analytical Perspectives, Budget of the United States Government, Fiscal Year 2015." Washington: Government Printing Office, 2014, at 119.

Mr. LANKFORD. Ms. Lockhart.

**STATEMENT OF JENNIFER SHAW LOCKHART**

Ms. LOCKHART. Thank you, Mr. Chairman and thank you, Ms. Speier. Thank you all for your time today.

On behalf of Sooner SUCCESS and every individual with disabilities, I am here today. I am here today to speak with you about the state of our existing system. I am here to tell you it does not work and I am here to tell you why.

You might ask what positions me to speak out so strongly about what I believe to be one the most undignified supports we have in our great Country. I have seen it firsthand and I have lived it. From the moment my family adopted four children with special needs over 30 years ago to the moment I stand here today, I have witnessed it up close and personal.

First let me tell you about Sooner SUCCESS. Sooner SUCCESS was piloted over 10 years ago by Dr. Mark Walraich. At the time, Dr. Walraich left Vanderbilt University for the University of Oklahoma to fill the chief of developmental behavior pediatrics Shaun Walters Endowed Chair, also known as the University of Oklahoma Child Study Center. Dr. Walraich, realizing the same struggles he found at Vanderbilt, developed Sooner SUCCESS.

Sooner SUCCESS was developed on a complex adaptive systems approach, CAS, allowing local coalitions to address their unique needs. We believe Sooner SUCCESS, exactly through this advancing and inclusive comprehensive unified system, does this. We do it within their community. Sooner SUCCESS embeds multiple levels of service delivery seamlessly so families can address both immediate and long-term goals and adaptive approaches.

Through this approach we are not only able to analyze the multiple systems, but educational, health, and social families struggle to navigate, but also mobilize the system as warranted within the community when needed through adaptive agents. This is where our local coalitions and county coordinators are tremendous assets. Change is inevitable, so we must organize the system in a way, adapting to change, but also educate providers, caregivers, self-advocates, and families and patients to understand an ever-evolving system instead of multiple independent, static structures or agencies.

Anecdotally speaking, we believe this model works. We see this observation in articles such as the recently published Newsweek article titled The Health Gap: The Worst Place in America for Mental Health, Child Poverty, and College Attendance Mapped. The article ranked counties in each State. Of the top 10 counties in Oklahoma, 5 are Sooner SUCCESS counties and part of the original program 10 years ago.

Last year alone, in 2013, Sooner SUCCESS made over 31,000 community linkages in our 13 pilot counties. Our 13 counties consist of Tulsa and Oklahoma City, Oklahoma's two most populated cities, and 11 rural communities. Within these demographics, we are able to serve close to half of Oklahoma's children with disabilities ages newborn to 21.

We often serve transitional years 18 to 24 as well. With that said, you could say we have a pulse on the grassroots level, the

view from the balcony, as to what our communities look like; each very different, with very unique needs. We are your eyes and ears on the ground. What does the view from the balcony look like? A victim of unintended consequences our system designed to assist individuals with disabilities is paralyzed by multiple levels of dysfunction.

For the sake of understanding why, we will understand Sooner SUCCESS. Sooner SUCCESS based on this system, is able to see—and I am going to skip through here because I want you to hear this. This is the problem: system complexity; weak ties and poor alignment among professionals and organizations; a lack of funding; incentives to support collaborative work; a bureaucratic environment based on command approach and control management.

Further, I quote from recent publication in the International Journal of Integrated Care: Lack of system change towards integration is that we have failed to treat the system as a complex adaptive system. The data suggests that future integration initiatives must be anchored in this perspective and focus on building the system's capacity to self-evolve. We conclude that integrating care for disabilities requires policies and management practices that promote system awareness, relationship building, and information sharing, and that recognized change as an evolving learning process rather than a series of programmatic steps.

What does this mean on the system level and what does it have to do with our issues here today?

Permission to continue further.

Mr. LANKFORD. I give you unanimous consent to do another minute.

Ms. LOCKHART. I am sorry?

Mr. LANKFORD. You want to close, then we will come back for questions, or do you need another minute?

Ms. LOCKHART. I need another minute, please.

Mr. LANKFORD. Go for it.

Ms. LOCKHART. Thank you, sir.

It means that unless the system fluid and adaptive, we leave it vulnerable. Those vulnerabilities expose themselves through certain outcomes, mostly gaps in service, system exploitation, duplicative services, and fragmentation or dissonance in services. Those vulnerabilities also tell us what often numbers cannot, what the system looks like from real-life application.

So in real world terms what does that look like? In the words of our Oklahoma County coordinator, proud Democrat and mother of a child with Downs Syndrome, I am tired of seeing those who need help unable to get it because people who don't need it are using the system. We see it every day.

From Donald Baily of South Carolina—I sent this to him; I wanted to be sure he was okay—I am testifying at a hearing next week in DC presenting testimony regarding disability reform. In my testimony, I hope to be discussing the higher Ed piece and referencing work with the College Transition Connection in South Carolina. Is this okay? Donald's reply—and I will tell you why this is important—good for you. Of course you can. Tell all. Thanks.

Donald is a former trustee with the University of South Carolina, father of a son with autism, founder of the South Carolina College

Transition Connection, a consortium of five universities in South Carolina providing higher Ed options for individuals with intellectual developmental disabilities. Donald and his wife, along with other parents, created the CTC because they wanted something more for his son than sitting at home after he aged out of the system.

I have chosen Donald and Lori, and could provide you with many more parent provider statements as to the barriers in the system. The bottom line is due to the many gaps we have created a pervasive problem in which we have left not only the system vulnerable, but the individuals we are to be helping. We see children with impairments labeled disabled. We see parents and adolescents remain underemployed so they may sustain their benefits. We see thousands on a wait list in Oklahoma who receive no service because they are waiting for assistance.

Aside from service gaps, we see something more concerning, deeply concerning. We see people with disabilities unknowingly segregated from their communities because the transition from the school support service stops often when the individual ages out of the system. Services stop; the sports system is gone instantly; and because transition services are programs rather than processes, we see individuals who should be out in their communities go from an active community life, that being their school, to nothing almost overnight.

In observation, we are able to see a gap where most young adults with disabilities should be transitioning into the community. Why weren't they in their community all along?

[Prepared statement of Ms. Lockhart follows:]

Wednesday, April 9th, 2014 – OGR Subcommittee hearing:
"Examining Ways the SSA Can Improve the Disability Review Process"
*Ms. Jennifer Lockhart, State Director, Sooner SUCCESS,*
*The University of Oklahoma Health Sciences Center*
Note: All times EST

On behalf of Sooner SUCCESS and every individual with disabilities I am here today. I am here today to speak with you about the state of our existing system. I am here to tell you it does not work. I am here to tell you why. You might ask what positions me to speak out so strongly about what I believe to be one of the most undignified supports we have in our great country. I have seen it first hand, I have lived it. From the moment my family adopted four children with special needs over 30 years ago to the moment I stand here today. I have witnessed it up close and personal.

First let me tell you about Sooner SUCCESS. Sooner SUCCESS was piloted over ten years ago by Dr. Mark Wolraich. At that time, Dr. Wolraich left Vanderbilt University for the University of Oklahoma, to fill the chief of developmental behavioral pediatrics Shaun Walters Endowed Chair, also known as the University of Oklahoma Child Study Center. Dr. Wolraich realizing the same struggles existed in Oklahoma for families he treated at Vanderbilt created Sooner SUCCESS. Sooner SUCCESS was developed on a complex adaptive systems (CAS) approach allowing local coalitions to address their unique needs. We believe Sooner SUCCESS does exactly this through advancing an inclusive comprehensive unified, system of health, social, and educational services for Oklahoma children with special healthcare needs or chronic illnesses within their community, Sooner SUCCESS embeds multiple levels of service delivery seamlessly so families can address both immediate and long term goals through an adaptive approach. Through this approach, we are not only able to analyze the multiple systems (educational, health, social) families struggle to navigate, but also, mobilize the system as warranted within the community when needed through adaptive change agents. This is where our local coalitions and county coordinators are tremendous assets. Change is inevitable, so we must organize the system in a way adapting to change but also educate providers, caregivers, self-advocates, and patients to understand an ever evolving system instead of multiple independent static structures or agencies. Anecdotally speaking we believe this model works. We see this in observation in articles such as the recently published Newsweek article titled The Health Gap: The Worst Place in America for Mental Health, Child Poverty and College Attendance Mapped: The article ranked counties in each state. Of the Top ten counties in Oklahoma five are Sooner SUCCESS Counties and part of the original pilot program ten years ago. Last year alone, in 2013 Sooner SUCCESS made over 31,537 community linkages in our 13 pilot counties. Our 13 counties consist of Tulsa and Oklahoma City, Oklahoma's two most populated cities and 11 rural communities. Within these demographics we are able to serve close to half of Oklahoma's children with disabilities ages newborn to 21. We often serve transitional years between 18-24 as well. With that said, you could say we have a pulse on the grass root level, the view from the balcony as to what our communities look like, each very different with very unique needs. We are your eyes and ears on the ground. What does the view from the balcony look like? A victim of unintended consequences our system designed to assist individuals with disabilities is paralyzed by multiple levels of dysfunction.

For the sake of understanding why, we will understand Sooner SUCCESS. Sooner SUCCESS based on CAS, a complex adaptive system model facilitates adaptation on the local level. Unlike typical service delivery programs, Sooner SUCCESS challenges the current system and integration process as well as the complex systems within which integrated care is enacted. In regard to disability services, integrated, comprehensive care has not developed widely nor as quickly as we hoped. We believe this is because integrated care is not a **program but a process**. Why is this important you might ask? Let me explain further. "...findings indicate that integration is challenged by:

- system complexity,
- weak ties and poor alignment among professionals and organizations
- a lack of funding incentives to support collaborative work
- a bureaucratic environment based on a command and control approach to management

Further, and I quote from a recent publication in the International Journal of Integrated Care "lack of systems change towards integration is that we have failed to treat...the system as complex-adaptive system. The data suggest that future integration initiatives must be anchored in a CAS perspective, and focus on building the system's capacity to self-organize. **We conclude that integrating care requires policies and management practices that promote system awareness, relationship-building and information-sharing, and that recognize change as an evolving learning process rather than a series of programmatic steps"**. What does this mean on the system level and what does it have to do with our issues here today? It means that unless the system is fluid and adaptive we leave it vulnerable. Those vulnerabilities expose themselves through certain outcomes, mostly gaps in service, system exploitation, duplicative services, and fragmentation or dissonance in services. Those vulnerabilities also tell us what often numbers cannot, what the system looks like from real life application. So in real world terms what does that look like?

**In the words of our Oklahoma County Coordinator, Lori Wathen proud democrat and mother of a child with Down syndrome**:

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**From Donald Baily of S.C.**

*"I am testifying at a hearing next week in DC presenting testimony regarding disability reform and Social Security. In my testimony I will be discussing the higher Ed piece and referencing your work with the CTC and the S.C. model. I just wanted to be sure this was OK?*

*Donald's reply: Good for you! Of course you can... tell all, thanks!*

**Donald is a former trustee with the University of South Carolina, father of a son with Autism, and founder of the South Carolina College Transition Connection, a consortium of five universities in S.C. providing Higher Ed options for individuals with intellectual/ developmental disabilities. Donald and his wife, along with other parents created the CTC**

**because they wanted something more for his son than sitting at home after he aged out of the system.**

I have chosen Donald and Lori and could provide you with many more parent and provider statements as to barriers in the system. The bottom line is due to the many gaps we have created a pervasive problem in which we have left not only the system vulnerable but the individuals we are to be helping. We see children with impairments labeled disabled, we see parents and adolescents remain under employed so they may sustain their benefits. We see thousands on a wait-list in Oklahoma who receive no services because they are "waiting" for "assistance". Aside from service gaps, we see something more concerning. Deeply concering. We see people with disabilities unknowing segregated from their communities because the transition from the school support service stops often when the individual ages out of the system. Services stop, the support system is gone instantly and because transition services are programs rather than processes we see individuals who should be out in their communities go from an active community life, that being their school, to nothing. Almost overnight. In observation we are able to see a gap where most young adults with disabilities should be transitioning into the community. Why weren't they in their community all along? Like you and me? People with disabilities deserve to be a part of our community, a natural part, not guests. And those programs while intended to be helpful...turn people away rather than towards each other. The "turning towards each other" ...is our instinctive way of facilitating integration one with another. When we impede this fundamental human transaction...we unknowingly stop the natural process of inclusion-to some extent. The family and the individual can become dependent on the services if they are not gradually removed over time preparing the person for more independent living. This is not an agency problem as much as it is a systems problem and reform is essential to change. Most agencies are merely trying to implement the parameters placed before them. However, this change includes better definitions of disabilities, understanding the differences between disability and impairment, and instigating a convergence between the two parallels of commerce, community and independent living with government support services. This will require fundamental change not only in how we perceive disability but how we support individuals, specifically children, with disabilities.

Lastly, as we move forward in the spirit of transformation understanding this is not a partisan issue. It is not a bi-partisan issue. It is a non-partisan issue, a civil rights issue, a human rights issue and lastly a dignity of life issue. It is our responsibility to prepare all individuals for independent living, to be productive contributing citizens of society. This is the root goal of education and individuals with disabilities deserve more than what we have in place now. Change will require efforts of both the public and private sectors working in tandem. Through a sound joint process we can create a system equally welcoming to all. In closing I want to share a quote with you from one of our Successforlife Foundation Trustees:

*Sooner Success is filling a significant need, to support Oklahoma Families secure the resources needed to access and achieve the American Dream, of enjoying a life that fulfills one's aspirations. Children with disabilities deserve the opportunity to grow up to be productive adults in society and secure gainful employment. Employers who recognize the value of all types of diversity in the workplace, will be the ones who enjoy a win/win experience, in*

*achieving their corporate goals. I am proud to be associated with the U.S. Chamber of Commerce, who recently stated that, "greater access and opportunity for individuals with disabilities, will also be beneficial to business."*

----Charles H. Van Rysselberge, President, CVR Consulting, LLC, in Charleston, SC (former President & CEO of the Oklahoma City and Charleston, SC Chambers of Commerce).

Former Greater Oklahoma City Chamber President Charles Van Rysselberge, one of the founding minds of Oklahoma City's Cinderella story. Charles returns to Oklahoma City after a decade of absence as a trustee of the SUCCESSforlife Foundation. Charles was recently honored by the National Chamber of Commerce Executives, with a lifetime membership award for his innovativeness and ingenuity essential to thriving communities. Through his work with the Atlanta Chamber, Oklahoma City Chamber and Charleston, SC Chamber, he has brought revitalization to systems and infrastructure, the life blood of communities. Charles understands the business of business. He also understands to attract businesses, you first must attract families. Charles teaches at the US Chamber-Institute for Organizational Management and is a graduate of the "Diversity Leadership Academy" sponsored by the Riley Institute at Furman University. A key focus of the Diversity Leadership Academy is to educate individuals on the value of diversity in the workplace...in solving workplace and corporate problems through the benefits of a diverse workforce.

STATE HEALTH POLICY

State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

This is the second in a series of Assuring Better Child Health and Development (ABCD) III issue briefs focusing on promising methods participating states are using to improve care coordination and linkages among providers of primary care and other community services for young children and their families. This brief describes the new web-based referral and tracking system that Oklahoma built into its pre-existing Preventive Service Reminder System (PSRS). The state designed this web portal to improve care coordination for children with or at risk for developmental delays. The web portal is being used in the state's four ABCD III pilot counties. The state is already considering ways to adapt the web portal to coordinate care for other populations.

The ABCD program is funded by The Commonwealth Fund, administered by NASHP, and designed to assist states in improving delivery of early child development services for low-income children and their families. The program assists states by strengthening primary health care services and systems that support the healthy development of young children. Since 2000, ABCD has helped 27 states create models of service delivery and financing through a laboratory for program development and innovation. The ABCD III Learning Collaborative began in October 2009. For more information about ABCD visit: http://nashp.org/abcd-history.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

# Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

FEBRUARY 2012

# Oklahoma's Web Portal: Fostering Care Coordination Between Primary Care and Community Service Providers

BY LARRY HINKLE AND CARRIE HANLON

Through the Assuring Better Child Health and Development Learning Collaborative (ABCD III) five states (Arkansas, Illinois, Minnesota, Oklahoma, and Oregon) are enhancing child development by improving care coordination and linkages among primary care providers (PCPs) and other providers of community services for young children and their families.[1] The ABCD III state initiatives began in 2009, and a number of early lessons have already emerged.[2]

A key feature of the Oklahoma ABCD III project is the adaptation of an existing statewide information system as the basis of a web-based mechanism ("web portal") for pediatric and community providers to make and track referrals for low-income children identified as at risk of developmental problems. The web portal is built into the state's pre-existing Preventive Services Reminder System. Currently, pediatricians, Early Intervention specialists and public health officials in four communities are testing the online system. The goal is to expand the use of the web portal to pediatric providers across the state as well as to explore its implementation to assist other populations served by Oklahoma's Medicaid program. The lessons from Oklahoma's ABCD experience in implementing a web portal outlined in this brief may inform the efforts of policymakers in other states as they strive to improve care coordination. They include:

- Provide clinic staff with the appropriate training needed to successfully operate a web portal upfront, along with ongoing technical assistance following implementation. Use hands-on practice facilitation to tailor and advance the implementation of technology in practices and referral sites.
- Develop information-sharing mechanisms that meet federal privacy protections.
- Partner with community stakeholders to ensure continued success.
- Collaborate/partner with a university.
- Look at existing web-based tools and infrastructure to see if they can be enhanced for care coordination.

## Introduction

Oklahoma's ABCD III project, Connecting the Docs: Improving Care Coordination and Delivery of Developmental Screening and Referral Services in Oklahoma, aims to advance systemic changes designed to improve outcomes for young children with and at risk for developmental delays. With the support of the state project team, four communities (Canadian, Garfield, Pottawatomie, and Tulsa counties) are piloting interventions to improve care coordination and communication of referral outcomes between primary care and community service providers. Each community has a core team representing primary care practices, Early Intervention agencies, local health departments, care coordinators, and family support (via the Oklahoma Family Network – a family-to-family health information center).[3] These county teams meet regularly to strengthen relationships and to work with state partners to identify community needs and fine-tune improvement strategies identified by the state team.

The project uses a multi-faceted "Facilitated Change" strategy to implement practice-based interventions. A key component of this strategy is two Practice Enhancement Assistants (PEAs or practice facilitators) who are based out of the University of Oklahoma Health Sciences Center. The PEAs support participating primary care practices as they implement the interventions conceived of by the state ABCD III team.[4] The PEAs help practices conduct Plan-Do-Study-Act (PDSA) cycles, which are four-step, rapid cycles designed to test and analyze the impact of improvements on a small scale. The PEAs also provide technical assistance to help practices use resources developed by the state team. The PEAs have been critical in both developing and nurturing the county teams during the pilot process. Foremost among the resources the PEAs have helped practices and community service providers implement is a web-based referral and tracking system or "web portal," which is meant to create: 1) an infrastructure to coordinate isolated

**Table 1 – Key Partners in Oklahoma**

| Partner | Agency and Description |
|---|---|
| Early Intervention | **SoonerStart** is Oklahoma's Early Intervention (EI) program. SoonerStart is a joint effort of multiple state agencies, however, the Department of Education is the Lead Agency for EI. |
| Care coordinators | **Sooner SUCCESS** provides care coordination for families, providers, and communities. Sooner SUCCESS sits in the Child Study Center Program at the University of Oklahoma Health Sciences Center. (See "University"). |
| Local health departments | Through the **Child Guidance** Program, local county health departments provide services to children and families including assessment, intervention, consultation, and education. The program is within the Oklahoma State Department of Health. |
| Family support | The **Oklahoma Family Network** (OFN) is a family-to-family health information center that provides peer support to parents of children with medical issues or disabilities. OFN also provides support groups for parents raising children with special needs or a disability. |
| Medicaid agency | The **Oklahoma Health Care Authority** houses the state's Medicaid program, which is known as SoonerCare. |
| University | The **University of Oklahoma Health Sciences Center (OUHSC)** provides technical support for the Preventive Services Reminder System. OUHSC also supports Practice facilitators (Practice Enhancement Assistants) who provide technical assistance to the ABCD III pilots. |

initiatives designed to ensure follow-up for referrals, linkages of subsystems, and monitoring of process and outcome measures; 2) a consistent single point of contact or service provision infrastructure across communities; and 3) a process to assure that families of children at risk for delay are connected with appropriate services.

### Web Portal Infrastructure

The "web portal" is the mechanism participating pediatric practices and community partners in pilot counties use to initiate, follow-up on, complete, and communicate information about referrals for early childhood services in Oklahoma. The Oklahoma ABCD III team developed the web portal by building it into the pre-existing Preventive Services Reminder System (PSRS). PSRS is an open-source academic system designed and maintained by the University of Oklahoma Health Sciences Center (OUHSC) Department of Family and Preventive Medicine. OUHSC designed PSRS to help primary care practices improve preventive and longitudinal care. Preventive care recommendations are based on U.S. Preventive Services Task Force (USPSTF) guidelines.

PSRS was originally designed for networked Palm® handheld devices. The device would remind primary care providers (PCPs) to ask patients about past preventive services and current risk factors. The system is now accessible via a web browser from any web-enabled device, and it contains a number of elements and tools for PCPs including: an immunization registry, a secondary preventive services registry, visit and patient-specific recommendations at the point-of-care, data exchange with the state immunization registry, and routine data collection for practice-based research.[5,6] The Agency for Healthcare Research and Quality (AHRQ) and the Medicaid agency (Oklahoma Health Care Authority) first funded the PSRS in 2002, and it has since been funded by a series of grants from the National Institutes of Health (NIH).[7] The PSRS started as a way to track immunizations, but as it developed further, the state decided to add the capability to track well-child visits since they fit so closely with vaccine periodicity.

As a part of the Oklahoma ABCD III project, OUHSC has developed and added a new component to the PSRS: a "Request for Early Childhood Services," also known among project participants as the "web portal."

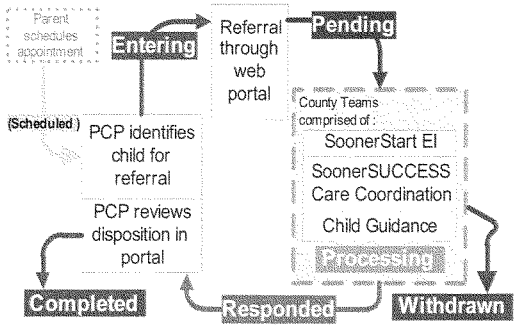
## How it Works: Oklahoma's Linkage Process

The web portal was designed specifically with the goal of improving care coordination for children with, or at risk for, developmental delays.[8] The service linkage process in Oklahoma starts when the parent schedules an appointment for a child with a PCP. If the PCP is participating in the ABCD III pilot process and identifies a child with, or at risk for, developmental delays (for instance, concern about a motor delay), the PCP will enter a request for referral through the web portal. At this time the web portal shows the referral as **pending**. There are usually few pending requests in the web portal at a given time because referral agencies respond within 24-48 hours. This response time is due to statutory guidelines for Early Intervention that dictate that the agency must begin an initial response within two days.[9]

Once in the system, county-specific teams receive an email flag alert that a referral is pending. These county teams are composed of: Oklahoma's Early Intervention (EI) Program; Sooner SUCCESS care coordination program (a collaboration between the OUHSC Child Study Center and the Oklahoma Department of Human Services); and Child Guidance (within the Oklahoma State Department of Health)(see Table 1). The agency most appropriate to meet the child's needs triages the request for referral. Though the county teams had the option to choose which agency was the first to triage the request for referral, all four county teams – independently of each other – opted to have EI be the initial triage point.

When the appropriate agency receives and triages the request, the web portal lists the referral as **processing.** The appropriate agency then sends information around eligibility and what services the child will be receiving back to the PCP through the web portal, which then lists the request for referral as **responded** (for instance, undertaking an assessment that identifies motor delays that qualify the child for Early Intervention services, and a plan for physical therapy services to address the delay). At this point the PCP receives an email flag from the portal with a notification about the request for referral. The PCP then reviews the information sent back from the county team. Once the PCP indicates in the portal that s/he has reviewed the information, the referral process is **completed** (i.e., the primary care provider now has information in a medical record that indicates that the child is under the care of a physical therapist to address motor delays). The web portal does allow for a request to be **withdrawn** if the referral

**Figure 1. Oklahoma's linkage process**[10]




was entered in error (i.e., a duplicate entry). For a map of the care coordination process please refer to Figure 1.

## Implementing the Web Portal

The Oklahoma ABCD III team is aware that in order for the web portal to be sustainable, it must meet the needs of those it serves. To successfully implement the web portal, the ABCD III team has relied upon both clinic support and community collaboration. By implementing the web portal this way, the ABCD III team has been able to facilitate clinic adoption of the web portal while also remaining receptive to feedback from community partners.

### Clinic Support

The Practice Enhancement Assistants (PEAs) mentioned previously work closely with participating primary care practice clinicians and staff to integrate the web portal into their everyday routine. The PEAs also provide technical assistance for the web portal. The PEAs train clinic employees on the web portal functions and provide IT support for installing the security certificate/user names/passwords for the web portal. Once the web portal is running, the PEAs remain available to offer technical assistance on the issues detailed above. They initially visit each clinic once every two weeks and provide additional support via telephone and email as needed. The Oklahoma ABCD III team has found that once the initial implementation is complete and the web portal is in use, requests for support decline quickly, from one or two minor questions a week, to one or two minor questions a month. Oklahoma estimates that one PEA can manage approximately 150 practices after they are fully operational with the web portal.

### Community Collaboration

The Oklahoma ABCD III team has responded to feedback on the design of the portal since the beginning of the project. Counties and practices have significant latitude to determine how they will respond to requests within the web portal – there is no one formal method across the state. This flexibility is critical to the project's success, as each county team can use the web portal in a way that is tailored to its specific individual, personnel, workflow, and population needs.

The ABCD III team also acts on suggestions for modifications to the web portal to make it more useful to the county teams. Changes to the web portal made as a result of community feedback include:

- the ability to search both by county and by referral, which enables PCPs to limit the search only to those who they have referred;
- the addition of a feature where PCPs can "hover" over a patient's name with the mouse in order to see a quick snapshot of actions taken to date; and
- a secure messaging feature that allows direct communication between clinics and community teams.

The ABCD III team has also worked closely with its community partners to ensure that all participating team agencies or

organizations have access to the web portal. Since family support professionals are not medical providers, the ABCD III team is collaborating with state partners to provide the necessary privacy (i.e., HIPAA) training prior to granting Oklahoma Family Network (OFN) team members access to the web portal. To date, one OFN representative has received this training, and the team is in the process of training more. Simultaneously, the ABCD III team is fine-tuning consent forms to clarify which community partner organizations have access to the web portal.

By being open to feedback, the Oklahoma ABCD III team has made the web portal more useful and practical to practices and community teams, which helps ensure that it will be used beyond the duration of the project.

## Advantages of the Web Portal

The web portal seeks to minimize the time and effort needed to initiate, track, and follow-up on referrals. Prior to its development, PCPs in Oklahoma did not have a standard tool to make referrals for early childhood services and receive feedback on those referrals. The web portal now serves that purpose. The project team originally intended to create a paper-based fax-back form. With a paper form, the burden is on the PCP to write in the child's demographic information and identify the appropriate referral agency. In contrast, the web portal pre-populates most of this information for the PCP; it includes the demographic information for all children enrolled in the state's Medicaid primary care case management program (SoonerCare Choice).[11] An interagency agreement between the state Medicaid agency (Oklahoma Health Care Authority) and the University of Oklahoma Health Sciences Center facilitates this data sharing.

The university pre-populates the web portal with local county team information. Therefore the PCP does not need to identify the referral agency or a specific contact at an agency. The web portal automates this process. Further automating the process, the state is developing a dual HIPAA/ Family Education Rights and Privacy Act (FERPA) form for families to sign to ensure that a PCP with HIPAA approval can receive information about a child from Early Intervention.

Another advantage of the web portal is that it helps eliminate duplicate screening. PCPs are able to upload the results of developmental screening from the Ages and Stages Questionnaire (ASQ) and attach them to the referral in the web portal. They can also elect to document ASQ screening scores only, without attaching a scanned instrument. This expedites the referral process for families by clarifying when Early Intervention does not need to screen the child and can move straight into in-depth assessment.

Furthermore, the web portal and its associated email alerts enable pediatric practices to stay informed about follow-up services provided to patients by Early Intervention and community service providers. Without the web portal, pediatric providers might not know the results of a given referral, including whether the child was assessed, if the child qualified for services, and/or whether the child is receiving support services.

In addition to minimizing the burden on PCPs, the web portal also facilitates the state's ability to monitor and evaluate the model. The web portal indicates completed feedback loops (in which the PCP refers a child for services and receives information about the results of the referral) and provides the screening/referral documentation necessary for billing purposes.[12] The design allows the Oklahoma ABCD III team to electronically review web portal usage to measure trends in referrals and track the average length of time a referral stays in each stage of the process by participating county. This information helps the ABCD III team identify any bottlenecks in the system or areas where additional improvement may be needed to help close the feedback loop.

## Financing

The initial Preventive Services Reminder System was funded by a grant from the Agency for Healthcare Research and Quality (AHRQ) with additional support provided by the Oklahoma Medicaid agency, and began in 2002. Since 2004, however, the PSRS has been funded through a Career Development Award (K08), which was awarded to the developer by the National Institutes of Health. Since the child development piece of the PSRS and the web portal enhance the usefulness of the program, the K08 funds were able to be used to build the web portal into the Preventive Services Reminder System. ABCD III grant funds were used to support the pilots. The state is using ABCD III funds, as well as funds from a medical home contract, to fund the practice enhancement assistants. The activities of the web portal are closely aligned with medical home activities within the state.

## Results to Date

The ABCD III team has been tracking the use of the portal in each of the four pilot communities as it has been

implemented. As of September 2011, there were 177 requests for referral in the web portal. Of these 177 requests, 85 percent (150) resulted in feedback to the primary pediatric provider, which is considered substantially higher than standard practice. Of this 85 percent of referrals for which there was pediatric feedback reported, about 75 percent (112) of the referrals were officially completed by the agency and reviewed by the pediatrician; 25 percent (38) showed that the local agency had determined eligibility and/or services and were awaiting pediatric provider review in order for the referral to be declared "completed." An additional 12 percent (22) were processing, whereby the county team had received the referral from the pediatric practice and were undergoing the assessment to determine eligibility and services. The remaining referrals (about 3 percent of total requests) were either pending county team review (1) or withdrawn due to error (4).[13] The state ABCD III team has found that the information flow process to date has, thus far, been useful and exciting for the participating communities.

Data from a previous University of Oklahoma Health Sciences Center project ("Helping Family Physicians Screen and Identify Children At-Risk for Developmental Delays")[14], which was funded by the Association of University Centers on Disabilities (AUCD) and the Centers for Disease Control and Prevention (CDC), included 862 chart reviews in three clinics. The chart reviews showed wide variability in the practices' results, but overall, primary care providers identified 47 children as having or being at-risk for a developmental delay; they referred 14 of these children to Early Intervention, and they had information concerning the outcome of the referral for 8 of those 14 children. The aggregate result is documented feedback to primary care providers in 17 percent of charts (8 out of 47 children), which is much lower than the web portal data to date of 85 percent (150 out of 177 children).

## Statewide Implications for Care Coordination

Oklahoma's ABCD III team offered each of its pilot counties the option of using the web portal or the paper-based fax-back form. Some of the practices were hesitant to use the web portal at first; but after hearing positive feedback about the portal, all four pilot counties chose to implement it. Oklahoma has experienced declining state budgets and increased financial pressure in the wake of the recession. The notion of providing more efficient care coordination (i.e., simplifying referrals for PCPs, and eliminating duplication of efforts) makes it very attractive to the practices.

In an effort to sustain and spread the successes of ABCD III, the state is looking to capitalize on the popularity of the web portal within the pilot practices by sharing it with others outside of the ABCD III pilot who may find it helpful. The project team has found a lot of interest in the web portal within the state. A demonstration of the web portal within the state Medicaid agency (Oklahoma Health Care Authority) drew more than 60 personnel.[15] Many attendees saw the portal as having uses and implications beyond ABCD III. Beyond child development, agency staff sees the web portal as an opportunity to potentially improve care coordination and service linkages for mental health and substance abuse services, among other ideas.

The ABCD III team is exploring these other uses/implications to ensure the sustainability and spread of the project. One potential future use of the portal for sustainability may be incorporating its use into Oklahoma's medical home program, which provides enhanced payment to primary care practices that varies based on increasing levels of medical home capacity. In addition, the state Chapter of the American Academy of Pediatrics is exploring ways for the practicing physicians to earn Maintenance of Certification (MOC) credit if they learn the web portal system. Maintaining certification is required for pediatricians every ten years.[16]

## Lessons Learned

The Oklahoma ABCD III team has learned a number of lessons while developing and implementing the web portal.

- **Provide the appropriate training up front, along with ongoing technical assistance following implementation.** The PEAs devoted significant time to training individual practices at implementation. The training was tailored to each individual practice so that the web portal would best fit with that practice's workflow. The PEAs' demonstrations and assistance with implementation and IT issues helped address some initial concerns in some practices about using a new tool (the web portal) while they were implementing other technology, such as electronic medical records. The PEAs have remained involved post-implementation and provide continued technical assistance.

- **Develop information-sharing mechanisms that meet federal privacy protections.** Oklahoma developed security certificates to ensure only authorized persons have access to the portal. These certificates dictate which computers can access the portal. This greatly increases security and makes the portal a secure, HIPAA compliant, web-based framework. The state also developed a dual HIPAA/FERPA consent form to ensure that a PCP with HIPAA approval can receive information back from Early Intervention. With this form in place the state was able to add boxes to the web portal to indicate that HIPAA and FERPA consent are on file.

- **Partner with community stakeholders to ensure continued success.** The Oklahoma ABCD III team has been very accessible and receptive to the practices and county teams piloting the web portal and this has resulted in positive feedback. The state has listened closely to feedback from community partners on what would make the portal more useful and made revisions to meet their needs. Examples of these improvements include the addition of check boxes at the bottom of the response page to indicate whom among the four partners touched the referral during the process and the addition of gentle guidance cues in the web interface to prevent and educate about system mismanagement, yet are minimally intrusive to workflow.[17]

- **Collaborate with a university.** The Oklahoma Medicaid agency's partnership with the University of Oklahoma Health Sciences Center is extremely fruitful and has been fundamental to the development and success of the web portal. Based out of the university, the practice facilitators have been instrumental in the implementation and continued technical assistance of the project. The university benefits from this partnership by learning more about the dynamics of early childhood referrals that can be used in the future to design and study similar interventions that improve the quality of care. Additionally, work on the ABCD III project informs and enhances university researchers' past and current research on child development.

- **Look at existing tools to see if they can be enhanced for care coordination.** As mentioned earlier, the PSRS, developed with funding by AHRQ and the Medicaid agency, was already considered a useful and well-accepted tool among PCPs. The Oklahoma ABCD III team was able to build the web portal into this already existing system, simultaneously improving its functionality and supporting care coordination. Other states should look at existing resources upon which to build an electronic system to facilitate referral and follow-up among various providers. Immunization registries, for example, might provide a useful platform from which to begin to build a care coordination information system.

## Conclusion

Oklahoma's web portal has emerged as an effective tool to coordinate care and share information across multiple providers on referrals and follow-up services for young children within four communities. Furthermore, the web portal's popularity has ensured not only its success in all of the pilot counties, but has also garnered interest from other stakeholders as well. The Oklahoma ABCD III team plans to use this interest to support its sustainability and spread throughout the state. The state plans to provide continued support for the web portal to make it more valuable to practices. Additionally, the state plans to explore avenues for expanding the web portal to other populations with the knowledge that doing so will likely ensure not only the web portal's survival and spread beyond the project but also advances in care coordination more broadly.

## Endnotes

1 For more information about ABCD III please visit the National Academy for State Health Policy's (NASHP), "About ABCD III" page: http://nashp.org/abcd-history.

2 C. Hanlon and J. Rosenthal, *Improving Care Coordination and Service Linkages to Support Healthy Child Development: Early Lessons from a Five-State Consortium.* (Portland, ME: The National Academy for State Health Policy, June 2011). Available online: http://nashp.org/publication/improving-care-coordination-and-service-linkages.

3 For more information about the Oklahoma Family Network visit: http://www.oklahomafamilynetwork.org/.

4 Hanlon and Rosenthal, *Early Lessons*, pg. 19.

5 Z. Nagykaldi and J. Mold, "The Role of Health Information Technology in the Translation of Research into Practice: An Oklahoma Physicians Resource/Research Network (OKPRN) Study," *The Journal of the American Board of Family Medicine* 20 (2): 188-195 (2007), pg. 189. Available online: http://www.jabfm.org/cgi/content/full/20/2/188.

6 Oklahoma Physicians Resource/Research Network, "Preventive Services Reminder System (PSRS)." Accessed 8/31/11. Available online: http://www.okprn.org/psrs.html.

7 *Ibid*, pg. 33.

8 For a thorough explanation of the web portal and how it fits in the Preventive Services Reminder System please see the presentation by Zsolt Nagykaldi, Assistant Professor of Research and Clinical IT Specialist, at the University of Oklahoma Health Sciences Center, in *Tracking Linkages: A Closer Look at Data tools in Minnesota and Oklahoma*. Available here: http://www.nashp.org/webinars/abcd-eval-workgroup/lib/playback.html.

9 Oklahoma State Department of Education, "SoonerStart Early Intervention Policies and Procedures," *The Individuals with Disabilities Education Act (IDEA) Part C: Program for Early Intervention Services*, pg. 16. Available here: http://sde.state.ok.us/curriculum/speced/pdf/SoonerStart/Publications/EI_Manual.pdf.

10 Oklahoma ABCD III Team, "Connecting the Docs: July 2011 Project Update." Presentation, *ABCD III: Improving Care Coordination, Case Management, and Linkages to Support Healthy Child Development Summer Learning Collaborative Meeting*, from Burlington, VT, July 18, 2011.

11 If the child is not enrolled in SoonerCare Choice the PCP can still use the portal, but must enter that child's demographic information.

12 Oklahoma ABCD III Team, "Connecting the Docs: July 2011 Project Update." Presentation from Burlington, VT, July 18, 2011.

13 Oklahoma ABCD III Team, "Connecting the Docs: 7/1/11 – 9/30/11 and Annual Report Combined." *ABCD III Project Report*. Submitted by Oklahoma ABCD III team to NASHP in October, 2011.

14 Research Topic of Interest #: 2008-02-18. Visit: http://www.aucd.org/template/page.cfm?id=356 to view archive with project abstract.

15 Oklahoma ABCD III Team, "Connecting the Docs: July 2011 Project Update." Presentation from Burlington, VT, July 18, 2011.

16 Providers must reach MOC requirements to remain board certified by the American Board of Pediatrics (ABP); practices can conduct quality improvement projects that meet the standards set by the ABP in order to maintain certification. Oklahoma is also exploring the option of setting use of the web portal as a tool that could help PCPs achieve medical home recognition. For more information please visit: https://www.abp.org/ABPWebStatic/?anticache=0.37695307220874186#murl%3D%2FABPWebStatic%2Fmoc.html%26surl%3D%2Fabpwebsite%2Fmoc%2Faboutmoc%2Fmaintenanceofcertification%28moc%29four-partstructure.htm.

17 Oklahoma ABCD III Team, *ABCD III Progress Report*, October 2011.

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# An Innovative Oklahoma Program to Coordinate Interdisciplinary and Interagency Services for Children with Special Healthcare Needs at a County Level

Mark Wolraich, MD; Jennifer Lockhart, BS; Louis Worley, MS

**ABSTRACT**

Children and youth with special health care needs (CYSHCN) and their families often require multiple services from multiple providers in order to meet their needs. The Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs), was developed based on a complex adaptive systems approach allowing local coalitions to address their unique needs. Sooner SUCCESS provides support to families and service providers at the community level including a broad range of supports from simply helping a family identify and access a service that already exists to innovatively marshaling generic resources to meet a unique need. The program uses these family support activities coupled with the Community Needs Assessment to identify local service needs encouraging community capacity building by coordinating the efforts of the health, mental health, social and education systems to identify service gaps and develop community-based strategies to fill those gaps.

## INTRODUCTION

Children and youth with special health care needs (CYSHCN) and their families often require multiple services from multiple providers in order to meet their needs. Families find themselves continually negotiating a complicated network of federal, state, local and private service systems that are governed independently and allocated through different sets of eligibility standards. Oklahoma's information and referral system currently lists on their web page over 105 services under developmental disabilities, 123 services under mental health and seven different categories for financial assistance.[1] For families and providers, figuring out how to access these services is often difficult and providers tend to focus on their specific areas of expertise. A provider within a specific service discipline may be very aware of the access mechanism for their own system, but unaware of how to get services from another system or even the availability of those services. Services in Oklahoma, like many other states, are organized within funding streams and along condition specific lines. Families and providers have difficulty navigating these service systems. Often a family must describe their child in one way to achieve access to services then in another, sometimes opposite, way to get the kind of service they need (i.e. special education provided in an inclusive setting). Providers are faced with many of the same obstacles as families and have the additional challenge of managing the flow of services from their own agency. It is extremely difficult to blend resources across different sectors such as education and health.

In addition to the inadequacy of the system to meet the families' needs, the systems are frequently very inefficient. Since it is difficult to determine the broad needs of CYSCHN, there are gaps in services in many cases and duplication of services in other areas. To keep costs down different sectors try to put in place measures that keep their costs manageable. As examples, in the past, CYSHCN often have been excluded from participation in managed care schemes and private health insurance coverage because both generally exclude people with preexisting conditions. Sectors such as education and health have each tried to limit their burden by designating services as ones that should be provided by the other sector. There are few structures in place that can facilitate the coordination of services so that they maximize efficiency and equitably divide the burden between different service sectors. As a recent example, the present need for intensive behavioral services for young children with autism[2] places a burden on both the education and health sectors, with no mechanism for the sectors to arrange to share the burden.

CYSHCN are often excluded from participation in managed care schemes and private health insurance coverage because both generally exclude people with preexisting conditions. A higher percentage (12.3%, compared to 8.8% nationally) of Oklahoma's CSHCN were without insurance at some point during the past year. 19.8 % of Oklahoma families responding to the survey indicated that they experienced financial problems due to their child's health needs (National Survey of CYSHCN Chartbook, 2005-06). The higher Oklahoma teen birth rates (which exceed the national average by almost 12 percentage points OSDH, 2003) are also a factor. The rate is higher in rural Oklahoma. Teen births coupled with the uninsured rate in some rural counties of over 37% and expected poor outcomes can seem daunting. A solution is needed that maximizes existing resources, fills shortfalls with innovative answers, enlists the energy of consumers and providers and other community members collaboratively and crosses condition-specific boundaries,

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The long-standing acknowledgement of the importance of interdisciplinary, interagency coordination of services for CYSHCN has stimulated a variety of improvement efforts in different human service sectors. However, implementing such services has been a challenge. A review published in 2007[3] identified the following 6 principles: (1) responsive to family challenges, priorities, and strengths; (2) developed in partnership with constituents; (3) reflective and respectful of the cultural norms and practices of the families participating; (4) accessible to everyone; (5) affordable to those who need assistance; and (6) organized and coordinated through collaboration so that resources are equitably distributed in an efficient and effective manner. They defined the macro level changes of: (1) standardized eligibility protocols developed jointly by the federal and state agencies contributing funds to the system; (2) legal and accounting mechanisms or vessels for blending (flexible use) funding streams; (3) development of cost-sharing mechanisms to allocate costs fairly among families, private insurers, government, and other payers; (4) measures to eliminate duplication of effort based on resource allocation procedures developed through intergovernmental agreements; and (5) a flexible point of entry such that a family need only apply once, with this application appropriate for all needed services. The micro level needs to include families, physicians, other health and mental health care providers, local schools, public transportation, and social service providers. The micro level also needs to include the creation of operational interagency collaborative relationships such that families access services when they need them. The creation of community grants or other incentives to encourage coordination across delivery agencies and providers, including the Medical Home to facilitate the arrangements and a local governing or organizing structure to help achieve this goal.

Historically, a majority of these initiatives have employed one-dimensional, "top-down" or "imposed" approaches. The major initiatives are change efforts such as new programs applied within a single human service sector rather than across multiple sectors. For example in the health care sector projects have been initiated in the primary care setting aimed at improving the screening of children for developmental delays or increasing their ability to provide Medical Home components. While these traditional efforts have resulted in some improvement, they often achieve only modest gains in integrating services.

Factors likely contributing to the less than desired level of improvement include: 1) the complex and frequently changing requirements of families and CYSHCN which pose significant challenges to designing an integrated system flexible enough to meet individual needs adequately; 2) the inability for the complex systems at a local level to form effective coordinating systems across agencies and sectors; 3) the ever changing current health care financing model with a number of unreimbursed costs of care and coordination serving as a strong disincentive to change. [4] In the absence of a coordinated system, families who must access human service systems frequently in order to provide the best care for their CYSHCN are often left on their own to navigate the complex array of different professional disciplines and agencies, each of which may have different and often conflicting eligibility requirements and financing options. Like others[5,6], we have attempted to begin to address the issues from the perspective of complex adaptive systems in order to achieve a more coordinated human service system for CYSHCN and their families. This approach requires focusing at the local level with a program that allows for the organizational development to be sensitive to the unique aspects of each county particularly with regard to existing community relationships, facilitates and adapts the process through a county coordinator (service navigator) not tied to a specific local agency, includes a communication structure between local community programs and agencies at a state level and provides a motivational system at the local level to help to encourage ongoing activities is likely to result in the more extensive local coordination and better and more extensive services.

The Sooner SUCCESS (*S*tate *U*nified *C*hildren's *C*omprehensive *E*xemplary *S*ervices for *S*pecial Needs), Oklahoma's Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs (CYSHCN) was developed based on a complex adaptive systems approach. The Sooner SUCCESS pilot project began as a coalition of family members, mid-to upper-level public service managers and advocacy groups met to discuss how Oklahoma could address service gaps and lack of interagency coordination across both public and private service systems not only at the state but at the community level. It began in 2002 with initial funding from the Department of Human Services Title V and a grant from the Oklahoma Developmental Disabilities Council. The initial program consisted of 6 county coalitions formed in 2002 and expanded to 9 in 2006, to 11 counties by 2010 and currently is in 12 covering about half of Oklahoma's children.

Sooner SUCCESS provides support to families and service providers at the community level including a broad range of supports from simply helping a family identify and access a service that already exists to innovatively marshalling generic resources to meet a unique need. The program uses these family support activities to identify local need. The infrastructure established at the local level supports community capacity building based on those needs. Sooner SUCCESS builds community capacity by coordinating the efforts of the health, mental health, social and education systems, identifying existing public and private services, identifying service gaps and developing community-based strategies to fill those gaps.

Families, educators, social and health professionals and others are provided a structure by Sooner SUCCESS to connect with one another in ways that multiply their capacity and effectiveness. This infrastructure provides the mechanism to integrate the system services provided by health, mental health, social and educational agencies supporting CYSHCN and their families. Sooner SUCCESS partners with family members, local communities, the Oklahoma Developmental Disabilities Council, Oklahoma State Departments of Human Services (OKDHS), Education (OSDE), Health (OSDH), Mental Health

and Substance Abuse Services (ODMHSAS), Rehabilitation Services (ODRS), Health Care Authority (OHCA), Oklahoma Commission on Children and Youth (OCCY), Office of Juvenile Affairs, (OJA), Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND) and the Center for Learning and Leadership (UCEDD).

Members of each coalition represent families, the OKDHS, OSDE, OSHD, and ODMHSAS. Regional and state coalitions consisting of similar elements plus representatives from ODRS, OHCA, OCCY, OJA, the UCEDD, the LEND and the Section of Developmental and Behavioral Pediatrics at the University of Oklahoma Health Sciences Center.

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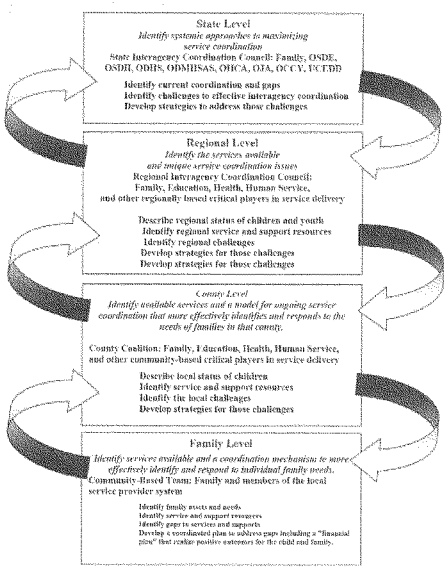
Each participating county was provided a half time coordinator to facilitate the development of their county coalition and provide navigation at the request of any families or family providers in their county. As an initial step, they determined all the services within their county so they can advise the families who request services when possible. Where they are unable to find a solution, they bring the requests to their coalition to help come up with a plan to address the need. In addition, the coalitions are provided with information from a bi-annual needs assessment that includes information specific to their county and information about the nature of the referrals that their coordinator received. The process provides information and motivating forces to each coalition to find innovative solutions to their needs and a forum whereby resources across agencies can be braid to most efficiently and effectively meet the families' needs. Identified issues which are broader than a local county can also be raised to the regional or state levels as needed. The support provided by Sooner SUCCESS to families and service providers at the community level include a broad range of services, from simply helping a family identify and access a service that already exists to innovatively marshalling generic resources to meet a unique need. The program uses these family support activities coupled with the Community Needs Assessment to identify local needs. It supports community capacity building by coordinating the efforts of the health, mental health, social and education systems, identifying existing public and private services, identifying service gaps and developing community-based strategies to fill those gaps.

The model project established an infrastructure for the pilot region that facilitates community-based capacity development through ongoing comprehensive interagency coordination and collaboration among families and service providers at four levels as depicted in **Figure 1**:

- **State Level:** The Sooner SUCCESS State Interagency Coordination Council has membership from families, State Departments of Health, Education, Human Services, Mental Health and Substance Abuse Services, Rehabilitation Services, Health Care Authority, Commission on Children and Youth, UCEDD, LEND and OU CSC. This group identifies current interagency coordination activities, challenges to effective interagency coordination and builds capacity to address those challenges through policy and/or procedural adjustments. The Sooner SUCCESS State Interagency Coordination Council meets monthly and also provides guidance to the project.
- **Regional Level:** A regional team made up of key public, private and family community leaders and project staff identifies the services available and unique service coordination issues within the multi-county region. A needs assessment process supports the regional team members in service assessment and service gap identification. The Community Needs Assessment identifies regional assets and challenges. The regional team is supported by a Regional Coordinator who also is responsible for support and guidance to county coordinators. The Sooner SUCCESS Regional Coordination Council meets monthly to accomplish regional capacity development and provide guidance to the Regional Coordinator. It provides an opportunity for counties to share their successes and challenges.
- **County Level:** At the county level, two components of the infrastructure were established. Coordinators in each county assemble a coalition of family members, education, health, mental health and social services and other community-based stakeholders. The county coordinator facilitates the project goals at the community level. The county coordinator and the coalition are charged with identifying available services and a model for ongoing service coordination across the county. The county coalition uses the Community Needs Assessment to develop community-based capacity building initiatives. The county coalition meets monthly.
- **Family Level:** The fourth level may be the most critical. Individual families, the county coordinator, coalition members and/or other community members can bring families, either literally or figuratively, to the monthly coalition meeting and ask the group to resolve service needs that one or more of the service agencies are unable to meet or the family can not otherwise access. The county coalition identifies services available and a coordination mechanism to more effectively identify and respond to individual family needs. The team identifies family assets, services needed, service gaps for individual families and develops a coordinated plan. Information generated by this process is communicated to the other levels within the model as one mechanism to determine need. Specifically, when a service gap is discovered, resolution is sought at local, regional and state level, whichever is appropriate.

The program was started with Title V funds and a developmental Disabilities Council Grant in order to develop the first 6 county coalitions to the northwest of Oklahoma City in suburban and rural counties. It further developed with an US Maternal and Child Health Bureau Systems Integration Grant expanding

**Figure 1.** Sooner SUCCESS Structural Organization




to three additional counties including Tulsa and several surrounding counties. As time limited grants have ended, it has continued with some State support as well as funds from the Commonwealth Fund, the Oklahoma Health Care Authority, the Department of Education and continued DHS Title Five funds so that there are now 12 county coalitions covering over half of the state's children.

## RESULTS OF ACTIVITIES

### Services to Individual Families

The coalitions have been meeting monthly since their inception with anywhere from 10 to 30 attendees representing human services, mental health, education health and families. Between 2007 and 2012 the program helped 3,048 children with 1,498 of those in the past two years. These children were within 2,585 families with 1,294 in the past two years. While county coordinators (navigators) mostly served the families in their county, 215 of those served were from out of the county which provided the service.

**As Specific Examples of Individual Family Navigation Activities:**

1. A county coordinator (navigator) in one county worked with the Department of Rehabilitation Services, Department of Human Services, a home improvement store, a local fund for children with special needs and a volunteer community group who donated the labor to provide a home bathroom wheelchair accessible modifications for an eight year old boy with spina bifida who wanted to be independent in his toileting.

2. A single mother with a son who was the product of an extremely difficult delivery that resulted in his having visual and intellectual impairment was referred to the county coordinator (navigator) in her county when her son was 2 years of age. The navigator was able to facilitate an evaluation at the OUHSC Child Study Center, other physician referrals, a Supplemental Security Income application and her referral to other DHS services. She also drove the mother and child to the appointment at the CSC and accompanied them so she could help them with the paperwork, and waiting for testing. She also helped the mother understand her child's disabilities, helped her to enroll her child in the school for the blind and later helped him integrate back into the community.

3. A county coordinator (navigator) helped a family of a 14 year old child with Muscular Dystrophy devise a system that enabled him to bathe utilizing a portable bath tub. The project cost $400 provided by the Ministerial Alliance and a pharmacy discount.

4. A county coordinator (navigator) helped several families who have had issues with their children's school such as absences and tardiness where she is able to act as a mediator between schools and parents.

### Capacity Building:

The program has been the impetus for several additional initiatives including the training of PCPs to use evidence based developmental screening which received additional funding from the Centers for Disease Control and Prevention and the development of a web portal that has enhanced communication between PCPs and Sooner Start the state early intervention regarding children from PCPs who are referred to the earlier intervention program in collaboration with OHCA and supported by a grant from the Commonwealth Fund. The county coordinator (navigator) in Canadian county and the regional coordinator also helped facilitate Canadian county's attainment of a Health Access Network status. Over the years the program has provided a 2-5 times the return in additional funding for the cost of the programs.

**As specific capacity building examples:**

1. A county coordinator (navigator) recruited a counselor from a neighboring county behavioral health program to provide sessions at school in the county once a week. The coalition was able to eventually to expand the county counseling services to

five days a week supported by fee for services and a grant.

2. A county coordinator (navigator) arranged through the Oklahoma Dental Foundation to have the Mobile Dental Van come to all 4 of the schools in her county. From the dental van visits, the Oklahoma Dental Foundation provided in excess of $100,000.00 worth of dental work to children in that county.

3. Based on a needs assessment of a county, it was evident that in that county they had no regularly occurring respite programs for children with special needs despite the fact that some funds were available for those services. The county coalition was able to design a respite program to address this need. The program provides a free evening of respite once per month for families in the county in partnership with a local church. It serves both children with special needs & their siblings ages 6 months to 12 years and provides a trained 1 on 1 volunteer for each child to support both individual and peer to peer play time as well as a volunteer support team to offer breaks, provide assistance, and ensure safety. As of July 1, 2012 the program has served 49 children from 12 families and has recruited and trained 40 community volunteers with growth in attendance each month. The program has been funded through community support and private donations.

## DISCUSSION

The requirements of children with special needs are frequently varied and complex. Addressing them requires multiple service domains including health, education, human services and mental health. Programs focusing on single conditions or domains of service fall short of meeting the families' needs. Directives that are generated at a state and national basis while helping to support and stimulate programs are not able to easily adjust to the unique needs individual communities.

The unique aspect of the Sooner SUCCESS program is that it takes a complex adaptive systems approach[5,6] allowing for unique local solutions to problems. It has put in place the organizational structure for local communities to address their needs in their own unique ways in a coordinated fashion and it provides ongoing feedback to the communities to help them in their activities and decisions.

The assumption is that the problems of this nature are not easily solved and that rather than trying to come up with initiatives to address the problems with major interventions, it will be more effective in the long run to have in place an organizational structure that provides gradual incremental small changes generated mostly at the community level. The initial results of this project over the past 10 years suggest that the desired results are slowly evolving.

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## Ages and Time Waiting

| Ages | Less than 1 year | 1 to 2 years | 2 to 3 years | 3 to 4 years | 4 to 5 years | 5 to 6 years | over 6 years | Total |
|---|---|---|---|---|---|---|---|---|
| 0-3 | 96 | 64 | 29 | 9 | - | - | - | 198 |
| 4-6 | 63 | 87 | 54 | 91 | 74 | 60 | 17 | 446 |
| 7-18 | 303 | 253 | 191 | 322 | 333 | 375 | 822 | 2,599 |
| 19-21 | 68 | 102 | 82 | 119 | 118 | 113 | 218 | 820 |
| 22-35 | 90 | 130 | 122 | 167 | 262 | 296 | 877 | 1,944 |
| 36-55 | 71 | 107 | 60 | 71 | 90 | 104 | 292 | 795 |
| 56-64 | 13 | 26 | 8 | 15 | 25 | 30 | 76 | 193 |
| 65-74 | 4 | 7 | 1 | 3 | 2 | 8 | 30 | 55 |
| 75 | - | - | - | 1 | - | - | 1 | 2 |
| 76 | - | - | - | - | 1 | - | - | 1 |
| 83 | - | - | - | - | 1 | 1 | - | 2 |
| | 708 | 776 | 547 | 798 | 906 | 987 | 2,333 | 7,055 |

**253 Aging Oklahomans Waiting**

**Obra - Omnibus Budget Reconciliation Act (1987) which created Preadmission Screening and Resident Review (PASRR) for people with or suspected of having mental illness, mental retardation and related conditions who are seeking admission to or are residents of nursing facilities. It is a Preadmission Screening evaluation because the person either sought admission to a nursing home or already was a resident of a nursing home. It does not mean the person was admitted to the NF necessarily, although they may have been if they met the need for NF services.

**As of May Dec. 9, 2013**
**6,998 WAITING**

## Services Received by Ages

| Ages | AL | CIE | ADC | FSS | GH | Medicaid | TEFRA | SNAP | Obra | SW | SSI | No services |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-3 | - | - | - | 96 | - | 150 | 22 | 74 | - | - | 101 | 25 |
| 4-6 | - | - | - | 178 | - | 300 | 37 | 138 | - | - | 207 | 97 |
| 7-18 | - | 3 | - | 822 | - | 1,737 | 144 | 759 | 1 | 5 | 1,318 | 637 |
| 19-21 | 1 | 28 | - | - | 6 | 510 | - | 251 | 1 | 29 | 425 | 209 |
| 22-35 | 4 | 123 | 1 | - | 43 | 1,181 | - | 705 | 15 | 175 | 868 | 512 |
| 36-55 | 16 | 47 | 3 | - | 35 | 489 | - | 242 | 31 | 98 | 250 | 205 |
| 56-64 | 10 | 6 | - | - | 12 | 120 | - | 38 | 21 | 24 | 47 | 47 |
| 65-74 | 4 | 4 | - | - | 6 | 35 | - | 7 | 9 | 7 | 13 | 13 |
| 75 | - | - | - | - | - | 2 | - | 1 | - | - | 1 | - |
| 76 | - | - | - | - | - | 1 | - | 1 | - | - | - | - |
| 83 | - | - | - | - | - | 1 | - | 1 | - | - | 1 | 1 |
| | 35 | 211 | 4 | 1,096 | 102 | 4,526 | 203 | 2,217 | 78 | 338 | 3,231 | 1,746 |

### Key Services Received

AL - Assisted Living
CIE - Community Integrated Employment
ADC - Adult Day Care
FSS (Family Support Subsidy) - $250 monthly
GH - Group Home
Medicaid - Oklahoma SoonerCare
TEFRA - SoonerCare for children w/severe medical needs
SNAP - Food Assistance Program (food stamps)
Obra (See explanation on left)
SW - Sheller Workshop
SSI - Supplemental Security Income

The "Services Provided" information is gathered by OKDHS. OKDHS uses their existing system along with other systems and reconcile the service recipients names with the waiting list names. It is a current as available to OKDHS.

Waiting in Oklahoma
www.okwaitinglist.org

### Key Resident Type

Res Cen - NORC & SORC
Custody - in state custody
OH/PH/RH - Own Home/Parents Home/Relative Home
GH - Group Home
FC - Foster Care
Inc - Incarcerated
ICF/MHF/AL/NF - ICF/MR type home
UNK - Unknown

**As of Sept. 30, 2013**
**6,268 live in family, parent's or own home**

## Request List by Residence Type and Age

| Ages | Res Cen | Custody | OH/PH/RH | GH | FC | Inc | ICF/MHF/AL/NF | UNK |
|---|---|---|---|---|---|---|---|---|
| 0-3 | - | 7 | 190 | - | - | - | - | 1 |
| 4-6 | - | 15 | 421 | - | 3 | - | 2 | 5 |
| 7-18 | 1 | 148 | 2,370 | 4 | 16 | - | 15 | 45 |
| 19-21 | 1 | 29 | 748 | 3 | 3 | 2 | 7 | 27 |
| 22-35 | 3 | 7 | 1,730 | 40 | 4 | 9 | 61 | 90 |
| 36-55 | 3 | - | 645 | 29 | 1 | 12 | 73 | 32 |
| 56-64 | - | - | 128 | 16 | - | 2 | 36 | 11 |
| 65-74 | - | - | 31 | 7 | - | - | 17 | - |
| 75 | - | - | 2 | - | - | - | - | - |
| 76 | - | - | 1 | - | - | - | - | - |
| 83 | - | - | 2 | - | - | - | - | - |
| | 8 | 206 | 6,268 | 99 | 27 | 25 | 211 | 211 |

School Age - After school and summer care needed
After high school - working parents
Aging individuals - who's supporting them now?

Printing provided by the Center for Learning and Leadership, Oklahoma's University Center for Excellence in Developmental Disabilities, through with funding from the US Administration on Intellectual and Developmental Disabilities (Grant #90DD0685)

Distributed by Wanda Felty parent & Coordinator of The Waiting List Meeting wfelty@okhighplains.com
12/12/2013 Waiting List Meeting - Tulsa

Mr. LANKFORD. Ms. Lockhart, we are going to move on. When we come back, we are going to pummel you with questions here in just a minute as well, so I want to make sure we have time for everybody, too.

Ms. LOCKHART. Thank you, sir. Yes, sir.

Mr. LANKFORD. Mr. O'Carroll.

**STATEMENT OF PATRICK P. O'CARROLL, JR.**

Mr. O'CARROLL. Good afternoon, Chairman Lankford, Ranking Member Speier, and members of the subcommittee. Thank you for inviting me to be here today.

A 42-year-old man was living out a childhood dream: he was the lead singer of his own hard rock band and he also owned a popular cafe. For almost 20 years his band had toured the Country and performed at large music festivals. He talked up his band's success on social media, touting performances for millions of fans and worldwide sales of thousands of albums and t-shirts; even been interviewed for local newspaper articles and TV interviews. And during this entire time he was receiving Social Security Disability for mood disorders.

Last year, during a continuing disability review, or a CDR, a disability examiner referred the man's case to one of our cooperative disability investigations, or CDI, units. The man's musical exploits made the examiner suspicious that he might not be eligible for benefits because he was more capable than he claimed. The CDI investigation confirmed that the man was able to work and perform activities contrary to his disability. With this information, SSA ceased the man's benefits in January.

I share this example because it combines the value of two of our most effective integrity tools: CDRs and the CDI program. CDI efforts usually focus on initial claims, but disability examiners can also refer questionable in-pay cases to a CDI unit for investigation, as in this case. It is one of the many reasons we are pleased that the acting commissioner has agreed to expand CDI by up to seven units by the end of 2015.

Of course, CDRs on their own have proven to be effective guards against improper payments in the disability programs. My office has long urged SSA to conduct more CDRs every year. We also consistently encourage Congress to fund these critical reviews. With the return on investment of $9 saved for every dollar invested in CDRs, appropriating funds to conduct these reviews is sound fiscal policy. However, after dedicated funding ended in 2002, CDRs declined by over 75 percent, creating a significant backlog.

Although SSA has been conducting more CDRs since 2009, the backlog still stood at $1.3 million last year. As a result, SSA continues to make payments that could be avoided. For example, according to past audit work, up to $1.1 billion in disability payments could have been avoided in 2011 alone if CDRs had been performed when due.

Similarly, re-determinations can prevent improper payments in the SSI program. These non-medical reviews will yield an anticipated 5 to 1 return this year. From 2003 to 2008, re-determinations decreased by 60 percent. Our audit work found that $3.3 billion in

SSI payments could have been avoided in just two years if more reviews were completed.

I am encouraged that SSA has completed more eligibility reviews in recent years. For this year, the agency has stated that it plans to complete 510,000 medical CDRs and almost 2.5 million re-determinations. We are currently evaluating SSA's progress in completing these reviews and we plan to issue a report later this year.

We have long focused our audit efforts on CDRs and re-determinations because there are such sound reasons for funding and conducting them as scheduled. For example, in a recent audit we found that SSA hadn't conducted 79 percent of childhood CDRs or 10 percent of age 18 re-determinations within the time frames required by law. The cost over four years was $1.4 billion. Payments made because of delayed reviews are troubling because they are largely avoidable. We recognize that SSA is a difficult task in processing and increasing number of new claims, but the agency must continue to seek ways to balance customer service with stewardship responsibilities.

Through our audit and investigative work, we keep working with SSA and Congress to protect these critical programs.

Thank you again for the invitation to testify, and I would be happy to answer any questions.

[Prepared statement of Mr. O'Carroll follows:]

**U.S. House of Representatives**

**Committee on Oversight and Government Reform**

**Subcommittee on Energy Policy, Health Care, and Entitlements**

**Statement for the Record**

# Examining Ways the Social Security Administration Can Improve the Disability Review Process

**The Honorable Patrick P. O'Carroll, Jr.**
**Inspector General, Social Security Administration**

**April 9, 2014**

Good afternoon, Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee. Thank you for inviting me to discuss the Social Security Administration's (SSA) management of its disability programs. I appreciate your continued interest in this and other Agency-related issues.

According to SSA, in February 2014, the Agency provided about $10.9 billion in Disability Insurance (DI) payments to almost 11 million citizens across the country, including more than 8.9 million disabled workers, and more than 2 million spouses and children. SSA also paid $4.7 billion in Supplemental Security Income (SSI) to more than 8.3 million recipients.

Increasing levels of disability claims and beneficiaries in recent years have challenged SSA's ability to deliver world-class service, creating workloads that strain resources, causing delays and backlogs, and leaving the Agency vulnerable to fraud and abuse. SSA must find ways to balance service initiatives, such as processing new claims and appeals, against stewardship responsibilities, to ensure that DI beneficiaries and SSI recipients continue to be eligible for the payments they are receiving.

**Continuing Disability Reviews**

For many years, we have identified full medical continuing disability reviews (CDRs) and SSI redeterminations as highly effective guards against improper payments and program fraud. After an individual is determined to be disabled, SSA is required to conduct periodic CDRs to determine whether the individual continues to be disabled. However, SSA generally cannot find an individual's disability has ended without finding medical improvement has occurred. As such, diaries are set for

- six to 18 months when improvement is expected,
- up to three years when improvement is possible, and
- five to seven years when improvement is not expected.

If SSA determines the person's medical condition has improved such that he or she is no longer disabled according to its guidelines, it ceases benefits. The Agency estimates that every $1 spent on medical CDRs yields about $9 in savings to SSA programs as well as Medicare and Medicaid over 10 years.

SSA employs a profiling system that determines the likelihood of medical improvement for disabled beneficiaries. SSA selects the records of those beneficiaries that have been profiled as having a high likelihood of improvement for a full medical review by State disability determination services (DDS).

In a March 2010 report, we determined that SSA's number of completed full medical CDRs declined by 65 percent from fiscal year (FY) 2004 to 2008, resulting in a significant backlog. We estimated SSA would have avoided paying at least $556 million during calendar year 2011 if SSA had conducted the medical CDRs in the backlog when they were due.

According to SSA, in FY2013, the Agency completed 428,658 medical CDRs; more than 115,000 of these, or about 27 percent, resulted in an initial cessation of benefits.[1]

The medical CDR backlog stood at 1.3 million at the end of FY2013. We are currently evaluating SSA's progress in completing program integrity workloads, in light of the Agency's annual congressional

[1] This number does not take into consideration the number of cessations that will be upheld on appeal. SSA estimated that about 67 percent of the 96,012 CDR cessations in FY2011 would be upheld on appeal, for example.

appropriations and dedicated funding for program integrity efforts like CDRs. We plan to issue the report later this year, but thus far, we have determined:

- In FY2002, SSA received $630 million in dedicated funding for program integrity work; that year, the Agency completed 856,849 medical CDRs.
- From FY2003 to FY2008, SSA did not receive any dedicated funding for program integrity; CDR workloads decreased, and the CDR backlog grew significantly.
- Since FY2009, SSA has received dedicated program integrity funding; the Agency began increasing its program integrity workloads, but despite recent improvements, it has completed less program integrity work than it had in the past.
- For example, in FY2013, SSA received $743 million in dedicated program integrity funding, but completed about half the number of medical CDRs it completed in FY2002 with less integrity funding.
- For FY2014, under the *Consolidated Appropriations Act of 2014*, SSA received about $1.2 billion in dedicated program integrity funding, and recent information received from the Agency suggests that they plan to complete 510,000 medical CDRs.

SSA has preliminarily reported it would need $11.8 billion in funding over the next 10 years to eliminate the medical CDR backlog by FY2018 and prevent its recurrence through FY2023. Under this scenario, SSA should identify tens of billions of dollars in lifetime Federal benefit savings.

However, to eliminate the backlog and achieve these savings, as SSA has reported, it would require program integrity funding in excess of that planned under the *Budget Control Act of 2011* (BCA), which was to provide SSA's integrity funding through FY2021.

The BCA funding level would provide SSA $10.3 billion for medical CDRs over the next 10 years, which should also enable SSA to identify tens of billions of dollars in lifetime Federal benefits savings and reduce the backlog dramatically by the end of FY2018, though the backlog would grow in subsequent years.

Therefore, SSA may only be able to reduce the CDR backlog temporarily based on the Agency's plans for integrity workloads under different funding scenarios. We have consistently recommended that SSA prioritize the use of available resources toward CDR workloads so it does not miss opportunities to realize potential savings.

Unfortunately, even when a CDR *is* conducted and the State DDS determines medical improvement, it does not always mean that SSA terminates benefits timely, or at all. In a November 2012 report, we identified DI beneficiaries and their auxiliaries and SSI recipients who improperly received payments after their medical cessation determinations, for a projected total of about $83.6 million. We recommended that SSA enhance its systems to perform automated terminations following medical cessation decisions. Although SSA has not yet implemented this change, it has agreed to do so.

Also, we are assessing SSA's adherence to the medical improvement review standard (MIRS) and its effect on the beneficiary rolls. During a CDR, SSA follows MIRS—mandated by the Social Security Disability Amendments of 1984—to determine if a beneficiary's impairment has improved since his/her

most favorable determination and can perform work activities. However, if SSA's decision to place the individual on disability was questionable in the first place—for example, if the allowance was not fully supported or documented but not clearly in error and the individual's condition has not changed—MIRS makes it difficult for SSA to take the person off disability, because under current law, there is no medical improvement. There are several exceptions to MIRS—for example, if evidence shows a person was mistakenly placed on the disability rolls, SSA can cease benefits—but thus far, we are unsure how often SSA applies these exceptions. We examined MIRS exceptions in an audit that we will soon issue.

In that same report, we estimated that SSA will pay about $269 million in benefits until the next CDR due date to about 4,000 adult beneficiaries who would not be considered disabled if MIRS were not place and SSA instead used its Initial Disability Standard (which is used during a claimant's initial application for disability) during a CDR.

**Redeterminations**

In the SSI program, SSA conducts periodic redeterminations of non-medical eligibility factors—such as income, resources, and living arrangements—to determine if recipients are still eligible for SSI and are receiving the correct payment amount. Unlike CDRs, SSA is not required to complete a given number of redeterminations; SSA determines the number to complete based on staffing and funding resources, including the amount of funds it will use for CDRs.

In July 2009, we reported that the number of SSI redeterminations SSA conducted had substantially decreased even though the number of SSI recipients had increased. Between FYs 2003 and 2008, redeterminations decreased by more than 60 percent. We estimated SSA could have saved an additional $3.3 billion during FYs 2008 and 2009 by conducting redeterminations at the same level it did in FY2003.

Following our report, SSA significantly increased the number of redeterminations it completed. Specifically, redeterminations increased from a low in FY2007 of 692,000 to almost 2.44 million in FY2013. SSA plans to conduct 2.44 million redeterminations in FY2014, which the Agency estimates will result in savings of $5 for every $1 spent on conducting them.

In our September 2013 review, *SSI High-error Profile Redeterminations*, however, we found that SSA was not completing all of the redeterminations identified as having the highest risk of overpayments. Each year, SSA identifies the number of high-error profile redeterminations it will complete based on the dedicated program integrity funding it expects to receive in its budget appropriation. Since SSA was uncertain of this amount at the beginning of the year, SSA intentionally selected more high-error profile redeterminations than it plans to complete. SSA's method for assigning redeterminations as high-error is based on the anticipated dedicated program integrity funding and the amount SSA allocates to redeterminations. Therefore, when actual dedicated program integrity funding is at or lower than expected, some high-error profile redeterminations selected are not completed.

For example, in FY2011, the dedicated program integrity funding level resulted in SSA's not completing up to 201,000 of the high-error profile redeterminations it had selected for review. If SSA had completed all these redeterminations, we estimate that it would have identified at least $228.5 million in additional improper payments—both overpayments and underpayments. We recommended that SSA continue to increase the number of the high-error profile redeterminations conducted as resources allow, and SSA agreed to do so.

In September 2011, we issued a follow-up report, *Childhood Continuing Disability Reviews and Age-18 Redeterminations*, in which we found that SSA had not completed 79 percent of childhood CDRs and 10 percent of age-18 SSI redeterminations, within the timeframes specified in the *Social Security Act*. SSA requested and received special funding for FY2009 to FY2012, but while the number of age-18 redeterminations increased, the number of childhood CDRs conducted declined.

We estimated that SSA paid about $1.4 billion in SSI payments to approximately 513,300 recipients under 18 that it should not have paid; and that it would continue paying about $461 million annually until the reviews were completed. We also estimated SSA improperly paid about $5.7 million in SSI payments to approximately 5,100 recipients who did not have an age-18 redetermination completed by age 20; the Agency would continue paying about $6.3 million annually until these reviews were completed. We recommended that SSA conduct all childhood CDRs and age-18 redeterminations within legally required timeframes, and SSA agreed to do so to the extent that its budget and other priority workloads allowed.

I know this Subcommittee is particularly interested in information on children receiving SSI. We have planned an audit to begin next year that will determine if certain geographical areas have unusually high numbers of approved children claims for mental impairments. As of July 2013, 1.3 million children under age 18 were receiving SSI, and more than 791,000 (61 percent) were receiving payments based on a mental impairment; of those, 223,671 received SSI for Attention Deficit Hyperactivity Disorders and 203,529 for Speech and Language Delays. We would be willing to initiate an audit that further examines this topic at your request.

**Cooperative Disability Investigations**

I'd be remiss if I didn't mention that one of the most effective ways that SSA can prevent disability overpayments is by dedicating resources to our Cooperative Disability Investigations (CDI) program. To improve program integrity, SSA should continue to make available the investigative efforts of CDI units to DDSs across the country. For many years, we have highlighted for Congress how CDI units assist DDS employees who suspect fraud in an initial disability claim.

SSA and OIG jointly established CDI to resolve questions of fraud in the disability claims process, in conjunction with State DDS and State or local law enforcement agencies. In 1997, CDI launched with units in five states. The program currently consists of 25 Units covering 21 states and the Commonwealth of Puerto Rico. In FY2013 alone, CDI efforts contributed to a projected $340.2 million in savings for SSA's disability programs—the program's greatest single-year savings total. Since the program was established, CDI efforts have contributed to projected savings of $2.7 billion for SSA's disability programs.

We're very pleased that the Acting Commissioner has approved plans to expand CDI by up to seven units by the end of FY2015—which would bring us to a total of 32 units. Last month, I traveled to Michigan to meet with state officials and expedite the process to establish a unit in Detroit; just last week, I met with the Puerto Rico Police Department and secured an agreement for the PRPD to temporarily assign three additional investigators to the San Juan CDI Unit.

CDI units generally focus on preventing improper disability payments from ever occurring, but DDS employees can also enlist CDI units to investigate in-pay beneficiaries who might not be eligible to continue receiving payments. In FY2013:

- CDI units opened 4,751 cases; about 75 percent of the cases were on initial claims, and about 16 percent were related to beneficiaries already receiving benefits. (About 9 percent did not indicate if the case related to an initial claim or an in-pay beneficiary.)
- DDSs denied or ceased benefits on 4,134 cases after CDI investigations. Fifteen individuals were criminally prosecuted, and civil monetary penalties were imposed on 34 individuals as a result of CDI investigations.

DDSs that have access to a CDI unit can easily refer suspicious claims to the CDI unit for investigation. CDI investigation reports include information that a disability examiner, or an administrative law judge, cannot normally obtain during the application or CDR process to assist in making an accurate disability determination. This can include independent observations and surveillance video of the claimant/beneficiary, interviews with the claimant/beneficiary or third parties, and corroborated findings from other available resources or databases. CDI is a key integrity tool that helps to ensure that only those who are eligible for benefits actually receive them.

**Conclusion**

It is critical that SSA invest sufficient resources to maintain and improve disability program integrity, through efforts such CDRs, redeterminations, and anti-fraud initiatives like the CDI program. These efforts safeguard the stability and integrity of disability payments, and they inspire Americans' confidence in Social Security's programs.

My office is committed to working closely with SSA and your Subcommittee to help the Agency achieve these and other goals. Thank you again for the invitation to testify today, and I'd be happy to answer any questions.

Mr. LANKFORD. Thank you to all of our witnesses.

I will begin our questions.

Ms. Lockhart, I have a question. Your statement about undignified supports and then your statement of multiple levels of dysfunction.

Ms. LOCKHART. Yes, sir.

Mr. LANKFORD. You tried to walk through some of those as well, but one of the key issues—you started to talk at the very tail end—I know I had to cut you off a little bit on your testimony. You started talking about the impact of families and individuals in communities and out of communities. What it seemed like you were saying is when these individuals are put into this, they are actually pulled out of society and they are separated out.

The question I have for you is what do you think the goal of the disability program should be?

Ms. LOCKHART. The goal should be to provide a route back into their community. The overarching goal should be that people with disabilities have an independent life. Also, define what disability is. Impairment does not necessarily mean disability.

Mr. LANKFORD. Okay. Now, hold on for just a moment on that one. You are right, impairment is not disability. The challenge of this is that once you get into the system, if you have an impairment and they define it as you are not able to do substantial gainful work, employment, then you may be impaired, but you are now tagged as disabled and you are actually prevented from employment. Is that what you are experiencing?

Ms. LOCKHART. Right.

Mr. LANKFORD. So what does that look like?

Ms. LOCKHART. We have situations where either the children aren't getting services that would help them move forward or children that in our professional position might be impaired, but not disabled. We have experienced families that the parents at times will—what is the word I want to use?—sometimes stall the process.

Mr. LANKFORD. You mean stall the process of re-engagement in society?

Ms. LOCKHART. Right. Right. So we see both. But we are saying that to those that do have disabilities, sir, we don't have a mechanism that is sure and sound that provides them a way into the community. We are still, for the first time, really understanding. And I know that we have programs, but what we see is we see the families on the system level here, so imagine two rails, and then we see commerce, private sector over here. And really what we need to see is they converge. So to say we want our disabilities to have jobs, people with jobs be paid fairly, those kinds of things, and be an integral part of our community, we have to prepare this side over here as well.

Mr. LANKFORD. Okay.

Mr. O'Carroll, you made a comment about increasing the CDRs and watching out for the reviews and such. Based on what Ms. Nottingham was saying, it is not just a matter of increasing the number of CDRs, it is actually the effectiveness of the CDRs. So what are you experiencing with the actual review when the review occurs?

Can I put this up on the screen as well?

[Slide.]

Mr. LANKFORD. There is a stat that we have been able to locate here. Social Security Administration provided this. This is from 2003 to 2013, so it goes back a decade for us, asking the question of when CDRs actually occur, what happens at that point. Once they have been evaluated, when they go into the system, evaluated, are they expected to recover from this or be out of the system possible or not expected.

So here is the number of reviews, the number of removals, and what we found interesting is over the decade there the people that were expected to at some point leave the system, there is only 18 percent of them that actually do. What is interesting to me is those that were not expected, 7 percent of the folks that were not expected leaving. It is really not that far apart, an 11 percent difference between the two.

So what we see is people that are even expected to be out of the system really don't leave the system. It sounds like, to go back to what Ms. Nottingham was saying, there is an issue with not just doing CDRs, but the effectiveness of CDRs based on even the initial expectation.

Mr. O'CARROLL. Yes, Mr. Chairman. On that, I guess from some of the work that we have done, a lot of the expectations that they are having aren't found as we are finding here. One of those issues that is part of this hearing is talking about medical improvement on it and the issues with medical improvement. And with medical improvement, if you were found disabled, by the next time you come back to a DDS on it, unless you have improved from what you were found the last time, you are going to be found still disabled.

And we are finding that if you use the standard that you use when you first come in, which would be different than the medical improvement, it would be an initial application, there would be a lot more findings in terms of a person improving. And what we found on that, we just did a report on it, we are waiting for comments back from the agency, but we found in that case about 4 percent of the people that were found disabled would not be found disabled if you used the initial disability application formula instead of the improvement formula.

Mr. LANKFORD. I am sorry, I am just about out of time. Can you say that last part again?

Mr. O'CARROLL. The last one I said is it is about 4 percent of the people that we looked at that were found disabled would not have been found disabled had they come in on an initial application. So, in other words, what they are saying is that what they purport with was below the level of what they would have been put on disability, but since they were already on disability, they couldn't be taken off it.

Mr. LANKFORD. Okay.

Mr. O'CARROLL. So we are seeing that 4 percent. To be truthful, it could be a much higher percentage. There is a problem, though, with the record-keeping that SSA was doing on it, and we find it could go as high as 12 percent, because there about 8 percent of the cases that we looked at were incorrectly cited. So, as an example, they said they were thrown off or they were taken off for a

medical improvement, but when we read the file on it, we found it was really because they had returned to work.

Mr. LANKFORD. Okay.

Mr. O'CARROLL. So we are asking for more accuracy on that so we can get a better standard. But that is an example of what you were saying here.

Mr. LANKFORD. Thank you.

Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you, and thank you to all of our witnesses.

The presentation that was made by the inspector general of this rock band that suggested they had lots of social media, you were able to access it on social media, Ms. LaCanfora, does the Social Security Administration have the authority to consult social media accounts when conducting CDRs?

Ms. LACANFORA. Our adjudicators do not consult social media. And let me explain why, if I may. We understand the committee's interest in this issue, and we are certainly open to more discussions and discussions with the IG, but let me be clear about one thing. Right now, our adjudicators refer 22,000 cases per year to the inspector general that they find to be suspicious. Our adjudicators are trained in fraud detection and they look at medical evidence, they look at the allegations of the individual, they weigh all of the evidence and they detect anomalies, and they do it very well.

Ms. SPEIER. I have very limited time, so you just have to answer the question. Right now they do not, is that correct?

Ms. LACANFORA. That is correct.

Ms. SPEIER. Do they have the authority to and they just don't?

Ms. LACANFORA. We do not allow them to look at social media.

Ms. SPEIER. Do you, within the Social Security Administration, have the authority to require them to look at social media?

Ms. LACANFORA. Yes.

Ms. SPEIER. All right, so we don't need legislation to do that.

Ms. LACANFORA. Correct.

Ms. SPEIER. All right, so this is a decision that you made.

Ms. LACANFORA. Correct.

Ms. SPEIER. All right. I would disagree with that decision because I think that social media is a very fair and appropriate way of doing a CDR. So that is just one area that we need to pursue a little bit more.

Inspector General, your office found that DI beneficiaries and SSI recipients improperly receive payments after medical cessation determinations, costing taxpayers $83.6 million. Does the Social Security Administration have a clawback provision for collecting improper payments?

Mr. O'CARROLL. Yes, they do, in two ways. One is that they can declare an overpayment and then of any benefits that are going in the future on it, they will take the penalty out of that. Then the other tool that we use is civil monetary penalties. So when we find that a person has lied, and if they aren't on benefits and we can't attach the benefits to get the overpayment from them, we will then charge them with a civil monetary penalty and get benefits back that way.

Ms. SPEIER. So does that clawback actually take place, then? And you are in charge of the clawback, not——

Mr. O'CARROLL. No. Unfortunately, all we do is, if it is in a court and the court has a judgment that the person has to pay it back, it is up to the Justice Department to collect it. And in the other ones where overpayment is assessed by SSA, they monitor it and collect it, we don't.

Ms. SPEIER. All right, so it is unclear whether or not we do any clawback. On the one hand, if someone is getting payments that shouldn't be getting them and it is our fault because it is a clerical error, I would not necessarily be supportive of a clawback.

Mr. O'CARROLL. Agreed.

Ms. SPEIER. But if it was adjudicated, they know they are not supposed to be getting payments, they continue to get payments, then I think there is a reason to clawback; and you are saying they have the authority and it is unclear whether or not they use it.

Mr. O'CARROLL. Yes.

Ms. SPEIER. All right. The IG report recommended that the Social Security Administration enhance its automated termination system following medical cessation decisions and the Social Security Administration agreed to that recommendation.

So my question to you, Ms. LaCanfora, is when will that recommendation be implemented?

Ms. LACANFORA. That recommendation has already been implemented. We discussed this at our hearing in November, if you might recall. We have made two systems changes to ensure automated cessation, so that there is no time delay between the decision at the DDS and the actual cessation. We have one more piece of that to implement, which we are going to do this fiscal year, to make sure that there is no gap at the hearings level. In addition to those systems changes, we are also going to continue to have a safety net in place where we do periodic runs to make sure no cases fall through the cracks. We fully support the idea that the cessations need to be made timely.

Ms. SPEIER. So to you, inspector, does that then cover all the potential terminations that don't take place that should take place?

Mr. O'CARROLL. Yes. In fact, our recommendation was that systems enhancements be made so that it is automated and that it will be caught, and that is being implemented right now. So we haven't audited it, we haven't declared it a success, but at least they are in the right direction.

Ms. SPEIER. All right, very good.

Mr. Chairman, I am going to actually give you back 15 seconds in the hopes that we will be able to have a longer second round.

Mr. LANKFORD. We will. We will.

Mr. Walberg.

Mr. WALBERG. Thank you, Mr. Chairman, and thanks to the panel for being here.

Mr. Bertoni, as I understand, every two years a high-risk list is established of agencies and programs. Can you explain how the GAO designates a program to be high-risk?

Mr. BERTONI. Sure. There is typically two criteria. The first criteria is whether they have significant management operational issues or problems that expose it to fraud, waste, and abuse, pro-

gram integrity issues, mismanagement. The second part is organizations may need urgent transformation in many ways.

Mr. WALBERG. As I understand it, Federal disability programs have been designated as high-risk every time the list was issued since 2003. Can you explain why?

Mr. BERTONI. On the first front, in terms of the management and operational side, we continue to see issues with their ability to get out in front of the backlogs, with their ability to make timely and accurate payments. We still have a significant overpayment situation. So even on that management and operational front, where we have seen some progress in some areas, it wouldn't be proper for us to remove it from the list.

On the other side, the area of transformation, we have said for many years they need to take a more modern approach to disability.

Mr. WALBERG. More modern approach?

Mr. BERTONI. More modern approach to disability. Disability today versus what it was 20 years ago, when we were a manual labor economy versus a service and knowledge-based economy is much different. Their criteria, their listings, their listings of jobs in the national economy have not kept up to date with the transitioning and what a disability looks like today, and we have had numerous recommendations that they address that.

Mr. WALBERG. Thus the illustration of the performing artist, being able to work and successfully raise a lot of funds.

Mr. BERTONI. Well, in that case, that is a significant management and operational issue there, not having appropriate tools to get out in front of that problem.

Mr. WALBERG. Mr. O'Carroll, which reviews, of the multiple reviews, adult CDRs for SSI, SSDI, childhood CDRs for SSI, age 18 re-determinations for SSI, which reviews are most cost-effective?

Mr. O'CARROLL. Mr. Walberg, probably the most cost-effective one would be the work CDRs, and work CDRs are the ones where we are showing wages are being posted against a person who is supposedly not working because they are disabled. Then, at that point, they would be brought in to SSA. But a little bit of texture to the conversation is that work CDRs are difficult to do; they are done by SSA, usually take a lot of study in terms of seeing if somebody had gotten a bonus or termination, another type of bonus like that. So, any way, they are difficult to do, but they have a very high return on investment.

The next one down would be the medical reviews, and the medical reviews are, just as we said, because of the person having a disability, getting better, they are probably the more easily accepted and understood of the type of reviews that are done; and they are done by DDSs, and that is where the DDSs are doing those.

So, anyway, I guess the best one to say on it is the word CDRs are the most effective.

Mr. WALBERG. Mr. Bertoni and Mr. O'Carroll, how much taxpayer money has been wasted because of SSA CDR backlog?

Mr. BERTONI. I can't speak to the dollar amounts. I can say that we had over 400,000 cases that we identified in the SSI kids realm that were well overdue for a CDR, and we didn't project that to

what that would be, but over time, a lifetime of benefits, that is a significant amount of dollars.

Mr. WALBERG. That was in the children's realm, you said?

Mr. BERTONI. Yes.

Mr. WALBERG. Thank you.

Mr. O'Carroll?

Mr. O'CARROLL. We are anticipating that several billion dollars are lost every year because of the backlog on the CDRs.

Mr. WALBERG. Four hundred thousand cases, several billions of dollars.

Ms. LaCanfora, why did the agency allow a huge backlog of CDRs for children with conditions that tend to be temporary?

Ms. LACANFORA. Well, with all due respect, I return that question in part back to the Congress. We have been inadequately funded over a series of years and unable to complete the number of CDRs that we need to complete. In fact, we have had to make very difficult tradeoffs in which CDRs we are going to do. And with respect to children, here is how we prioritize: we look for the greatest savings to the taxpayer; and the reality is the greatest savings to the taxpayer does not lie with children, because their benefits tend to be lower than adults. So we strictly look for savings to the taxpayer when we prioritize.

Mr. WALBERG. But the length of time is significantly more, correct, with children?

Ms. LACANFORA. We take into consideration the fact that we do review all children at age 18, so the average lifetime savings is actually lower when you look at children.

Ms. SPEIER. Would the gentleman yield?

Mr. WALBERG. I will yield.

Ms. SPEIER. Ms. LaCanfora, my understanding is the difference between adult payments and child payments is about $100 a month, isn't that true?

Ms. LACANFORA. I don't know off the top of my head what it is, but children's payments can be significantly less than adult payments. And, remember, the SSI program, there is all kinds of rules for children like deeming. Children's benefits are offset by income from the parents.

Ms. SPEIER. All right. I don't want to take any more time of the gentleman. My understanding is that the actual payments are about $100 in difference.

Mr. WALBERG. In difference. Correct.

I yield back.

Mr. LANKFORD. Ms. Duckworth.

Ms. DUCKWORTH. Thank you, Mr. Chairman.

Ms. LaCanfora, I would like to continue on the CDRs. My understanding is that the Federal Government saves about $10 for every dollar spent on CDRs. Is that correct?

Ms. LACANFORA. It is about one to nine, but close.

Ms. DUCKWORTH. One to nine? And I wanted to sort of touch on this history. You mentioned the fact that we had adequately, at one point, funded CDRs and you were able to catch up. In your opinion, what is your recommendation in terms of funding? You just said that you are not being adequately funded. Are you asking, recommending a similar funding to get rid of this particular backlog of,

what is it, $1.3 million over a multi-year period? What is your recommendation as an expert in the field?

Ms. LACANFORA. Yes. Absolutely, the bottom line is you get what you pay for when it comes to CDRs. In fiscal year 2014 we received the Budget Control Act funding level, $1.197 billion, which will allow us to do 510 medical continuing disability reviews. If, in fiscal year 2015, we get the BCA level, we will be able to do 888,000 CDRs, and we are asking for $1.396 billion to do that. Subsequent to 2015, the President's budget has a proposal for mandatory sustained funding separate from our administrative budget so that we can continue the momentum and eliminate the CDR backlog.

Ms. DUCKWORTH. So what you are saying is you need to get help covering the next two years to make a big dent in getting caught up in the backlog, and after that you have the mandatory that kicks in and then you will be able to work towards getting rid of the backlog and maintain parity with the new cases coming in? Am I saying that correctly?

Ms. LACANFORA. Yes. Yes.

Ms. DUCKWORTH. Okay, thank you.

Ms. LACANFORA. And that is our objective.

Ms. DUCKWORTH. Mr. O'Carroll, you wanted to say something?

Mr. O'CARROLL. Yes, Ms. Duckworth. Just to give a little context on that, what we are finding with that $1.3 million that is in the backlog on it, just doing the 510 on it won't touch the backlog at all. And under the current funding level, what we took a look at is in the next five years is four of the five plans on it will not reduce the backlog.

So what we are finding is that, at least from our studies on it, they are going to have to be doing up in about the 900,000 level to be able to have a significant impact on that backlog. So that is the biggest issue. They are keeping current, but they are not getting the backlog down, and that is where the more funding and more direction is needed.

Ms. DUCKWORTH. Are there any other reasons why a backlog has developed, other than inadequate funding, in your opinion?

Mr. O'CARROLL. No, because we can pretty much show from all the work that we have done is when SSA dedicates the resources to doing it and the dedication is coming from their funding, that they will reduce that backlog back. That is what we were talking about in the early 2000s, was when the money was there they did reduce the backlog.

Then after that, when the funding wasn't there, the backlog kept growing, and then what would happen is they would be doing less and less each year, so the backlog kept growing. In fact, last year, even with funding on it, it went from $1.2 to $1.3 million as the backlog of it. So it goes to show even with the current funding on it it is difficult for them to be getting any progress on the backlog.

Ms. DUCKWORTH. I just have a little time left. Inspector General, can you touch a little bit on CDIs and on how the CDI units have become effective in rooting out fraud and preventing disability overpayments? How do the CDI complement CDRs?

Mr. O'CARROLL. The CDI program is, I guess, one of our most effective anti-fraud programs going on; it is a group of between us and the SSA that we do it. And one of the things you were saying,

how it ties in with the CDR is that we work very closely, because we have two DDS employees assigned to the CDI unit, and as the DDS is noticing anything suspicious either in an initial application or when somebody is brought in for a CDR and they need more information on it, they will refer it to the CDI unit. The CDI unit then will be using all the different tools that they have, between records to find out whether persons have licenses or other types of information that is contrary to the disability; social media; surveillances, and all those ones. So that usually there if there is a question on a CDR, the CDI unit can help.

Ms. DUCKWORTH. Thank you.

I yield back the remainder of my time.

Mr. LANKFORD. Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman, and I thank the chairman and the ranking member for bringing this important hearing, and certainly all of our witnesses for appearing here today to shed light on this important subject.

The public trust in this Country really depends on the Social Security Administration's efforts and success at ensuring that people are not getting Social Security Disability payments who don't qualify for them and also that everybody who does qualify for Social Security and should be getting Social Security Disability is getting it. And I thank you for appearing here today.

Ms. LaCanfora, I have a question for you. Your testimony lays out some of the steps SSA has taken to improve program integrity and to help ensure CDRs are done right and that their outcomes are based on consistent application of policy. These efforts demonstrate an organizational priority on improving the quality of CDRs, the efficiency of the process, and fair treatment of the beneficiaries. In fact, the truth is SSA's efforts have resulted in a very high CDR decisional accuracy rate. Am I correct in that?

Ms. LACANFORA. You are correct.

Mr. CARTWRIGHT. Okay. In prior testimony, SSA Deputy Commissioner Sklar stated, "The aging of baby-boomers, the economic downturns, additional workloads, and tight budgets increase our challenges to deliver." Isn't it true that actuaries have known for years that the number of people eligible to receive Social Security Disability was going to grow? Is that true?

Ms. LACANFORA. Yes.

Mr. CARTWRIGHT. And how did they know that?

Ms. LACANFORA. Not only the actuaries, but the Social Security trustees, as well as the Congress have known for a very long time that the program was not sustainable.

Mr. CARTWRIGHT. It was as plain as the nose on your face, wasn't it?

Ms. LACANFORA. Safe to say.

Mr. CARTWRIGHT. Does SSA have the funds necessary to ramp up its program integrity efforts in view of the greater need created by this anticipated growth in SSD claims?

Ms. LACANFORA. We are very pleased with the fiscal year 2014 budget; it is the first time that we have received the money authorized in the Budget Control Act. It will put us on a trajectory that will allow us to eliminate the CDR backlog, yes.

Mr. CARTWRIGHT. Does SSA have sufficient legal authority to protect the integrity of the disability program?

Ms. LACANFORA. Yes.

Mr. CARTWRIGHT. Okay, so we don't have to legislate new law; it is just about money, isn't it?

Ms. LACANFORA. That is the single biggest determining factor, yes.

Mr. CARTWRIGHT. All right. Well, I thank you for that.

I think our witnesses have made clear that SSA has to have sufficient resources, and I appreciated your comments, Inspector General O'Carroll, about the return on investment, as I think you put it. We got an ROI of nine to one if we properly fund your efforts, and I think that the CDR proper funding is a subset of the entire question of proper funding of the SSA, again, to make sure not only that people who are getting disability checks are supposed to be getting them, and that is the work of the CDRs, but also that the people who should be getting disability checks and aren't getting them, that the process is sped up for those people, that justice is done for those people, and that the public trust in SSA is maintained and restored so that we clean up the backlogs not only in the CDR system, but also for the claimants to begin with.

I thank you again for appearing today and I yield back to the chairman.

Mr. LANKFORD. Thank you, Mr. Cartwright. I do agree that the CDR time—by the way, we are going to start a second round here to be able to jump in and we will have a more open conversation as we go through.

CDRs are incredibly significant in this, but I go back again to Ms. Nottingham, and I want to be able to mention this to you and want to be able to pull something out. It seems to be that it is not just the quantity of CDRs, it is the quality of what they are able to actually accomplish with it.

I want to go back to your comments earlier about the definition for medical improvement. Both what is coming out from the ALJs and what you see, the quality of that product, that work product that is coming and the determination of does this person actually have medical improvement, how is that working? Because with 18 percent of the people that were expected to be removed actually removed, those are CDRs that actually occurred, were paid for, and I am quite confident that many of them that were expected to be removed shouldn't be removed yet, they still qualify. But 18 percent seems like a very low number to me, and it goes back to your comment earlier, trying to deal with the definition of medically disabled. Can you help me with this?

Ms. NOTTINGHAM. Most cases wouldn't get a medically improvement expected diary for when it should come back to CDR. Conditions, there are some that really are unknown that tend to get that, like certain cancers, where it really depends upon the result of the treatment, so we might give a shorter diary for that. I think that we tend to see an expected diary given from an ALJ, and I think, from what I have seen, or believe that there might be in a belief that the person will return to their own; they will get treatment, improve, and just return to work on their own. And that is just not what happens.

Ms. SPEIER. By returning to work, is it returning to the same kind of work they were doing before or just being able to work in some job?

Ms. NOTTINGHAM. That is not something that we would look at.

Ms. SPEIER. No, but I was just wondering in terms of the definition.

Ms. NOTTINGHAM. Oh. Depending upon their age and education, the vote grids is where that comes into play. We first look and see if they can return to their work as it was described or as it was performed in the general economy and if not, then is there other work out there, and that is where we take into consideration age and education.

Mr. LANKFORD. Are you talking about at the CDR or are you talking about at the initial evaluation?

Ms. NOTTINGHAM. The initial. The vocational grids and those factors only come into play on a CDR if we have already found that medical improvement has occurred; otherwise, we wouldn't look at that at all.

Mr. LANKFORD. Okay, that is my preference on the question when we are coming back. Let me see if we can broaden this out.

When you are doing the disability determination, you have it on a State level. Do you have access to social media? Are you doing some of your own investigations or are you dealing with just all the documents that are in front of you? Do you have authority to be able to do any of your own investigation as well?

Ms. NOTTINGHAM. We would basically mainly look at medical records. We might get information from a third party if we have permission from the claimant to contact other people. Sometimes we might contact a former employer, but it is hard to actually get that information. The CDIUs have access to social media, the examiners do not have access.

Mr. LANKFORD. Okay, wait. Run that passed me again. Who doesn't have access?

Ms. NOTTINGHAM. Adjudicators or examiners would not, only CDIU.

Mr. LANKFORD. Okay, so a typical case. But the CDI, that is not normal on that.

Ms. NOTTINGHAM. Right.

Mr. LANKFORD. That is a smaller number and only in certain regions, correct?

Ms. NOTTINGHAM. Yes, only 22 office or States.

Mr. LANKFORD. Okay, so in a typical disability determination you are taking only basically the documents that are in front of you. If you are going to contact a next door neighbor or if you are going to contact an employer, you have to actually get permission typically from the person that you are looking at the forms from.

Ms. NOTTINGHAM. Yes. Usually when they file an application there is a place for them to list a contact person. Sometimes they don't have anyone or don't list anyone; generally they do. And we also use that just to follow up with them in case we lose contact with them. So if it is on there, then we already have permission to contact them, so we wouldn't necessarily ask during the middle of development.

Mr. LANKFORD. Okay, what I am trying to figure out is there is really no investigation; you are taking the documents, the one-sided—and this is going to sound more caustic than it should—the biased documents, because everyone has a natural bias; they are applying for disabilities, they are going to make sure they write it, prepare it, or they have counsel that is helping them prepare it to make sure they get all the right words on there to be able to detail out here is what needs to be. That is really all you have to evaluate by.

Ms. NOTTINGHAM. We are very limited in what we can get. That is why I mentioned the point about having only a consultative examination when someone doesn't have treatment. It is best when we have records for years because the consistency helps make sure we are making the right decision if there is a consistent history of how they have been doing. But when we only have an exam or one-time exam, it really leaves the decision a little bit more questionable.

Ms. SPEIER. Can we have Ms. Nottingham go through her recommendations that were in her statement that I don't think you actually got to, did you, or you kind of rushed through?

Ms. NOTTINGHAM. One of the things that we would like to look at the MIRS policy, the medical improvement review standard, in general.

Ms. SPEIER. Right.

Ms. NOTTINGHAM. Because we do see that very few people get off the rolls through this process.

Ms. SPEIER. And you would attribute that to the MIRS process.

Ms. NOTTINGHAM. Yes.

Ms. SPEIER. So how would you have us change that?

Ms. NOTTINGHAM. When the diaries do have a new decision to see if they are disabled at that point, following the initial rolls.

Ms. SPEIER. So that is your reference to de novo review, is that what you are suggesting?

Ms. NOTTINGHAM. Yes.

Ms. SPEIER. So it basically would allow you to open up the entire case to look at, as opposed to just looking at documents. So you could, for instance, look at social media.

Ms. NOTTINGHAM. By policy we are not allowed to look at social media.

Ms. SPEIER. I have a hard time with that.

Ms. NOTTINGHAM. I do have some concerns with social media.

Ms. SPEIER. All right, tell me what they are.

Ms. NOTTINGHAM. Just that it could be of some benefit, but someone posting on their social media, we would have to make sure you can confirm that that was actually them, and also a picture of them working on a truck or something like that could have been years prior to their actual injury. So it is a piece of information that could be useful, especially when you are looking into fraud or similar fault, but it is only one piece of information.

Ms. SPEIER. All right, Inspector, how would you comment to that?

Mr. O'CARROLL. Thanks for asking. I have to say of course we have concerns what would happen if they rolled out social media

to all SSA employees, and I think that is a management issue with SSA.

But what we think in terms of the social media, and I used that in my example here, we have used it on other examples, we think it is a good tool. And as it happens now, we call it in the investigative world it is a clue. And you take a look at that clue, you take a look at other clues, and it is part of a big picture, not the picture itself.

So one of the suggestions that I have been coming up with is with SSA we now have an national anti-fraud committee, which is co-chaired by myself and the CFO of the organization, and one of the subcommittees under it I would like us to do a pilot program when we start taking a look at giving different SSA employees access to social media and give it a pilot and see how it works out. So that is one of the things that I am taking to the national anti-fraud, is to see if we can start doing that.

Ms. SPEIER. You know, I just am sitting here thinking if 60 Minutes did a piece and showed all of the potential abuse, and then it was then turned on us and what are you doing about it, and we are basically saying, well, we don't allow people to look at social media. I think we would be laughed at.

Mr. O'CARROLL. I agree. That is why I am saying it is a good tool and it is something that SSA should start piloting and see. But it is one of those things that, in fairness to them, probably some caution needs to be done in doing it; is not something of the snap of the fingers. But I think it is something to move into the 21st century, that it has to be considered.

Mr. LANKFORD. It doesn't solve everything, we understand that, but it is a tool. As you mentioned, it is a clue; it is something that could be out there. It just provides an opportunity for a question. Even if there was the opportunity to be able to say notice this, tell me about this. Just to be able to initiate the conversation. By the way, notice that you also have on your social media that you hire out to also mow lawns. That would be something that you would ask a question about at some point.

I want to go back to this MIRS process. We need to drill down on this more. There is a difference between their initial evaluation and then what happens when we have a CDR. Talk to us about the differences here between the two.

Ms. NOTTINGHAM. In my testimony, I mentioned that the definition of disability is removed from the CDR process.

Mr. LANKFORD. Right.

Ms. NOTTINGHAM. The initial claim process, we are looking at their conditions and making assessment of their functioning, and then applying the vocational grids and finding out, then, if they meet the criteria for disability. We don't consider that at all in a CDR with the MIRS, if there is no indication of significant medical improvement.

Mr. LANKFORD. Okay, so help me understand. When you are dealing with this and you have to evaluate medical improvement, what is the grid that you are working through on that one? There is the grid that is the prior one. How do you make a decision of medical improvement? Because you really have two issues here, the medical improvement and then can they engage in substantial

gainful activity. Or is this at this point, once we have left it, gainful activity is not there, it is just medical improvement?

Ms. NOTTINGHAM. You have to consider medical improvement. If we can't establish that there is medical improvement, we would not go on to the vocational aspects.

Ms. SPEIER. But the problem there is that if it was questionable in the initial evaluation, but they got benefits anyway, then you are perpetuating what may have been a bad decision to begin with, correct?

Ms. NOTTINGHAM. Correct. That happens regularly.

Mr. LANKFORD. When you say regularly, are you talking 4 percent or are you talking 40 percent? I know this is going to be your ballpark guess. We get that. So we are not going to hold you to an absolute statistical number. Your experience.

Ms. NOTTINGHAM. My experience, and the experience of many examiners, would perceive it to be higher than 4 percent. I would think maybe something 20 percent is a ballpark.

Mr. LANKFORD. That should have never been on in the first place.

Ms. SPEIER. Mr. O'Carroll, what do you say?

Mr. O'CARROLL. As I said, on that one there, when we did the study on it, we found 4 percent for sure, and then we found 8 percent that was questionable because of the information. So anywhere from 4 to 12 is us.

Mr. LANKFORD. Okay.

I am sorry to interrupt. Keep going on that, then.

Ms. NOTTINGHAM. It becomes difficult because a lot of subjective conclusions are made in the disability process, and we can't substitute judgment, so if we can't establish an actual true error was made, we end up continuing, and we look at, then, if there is medical improvement.

So someone who is allowed for very minimal impairments, their functioning wasn't really limited but they were granted disability benefits because of maybe the statements they made. The statements should have been supported by the evidence and consistent with everything else, but even though that wasn't given appropriate weight and they maybe just based the decision solely on the statement of the claimant, or maybe even one of their doctors, that would be substitution of judgment is how I understand the policy, so we would then use the MIRS to find out if there is medical improvement, it would not be an error.

Mr. LANKFORD. But we are still back to the same spot. How are you defining medical improvement? You are not substituting judgment, but there is some judgment in this.

Ms. NOTTINGHAM. Yes, the medical improvement is going to be subjective. We look at the signs, symptoms, and laboratory findings. Some conditions have a lot more objective findings, particularly physical.

Mr. LANKFORD. Okay, so help us with an example. Give us an example of something working through.

Ms. NOTTINGHAM. A back impairment is something that is very common, and we usually look at things. They have x-rays, so that is a very objective test, or other imaging, and then we look at things like their muscle strength, their range of motion, and any

neurological injuries. So we would look at that, and if they still continue to have decreased range of motion and some normal strength or decreased strength, if those are consistent with what we saw before, then we would say that that is not medical improvement.

How much medical improvement is where a lot of the subjectivity and differences may come in. I would think, though, that most—I have seen people who try to use very little improvement, something like a range of motion that was limited to 60 degrees and then they have 90 degrees range of motion, something minor like that, they would try to use that as an argument, and then we get overturned. Those would not fight through appeal.

Ms. SPEIER. So, Mr. Chairman, I have a question here. You are attorneys or you are judges, correct?

Ms. NOTTINGHAM. No.

Ms. SPEIER. What are you? I mean what are the examiners.

Ms. NOTTINGHAM. The DDS examiners are State employees and the qualifications range from State to State. Most require a bachelor's degree of some sort, and we have extensive training in medical policy.

Ms. SPEIER. Okay, but no medical training per se, I mean, you are not professionally physicians or health care professionals.

Ms. NOTTINGHAM. Correct. Most people would not have a medical background.

Ms. SPEIER. So you came up through the ranks with a bachelor's degree and then, through training, became examiners, is that correct?

Ms. NOTTINGHAM. Correct. We usually have quite extensive training, at least of 10 to 12 weeks of pure training, and then we ease people into a caseload with extensive review. In my State we have a one-year probation for an examiner.

Ms. SPEIER. But here is my concern. In a workers comp system, in an interesting sort of way, this is like a workers comp system. In a workers comp system, it is a system that is very different from this system, but there is a physician that evaluates the claim and then the continuation of the benefits depends on that physician review and by a second physician review that may be from the employer.

Ms. NOTTINGHAM. We do have doctors that review things, review the decisions, the medical assessment in most States.

Ms. SPEIER. What States don't?

Ms. NOTTINGHAM. There are single decision-maker States and there are some decisions that do require like any denial for psychological impairment would require a doctor. They are the prototype States and the 10 additional.

Ms. SPEIER. They are the which States?

Ms. NOTTINGHAM. I don't know. There was a prototype that started about 16 years ago, and we are still running on a prototype for those 10 States, and there were an additional 10 States that receive single decision-maker authority.

Ms. SPEIER. Oh, prototype. A permanent pilot.

Mr. LANKFORD. Yes, that is a pretty long pilot project.

Ms. NOTTINGHAM. Yes, exactly. I can name a few States, but I don't have that information.

Ms. SPEIER. Can you just name them?

Ms. NOTTINGHAM. Michigan, Missouri, North Carolina.

Mr. LANKFORD. Anyone else can jump in on this if you know what some of the States are as well.

Ms. LACANFORA. I don't know the States off the top of my head, but I do want to say I think we are getting into a very confused area on this issue. If the question is do the examiners have access to medical consultants, we have hundreds of medical consultants on contract, and they review cases. There are certain cases where we do not have a medical review, but we are pretty specific about where that is. For example, we have cases called compassionate allowances; they are very specific impairments where the objective medical evidence will prove a finding of a severe disability. In those cases we don't require medical consultation.

It is a little bit of a complicated area I think that we are getting into, but disability examiners generally have access to medical professionals.

Mr. CARTWRIGHT. Mr. Chairman, may I jump in for a moment?

Mr. LANKFORD. Sure. Jump in.

Mr. CARTWRIGHT. Now, we have heard testimony today about the backlog of CDRs being $1.3 million, is that right? So we are talking about 1.3 million people who are receiving SSD or, in some cases, SSI who have gone passed their scheduled date for review, which makes them part of a backlog, is that it? I see heads nodding.

So one thing that I am wondering about is whether this is a backlog that is disproportionate to the CDR process in SSD. Specifically what I am wondering is the people who have originally applied for SSD, somebody has had a horrible illness which has left him or her, rendered them unable to work, at least that is what they think and that is what they claim, so they put in for Social Security Disability. And I have heard talk that there are backlogs for those applicants as well. Anyone disagree with that? Seeing no nodding heads there.

Does anybody have an idea of what the number of the people is who are in that backlog, the people who are waiting for overdue Social Security Disability initial determinations in this Country?

Ms. LACANFORA. I don't have that number off the top of my head, but let me try to answer your question this way. I think you hit upon a very important point. We have seen extreme service degradation in the past few years that ranges far beyond the realm of program integrity or medical CDRs. We are closing our field offices an hour early every day and on Wednesdays we close at noon simply because we do not have the resources to handle all the work coming in the door. We have lost 11,000 employees in the past few years. Our wait times have gone up across the board.

Mr. CARTWRIGHT. So that is exactly what I was getting at, Ms. LaCanfora, and thank you for your candor there, because when you talk about severe degradation, it doesn't just apply to the CDR process; it applies across the board at SSA, doesn't it?

Ms. LACANFORA. Absolutely.

Mr. CARTWRIGHT. Thank you.

I yield back.

Ms. LACANFORA. May I also just give you the data that you wanted regarding the benefits of individuals on whom we perform

CDRs? The average benefit payment for an SSI child is $545 a month; the average benefit payment for an adult getting SSDI is $1,146 a month. Thus, the reason I said that the payoff is much greater for adults on disability.

Mr. LANKFORD. Okay, I am going to go to Ms. Lujan Grisham in just a moment here, but when we talk about the benefits, the administrative costs, and the backlog, and all that is happening is accelerating, is some of the issue just the number of people that are trying to enter the system? We are dealing with fairly static numbers. When you look at the last five years, the numbers have been fairly static for what is actually coming in in administrative costs for SSA.

Ms. LACANFORA. Our workloads have consistently increased, while our staffing levels have consistently decreased.

Mr. LANKFORD. You have a tremendous number of new people that are coming in, your funding levels are not going up, so part of our issue is the number of applicants that are coming into the system. So part of our question is why have we seen this giant jump in the number of applicants get in the system?

Ms. LACANFORA. Well, I think as we discussed before, this is not news. The Social Security actuary, the board of trustees, the Congress has been well aware, and this has been predicted for many, many years. The reason for the growth in the disability programs, and we have research done by economists on our Web site which corroborates the findings of our actuary, demographic changes have resulted in an increase in the number of people on disability, specifically the aging of the baby-boomers, individuals entering into their disability-prone years, and women entering the workforce and gaining insured status under the program. Those demographic changes are the reason for the increase in the growth in our programs.

Mr. LANKFORD. But that is not going to show an increase in why we have more children in the program, aging and all those things, that dynamic. We have this dramatic increase as well in SSI.

Ms. LACANFORA. There is a very good CBO report that is out that talks about the increase in the growth in the childhood program, and it talks about a variety of factors that are also demographic. First, there is more widespread acknowledgment and diagnosis of medical conditions among children. We don't create the diagnosis at Social Security, we follow the medicine. There has also been an increase in the number of children living in poverty. And you have to remember that SSI is a needs-based program. So as more children live in poverty, more applications come in for SSI.

Mr. BERTONI. If I can just jump in here. There is a big gap between the growth in physical impairments versus mental impairments. If you look at physical impairments in the SSI program, the line goes like this. If you look at mental impairments, the line goes like. So we don't know what explains that, but we do know that on the mental impairment side, when those cases are decided, at least in the case of speech and language delay, 80 percent of those cases are decided on the functional criteria, which is very subjective. So it is not a listing, it is not a grid; it is a functional criteria.

Ms. SPEIER. So let's drill down on that, because a whole group from Social Security came in and met with me on ADHD. Speech

and language is one of those conditions that does improve as the child advances, and you are saying that you are seeing a dramatic increase in that particular area.

Mr. BERTONI. Absolutely. It is one of the top three impairments where there are increases. Speech and language delays has increased significantly, and it is considered by many to be a transient impairment, where you can grow out of it with maturity. And the allowance rates are very high, so I think it is evident that these children have that condition. But the cessation rates are very high down the road when they finally do these, MIRS notwithstanding; 38 percent cessation rate. So it tells me that these folks, these children are likely growing out of this condition, but SSA is not reviewing the cases.

Ms. SPEIER. Okay. So, to that point, you would say, Ms. LaCanfora, that they don't reap the same benefits, so you don't focus on those cases. But it would seem, based on the GAO's study, that that is the one area where there is dramatic improvement; whereas, in many medical conditions of adults, there isn't improvement. Certainly in these mental, for the most part, disabilities there is dramatic; I know ADHD is one of them. So why wouldn't we, then, focus more attention on those cases, as the GAO is suggesting?

Ms. LACANFORA. So the math here is very simple. We could. We could do more childhood CDRs. But if we did more childhood CDRs, we would do fewer of something else. And then my colleague, Mr. Bertoni, would be here with a different report citing the much greater loss to the taxpayers in revenue by not doing that other group of CDRs.

Ms. SPEIER. No, he is going to disagree with you, and I think I will as well. Go ahead, Mr. Bertoni.

Mr. BERTONI. I think we acknowledge that there are resource issues and there are tradeoffs to be made. Managers manage; managers to the pain. We have put on the record at least three impairments that have cessation rates in excess of 30 percent; ADHD at 25 percent, some personality disorders 39, and then, of course, the speech and language delay. For SSA to come here at some later date to say we understand that, we may have a problem, we are going to take some piece of the DI money, given the return on investment, and perhaps do a limited 10-year look at these cases to perhaps cease the ones that need to be ceased, we would not have a problem with that; that is managing to your resources.

Mr. LANKFORD. Ms. Lujan Grisham, just to let you know, we are in a second round on this, so anywhere you want to jump in, you are welcome to be able to jump in with any set of questions. So take off.

Ms. LUJAN GRISHAM. Thank you all for being here. This is a subject that, in both a positive and not so positive way, are very near and dear to my heart. First, my sister, who has been gone many, many years, unfortunately, had a significant disability, both physical and developmental back when special education was brand new. So just in terms of getting any resources for a family tough. And I know all too well what it is like even today, decades later, what it is like to get disability services, whether it is a Medicaid through a waiver, whether it is SSI, whether it is SSDA. Whatever

that resource component is, it is very difficult still to get it, attain it, hold it, and then make it last for the things that you need.

And I also worked in the field of aging and long-term care and DD, adults with disabilities, world for 30 years. I also come from a State who, unfortunately, as has been highlighted now in every major news media, has the worst public health outcomes of any State in the Country, largely related certainly to socioeconomic issues.

But just look at our fetal alcohol syndrome issues and look at our higher than national averages, which are way too high, for autism. So when you are looking at the number of kids that are spiking, we are also seeing a whole new host of significant increases, and I think a lot of it is better diagnostics, but I think probably we will find, and that is beyond my pay grade, some researcher is going to find very clearly what is going on, I hope, so that we can do something about it.

The balance here, and I appreciate this committee's hearing today and the comments of my colleagues, when we are wasting billions of dollars by doing overpayments and not doing an effective administrative service, because I worry about the 220 average days for somebody to get a disability determination. I am concerned about the growing waiting list on the other side. And I do respect that you have to manage to your resources, but I worry that in the context of this hearing we are going right back to where we go; it is all of one and none of the other.

I think that there can be much more accountability in all of these offices. And maybe I am on a diatribe with no question, I am so sorry, Mr. Chairman—that is what happens on the second round, I guess—that I expect this Administration, probably more than most, to do it. But managing to your resources isn't going to change that we need to, I am going to call it a level of care in some of the claims determinations review.

But the last time I heard, when you have Down Syndrome, that doesn't change, that diagnosis; you keep it. So the notion that you get better; you can improve some functional limitations, but I always am offended when there is a sense that people can get dramatically better. And that is not to say, by any stretch of the imagination, that I don't expect accountability where there can be, because it is finite. We have a growing number of people and we want to do the best by the number of people we have.

So if I can maybe boil this down to a question, what can we do to balance those two issues more than just we need more resources in Social Security? I would be one of those there, I would be one of those who is there. But I also want you to be accountable with those resources and expect that you do everything in your power. How do you start, today, catching up in a way that recognizes that I don't want this to be on the backs of beneficiaries and I don't think—I heard Ms. Lockhart earlier. I may disagree with your characterization about how people with disabilities come to you and what those situations are.

How do we right-size those so that we are aggressive on the management side, we don't create more discrimination and a more difficult process for people to attain the benefits that they are entitled to, which are intended to provide dignity, respect, independ-

ence, a savings on the long-term care side somewhere else, and an opportunity for people to reenter the workforce and to do the things that we want them to have every opportunity to do?

Give me as many quick ideas as you can about right-sizing. Nobody can.

Ms. LACANFORA. I will start out. You mentioned the funding issue, and I know you are well aware of that, but with respect to the discussion of prioritizing CDRs, we wouldn't have to prioritize CDRs if we had adequate funding. We wouldn't have to prioritize them at all because we would be doing all of them.

Now, with respect to what else we can do, we fully acknowledge that we have to evolve the policies in the disability programs to keep pace with medicine, technology, the world of work. We also have to focus on consistency and objectivity in the decision-making process. And we discussed at the last hearing and in our intervening meeting all of the host of things that we are doing at Social Security in that area, and we are working with experts across the Nation; the Institute of Medicine, the National Institutes of Health, ACIS, the Bureau of Labor Statistics. We have a whole variety of initiatives underway to make sure that, in fact, our policies are evolving and reflecting today's economy and today's world of medicine.

Ms. LUJAN GRISHAM. If the chairman will let me, Mr. Bertoni, do you have any? Because I worry about that imbalance, which tends to occur every time, all or none.

Mr. BERTONI. Sure. And I think you mentioned Downs Syndrome. That was not an impairment we focused on. We look at the broad spectrum of impairments, and we just flagged three that looked to be impairments that could yield a return on investment in terms of recovery. So we have given them that information, acknowledge that there are resource tradeoffs, but again, within that pot of money, I think they can work more efficiently. Should that money come down the road, we would hope that they would continue to prioritize to the areas that would continue to give them a return on investment. That is unclear whether they would going forward.

Mr. LANKFORD. I want to recognize the ranking member of the full committee, Mr. Cummings. I saw you came in and I want to be able to recognize you for time. And this is a second round, so it is open microphone, so you have all the time that you need on it.

Mr. CUMMINGS. Thank you very much. I want to thank the committee, Mr. Chairman, and the ranking member, for highlighting the need to conduct timely CDRs to help make sure disability programs are serving the truly disabled. When I served in the Maryland legislature for some 14 years, I was the chairman of the committee that oversaw Social Security for the State of Maryland, so this is of great interest to me.

Now, Ms. LaCanfora, would you agree that CDRs are a highly cost-effective program and an effective way that ensures that disability benefits are going to only those individuals who continue, continue to be eligible?

Ms. LACANFORA. Absolutely.

Mr. CUMMINGS. And so when a CDR finds that an individual is no longer eligible for benefits, does that mean that the original eligibility determination was in error?

Ms. LACANFORA. No. In fact, more often than not, it is due to the fact that the person has medically improved.

Mr. CUMMINGS. And that is what we would hope for, is it not?

Ms. LACANFORA. Correct.

Mr. CUMMINGS. I mean, that is a great result. In other words, instead of somebody being disabled for years and getting benefits, when they have improved, then that helps the person, I guess that gets them back to work or whatever, so that helps all the way around.

Ms. LACANFORA. That is right.

Mr. CUMMINGS. Does a CDR decision to cease benefits because an individual is no longer disabled mean that there was fraud? Does it?

Ms. LACANFORA. No, absolutely not.

Mr. CUMMINGS. And how often is fraud found, though?

Ms. LACANFORA. Well, this is a question that I think we have debated quite a lot in prior hearings. The only real data that we have on fraud in our disability program is a study that was done by our inspector general in 2006 that cited less than one percent of fraud in the program.

Mr. CUMMINGS. So when a CDR is done and fraud is suspected, what happens then?

Ms. LACANFORA. We refer that case to the inspector general. And as I said earlier, we refer 22,000 cases each year to the inspector general, and those instances of suspicion arise when our examiners look at the facts of the case, the assertions of the individual claimant against all of the records that they have, and they detect some sort of anomaly or gap in the evidence. So 22,000 times a year we refer those cases to the inspector general for further investigation.

Mr. CUMMINGS. And you said that is about 1 percent?

Ms. LACANFORA. The 1 percent is a little bit different. What I am saying is you asked how much fraud is in the program.

Mr. CUMMINGS. YES.

Ms. LACANFORA. And the best indicator we have is a study that was done in 2006 by the inspector general citing less than 1 percent fraud.

Mr. CUMMINGS. Well, let's go back. I am trying to get to the CDRs. What percentage of the CDR cases—you may not have this information, and let me know—of the CDR cases is fraud suspected and then you pass them on? You follow what I am saying? In other words, the CDR is conducted, it appears that there is a problem that is connected with fraud. I am asking you do you have any idea what percentage of the CDRs that are conducted result in suspected fraud. Does that make sense?

Ms. LACANFORA. It does make sense, and Mr. O'Carroll can chime in.

Mr. CUMMINGS. Somebody can answer. If you can't answer, somebody else can.

Ms. SPEIER. Actually, Mr. Ranking Member, I think one of the points of the CDR, of the CDRs that aren't done because of the backlog, they have established that it is $2 billion—was that the

figure you used, Mr. O'Carroll?—of money that would come back to the system as a result.

Ms. LACANFORA. But those cases are not an indication of fraud.

Mr. CUMMINGS. Okay.

Ms. SPEIER. Not fraud, but they no longer have the medical disability.

Mr. CUMMINGS. All right.

Mr. O'CARROLL. There are 22,000 that are referred to us by SSA. A small portion, Mr. Cummings, is going to be from the CDRs and fraud related to that, and that is sort of the subset that goes to our CDI units. We figure of the 22,000 referrals that SSA sends to us, about one-third of them are going to the CDI units. So that is where there is suspicion in a DDS referred to our CDI units. So about one-third of our referrals are in relation to suspicions or concerns in disability.

Mr. CUMMINGS. You know, I am sure you all are familiar with that 60 Minutes show that came on not long ago. It seemed like there were—they talked about these attorney mills. And I am an attorney, so I just want you to know, but do you see a lot of that? Yes, sir.

Mr. O'CARROLL. As you said, with that series on it, there were a number of news articles on it, The Wall Street Journal covered it. It was in a number of things. It is one of our biggest concerns, what we call facilitator fraud, and that is where you have sort of the mills that are going, where there are going to be people do introductions to people saying that they will get them on disability; they will be using unscrupulous medical providers; there will be facilitators for it. It has been in the news quite a bit.

And, yes, we are concentrating on that very heavily. We are doing it in, I guess, three regions now; we have units that are just out there taking a look at facilitator fraud. They are very difficult investigations to do because usually you are using undercover agents to be inserted in to be able to show what was happening. We film it, we videotape it, we do all that, but it usually takes a couple years, where you establish an identity for a person to go in as an undercover on it.

So, yes, we are exploring that extremely a lot.

Ms. SPEIER. But, Mr. O'Carroll, in a prior meeting that we had, didn't you indicate that there were thousands of these cases in Puerto Rico and so many hundreds of them in New York and so many more in West Virginia?

Mr. O'CARROLL. Yes.

Ms. SPEIER. Could you just give that number?

Mr. O'CARROLL. The two examples that I used that were really specific was Puerto Rico. It is hundreds at this time, but there is also suspicion of over 1,000. And in New York City there was a large amount on that one, too, where facilitators were going to people as they retired from Government and said to them, we will get you on benefits. So we have a couple of those and we have others going in the other regions that I talked about.

Mr. CUMMINGS. Now, Ms. LaCanfora, it has been suggested that the medical improvements standards, going back to the CDRs, does not allow the removal of beneficiaries who were wrongly awarded benefits in the first place. Is it true that under the existing review

standards, if a clear and indisputable error in the initial disability determination was found during a CDR, the examiner can cease benefits?

Ms. LACANFORA. That is correct.

Mr. CUMMINGS. So Social Security actuaries projected the disability insurance trust fund is only years away from being unable to fully finance disability insurance benefits. I would like to just as a few questions about that. If the agency performed every CDR required in a timely manner, would the savings in spending make a small, medium, or large dent in the shortfall in the trust fund?

Ms. LACANFORA. It would be small.

Mr. CUMMINGS. How small?

Ms. LACANFORA. Not being an actuary, I am a little concerned about commenting on it, but I think it would not significantly extend the life of the DI trust fund.

Ms. SPEIER. [Remarks made off microphone.]

Mr. CUMMINGS. Okay, I am just asking a question.

Ms. LACANFORA. But it would not extend the life of the trust fund.

Mr. CUMMINGS. I am just asking questions. Thank you.

So go ahead, what were you saying?

Ms. LACANFORA. Just that if we did all of the CDRs, certainly that is desirable, that is what we all want to do. With adequate funding we will do it. But in terms of extending the life of the disability trust fund, it would not have a significant impact.

Mr. CUMMINGS. Well, going to Ms. Speier's point, we are talking about billions of dollars? I see everybody shaking your heads.

Ms. LACANFORA. Yes. Yes.

Mr. CUMMINGS. Okay. But you are saying that it wouldn't, you see that as small.

Ms. LACANFORA. I don't see it—okay, let me put it into perspective. I think was said before, but for every $9 that we save the taxpayers, we have to invest, on average, $1. So it is clearly an excellent investment to do continuing disability reviews; they are essential, they should be fully funded without question.

Mr. CUMMINGS. I agree.

Ms. LACANFORA. But your question was to what extent would doing all of them extend the 2016 date of reserve depletion which is currently projected, and my answer is that doing the rest of the CDRs isn't going to have a dramatic impact on that date.

Mr. CUMMINGS. So what is a meaningful way, do you think, to address the shortfall?

Ms. LACANFORA. The shortfall is not new; there have been shortfalls in our trust funds at least a half dozen times since the inception of the programs, and the Congress has a couple of options. They can do payroll tax redistribution and there are a couple of legislative mechanisms through which to do that.

Mr. CUMMINGS. And Congress has acted before?

Ms. LACANFORA. Yes.

Mr. CUMMINGS. All right, thank you very much.

Mr. LANKFORD. Was that for disability insurance specification you are talking about the redistribution?

Ms. LACANFORA. It has been done for both trust funds.

Mr. LANKFORD. Short of that, what else can we do? Because one of the things that Ranking Member Speier and I, when we sent the letter, we were trying to detail 11 different items that can be done that are not just about efficiency and dollars; they are about people in this process, going back to what Ms. Lockhart was talking about before. These are lives and people that we hope to be able to transition back into productive lives for the sake of their children and the sake of the community as a whole and what they bring to society. So there are multiple issues here. What are other things, besides just redistributing payroll taxes, to be able to stabilize this and be able to bring down some of the cost areas?

Ms. LACANFORA. So I think that there is not a connection between any of the items in your letter or any of the things we are working on at Social Security and the reserve depletion that is projected in 2016. In other words, all of those things that we are working on are wonderful ideas and we need to keep our eye on the prize and evolve the policy and the program to be more efficient and effective. You all have some good ideas as well, but those things are not going to extend the life of the DI trust fund. You would need to fundamentally, through legislation, completely change the nature of the program.

But I want to go back to something I said earlier, which is the policy and the process and the management of the agency is not the cause of the reserve depletion. The cause of the reserve depletion is demographics; baby-boomers aging, women entering the workforce.

Mr. LANKFORD. I understand. I only partially accept that just from some of the other things. We talked last time about the Federal Reserve in San Francisco and the report, I am sure you are very familiar with that. They also tracked those same issues, about women, age, all those things, but they came out with a 44 percent of unexplainable increase beyond just demographics.

So it wasn't just, hey, this is a pure demographic issue; they identified, of the additional people in the system, 44 percent of them no one can identify. This shouldn't be there. That is a fairly high number of individuals to enter into the system unexplainable. We have talked about the high number of people that are actually applying that create this backlog not only of CDRs, but there is a backlog of actually getting into the system because so many people are hitting the system. They go through the two different DDS reports and they just automatically go to the ALJs. So there is a press in the backlog of the ALJs that SSA has worked on to try to fast-track and get people in the system and have the ALJs deal with this.

So we have issues on every side of this. We have 44 percent of the people unexplainable while they are pressing into the system; we have a fast-track system of actually getting people through the ALJ system; we have CDRs that are occurring that we are getting 18 percent turnaround rate of what we are expecting, and we are dealing with the definitions of it. There are issues on each side of this that have to be addressed. Some of these are legislative, we get that. That is one of the questions that we are asking, what is it legislatively do you need.

But we do feel like there is a need administratively that does make a difference in billions of dollars. If it takes us from 2016 to 2017, that is a gain. What are we doing to be able to get ahead of this? It is just unacceptable to get to 2016 and for Congress to wake up and go, gosh, we have a problem. When do we all see it?

Ms. SPEIER. Well, and let me also say that regardless of whether it is a lot of money or not a lot of money, the system has to have integrity; and people who are receiving benefits should be eligible to receive benefits, and those that are ineligible or grow out of eligibility should not receive benefits. And we should have a system that works for that end.

I am curious about, if we could go back to Ms. Nottingham's statement and her recommendations. I would just like to understand some of the ones you referenced. You said electronic claim exceptions should be eliminated to prevent any future claims from being processed in a paper format. Makes a lot of sense. Are claims still being processed in a paper format?

Ms. NOTTINGHAM. There are still some exceptions. It is very few, but it happens still to this day.

Ms. SPEIER. Well, by very few, then why is that a recommendation if it is de minimis. Is it de minimis?

Ms. NOTTINGHAM. Well, the claims that are currently processed that are paper may be de minimis. The problem is that just more paper folders in general. When they come up for CDRs, some of them are still paper, so the fewer that we have coming in as paper, when they become CDRs, the few we all have that are lost. We see at CDR maybe a small percentage, but one or two percent of claims that are lost is still a large amount.

Ms. SPEIER. So you also said the lost folder policy should not apply to cases of fraud or similar fault. What is the lost folder policy?

Ms. NOTTINGHAM. In the CDR, if the prior decision folder is lost, we have to try to reconstruct the file, and if we are unable to do that, then we just continue benefits. Prior to reconstruction, we actually try to see if they meet the criteria currently, but generally we don't have anything to compare because it becomes really hard to reconstruct the prior file.

Ms. SPEIER. So that is our fault for losing the file.

Ms. NOTTINGHAM. Correct.

Ms. SPEIER. So what percentage of cases are lost folders?

Ms. NOTTINGHAM. My belief, what I see is that it might be more than SSA has fully accounted for or been able to track, I should say, and I think it is probably like 1 or 2 percent, still.

Ms. SPEIER. Okay, so those are small, although, even though they are small, they could be a significant number. I understand that.

Revisions to the fraud or similar fault policies are needed. Can you kind of expand on that and what kinds of changes should be made there?

Ms. NOTTINGHAM. There is very minimal policy at this point in time addressing that. Claims are very complex and it is hard to prove fraud or similar fault, particularly on CDRs. With CDRs, we have to prove that there was fraud or similar fault at the prior de-

cision as well, so I don't actually handle those types of claims, though.

Ms. SPEIER. Okay, I understand that. Mr. Bertoni was nodding his head. Maybe you can give us some——

Mr. BERTONI. I just think when you start talking about the issue of fraud, fraud is a very high bar. To get to fraud, you had to suspect something, you had to develop a case, and then you had to actually get a conviction for fraud, typically. Then there is your fraud figure. But is there waste? Is there abuse in the program? Absolutely. A person who gets on the rolls five years ago, recovers, but doesn't have a CDR for the next three years, you finally call that person in, they are deemed not to be medically eligible anymore, they have three years of overpayments. Was that fraud? Probably not; you probably couldn't go there and prove that. But was it potential waste and abuse in the program? Absolutely. So you have to look at this in a broader context, and it is very costly.

Ms. SPEIER. So ADHD, can I have your opinion on how we are handling ADHD cases?

Mr. BERTONI. I think similar to the speech and language delay. We have, again, an impairment that could possibly, according to many experts, improve. We know that there is a high approval rate, a high cessation rate, and it doesn't appear to be on the radar screen of the agency. I think there is, again, opportunity to look at these impairments and do some targeted reviews, again, within the current resource structure. And believe me, with additional resources head on into this area, but right now I would guess that the numbers of backlog claims in that $1.3 million are disproportionate to the SSI population. So I think there is opportunity here to look at that population.

What is the benefit? The taxpayers certainly benefit. The child benefits because they get early intervention, early services, they get mainstreamed back into a regular school environment and back into perhaps a more productive future.

Ms. SPEIER. So here is my one concern here with ADHD. Most of the recipients are poor families, probably single parents. From my discussions with the experts at Social Security, many of these people aren't eligible for SSDI, the parents, so the SSI is the one benefit that can come to a family that has no resources. So I understand that.

But what happens, evidently, is that at age 18 there is a review done. If it is determined that you still have ADHD, then that benefit continues into adulthood, which does not make sense. I mean, I have a lot of experience with ADHD on a personal level, so we need to do something about that point.

Mr. BERTONI. Almost half of those re-determinations end up going into the adult disability population. So the cessation rate, although it is high, upper fifties, you would surmise that those who are deemed eligible, are still disabled at that time, are going to go into that next phase of disability.

Ms. NOTTINGHAM. What I see for ADHD claims that come back with age 18 for review, we then use the adult standards, so we are not using the medical improvement standard at that point, at the age 18 re-determination. A lot of those we are not able to find disabled at that point in time.

Ms. SPEIER. I am sorry, what?

Ms. NOTTINGHAM. We are usually not able to find someone who was allowed for ADHD as a child; we usually don't find them disabled as an adult, because we are using a new criteria.

Ms. SPEIER. I think the numbers are actually pretty high, if I remember correctly, the percentage that continue to be. The percentage of children who have ADHD who then continue to have SSI after 18 is not a small percentage.

Ms. LACANFORA. Ms. Nottingham is correct, and so is Mr. Bertoni. We actually cease 50 percent of all of the beneficiaries. Specific to ADHD, I don't know off the top of my head, but childhood beneficiaries at age 18 get the de novo review, to use Ms. Nottingham's term. We are not using the medical improvement review standard at that point. By law, the age 18 re-determinations look at the claim fresh and we apply the adult disability standards and we process an initial claim at that point, not looking at whether they have improved. That is not a requirement.

Ms. SPEIER. But if they still have difficulty focusing, they still have ADHD, and so their benefits can continue.

Ms. LACANFORA. The medical standards are, obviously, a lot more complicated than that, and what we look at is, despite treatment intervention, medication, and so forth, the individual still has significant impairments in multiple domains of function. So it is a little bit more complicated, but generally those are the more severe cases.

I would also add that there are 74 million children in the United States. Less than 2 percent of them get SSI. They are the poorest children in the Nation, and 32 percent of the children getting SSI, despite the receipt of SSI, are still living in poverty. Without SSI, it would be more like 60 percent living in poverty.

Mr. LANKFORD. Mr. Horsford, just to give you a head's up, you have been here before, this is a second round, so you can jump in at any point.

But I do want to be able to ask Ms. Nottingham you had on your statement, to finish up with Ms. Speier was talking about your statement, there is to be a consideration of the possibility of requiring treatment for conditions that may improve. The challenge of this is if there is a disability that is treatable, that is manageable, and we go to ADHD or other things, whether it may be hearing loss or they have hearing aids, whatever it may be, a disability that is treatable and manageable, how is that then evaluated for long-term disability? Is there the possibility, going back to Ms. Lockhart's earlier statement here, how do we get folks back into the community if they have a disability, it is being managed, they are capable of getting back in the workforce? Do we?

Ms. NOTTINGHAM. I think this is an area where there is possibly room for improvement. We have some conditions where the policies are very—maybe the listings address it. Hearing is one thing. When we measure their hearing, it is with best correction. Or vision as well. There are some conditions like seizures are ones that we are very specific that if they are not following prescribed treatment, then we would not allow them, because most times seizures are treatable.

There is an exception for following prescribed treatment, it is good cause; and usually that is—one of them is access to medical care. So you might have a condition, depression, anxiety, ADHD, some of these conditions that could very well be improved with treatment, but they don't have access to it, so the hope is when they get benefits that they could get treatment and get better; however, at CDR many claims we see do not actually have any treatment.

The failure to follow prescribed treatment is something that, from my experience, is not really used much at CDRs, and I am wondering if that is a possibility where we consider that more.

Mr. LANKFORD. Okay, slow down. Say that last statement one more time.

Ms. NOTTINGHAM. The failure to follow prescribed treatment policy is not something that is really considered at CDR. I don't know if that is the direct policy on that, whether we should be or not, but in practice it is not really followed and I am thinking that is a possibility of where we can be looking into that more.

Mr. LANKFORD. Okay, so I want to lean into this. If a person could improve, be in the community, be employable if they maintain medication or treatment, or whatever it may be, and they choose not to, you are saying that is not considered? Hey, this person still should be listed as disabled because they are not taking the treatment that has been prescribed for them?

Ms. NOTTINGHAM. It depends on the condition. There are some that you don't know, with treatment, how they would do. Some are much more likely, like I mentioned seizure disorders, if people get treatment on that, they get better and, if not, then they should be found disabled. So we would find someone to not be found to be disabled because they are failing to follow prescribed treatment. However, some conditions it is harder to tell how they would respond to treatment, like depression or anxiety. But there is little guidance on that at this point in time on CDRs and when that would apply, outside of a few conditions.

Ms. LACANFORA. If I might just add one point, and that is we do take into consideration a person's compliance with treatment and we do have tools to cease benefits or disallow benefits if a person does not comply with treatment, but understand that for medical impairments the failure to follow a prescribed treatment is often part of the mental impairment; it is not just that the person is trying to be obstinate, it is that they have a serious mental condition, whether it be schizophrenia or something else, that creates an intense, let's say, fear of the medication or fear of the side effects that the medication creates. So it is a difficult determination and we would be happy to work with NADE and anybody else to clarify it or provide training on it, if that would be helpful.

Mr. LANKFORD. And I am not necessarily talking about the mental illnesses and such. This is a physical thing. If they have a physical disability and they choose not to take medication just because they don't feel a requirement to and say, it doesn't matter to me one way or the other. That is a more serious thing not only for the taxpayer, but also for that individual and their families, obviously, and somehow we have to have a way to be able to incentivize, saying re-engage in culture.

Again, I come back to what Ms. Lockhart was saying. It is a very big issue to isolate people and to be able to separate them out, and we basically discourage them from future work, because if they are able to work, we want them to be able to re-engage in culture and be able to get back to work. But if benefits and all those things suddenly go away, there is no sliding scale, there is no possibility to be able to drift off this even when there was a pilot, even; how do we help people that are capable of doing that actually being able to re-engage. So that is something I think we have to take a look at, at how we actually can do that. Is that something you need a legislative fix on or is that something you have administrative authority? Can we pilot something or how do we help to be able to transition out?

Ms. Lockhart, are you trying to say something on that as well?

Ms. LOCKHART. Yes. On the compliance, I just want to add to that real quickly. We are currently working with our Department of Health, for example, with patients with sickle cell anemia. The biggest problem with barrier of care we have is compliance. It is simply getting the patients to get to the doctor and follow the protocol they are given. It is not always a psychological issue as much as it a socioeconomic or cultural issue. So we work with them on education to help them follow those protocols.

ADHD, our chief rights on the international level, the standards for that, I am not sure he would always agree it is a disability, so I would welcome you to contact him at any time to follow up on that.

Currently, Oklahoma has 19,475 children in the aid category that are receiving some sort of disability aid. My concern, as we are talking about all of this, is not are they getting disability or not, but what happens to them. Where are they going and what is their future? And within these programs the bigger picture. That would be my question.

Ms. LACANFORA. If I might jump in on the bigger picture, which goes back to your question about creating self-sufficiency and having people re-engage in the community and be productive members of society, we believe at Social Security, as Ranking Member Speier said, that we need to pay the right check to the right person at the right time. That is the law and we work hard to do that well. But we also believe that part of our mission is evolving policy and practice to support people to become self-sufficient and to re-engage.

And I think at the last hearing I may have mentioned we have a research budget and we use that money to test new policies and demonstrations, and right now we have a couple right along the lines of what you are suggestion. PROMISE is the Promoting Readiness of Minors in Social Security Program. It is an interagency effort to grant money to States around the Country. There are 11 States participating. And the idea is to create community-based incentives very similar to what Ms. Lockhart is doing, and to figure out what community supports will work to help children, in particular, re-engage and become productive potential working members of society as they age.

Ms. SPEIER. Let me just add that for a number of years I worked with the developmentally disabled community in my county, where what we were doing was placing adult developmentally disabled in

positions, in local grocery stores, at drug stores, in law firms, doing meaningful work, getting a paycheck, turning tax receivers into taxpayers was one of the lines that was used by this nonprofit, with great success. And they were developmentally disabled. So I would hope that, as we look at ways to just enhance the program and create greater self-sufficiency, that we would look at some of the models that exist around the Country. I mean, it is not like we are reinventing the wheel here.

But certainly this PROMISE program, if you have youngsters who have speech delays or ADHD, I think it would be really important, when they are still minors, to get them working, getting them placed in jobs in the communities so that if in fact 50 percent of them are ceasing that benefit at age 18, that there is somewhere for them to go in terms of being valued members of society in terms of employment.

Ms. LACANFORA. Absolutely. And the PROMISE program does include employment support, placement, benefit counseling, and all of those integrated supports that Ms. Lockhart was referring to. That is the point of the program. And it is not the first time that we have engaged on that front. We have completed the Youth Transition Demonstration, which targeted youth between the age of 14 and 25, and did generally the same thing; we provided community-based supports in many different locations and it proved effective.

Ms. SPEIER. Well, I guess my point is I think it should be something that we do automatically with most of these youngsters, not just as pilot programs. Because if they are successful, let's fold it into the existing——

Ms. LACANFORA. Absolutely. Our demonstrations are intended to inform the dialogue and provide the Congress with some food for thought as you consider legislative changes to the program.

Mr. LANKFORD. It is not going to be a 16-year prototype, though, is it?

Ms. LACANFORA. No.

Mr. LANKFORD. We would like to see some progress on.

Ms. LACANFORA. We have actually completed the Youth Transition Demonstration. The findings are publicly available and there are some really interesting things that we found. Community-based programs do work. PROMISE is going to, I believe, further corroborate that evidence.

Mr. LANKFORD. Great. Let me ask about the vocational grid. We have talked about this before. I was six, I think, when it was finalized. How are we doing on the vocational grid?

Ms. LACANFORA. We are doing well. I think there are two pieces to this. The first is the update of the occupational information system. That is the dictionary of jobs that you mentioned has not been updated in a long time. We have partnered with the Bureau of Labor Statistics. We are cooking along.

Mr. LANKFORD. Our date for that to be completed?

Ms. LACANFORA. Our date is 2016, when we believe we will have something useful.

Mr. LANKFORD. Still on track.

Ms. LACANFORA. We are on track, absolutely. The grids is a slightly different, yet very much related issue. You know, and we

discussed it at the last hearing, we attempted rulemaking on the grids in the past and we were shut down, essentially, and the reason for that is that we did not have an evidence base behind the proposal that we made to increase the age limits in the grid; and when we got questions about the disproportionate effects to minorities and other questions, we didn't have the science to back it up. We learned from that experience; we are not going to make that mistake again.

So we are, as I described to you before, in the process of building our evidence base to support logical changes to the grid, and we are well under way. We are working with the Disability Research Consortium and the Library of Congress. We are engaging them in a literature review to look at how other disability systems, both internationally and in the private sector, use age, education, and work in their systems so that we can learn from that and shape our own policy.

Mr. LANKFORD. The date for that?

Ms. LACANFORA. The initial phase of literature review from the Disability Research Consortium, we expect their report in a couple of months.

Mr. LANKFORD. Okay. Is that something that will be available to us as well to be able to review?

Ms. LACANFORA. Yes.

Mr. LANKFORD. How publicly available is that?

Ms. LACANFORA. We can share. We can share the findings with the committee.

Mr. LANKFORD. So we are talking July-ish, somewhere through there?

Ms. LACANFORA. Yes. Now, understand that is the first phase of our exploration.

Mr. LANKFORD. I understand. That is getting the science out there to be able to review it. Then the next part of it, after that is done, then it is a matter of starting to make the recommendations.

Ms. LACANFORA. Exactly.

Mr. LANKFORD. You hope to get all this together by 2016, but the vocational grid and the other recommendations, get them to complete proposal?

Ms. LACANFORA. That would be ideal, yes. It really depends on what we find in the exploration. Remember that the law requires us to consider age, education, and work as part of the determination. How we do that needs to evolve over time, as people work longer and so forth. But it is a very complicated analysis. So we are in the fact-finding stage.

Mr. LANKFORD. Okay, let me ask another question we have talked about before, and that is the high rate of reversal judges for the ALJs, whether it be Judge Daltry or any number of others there. You have CDR funds that have been allotted. You have said you are setting aside some of those for the high priority cases. Are those some of the high priority cases that you are actually targeting, some of these high reversal ALJs?

Ms. LACANFORA. Yes.

Mr. LANKFORD. Okay. How is that coming so far?

Ms. LACANFORA. So we have been looking at this from a legal standpoint, because you know we try hard to respect judicial independence of our ALJs, so there are some legal parameters that we need to work within, and we have been working hard to kind of figure out a path forward. But we believe that we are going to get to where this committee wants us to be and where we need to be by looking at the cases that have the potential of being out of policy compliance.

In other words, we know what cases are problematic from a policy standpoint, and we are going to target those cases; and in doing so we will get to a lot of the decisions that were problematic and made by those judges that were outliers or that were high allowance rate judges. And we will take those cases and put them to the front of the CDR pipeline. So we will do CDRs.

Mr. LANKFORD. So give me a date on that. When does that begin?

Ms. LACANFORA. We are going to start that now.

Mr. LANKFORD. Okay, that is ongoing now. One other quick question on the medical improvement definition GAO. You have some thoughts on this as well, Mr. Bertoni, I understand, of how we handle this.

Mr. BERTONI. Well, in our report essentially there was much confusion about how to apply some of the provisions in terms of the exceptions; how much improvement in medical capacity was sufficient to determine or make a judgment of cessation. It just wasn't clear. There was a lot of confusion. We surveyed every DDS director and a number of examiners, had a 95 percent response rate, I believe, and there was a lot of confusion as to how to apply those two critical provisions. And we asked the agency to go in and put some more granularity around those instructions. It hasn't occurred, and we still think it needs to.

Mr. LANKFORD. How does that happen?

Mr. BERTONI. That is in SSA's ball court, ball whatever, field.

Mr. LANKFORD. Ms. LaCanfora, it is on your desk. How does that happen?

Ms. LACANFORA. So it has happened. We have done training on the medical improvement review standard and the exceptions. However, as I mentioned before, we have lost 11,000 people. The lack of funding has resulted in high turnover in the DDSs, so training is not a one-time thing; we need to do continual training. We have been reviewing cases where the medical improvement review standard was utilized and we are looking at where we need to provide new improved training and clarity, and we will do that. And we are happy to work with NADE to do that.

Mr. LANKFORD. And the goal here, again, is to get people back out to work. We are all on this dais we are all unanimous. There needs to be a safety net for the most vulnerable. But if there is an expected return to work, how do we help transition people back out to work and be evaluated? When they are in a vulnerable moment that our society comes alongside of them, but also incentivizes that there is an end-date for people that are expected to have returned, so how do we help you in that process.

So the medical improvement, and this definition becomes very helpful to us to know that it is not a matter you are 100 percent back, you are not going to be 100 percent back. Everyone lives with

aches and pains. My ranking member lives with aches and pains all the time from past injuries. She is doing extremely well. So there are other people I have talked about before in my own family, in a wheelchair, all sorts of different medical issues that do extremely well vocationally. How do we help incentivize that and to be able to encourage people to re-engage with culture, again going back to what Ms. Lockhart asked.

So I am not saying we have to determine that today. I am saying from this panel we want to see a way that medical improvement is clear and that they see improvement not back to 100 percent, but see improvement where they can re-engage again for the sake of their families and our economy.

Mr. BERTONI. Mr. Chairman, earlier you talked about the initial decision and not being able to overturn a case on the initial decision. It is really the last decision. In many cases, in our work, it was the ALJ decision that the DDSs were revising in CDR, and the information just wasn't there to determine medical improvements.

So I really think the agency needs to look at reconciling the tools that they have at the initial level, and I think they are doing some things there to standardize and to get enough information in the record, where you can revisit and determine medical improvement. I think there are real issues at the ALJ level, where that tool just doesn't exist yet. I know they are thinking about it, but I think something needs to happen there.

Ms. SPEIER. I am not following you. What tool are you talking about at the ALJ level?

Mr. BERTONI. I don't believe there is at this point. At least at the DDS level we have eCAT, which provides a platform for the examiners to more thoroughly document their rationale for the decision. And if you had to revisit that in a CDR, perhaps you would have more information to document medical improvement.

At the hearings level, at least in our work, most of the concern was that when the DDS revisited that case in a CDR that was decided at the hearings level, the information was not there; there wasn't enough information to document medical improvement; and the agency, I think, needs to look to additional tools that the ALJs can use to document more thoroughly that rationale. When you are under pressure to process claims, 700 a month, it is real easy to fly through these claims with limited rationale; and in the event of a CDR there is not enough there for the DDS representative to make a decision.

Ms. SPEIER. So are you saying that the ALJ, because they don't have enough information, tends to continue the benefit, but doesn't document it enough? Is that what you are saying?

Mr. BERTONI. I would say in our case, in our review, the concern was that when the DDS examiner received the CDR for review, and the last person who touched it was an ALJ, that decision, that justification did not have sufficient information for them to determine medical improvement. So there could be an opportunity to provide additional tools at the ALJ level so that decision is more thoroughly documented, the rationale is there for the DDS examiner, should there be a CDR, to make a determination of medical improvement.

Ms. SPEIER. And the ALJ typically has attorneys write their decisions, correct?

Mr. BERTONI. I will defer to the agency on that. I know that happens; I don't know to what extent.

Ms. LACANFORA. That is true. There are four support staff to every ALJ. I do want to agree with Mr. Bertoni, though, in terms of the importance of documentation. He mentioned eCAT, which is the electronic case analysis tool. It is basically a tool that the DDSs use to thoroughly document the rationale for their decisions. We love that took because it inspires policy compliance consistency across the board. We are implementing a version of that with the ALJs, we call it the electronic bench book, but it is essentially the same thing. Think of it as sort of a tool that pads you through the decision and makes you document your rationale.

Mr. LANKFORD. When?

Ms. LACANFORA. I have to get back to you on that one. I have to ask Mr. Sklar what his plan is.

Mr. LANKFORD. But we are thinking in the next year, the next five years? What are you thinking? Give me a ballpark.

Ms. LACANFORA. Probably somewhere in between for a full rollout.

Mr. HORSFORD. Mr. Chairman? Mr. Chairman, I want to break in here because I want to ask about the continuing disability reviews, which was the primary purpose for the hearing today, and talk about this annual report on continuing disability reviews report that was done by the SSA that found that the Government saved approximately $5.4 billion in fiscal year 2011 alone as a result of completed continuing disability reviews. I think, from what I understand, part of this problem is a huge backlog and a lack of staff resources at the front end of the process where the initial determinations are made, is that correct?

Ms. LACANFORA. Yes.

Mr. HORSFORD. So what are the current barriers, then, to conducting more medical CDRs?

Ms. LACANFORA. We need adequate, sustained, and predictable funding; and that is the number one way to get current on medical CDRs. The only way.

Mr. HORSFORD. So the chairman and the ranking member sent an 11-page letter yesterday regarding recommendations for improvements to the disability program. What were some of the examples of how SSA is already addressing some of those concerns?

Ms. LACANFORA. Well, the committee suggested, for example, that we ensure that claimant representatives give us all of the evidence at their disposal, and we have actually already done that. We have a notice of proposed rulemaking out for comment right now; it went out on February 20th. The comment period is open, so we are already there.

Mr. HORSFORD. And what is the estimated number of positions that you need based on the current backlog that is in place?

Ms. LACANFORA. I will give you a dollar amount. In fiscal year 2014, we were given the Budget Control Act level of funding, $1.197 billion, to do program integrity work. In fiscal year 2015 we need from the Congress $1.396 billion for program integrity. Subsequent to fiscal year 2015, the President's budget has a proposal for

mandatory sustained funding for program integrity, and we hope that the Congress will support it. That is what we need to get the job done and to eliminate this backlog of medical CDRs.

Mr. HORSFORD. So despite the fact that every dollar that is spent on CDRs saved the Federal Government $9, that lack of funding, in large part, is what is contributing to this 1.3 million backlogs of CDRs.

Ms. LACANFORA. That is the reason.

Mr. HORSFORD. So, Mr. Chairman, I would just ask that we enter this report into the record. I agree that there are a number of different policy and operational recommendations that need to be implemented, but I also think that the main thing we need to do as Congress is to properly fund and resource where there is the greatest return on investment, and that is through the CDRs. That is the front-end part of the process.

I know we had an extensive hearing about the ALJs and whatever discretion that they have, and that is an important discussion, but I just feel like the meat of the problem is at the front-end, and it is really about a lack of resources to a program that we know, when you fund it, it works and it provides the types of medical reviews that are necessary.

So I yield back.

Ms. SPEIER. Ms. LaCanfora, the inspector general had put up that one photo of the rock band star who obviously was provided benefits inappropriately. Have you clawed back that money?

Ms. LACANFORA. I don't know that specific case. I will say that we identified that case and referred it to the inspector general.

Ms. SPEIER. All right. Would you just inform us as to whether or not you have attempted to claw back that money?

Ms. LACANFORA. Sure.

Ms. SPEIER. All right.

And then to you, inspector general and to you, Mr. Bertoni, you have spent a lot of time in this issue area, and I would like to just know from each of you recommendations you would make to us for improvements to the system beyond what you have provided. And I guess to you, Mr. Bertoni, if there is another issue area that you think we should be requesting you to look at at the GAO, we would be happy to make that request of you to kind of make the system work more effectively.

Mr. BERTONI. Well, I think we have done a lot of work on the front-end of the process, looking at the initial claims process, SSA's processes for moving claims through the system. I think there are opportunities to gain some efficiencies there. I understand the resource issues, I certainly do, but again I think there are opportunities for efficiencies there to be able to process claims more quickly and smoothly.

I think there is opportunity in the area of quality assurance to make sure that if we are in an environment where we have a backlog situation, we are telling people to process a lot of claims, that we also keep our eye on the quality assurance piece so that these are not only quickly processed, but accurately processed. And ultimately I think follow-on work, I would be interested in doing a top-to-bottom review of the medical continuing disability review process, the CDR process, some of the assumptions, some of the for-

mulas, things that are being used to drive these reviews. I think that would be great work.

Ms. SPEIER. Mr. O'Carroll?

Mr. O'CARROLL. Just a couple things, and I guess this is a good time to say it. I think one of the common tones or themes throughout this hearing has been what we talk about all the time. There is a balance between stewardship and service, and one of the things I guess that has come out, and I was looking at my numbers as we were sitting here, is that there is about—we are talking about the 1.3 backlog on CDRs, million backlog on it, and there is about that same, if not more, backlog for initial claims going into SSA. So the agency has to make that balance out between stewardship and the service part of it.

Our job is to keep reminding them about the fraud, waste, and abuse side of it. And I think one of the other themes from this thing has been if we prevent the fraud, one prevention is best. Let's get the money before it goes out the door and prevent it. That is the reason why the CDI units have been so effective. And along that same line, with the CDI units, we bank now about $10 billion in savings by using the CDI units, and going back to what Mr. Cummings was talking about in terms of the trust fund on it, that might equate to $10 billion, it would be about an extension of a month into the trust fund, which is a big deal. So my feeling is that these anti-fraud initiatives are major money savers for the trust fund and it is something that are very successful and we can show it.

So, anyway, one other thought on the funding part that we were talking about, too, was that we suggested a number of times, we put it every year when we go to OMB for our budget presentation, we put it in each time with our appropriators, is an integrity fund for SSA. And with that integrity fund is with the $3 billion-plus that are recovered every year in terms of overpayments, if SSA could have access to some of that money. What we have suggested is 25 percent of that money, and use that for the anti-fraud initiatives like CDRs and other things that would fund it; it wouldn't need any additional funding for it.

One of the other things we would like is if the IG could get a percentage of that, we can use that for expansion of the CDI program and be better able to address the 22,000 disability referrals we get from SSA every year. In terms of our resources that we have, we are doing about 10,000 cases from the resources that we are getting, and we could do a lot more if we had more resources, and I think an integrity fund, instead of coming and asking for a bigger appropriation, would be very helpful.

Mr. LANKFORD. What is the source of the integrity funding?

Mr. O'CARROLL. Integrity fund would be the recovered dollars that are coming from the recovery of overpayments. So SSA is banking $3.26, I think, in overpayments every year that are recovered, so instead of that going back into the trust fund or into the general fund, which some of the money goes back to, redirect that back into anti-fraud initiatives.

Mr. LANKFORD. Okay. I have one last question, unless you have additional things, and that is this issue that you referred to the

bench data system that is trying to line up, the eCAT and then there was the other one.

Ms. LACANFORA. The electronic bench book.

Mr. LANKFORD. The electronic bench book. Until that is up to speed, we are still going to have an issue with ALJs that have final basically document that we can't track all the reasons for and all the policy documents for. So when we come back to do CDRs, it is not written in such a way that we can really evaluate medical improvement.

Ms. LACANFORA. Let me say that we have no indication that that is a widespread problem. Certainly we want the ALJs to do extensive documentation, and the electronic bench book will help that, but under current policy and process they are doing that today; and there are always going to be cases where we don't do as good a job as others, but I don't have an indication that that is a systemic problem.

Mr. LANKFORD. Okay. Anyone else experience that? Ms. Nottingham?

Ms. NOTTINGHAM. I would disagree with that. The most common complaint I hear from other examiners about ALJs is that the allowances are not well documented. I can tell you that the denial decisions that they do usually are well documented, but the allowances, it is very hard for us to make a finding of medical improvement when we don't really know what they were allowed for. It is sometimes difficult to really see what their rationalization was when there is—you know, their rationalization on the decision on a denial might be 9 or 10 pages long; whereas, an allowance is generally like 1 or 2 pages.

Mr. LANKFORD. Tough to be able to tell on that, then, 1 or 2 pages. So when we are dealing with that, how do we process this in the meantime? We have something coming in the future with the bench book. How do we deal with medical improvement until we get that in place?

Ms. LACANFORA. Let us get back to you on the bench book, because I don't want to speak prematurely, but I believe we are already well into the rollout of the electronic bench book.

Mr. LANKFORD. Okay.

Okay, final questions or thoughts? Anyone else have final questions or thoughts as well?

Long day. Thanks for allowing us to be able to pummel you with questions. We want to help in this process and I appreciate what everybody is doing to be able to serve some of the most vulnerable in our society. So thank you.

With that, we are adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned.]

# APPENDIX

Material Submitted for the Hearing Record

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# Congress of the United States
## House of Representatives

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April 8, 2014

The Honorable Carolyn W. Colvin
Acting Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Ms. Colvin:

The Committee on Oversight and Government Reform is continuing its oversight of the Social Security Administration's management of two large federal disability programs: the Social Security Disability Insurance program (SSDI)[1] and the Supplemental Security Insurance program (SSI).[2] On June 27, 2013, five current and former SSA employees including Deputy Commissioner of Disability Adjudication and Review, Glenn E. Sklar, testified at a Subcommittee on Energy Policy, Health Care and Entitlements hearing titled "Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges."[3] At the hearing and throughout the Committee's oversight efforts, a number of current and former SSA employees expressed concern about the agency's inability to limit program benefits to individuals who have a genuine disability that makes them unable to work.

Accurate disability determinations are crucial given that the lifetime value of federal benefits to disability program beneficiaries, including benefits in other programs linked to disability program participation, has been estimated at $300,000.[4] One of the primary problems identified by the Committee is the agency's motivation, authority, and oversight structure to address these concerns while a large number of SSA Administrative Law Judges (ALJs) appear to have rubber-stamped individuals onto disability programs over the last decade.

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[1] SSDI is the federal disability program for adults aged 18 to 64 who are eligible for both old-age Social Security and SSDI because of their work history and payroll tax contributions.

[2] SSI is the federal disability program for both children under age 18 and adults aged 18 to 64 who lack significant work history and meet the income requirements.

[3] *Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013).

[4] DAVID H. AUTOR & MARK DUGGAN, SUPPORTING WORK: A PROPOSAL FOR MODERNIZING THE U.S. DISABILITY INSURANCE SYSTEM 8 n.10 (2010), *available at* http://www.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/autordugganpaper.pdf.

Cases reach an ALJ after a state Disability Determination Services (DDS) review finds that the individual does not meet the requirements for receiving disability benefits. In 40 states, cases only reach an ALJ after two separate denials from the state DDS.

Despite the fact that cases typically reach ALJs after two separate DDS denials, hundreds of ALJs routinely reversed more than 80 percent of DDS denials each year, with dozens routinely reversing more than 90 percent of DDS denials each year.[5] Between 2005 and 2009, nearly one-third of ALJs were reversing at least 80 percent of DDS denials.[6]

During a transcribed interview with the Committee staff on October 22, 2013, Jasper Bede, the Regional Chief ALJ (RCALJ) for Region 3,[7] testified that when ALJs have a high allowance rate, which he defined as over "75 or 80 percent,", "it raises a red flag" about the quality of the decisions.[8] The OIG has similarly identified similar ranges as outliers.[9] The Committee calculated that 930,250 individuals were awarded federal disability benefits between 2005 and 2012 by ALJs who had annual allowance rates in excess of 80 percent.[10] Of these 930,250 individuals, over 350,000 of them were awarded benefits by ALJs with annual allowance rates in excess of 90 percent.[11] In addition to ALJs with extremely high allowance rates, RCALJ Bede also testified that when an ALJ was deciding more over 700 cases "it brought into question whether or not the judge was properly handling cases."[12]

According to OIG, 44 ALJs out of approximately 1,570 ALJs issued at least 700 dispositions a year while approving more than 85 percent of those cases for at least two years between 2007 and 2013.[13] Between 2007 and 2013, these 44 ALJs allowed benefits to more than 180,000 individuals.[14]

Both the Social Security Board of Trustees[15] and the Congressional Budget Office[16] estimate that without reform, the SSDI trust fund will be depleted within the next two years. If

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[5] Social Security Administration Adjudication Data for Administrative Law Judges (FY2005-FY2009)..
[6] *Id.*
[7] Region 3 consists of 18 hearing offices in Pennsylvania, Maryland, Delaware, Virginia, Maryland, West Virginia, and the District of Columbia..
[8] Defined by Mr. Bede as "certainly anything over ... 75 or 80 percent. Several years ago, that might have been [defined as] 85 percent, when everyone, as a whole, nationally and regionally, were reversing cases in the 65 percent range." Transcribed Interview with Jasper Bede, Regional Chief Administrative Law Judge, Social Security Administration, in Wash., D.C. at 75 (October 22, 2013).
[9] SSA OIG Audit Report, "Oversight of Administrative Law Judge Workload Trends," (February 2012), *available at* http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-12-11-01138_0.pdf.
[10] Social Security Administration data provided to the Committee. The data was provided in fiscal years.
[11] *Id.*
[12] Transcribed Interview with Jasper Bede, Regional Chief Administrative Law Judge, Social Security Administration, in Wash., D.C. at 18 (October 22, 2013).
[13] Office of the Inspector General at the Social Security Administration, *Congressional Response Report: ALJs with both High Disposition Rates and High Allowance Rates.* As a point of comparison, 1,123 ALJs had at least 50 dispositions in FY 2007 and 1,508 ALJs had at least 50 dispositions in FY 2012.
[14] *Id.*
[15] Social Security Administration, "2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds."

this occurs, there will be large across-the-board cuts for all beneficiaries. Because we are committed to ensuring that the federal disability programs serve the truly disabled, we write to urge you to quickly adopt common-sense reforms that will likely reduce a significant amount of misspending within these programs.

In June 2013, the Administrative Conference of the United States (ACUS), a non-partisan, independent federal agency, issued recommendations for ways SSA can improve its disability adjudication system and save taxpayer dollars. The ACUS report states, "Consistency and accuracy ... have suffered under the strain of administering such a sprawling program. ... Bringing greater consistency and accuracy to the disability claims adjudication process will enhance the fairness and integrity of the program."[17]

Necessary program reform must close loopholes that allow some attorneys and other representatives to submit biased and incomplete evidence in an attempt to game the disability determination system. In implementing program reform, however, we want the agency to ensure that its actions do not disadvantage claimants who lack representation.

Many of our recommendations are informed by the ACUS report, as well as academic literature, oversight hearings,[18] and empirical analysis. Given the dire nature of the problem, we urge the agency without delay to overcome bureaucratic inertia and initiate these necessary administrative actions, many of which would significantly improve the integrity of the federal disability programs.

1. SSA needs to conduct timely CDRs and revise Medical Improvement Standard.

SSA is not in compliance with the law that requires SSA to conduct medical continuing disability reviews (CDRs) every three years, for persons other than those expected to be permanently disabled.[19] CDRs are necessary to evaluate whether individuals receiving benefits continue to meet eligibility requirements. SSA is currently behind on CDRs for 1.3 million beneficiaries[20] including a backlog of 325,000 CDRs for SSDI and a backlog of nearly one million CDRs for SSI.[21] For every $1 SSA spends engaging in review of prior awards, the

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[16] The Congressional Budget Office, *2012 Long-Term Projections for Social Security: Additional Information*, October 2012.
[17] Administrative Conference Recommendation 2013-1: Improving Consistency in Social Security Disability Adjudications (Adopted June 13, 2013).
[18] *Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Glenn Sklar, Deputy Comm'r, Soc. Sec. Admin.) and *Continuing Oversight of the Social Security Administration's Mismanagement of Federal Disability Programs: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013).
[19] 1980 Amendments to the Social Security Act (P.L. 96-265).
[20] SSA staff briefing (April 12, 2013).
[21] *Id.*

agency recovered $11 in benefits that otherwise would have been paid to undeserving individuals.[22]

From 1980 to 1983, SSA reviewed a large number of prior awards, finding that 40 percent of program beneficiaries were not disabled.[23] The agency received additional funding in the FY 2014 appropriations for an increased number of CDRs; the Congress expects a significant increase in the number of CDRs performed this year because of this additional funding. However, an increase in CDRs must be coupled with a change to the "medical improvement" standard, because this standard does not allow the agency to remove claimants who were wrongfully awarded benefits in the first place.[24] Under the current standard, the claimant's record must show that the claimant made significant medical improvement in order to end benefits; if the claimant was not disabled and wrongfully received benefits initially, this standard of review will not remove them.[25]

2. SSA's risk-based approach for conducting CDRs should take into account individuals awarded benefits by red flag ALJs.

We endorse the agency's decision to use a risk-based approach for prioritizing CDRs. However, during a December 13, 2013, briefing, agency officials stated that the formula does not take into consideration the allowance rates of the ALJ who approved the recipient for benefits.[26] Because of the backlog of medical CDRs, SSA has not yet evaluated whether or not many of the 930,000 individuals placed on the program by a "red flag" judge between 2005 and 2012 continue to meet eligibility guidelines for the program. This could be a substantial problem since many of these individuals may not have met the eligibility guidelines at the time they were awarded benefits.

During his transcribed interview, RCALJ Bede testified that at least seven ALJs in Region 3 had skewed adjudication data that raises questions about the merit of their decisions. During his tenure as Region 3's RCALJ, the two judges with the most troubling adjudication data were ALJ Charles Bridges and ALJ David Daugherty.

RCALJ Bede testified that he approached ALJ Bridges, a Harrisburg, Pennsylvania, ALJ, about the fact that ALJ Bridges was typically deciding more than 2,000 cases per year and awarding benefits to nearly all of the claimants before him.[27] RCALJ Bede alleged that ALJ Bridges was using inappropriate factors other than symptoms of disability, such as an individual's economic circumstances, to make disability determinations.[28] RCALJ Bede testified

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[22] Richard J. Pierce, Jr., *What Should We Do About Social Security Disability Appeals?*, 34 REGULATION at 38 (CATO INSTITUTE, 2011), *available at* http://www.cato.org/sites/cato.org/files/serials/files/regulation/2011/9/regv34n3-3.pdf.
[23] *Id.*
[24] 20 CFR 404.1594(b)(1)
[25] *Id.*
[26] SSA Briefing with Committee Staff, (December 11, 2013).
[27] Transcribed Interview with Jasper Bede, Regional Chief Administrative Law Judge, Social Security Administration, in Wash., D.C. at, 74, 77, 80-81 (October 22, 2013).
[28] *Id.* at 89, 90, and 137.

that he had several discussions with ALJ Bridges to try to convince him to properly review cases prior to awarding benefits, but that his efforts largely failed.[29]

The SSA OIG and the U.S. Attorney for the Southern District of West Virginia are currently investigating Judge Daugherty for his alleged role in a long-lasting criminal conspiracy to award benefits to thousands of individuals represented by one law firm.[30] From 2005 to his retirement in mid-2011, ALJ Daugherty had a 99.7 percent allowance rate and awarded disability benefits to 8,413 individuals, the equivalent of $2.5 billion of in federal lifetime benefits.[31]

In light of RCALJ Bede's testimony that ALJ Bridges appears to have decided cases inappropriately and the evidence that ALJ Daugherty was apparently rubber-stamping individuals onto disability programs, we find it indefensible that the agency has seemingly done nothing out of the ordinary to review individuals who were awarded benefits by these two ALJs. According to SSA officials, there are currently no plans to prioritize medical CDRs for the thousands of individuals that ALJ Bridges, ALJ Daugherty, or other "red-flag" ALJs added to the program in order to determine whether or not they are or were ever eligible for the program.[32] We understand that SSA is reviewing whether it has the authority to prioritize CDRs of individuals approved by "red-flag" ALJs. If SSA has the authority to do so, we urge SSA to take the common sense action of prioritizing medical CDRs for persons added to disability programs by Judge Bridges, Judge Daugherty, and other red-flag ALJs.

3. SSA should expand the use of focus reviews.

Despite having the authority to review ALJ decisions through a process called "focus (or focused) reviews," SSA has failed to adequately review or discipline ALJs with extremely high reversal rates or those who had decided an inappropriately large number of cases.

RCALJ Bede testified that several ALJs in his region had inappropriately high reversal rates, but his ability to properly manage these ALJs was limited.[33] He testified that more focus reviews are needed to determine whether or not ALJs are producing quality decisions.[34] RCALJ Bede testified that "it's most likely that if you don't look at the decisions ... you can't really get an idea" about whether or not an ALJ is issuing legally sufficient decisions.[35] RCALJ Bede

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[29] *Id*, at 30, 74, 91, 144-147.
[30] E-mail between SSA OIG staff to Committee staff (October 29, 2013).
[31] The present value of federal benefits from gaining eligibility in SSDI, which includes benefits from other programs that an individual has been made eligible for because of enrollment in SSDI, has been calculated at $300,000.
[32] Individuals are generally only removed from federal disability programs if they show medical improvement. This is a concern since many individuals put on the program initially, particularly those put on the program by "red flag" ALJs, did not originally have a disabling condition that met eligibility requirements. There is, however, an error exception to the medical improvement standard in which an individual can be removed if their initial award was in error.
[33] Transcribed Interview with Jasper Bede, Regional Chief Administrative Law Judge, Social Security Administration, in Wash., D.C. at 27, 57, 97, 103 (October 22, 2013).
[34] *Id*, at 131.
[35] *Id*, at 124.

testified that one option available to SSA—the focus review program—is a "good first step."[36] However, according to RCALJ Bede, RCALJs do not have the authority to order focus reviews of ALJs they supervise; only the Chief ALJ or her supervisor, the Deputy Commissioner of Disability Adjudication and Review, can authorize these reviews.[37]

We recommend that the agency conduct additional focus reviews so that the problems emanating from red-flag judges can be reduced. In order to prevent additional benefits from being wrongly awarded while SSA conducts reviews of ALJs who are suspected of gross misconduct, we recommend that the agency place ALJs on administrative leave until the reviews are completed.

4. SSA should require claimants and their representatives to submit all evidence.

Since an SSA administrative law hearing is non-adversarial,[38] the ALJ has a responsibility to represent taxpayer interests. However, the agency does not currently require claimants to submit all medical evidence.

When SSA last revised regulations in this area in 2006, the agency required that claimants submit evidence, such as medical documents, without redaction. However, due to complaints from claimant representatives' trade associations, in the final regulation, the agency did not require claimants to submit evidence adverse to their claims.[39] As a result, ALJs often make decisions based on incomplete and biased information.

During a transcribed interview on September 30, 2013, George Mills, hearing office chief ALJ in Morgantown, West Virginia, testified that some claimants' representatives "will not give you everything" and he only finds out about the missing evidence if the case is later remanded by the courts.[40] Several other ALJs have informed the Committee that this is a significant problem as they try to accurately and fairly develop the record.

During the Subcommittee's June hearing, Mr. Sklar testified that "the regulations right now are ambiguous and I think they need to be fixed, and we will be moving to fix them. We haven't decided precisely which route we are going to take, we are discussing them back at Social Security with my boss, the acting commissioner of Social Security, and you can be sure we are going to take [ACUS's] recommendation very seriously."[41] In 2012, ACUS recommended several options for revising the current regulations that are modeled after other

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[36] *Id*, at 131.
[37] *Id*, at 140-141.
[38] In SSA hearings, claimants may retain legal representation to argue on their behalf, but the government does not have a representative.
[39] SSA Disability Benefits Programs: The Duty of Candor and Submission of All Evidence, Administrative Conference of the United States (Final Report: October 15, 2012).
[40] Transcribed Interview with George Mills, Morgantown Hearing Office Chief Administrative Law Judge, Social Security Administration, in Wash., D.C. at 34 (September 30, 2013).
[41] *Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Glenn Sklar, Deputy Comm'r, Soc. Sec. Admin.).

agencies that have processes similar to SSA's non-adversarial system- -such as the Patent and Trademark Office and the Department of Veterans Affairs.[42] The agency should act quickly to remedy this problem.

5. SSA should revise the "treating source" rule to allow ALJs to consider all relevant medical opinions.

Opinions from credible medical experts should carry substantial weight with SSA disability determination decision-makers. SSA regulations currently require that adjudicators give controlling weight to the opinion of the claimant's treating physician even though other medical professionals with differing opinions may have examined the claimant more recently or more frequently.

According to Richard Pierce, Jr., a professor of law at George Washington University, attorneys and other professional advocates manipulate the current treating physician rule to win benefits for clients who are not truly disabled.[43] According to Professor Pierce, attorneys and advocates identify physicians who are known to be sympathetic to subjective claims such as mental illness or chronic pain.[44] Then, disability advocates "often urge their clients to seek 'treatment' from such a physician in order to obtain an opinion of a treating physician that an SSA Administrative Law Judge must give powerful effect through application of the treating physician rule."[45] Professor Pierce states that this abusive practice "force[s] ALJs to grant benefits in cases in which they would not do so in the absence of the treating physician rule."[46]

According to the ACUS report, "[d]ramatic changes in the American health care system over the past twenty years also call into question the ongoing efficacy of the special deference afforded to the opinions of treating sources. Individuals typically visit multiple medical professionals in a variety of settings for their health care needs and less frequently develop a sustained relationship with one physician."[47] ACUS recommended that SSA revise its regulations and policies so that other medical professionals such as nurse practitioners, physician assistants, and licensed clinical social workers can be considered acceptable medical sources. Based upon what we have heard from disability experts, we believe that revising the treating physician rule is an important reform that the agency can make unilaterally to reduce the manipulation and abuse within the program.[48] The agency should act quickly to remedy this problem.

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[42] SSA Disability Benefits Programs: The Duty of Candor and Submission of All Evidence, Administrative Conference of the United States (Final Report: October 15, 2012).
[43] Richard J. Pierce, Jr., "What Should We Do About Administrative Law Judge Disability Decisionmaking?" *GW Law Faculty Publications & Other Works*. Paper 851. (2011), *available at*, http://scholarship.law.gwu.edu/faculty_publications/851.
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] Administrative Conference Recommendation 2013-1: Improving Consistency in Social Security Disability Adjudications (Adopted June 13, 2013).
[48] *Id.*

6. Hearings should be properly noticed and the evidentiary record should be closed a suitable amount of time prior to the hearing.

In SSA hearings, the case record remains open so that the claimant may present any information to support his or her case at any time prior to the ALJ's decision.[49] This is incompatible with an ALJ's proper review of the individual's case file. This policy allows claimants and their representatives to submit evidence after their hearings, which hampers ALJ's ability to consider the evidence and prevents questioning of the claimant about the evidence while the claimant appears in court. Several ALJs have informed the Committee that claimants and their representatives frequently take advantage of this SSA rule by submitting substantial medical evidence either the morning of a hearing or after the hearing.

SSA is running a pilot program in Region I that requires ALJs to give claimants a 75 day notice before the hearing and requires claimants to submit all evidence five days before the hearing subject to good cause exception (also known as "soft" closing of the record).[50] ALJs in other regions are required to give claimants notice at least 20 days before the hearing.[51] This additional notice of the hearing allows claimants and their representatives more time to gather and submit evidence and gives the ALJ at least five days to examine it prior to the hearing.

According to agency regulations, ALJs must consider all of the evidence and use the entire case record along with statements made at the hearing to determine whether to award disability benefits. Thus, it is imperative that they have time to consider all the evidence before the hearing. Mr. Sklar testified in June that the pilot "appears to be working reasonably well"[52] and other SSA officials told Committee staff that they agree with Mr. Sklar's assessment of the program.[53] If the pilot program is successful, we recommend SSA expand the program to the other regions of the country so that all ALJs have adequate time to consider all the evidence before issuing decisions.

7. SSA should review each applicant's social media accounts prior to awarding benefits. SSA should require that all CDRs incorporate a review of beneficiaries' social media accounts.

SSA prohibits ALJs from using social media to develop the case record. Many ALJs told the Committee that access to social media sources would be extremely useful in determining credibility of a claimant's statements. Currently, an ALJ must report any allegations of fraud to the OIG for further investigation, but it is extremely rare for an ALJ to discover evidence of alleged fraud during normal case review without access to social media.

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[49] 20 C.F.R. §§ 404.900(b), 416.1400(b) (2012).
[50] Administrative Conference of the United States, "Assessing SSA's Region I Pilot Program" (December 23, 2013), *available at:* http://www.acus.gov/research-projects/assessing-ssas-region-i-pilot-program.
[51] §§ 404.938, 416.1438 (2012).
[52] *Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Glenn Sklar, Deputy Comm'r, Soc. Sec. Admin.).
[53] SSA Briefing with Committee Staff (September 4, 2013).

ALJs and SSA Office of Disability Adjudication and Review staff only reported 411 total allegations of fraud between FY2010 to FY2012 to the OIG for further investigation.[54] The 411 allegations reported represent only 0.0048 percent of the 8.636 million claims of disability during that period.[55] To increase efficiency and reduce the number of erroneous disability determinations, SSA personnel should be allowed to review each applicant's social media accounts prior to the decision to award benefits. Additionally, we suggest that SSA require that all CDRs incorporate a review of the beneficiary's social media accounts.

8. SSA needs to modernize its medical-vocational guidelines.

The agency currently uses outdated rules to determine whether or not a claimant meets SSA's definition of disability. In 1978, SSA implemented medical-vocational guidelines ("the grid") consisting of four factors – physical ability, age, education, and work experience – to determine whether or not an individual can work. The age categories of the grid have not been updated to reflect that Americans live longer, work longer, and collect Social Security benefits later in life and for a longer period of time.[56]

The grid is also problematic in that it categorizes the inability to communicate in English as a disability, whether or not a claimant is able to perform work that does not require communicating in English. This provision is applied in all U.S. states and territories, including Puerto Rico. While SSA officials have indicated that they are currently undertaking an update of the vocational grid, the complete update of the occupational grid is not expected to be completed until 2016,[57] after the SSDI trust fund is projected to be insolvent. We urge you to explore ways to update the grid more quickly, and in the interim, issue alternative guidance to assist ALJs when they assess an individual's ability to work in the modern job market.

9. SSA should expand the Appeals Council's use of "own motion" review.

SSA's Appeals Council has the authority to grant an additional review to a claimant who has been denied benefits by an ALJ. If a claimant appeals a denial, the Appeals Council will remand the case back to an ALJ or deciding the case itself. The Appeals Council also has the ability to review un-appealed decisions through a process known as "own motion" review.[58] However, the Appeals Council has declined to use selective sampling as a method of quality control, and only conducts own motion reviews through random selection. ACUS recommends that the Appeals Council "use announced, neutral, and objective criteria, including statistical assessments, to identify problematic issues or fact patterns that increase the likelihood of error and, thereby, warrant focused review."[59] We support these ACUS recommendations so that

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[54] E-mail from SSA OIG staff to Committee staff (January 31, 2014).
[55] SSA data, see http://www.socialsecurity.gov/OACT/STATS/table6c7.html and http://www.socialsecurity.gov/oact/ssir/SSI13/V_C_AllowanceData.html (tables V.C1. and V.C2.).
[56] Hon. Judge Drew A. Swank, *Money for Nothing: Five Small Steps to Begin the Long Journey of Restoring Integrity to the Social Security Administration's Disability Programs*, 41 Hofstra L. Rev. 155, 179.
[57] SSA Briefing with Committee Staff and Members (December 11, 2013).
[58] 20 C.F.R. §§ 404.969(b)(1), 416.1469(b)(1) (2012)
[59] *Id.*

more decisions are systemically reviewed to identify errors before payments begin.

10. SSA should increase the number of video hearings.

Most ALJs reside in the vicinity of the hearing office they are assigned to and thus they often must decide whether or not their neighbors are entitled to disability benefits. In a small community, an ALJ may feel pressure to grant appeals.[60] Increasing the number of video hearings with ALJs that have no ties to the local hearing office would reduce the potential conflict of hometown bias. Opting for video hearings often results in more efficiency, faster scheduling, and more convenience for the claimant.[61]

11. SSA should expand the Cooperative Disability Investigations program.

SSA and OIG jointly established the Cooperative Disability Investigations (CDI) program in Fiscal Year 1998 to pool resources and expertise among federal, state, and local law enforcement agencies to investigate suspicious disability claims.[62] Each unit is comprised of an OIG special agent, employees from the state DDS and SSA offices, and state and local law enforcement officers.[63] CDI units investigate questionable claims before benefits are paid, but can also investigate fraud allegations for current beneficiaries.[64] The CDI program currently consists of 26 units in 21 different states and Puerto Rico.[65] In FY 2013, the CDI program reported $340.2 million in projected savings to SSA disability programs as well as an additional $246.4 million in projected savings to other entitlement programs, such as Medicare and Medicaid. During the lifetime of the program, CDI efforts have resulted in $2.5 billion in projected savings to the SSA disability programs and an additional $1.6 billion in projected savings to other entitlement programs.[66] We urge SSA to immediately begin working collaboratively with the OIG to expand the CDI program nationwide.

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[60] Richard J. Pierce, Jr., "What Should We Do About Administrative Law Judge Disability Decisionmaking?" *GW Law Faculty Publications & Other Works*. Paper 851. (2011), *available at*, http://scholarship.law.gwu.edu/faculty_publications/851.

[61] Administrative Conference Recommendation 2013-1: Improving Consistency in Social Security Disability Adjudications (Adopted June 13, 2013).

[62] *Continuing Oversight of the Social Security Administration's Mismanagement of Federal Disability Programs: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Patrick P. O'Carroll, Jr., Inspector General, Social Security Administration).

[63] *Id.*

[64] These allegations are often referred to a CDI unit by SSA or DDS as a result of a medical CDR.

[65] *Continuing Oversight of the Social Security Administration's Mismanagement of Federal Disability Programs: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Patrick P. O'Carroll, Jr., Inspector General, Social Security Administration).

[66] *Continuing Oversight of the Social Security Administration's Mismanagement of Federal Disability Programs: Hearing before the Subcomm. on Energy Policy, Health Care, and Entitlements of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. (2013) (statement of Patrick P. O'Carroll, Jr., Inspector General, Social Security Administration).

With the SSDI trust fund rapidly approaching insolvency, we urge the agency to make common sense reforms sooner rather than later so that the truly disabled will not suffer because of the agency's inability to properly oversee the federal disability programs. In addition to these recommendations, we ask that you continue to meet and work together with union representatives, other stakeholders, and Congress about additional cost saving measures.

If you have any questions about this request, please contact Sharon Utz or Brian Blase of the Committee staff at 202-225-5074 or Mandy Smithberger in Ranking Member Speier's office at 202-225-3531. Thank you for your attention to this matter.

Sincerely,

James Lankford
Chairman
Subcommittee on Energy Policy,
Health Care and Entitlements

Jackie Speier
Ranking Member
Subcommittee on Energy Policy,
Health Care and Entitlements

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