AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMISSIONER OF SOCIAL SECURITY'S PROPOSAL TO IMPROVE THE DISABILITY PROCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

AND

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

SEPTEMBER 30, 2004

Serial No. 108–64

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
99–682 WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

BILL THOMAS, California, *Chairman*

PHILIP M. CRANE, Illinois
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHIL ENGLISH, Pennsylvania
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY C. HULSHOF, Missouri
SCOTT MCINNIS, Colorado
RON LEWIS, Kentucky
MARK FOLEY, Florida
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
ERIC CANTOR, Virginia

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
EARL POMEROY, North Dakota
MAX SANDLIN, Texas
STEPHANIE TUBBS JONES, Ohio

Allison H. Giles, *Chief of Staff*
Janice Mays, *Minority Chief Counsel*

SUBCOMMITTEE ON SOCIAL SECURITY

E. CLAY SHAW, JR., Florida, *Chairman*

SAM JOHNSON, Texas
MAC COLLINS, Georgia
J.D. HAYWORTH, Arizona
KENNY C. HULSHOF, Missouri
RON LEWIS, Kentucky
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin

ROBERT T. MATSUI, California
BENJAMIN L. Cardin, Maryland
EARL POMEROY, North Dakota
XAVIER BECERRA, California
STEPHANIE TUBBS JONES, Ohio

SUBCOMMITTEE ON HUMAN RESOURCES

WALLY HERGER, California, *Chairman*

NANCY L. JOHNSON, Connecticut
SCOTT MCINNIS, Colorado
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
PHIL ENGLISH, Pennsylvania
RON LEWIS, Kentucky
ERIC CANTOR, Virginia

BENJAMIN L. CARDIN, Maryland
FORTNEY PETE STARK, California
SANDER M. LEVIN, Michigan
JIM MCDERMOTT, Washington
CHARLES B. RANGEL, New York

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

COMMISSIONER OF SOCIAL SECURITY'S PROPOSAL TO IMPROVE THE DISABILITY PROCESS

THURSDAY, SEPTEMBER 30, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SOCIAL SECURITY,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Subcommittees met, pursuant to notice, at 1:17 p.m., in room 1100 Longworth House Office Building, Hon. E. Clay Shaw, Jr. (Chairman of the Subcommittee on Social Security), and Hon. Wally Herger (Chairman of the Subcommittee on Human Resources) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
September 30, 2004
SS–11

CONTACT: (202) 225–9263

Shaw and Herger Announce Joint Hearing on Commissioner of Social Security's Proposal to Improve the Disability Process

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security, and Congressman Wally Herger (R–CA), Chairman, Subcommittee on Human Resources, Committee on Ways and Means, today announced that the Subcommittees will hold a joint hearing on the Commissioner of Social Security's proposal to improve the disability determination process. **The hearing will take place on Thursday, September 30, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittees and for inclusion in the printed record of the hearing.

BACKGROUND:

In September 2003, during a hearing before the Subcommittee on Social Security, the Commissioner of Social Security announced a proposal to reform the disability determination process. The Commissioner's goal is to enhance the agency's ability to make the correct determination as quickly as possible on claims for Social Security Disability Insurance (DI), and Supplemental Security Income (SSI) benefits. The proposal also aims to help individuals with disabilities return to work by establishing a number of new demonstration projects. The Commissioner intends to implement the proposal through the regulatory process once the Social Security Administration (SSA) successfully converts from a paper to an electronic disability claim folder.

Individuals with disabilities applying for Social Security DI or SSI must first file an application online, via telephone, or in a local SSA field office. From there, the application is forwarded to a federally funded State Disability Determination Service (DDS) to determine medical eligibility for benefits. If the case is denied, the applicant may ask the DDS to reconsider the claim, and if the claim is denied again, the applicant may request a face-to-face *de novo* hearing with an Administrative Law Judge (ALJ) in the SSA's Office of Hearings and Appeals. Applicants who are not satisfied with the ALJ's decision may appeal their cases to the SSA's Appeals Council, and finally, to the Federal courts. If an individual exercises all rights of appeal, the SSA projects it would take over 1,100 days, on average, before the individual receives a final decision.

The Commissioner proposes to reform the initial disability determination process by establishing Regional Expert Review Units, staffed by medical experts, to handle claims from individuals who are clearly disabled. These "Quick Decision" claims would be earmarked by the SSA's field offices, and would be sent directly to the Regional Expert Review Units, bypassing the DDSs. State DDSs would continue to handle all other claims, but the reconsideration step of the process, currently performed by the DDSs, would be eliminated.

After the initial decision, the Commissioner would change the process by allowing claimants to request a review by an SSA Reviewing Official (RO). The RO could either approve the claim, or prepare a recommended denial or a pre-hearing report. If the claim is denied by the RO, the claimant could then request a hearing before an ALJ. While the *de novo* hearing process would not change, the claimant's record would be closed after the hearing, and the Appeals Council would be eliminated. While some cases would be reviewed by an Oversight Panel of two ALJs and one Administrative Appeal Judge, the decision rendered by the ALJ after the *de novo* hearing would be the final agency action for most claimants.

The Commissioner anticipates that these changes to the disability determination system, along with the demonstration projects to help people return to work, will reduce processing time by at least 25 percent, provide quick decisions to people who are obviously disabled, improve accuracy and consistency in decisions, and remove barriers for those who wish to return to work.

In announcing the hearing, Chairman Shaw stated, "Since her term began, Commissioner Barnhart has rightly made improving the disability process one of her top priorities. Her proposal to improve service to individuals with disabilities applying for benefits holds real promise. In the last year, much feedback has been provided to the Commissioner by key stakeholders. This hearing provides the opportunity for us to learn more about the details of that feedback, and how the Commissioner plans to move forward."

Chairman Herger stated, "As we all know, Social Security's disability determination process is in need of improvement. Commissioner Barnhart is to be commended for putting forward a plan to make the process more accurate and efficient, and for focusing on return-to-work initiatives. I look forward to learning more about how this plan stands to benefit program applicants and recipients, as well as taxpayers."

FOCUS OF THE HEARING:

The Subcommittees will examine Commissioner Barnhart's proposal to reform the disability determination process and to implement new return-to-work demonstration projects.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "*108th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=16*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, October 14, 2004. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman SHAW. Good afternoon. Today, the Committee on Ways and Means Subcommittees on Social Security and Human Resources are holding a joint hearing to examine the Commissioner of Social Security's proposal to reform the disability determination process. The Social Security Administration's (SSAs) Disability Insurance (DI) and Supplemental Security Income (SSI) programs provide critical income support for individuals with disabilities. Unfortunately, many people who apply for these programs will experience a long wait, in some cases 3 or more years, to learn whether they are eligible to receive assistance. This wait can place crushing financial and emotional burden on individuals with disabilities and their families.

In January of 2003, the U.S Government Accountability Office (GAO), designated Federal Disability Programs, including the DI and SSI Programs, as "high-risk." The GAO found that the agency has difficulty managing its disability programs, as evidenced by lengthy processing times, inconsistencies in disability decisions across adjudicative levels and locations, and challenges with implementing effective quality control systems. Without change, these programs would likely worsen as the baby boomers age and more individuals enter their disability-prone years.

In response to these challenges, Commissioner Barnhart has rightly made improving public service provided by SSAs disability programs one of her highest priorities. The agency is currently in the midst of an 18-month transition from a paper to an electronic disability (eDIB) folder that began just last January. Following this transition, the Commissioner has proposed implementing a major reorganization of the disability determination process. It is this latter proposal that we will examine today.

Key components of this proposal include: a new quick decision step to approve benefits for those who are obviously disabled; centralized medical expertise; in-line as opposed to end-of-line quality review; replacement of the reconsideration step completed by the State disability determination agencies with a review by a Federal

reviewing official (RO) attorney; closing the record after the hearing by an administrative law judge (ALJ); and elimination of the Appeals Council step. The Commissioner's proposal would change almost every facet of the disability determination process and affect about 4 million applicants a year. Changes of this magnitude must be thoroughly vetted and studied in order to protect individuals with disabilities and the American taxpayers.

Today, we welcome the Commissioner, who will tell us more about the feedback she has received since premiering her proposal before the Subcommittee on Social Security 1 year ago. I look forward to learning how that feedback will shape implementing regulations and the timetable for moving forward. Following the Commissioner, the Subcommittees will hear from representatives of the employees who must transform these ideas into action, along with advocates for individuals with disabilities, claimant representatives, and the Chairman of the bipartisan Social Security Advisory board (SSAB) and former Member of the Committee on Ways and Means, Hal Daub. Each of these individuals and the organizations they represent have carefully considered the Commissioner's proposal and have offered thoughtful suggestions for change. We thank you for your commitment to improving service provided through these vitally important programs.

The disability determination process cannot continue to operate the same as it has in the past. Too many vulnerable individuals with disabilities are waiting too long for a decision from SSA. The Commissioner has said her proposed disability determination process will reduce the time between an application and a decision by at least 25 percent, improve accuracy and consistency in decisions, and remove barriers for those who wish to return to work. We must give this bold and ambitious plan the attention that it deserves. As I said, this is a joint meeting, and now I would defer to Mr. Herger, the Chairman of the Subcommittee on Human Resources.

Chairman HERGER. Thank you, Chairman Shaw. I would like to take a moment to welcome Commissioner Barnhart and our other witnesses to the hearing today. I am looking forward to hearing comments on the disability determination process and ways to improve it for all those involved. With that, I submit my full statement for the record.

Chairman SHAW. Mr. Cardin?

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank you for holding this hearing. I particularly appreciate the fact that this is a joint Subcommittee hearing between the Subcommittee on Social Security and the Subcommittee on Human Resources. Since I serve on both of the Subcommittees, it is nice to be able to have one hearing and get credit for two attendances.

Chairman SHAW. You only get to speak once.

Mr. CARDIN. Oh.

[Laughter.]

I want to thank Mr. Matsui for yielding me his time as the Ranking Member of the Subcommittee on Social Security, so I get double time. Let me welcome all of our witnesses here today, and particularly my colleague Congressman McIntyre from North Carolina. It is a pleasure to have you here, and I know of your interest

and work in this area and bringing it to our attention, and we certainly appreciate that.

Commissioner Barnhart, it is always a pleasure to have you before our Committee, and we appreciate your leadership at the SSA. Every Member of Congress knows about the problem we are confronting on disability determination. All they need to do is talk to the people in their district office, the number of calls that we receive, the number of concerns about the length of time for disability determinations, particularly those that are on appeal. We know that there is frustration out there because of the long time it takes in order to make a full determination, particularly when the individual is in the appeal process.

Now, I understand this is a very complex process, and we all understand that. We want to get it done right, but we also want the process to be streamlined. I particularly appreciate the Commissioner's work on computerizing the entire files. I find it somewhat surprising that we have not done that to date, and I know that she has been fighting battles within the Administration to move that forward, and we are making progress in that area. I think that is absolutely essential to be done. It still takes on average about 3 months for a decision on a benefit application, and nearly a year in regards to those cases that are appealed to the ALJ. That is a long time. They are averages. Of course, there are people that are well beyond that time period. It can take, in fact, several years if you go through the entire process, and that is just too long, and we need to be able to shorten that period of time.

We need to be able to do that and still maintain the independence of the appeal process at the ALJ level. We do not want to compromise the integrity of the independent appeal, and we also want to make sure that this is still truth-seeking and not an adversarial process so that we try to make the right decisions. After all, fairness is the key here to treat all of our people fairly within the system itself. I think that really presents the challenges. You have 2.5 million applications for disability that are filed every year, 2.5 million. We have half-a-million claims that are appealed to the ALJ on an annual basis. The backlog is more than is acceptable. We understand that. The Commissioner has attempted certain demonstration projects in order to test some ways of getting people through the process faster, as well as trying to get people back to work, which is always our objective, those who can work. So, I look forward to hearing from our witnesses today as we continue our partnership in streamlining the process to make it more efficient for the people who depend upon disability income, and to make sure that we do this in the fairest way. Thank you, Mr. Chairman.

Chairman HERGER. Thank you. Now I would like to introduce our first witness, who is a Member of Congress, the Honorable Mike McIntyre, Representative from the State of North Carolina. Congressman McIntyre, I thank you for your involvement. I understand in your private practice you have been involved with this, and also you have legislation before us now.

Mr. MCINTYRE. Yes, sir.

Chairman HERGER. So, we invite you to present your testimony.

STATEMENT OF THE HONORABLE MIKE MCINTYRE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. MCINTYRE. Thank you, Mr. Chairman, and thanks to all of you for your time this afternoon. In very brief comments, I want to say how much it is a pleasure to be with you today as we discuss an issue that is of great importance, reforming the Social Security disability determination process. As you just mentioned, before I came to Congress, I represented several individuals in Social Security disability cases in my hometown as their attorney in Lumberton, North Carolina, and throughout Robeson County. Time after time, I saw the flaws in the current system. I saw the hurting citizens suffer needlessly. I saw claimants forced to wait and wait and wait several months for an appeal that ultimately results in a second denial from the exact same agency that denied their first claim.

Throughout my time here in Washington, I have continued to hear these concerns from constituents and caseworkers in both my Washington and North Carolina offices. In fact, my District Director of Constituent Services, Marie Thompson, who has a passion for these issues and the individuals affected by them, knows too well the headaches that many claimants face on a repeated basis. In fact, she is currently, as my District Director, working on over 200 cases that will take literally years to finalize, given the current process.

In addition, the 3 caseworkers in my office handling Social Security cases are assisting approximately 500 of our constituents who have cases now pending. Many of these constituents have already waited for over a year for a decision while others are just beginning a process they know may be long and, indeed, agonizing. A larger number of these claimants are from single-income homes who now have no income at all with which to support themselves and their families, thus just exacerbating the situation. Many face increasing medical bills, while others simply are unable to receive needed medical care because they have no money and no health insurance. Others will watch as another family member struggles to earn enough money to keep the family just barely afloat while waiting. There will be families faced with mounting past-due bills and disconnection of utilities, basic quality-of-life issues for anyone. Yes, there will be those who will indeed lose their homes in which they live while they are simply waiting. All of this occurs while they battle a condition or an illness which keeps them from working, and, unfortunately, there will be those who will even lose that battle while they wait.

To address these concerns, I introduced a bill earlier this year that would reform the disability determination process by eliminating the first level of appeal. This level, known as reconsideration, is redundant, and eliminating it will save time and resources and unnecessary delay. I am pleased that Commissioner Barnhart and her staff have included the elimination of this phase, known as reconsideration, in her proposal to reform the disability claims system.

As someone who has worked on this issue on a personal and professional level before coming to Washington, and now over the last

years on a congressional level, I am committed to ensuring that the Social Security disability determination process is reformed and is fair to all concerned. Therefore, I offer my support and my willingness to work with Commissioner Barnhart and Members of both of these Subcommittees represented here today on these issues. It is indeed time that we in Congress work to make real reform, so that our constituents can finally receive the benefits that they deserve. Reforming this broken process is the next step to bringing real relief to claimants who truly deserve disability benefits and who truly do not need to face another unnecessary delay. Thank you, thanks to both of you, to your Subcommittees and the Committee in general. I thank you, gentlemen, and may God bless you in your kind consideration of literally this life-changing matter as we consider these important issues involving Social Security reform.

[The prepared statement of Mr. McIntyre follows:]

Statement of The Honorable Mike McIntyre, a Representative in Congress from the State of North Carolina

Mr. Chairman, Ranking Member, and fellow colleagues: It is a pleasure to be here today as we discuss an issue that is of great importance—reforming the Social Security disability determination process.

Before coming to Congress, I represented several individuals in Social Security disability cases as an attorney in my hometown of Lumberton, North Carolina. Time after time, I saw the flaws in the current system. I saw the hurting citizens suffer needlessly. I saw claimants forced to wait several months for an appeal that ultimately results in a second denial from the *same agency* that denied their first claim.

Throughout my time in Washington, I have continued to hear these concerns from constituents and caseworkers in my Washington and NC district offices. My District Director of Constituent Services, who flew up from NC and is here today because of her passion for this issue, knows too well the headaches that many claimants face on a repeated basis. In fact, she is currently working on over 200 cases that will take years to finalize.

In addition, the three caseworkers with my office handling Social Security cases currently are assisting approximately 500 of our constituents who have cases pending. Many of these constituents have already waited for over a year for a decision while others are just beginning a process they know may be long and agonizing. A large number of these claimants are from single-income homes who now have *no income at all* with which to support themselves and their families. Many face increasing medical bills, while many others simply are unable to receive needed medical care because they have *no money* and *no health insurance*. Others will watch as another family member struggles to earn enough money to keep the family *just barely afloat* during the wait. There will be families faced with mounting past-due bills and disconnection of utilities. And, yes, there will be those who will *lose the homes in which they live*. All of this occurs while they battle a condition or illness which keeps them from working. And, unfortunately, there will be those who will even lose that battle during the wait.

To address these concerns, I introduced a bill in July that would reform the disability determination process by eliminating the first level of appeal. This level, known as reconsideration, is redundant, and eliminating it will help to save time and resources. I am pleased that Commissioner Barnhart has included the elimination of reconsideration in her proposal to reform the disability claims system as well.

As someone who has worked on this issue on a personal level, I am committed to ensuring that the Social Security disability determination process is reformed and is fair to all concerned. Therefore, I offer my support and willingness to work with Commissioner Barnhart and Members of the two subcommittees represented here today on these issues. It is time that we in Congress stood up and worked to make real reforms so that our constituents can finally receive the benefits they deserve. Reforming this broken process is the next step to bringing real relief to the claimants who truly deserve disability benefits and who truly do not need to face any further delay! Thank you, and may God bless you in your kind consideration of this important matter!

Chairman HERGER. Any questions?

Mr. CARDIN. Mr. Chairman, let me again thank my colleague. We have the benefit of having Mr. McIntyre's advice that we can seek while we deal with this issue. I think his practical experience particularly in his former role is going to be very helpful to this Congress as we try to confront these issues. Once again, let me thank you for appearing here today before our Committee, and I assure you that we look forward to working with you as we try to deal with these issues.

Mr. MCINTYRE. Yes, sir. We will be available as necessary. Thank you. Thank you, gentlemen.

Chairman HERGER. Thank you.

Chairman SHAW. Before you leave, I just also want to compliment you for your statement. It is good to have somebody here who is one of us, and has the experience of being one of them and has confronted many of these things. Our Subommittee, for the 6 years that I have been Chair, has been examining and re-examining ways that we can change the system, and I think in a bipartisan way we want to do that so that we can get a quick, decisive decision for people that are probably tremendously fragile.

Mr. MCINTYRE. Yes, sir.

Chairman SHAW. So, your view is valuable to the Committee. Thank you.

Mr. MCINTYRE. Thank you. Thank you, gentlemen.

Chairman SHAW. The next panel of one is the Honorable Jo Anne Barnhart, the Commissioner of the SSA. We are pleased to again have you before the Committee and are looking forward to your testimony. Ms. Barnhart.

STATEMENT OF THE HONORABLE JO ANNE B. BARNHART, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

Commissioner BARNHART. Thank you very much, Mr. Chairman.

Chairman SHAW. I don't know that your microphone is on.

Commissioner BARNHART. Can you hear me now?

[Laughter.]

Chairman SHAW. We can hear you now.

Commissioner BARNHART. Thank you very much, Mr. Chairman. Chairman Shaw, Chairman Herger, Mr. Cardin, and Members of the Subcommittees, it is really a pleasure to appear before you today to discuss my approach for improving the Social Security disability determination process. I always welcome the opportunity to appear before this Committee because I so greatly appreciate your ideas and insights as well as your consistent support for our agency. I am doubly pleased to be here today because it was before you that just about a year ago I first described my vision for an improved disability system, and it is particularly nice to go after Mr. McIntyre, who actually endorses one aspect of my proposal.

Today I would like to update you on how we are proceeding to convert my approach into a detailed plan and ultimately into an effective process to make the right decision as early in the process as possible. I know that your Subcommittees are painfully aware

of the length of time that claimants have to wait for an initial determination or an appeal. In fact, it was the subject of many of your opening comments. Delays in the current system occur in spite of the best efforts of the dedicated public servants in the SSA and in the State Disability Determination Services (DDSs), who are such a vital part of our agency's work.

We have moved forward in several areas: we are implementing the eDIB process, which provides the infrastructure that is needed to support the new approach; we have conducted a massive outreach effort to obtain comments on the current system and the new approach, and we are giving thoughtful consideration to all of them; we are conducting an exhaustive study of all the issues. The Disability Service Improvement staff that I created is located organizationally in my immediate office, and it is coordinating this effort, making sure that we have all the information that we need to make decisions.

Before I go any further, I do want to take this opportunity to emphasize that the new approach is just that. It is an approach or an outline. I have made no final decisions on how to implement it. Everyone I speak with understands the urgency of the need to improve the disability process; because this is such an important program and because it is so complex, as you have indicated and acknowledged in your opening statements, I really needed time to listen to the people involved at all stages of the process, both outside of and within the SSA. I have personally participated in 51 meetings with more than 35 organizations involved in the disability process, within our agency and outside it. Among the hundreds and hundreds of comments that we received, more than 500 came in through our website from individuals. Many of those individuals were themselves disability claimants or current recipients.

I am not going to take time here to describe my new approach because it is summarized in my written testimony, and I know you are all familiar with it. I would say generally the approach has been well received. Certainly there are issues on which there is not consensus, but every group that I have talked to agrees on one thing, and that is that the current system needs to be changed. I want to thank everyone who is giving us the benefit of their views and sharing their concerns. I would like to make a special note of the cooperative and constructive attitude of all who have provided comments, and especially the individuals and organizations that I have met with personally. I really appreciate their willingness to work with me to improve the disability process. The comments that we have received have been extremely valuable and have definitely shaped and are continuing to shape my thinking. Many of the decisions are not going to be easy because there are multiple considerations for each issue.

For example, when I developed the new approach, I envisioned Regional Expert Review Units (RERU) to provide specialized medical and vocational expertise for each step of the process. A number of organizations and individuals have raised excellent questions about how these units would work, questions such as how to ensure that DDSs can access the medical expertise they need; how these units could and should be staffed; how to use specialized ex-

perts in cases of multiple disabling conditions; and how experts in these units would relate organizationally to the DDSs and to the Office of Hearings and Appeals (OHA). Similarly, there is a wide range of views as to where responsibilities for quick decisions should reside. The new approach calls for field offices to send them to the RERUs immediately after taking the application.

Virtually everyone we have talked to thinks the idea of a quick decision process for the obviously disabled is a good idea. My idea was to allow DDSs to concentrate more on difficult cases by removing the obvious cases from their workload. We have heard from a number of parties who think the DDSs should handle the quick decision process. Eliminating the Appeals Council is another element of the new approach that has generated a large number of comments. Advocacy groups have expressed concern about the effects of such a step, especially because it means closing the record after the ALJ decision. These groups have suggested there should be a provision for good-cause exceptions. On the other hand, others fear that eliminating the Appeals Council could lead to significantly more cases being appealed to Federal court and, thus, overwhelming the court system.

I cannot tell you today how I am going to resolve these issues because, as I said earlier, I have not made decisions. My task is to put together a cohesive package in which every element of the process contributes to its effectiveness and removes obstacles to our goal to make the right decision as early in the process as possible. I expect to make decisions relatively soon on the major issues so that we can put together a proposed rule on the new approach by early 2005. Of course, the draft proposed rule will be available for public comment, and I expect that we will receive many comments that will be very helpful. I look forward to the opportunity to hear these Subcommittees' views as well. When I first described my approach to you, I said that it would require having an eDIB system fully implemented and in operation long enough for us to identify and address any startup problems.

The new approach to disability claims processing can work efficiently only when all components involved in disability claims adjudication and review move to an electronic process through the use of an eDIB folder. I am pleased to say eDIB is right on schedule. Fourteen States have begun using the electronic folder, and the first three electronic hearings were held in Charlotte, North Carolina, in the last few weeks. I know that moving to eDIB poses significant challenges for the employees at SSA who are involved at all levels. I want to publicly thank them for their dedication, their willingness, and their hard work in making eDIB a success.

I would like to give special thanks to Butch McMillen and Sheila Everett from the State of Mississippi. Under their leadership, earlier this month Mississippi became the first State to completely roll out the electronic folder, with all disability examiners (DEs) now using the electronic folder, and to thank our Regional Commissioner in Atlanta, Paul Barnes, for his superb leadership in making Region 4 the first region to lead the way for the Nation.

Finally, I would like to thank you, Chairman Shaw, Chairman Herger, and the Members of the Subcommittees for your support and your guidance. I really appreciate the relationship that we

enjoy, and I look forward to working with you and your staff as we continue in our mutual efforts to improve the service provided to disabled individuals and their families because that is what this is all about. I will be happy to try and answer any questions Members of the Committee may have for me.

[The prepared statement of Commissioner Barnhart follows:]

Statement of The Honorable Jo Anne B. Barnhart, Commissioner, Social Security Administration

It is a real pleasure to appear before these two subcommittees today to discuss my approach to improving the Social Security disability determination process. I always welcome the opportunity to appear before you because I so greatly appreciate your ideas and insights as well as your consistent support for our agency. And I am doubly pleased to be here today because it was before you that I first described my vision for an improved disability system.

Today I would like to update you on how we are proceeding to convert my approach into a detailed plan and, ultimately, into an effective process to make the right decision as early in the process as possible.

I know that these subcommittees are painfully aware of the length of time claimants have to wait for an initial determination or an appeal. And delays in the current system occur in spite of the best efforts of the dedicated public servants in SSA and in the state Disability Determination Services (DDS), who are such a vital part of the agency's work. In fact, when I talk about SSA employees, I also refer to those who work in the Disability Determination Services, or DDSs.

Where We Are Now

We have moved forward in several areas:

- We are implementing the electronic disability process, which provides the infrastructure needed to support the new approach.
- We have conducted a massive outreach effort to obtain comments on the current system and the new approach and are giving thoughtful consideration to all of them.
- We are conducting an exhaustive study of all the issues. The Disability Service Improvement staff, or DSI, located organizationally in my immediate office, is coordinating this effort, making sure that we have all the information we need to make decisions.

Before I go any further, let me emphasize that the new approach is just that—an approach or an outline. I have made no final decisions on how to implement it. Everyone I speak with understands the urgency of the need to improve the disability process. But because this is such an important program, and because it is so complex, I needed to take the time to listen to people involved at all stages of the process, both outside of and within SSA.

I have made an active personal role in this process one of my highest priorities. For example, I have personally participated in more than 40 meetings with more than 30 organizations involved in the disability process—within SSA and outside the agency. Among the hundreds and hundreds of comments we received were more than 500 comments on our website from individuals, many of them disability claimants or recipients.

Elements of the New Approach

As I said a moment ago, the new approach is designed to make the right decision as early in the process as possible. Another major purpose is to encourage return to work at all stages of the system. I made a decision early on, to focus on those steps that we can implement through regulation rather than legislation.

The approach preserves some of the significant features of the current system. Initial disability claims will continue to be handled by SSA's field offices; DDSs will continue to adjudicate claims for benefits; and Administrative Law Judges (ALJs) will continue to conduct de novo hearings and issue decisions.

But there also are a number of important changes to the current system:

- A "Quick Decision" step at the earliest stages of the claims process for people who are obviously disabled would allow their claims to be decided within 20 days.

- Medical expertise within Expert Review Units would be available for decision makers at all levels of the process, including DDSs and the Office of Hearings and Appeals (OHA).
- The DDS reconsideration step would be eliminated.
- A Reviewing Official (RO) position would be created within SSA to evaluate claims appealed from the DDS. The RO could allow a claim or agree with the DDS decision.
- The Appeals Council step would be eliminated. The ALJ decision would be the agency's final action, unless the case was selected for review by an Oversight Panel of ALJs and an AAJ.

The lynchpin of quality assurance under the new approach is accountability and feedback at each level of the process. At all levels, the quality process would focus on denials as well as allowances, and concentrate on ensuring that cases are fully documented at each stage. This last point is crucial because I believe that better documentation will allow cases to move through the system more quickly and will produce better decisions.

The new approach would be workable only when SSA's electronic disability system—which we call e-Dib—is fully functional so that a claimant's file could be accessed by those working on the case anywhere in the nation. I'll discuss that in more detail a little later.

We also are working on several demonstration projects to encourage voluntary return to work. I believe these projects will let us learn a great deal about how to expand beyond the incentives in the Ticket to Work program that your Committee was so instrumental in creating.

Reaction to the New Approach

I began my presentation by describing our outreach to hear the full spectrum of views and concerns from those who are involved at every step of the process. Generally, the approach has been well received.

Certainly, there are issues on which there is not consensus. For example, the two most common comments we have received on the Reviewing Official step are that the reviewing official does not need to be an attorney and that the reviewing official absolutely should be an attorney. But every group I've talked to agrees that the current system needs to be changed.

I want to thank everyone who is giving us the benefit of their views and sharing their concerns. The comments we received have been extremely valuable and have definitely shaped my thinking. Many of the decisions will not be easy because there are multiple considerations for each issue.

For example, when I developed the new approach, I envisioned Regional Expert Review Units to provide specialized medical and vocational expertise for each step of the process. A number of organizations and individuals have raised excellent questions about how these units would work—questions such as:

- How to ensure that DDSs can access the medical expertise they need;
- How these units should be staffed;
- How to use specialized experts in cases of multiple disabling conditions; and
- How experts in these units will relate organizationally to the DDSs and OHA.

Similarly, there is a wide range of views as to where responsibilities for Quick Decisions should reside. The new approach calls for field offices to send them to the Expert Review Units immediately after taking the application. Virtually everyone we've talked to thinks the idea of a quick decision process for the obviously disabled is a good idea. My idea was to allow DDSs to concentrate more on difficult cases by removing the obvious cases from their workload. But we've heard from a number of parties who think the DDSs should handle the Quick Decision process.

Eliminating the Appeals Council is another element of the new approach that has generated a large number of comments. Advocacy groups have expressed concern about the effects of such a step—especially because it means closing the record after the ALJ decision. These groups have suggested that there should be a provision for good cause exceptions.

On the other hand, others fear that eliminating the Appeals Council could lead to significantly more cases being appealed to Federal court, and, thus, overwhelming the court system.

I cannot tell you how I will resolve these issues because I have not made decisions. My task is to put together a cohesive package in which every element of the process contributes to its effectiveness and removes obstacles to our goal to make the right decision as early in the process as possible.

What Next?

I expect to make decisions relatively soon on the major issues so that we can put together a proposed rule on the new approach by early in calendar 2005.

Of course, the draft proposed rule will be available for public comment. I expect that we will receive many comments that will be very helpful. And I will look forward to the opportunity to hear your views.

Advancements in Systems Technology

When I first described my new approach to you, I said that it would require having the Electronic Disability System that we call eDIB fully implemented and in operation long enough for us to identify and address any startup problems. The new approach to disability claims processing can work efficiently only when all components involved in disability claims adjudication and review move to an electronic business process through the use of an electronic disability folder.

I am pleased to say that eDIB is right on schedule.

As you know, SSA field offices throughout the agency are now using the Electronic Disability Collect System (EDCS) that provides DDSs an electronic folder. In the DDSs, we rolled out eDIB in January 2004 starting in Jackson, Mississippi, and implementation has begun in 14 states. We expect this process to be complete by June 2005.

The Office of Hearings and Appeals (OHA) has begun using the new Case Processing and Management System. CPMS is a new software system for processing cases and managing office workloads in the OHA. CPMS is a replacement system and will provide OHA with the ability to work with the electronic file.

When these electronic processes are fully implemented, each component will be able to work claims by electronically accessing and retrieving information that is collected, produced and stored as part of the electronic disability folder. This will reduce delays that result from mailing, locating, and organizing paper folders.

I know that moving to eDIB poses significant challenges for the employees at SSA who are involved at all levels. And I want to publicly thank them for their dedication and hard work that is making eDIB a success.

Conclusion

I'd like once again to thank Chairman Shaw, Chairman Herger and the members of these subcommittees for their support and guidance. I look forward to working with you and your staffs as we continue our mutual efforts to improve the service provided to disabled individuals and their families.

Chairman SHAW. Commissioner, you propose to establish RERU which would centralize the medical expertise to make it available to decisionmakers across the country. More detail is needed in terms of whether these experts will replace current personnel or whether they will be doctors or nurses, or both, and what their role would be. My question is: your proposal to reform the disability determination process would create new medical expert units located in Social Security regional offices. Would you agree that on-site doctors at the State DDSs currently provide essential services, including reviewing cases, training, preventing fraud, and working with other doctors in the State to bolster the medical evidence at a lower cost?

Commissioner BARNHART. Let me say, Mr. Chairman, what I believe is at the root of your question is the idea that we want to have the best possible medical expertise all through the disability determination process. My goal in the new approach was to augment or fill in gaps that may exist in our existing medical expertise. We have very hardworking MCs across the country in our DDSs. When you look at the cases that come in to the DDSs, not always is the right set of medical eyes looking at those cases. Let me give you an example. Doing an inventory of the MCs that we

have, 2.5 percent of our MCs are orthopedic doctors, yet over 20 percent of the cases that we decide on an annual basis deal with orthopedic issues. I think the medical personnel should reflect and certainly have the expertise to be able to handle the types of cases that are coming in.

In one State that I visited earlier this year, I spoke with a pediatric oncologist at a DDS, and I said, "How many of the cases that you do have to do with pediatric oncology?" He said, "About 20 percent." I said, "Well, in the new approach I want to change that. I want to make sure you are looking at 80 percent pediatric oncology cases and that we are using your expertise to make the right decision as early as possible." I have read all the testimony of the other witnesses that are appearing here today, and I am aware of the concerns that have been expressed, and the basis of the Chairman's question, and I would say this: my goal is to improve the availability of medical service. In the new approach, I recommended RERUs. As a result of the back-and-forth discussions that I have had with various interested parties over this last 12 months, I am looking at the possibility of having doctors in the DDSs provide service to other DDSs. If you are a pediatric oncologist in one State, maybe you can help with pediatric oncology cases coming in from another State. There are a number of issues that need to be dealt with: State licensure requirements for physicians, reimbursements between one State and another. So, I think that we will get to the right place in terms of making sure that we take the greatest advantage we possibly can of our existing medical expertise, but at the same time fill in the gaps that may exist.

Chairman SHAW. Is State licensing a problem?

Commissioner BARNHART. Well, the issue there, Mr. Chairman, as I have been advised by the medical commenters we have heard from, is that you get licensed to practice in a particular State, and so you might, let's just say you are in the State of Delaware, my home State, and we are asking you to look at cases from Pennsylvania, we have to look at what the implications are of doing that and whether we have to address any State licensure issues.

Chairman SHAW. I wonder whether examining a patient and testifying would be practicing medicine in another State if you are under the guidance of the court.

Commissioner BARNHART. Those are the kind of issues that we are looking at, Mr. Chairman, and I will be happy to keep the Committee apprised as we identify the correct answers and resolve some of those operational issues.

Chairman SHAW. It would be helpful if that is not an impediment, but you mentioned the specialty of doctors. What is the predominant specialty of the doctors that are now testifying or doing reviews?

Commissioner BARNHART. You know, I did not bring the listing with me, but I would be happy to submit the inventory that we did to the Committee for the record.

Chairman SHAW. I would appreciate it. I think that is important.

[The information follows:]

As of May 2004, there were 2,136 Medical Consultants on staff within DDSs. Of those, 1,700 (80 percent) were less than full time.

Clinical Specialist	Percent of DDS MCs*	Percent of DDS Workload**
Cardiologists	1.70	6.70
Child Psychiatry	0.60	0.50
Child Psychology	0.01	3.70
Endocrinologists	0.20	3.80
Family Practice	6.80	0.00
Gastroenterologists	0.30	2.40
Internists	6.30	6.30
Neurologists	1.90	6.80
Oncologists	0.30	4.70
Orthopedists	2.50	19.90
Pediatricians	9.80	0.90
Psychiatrists	10.70	19.60
Psychologists	31.20	7.50
Pulmonologists	0.30	4.70
Rheumatologists	0.30	6.70
Other	17.09	5.80

*Percentages weighted based upon full-time or part-time status as of May 2004.
**Workload percentages are based upon primary impairment only for FY 2003.

Chairman SHAW. Are you eliminating some of the on-site doctors, and are you replacing some of them with nurses?

Commissioner BARNHART. We have not, well, first of all, we have not done anything. I was laying out an approach of how we might get at the medical gaps that exist. I am listening to the comments. We have gotten a number of papers in from DDSs, and some of the witnesses today are going to speak to that fact, from the National Association of Disability Examiners (NADE) and from the National Council of Disability Determination Directors (NCDDD), as well as the medical consultant who is going to testify. We have talked with all those groups ourselves, and so we are looking at how we address the concerns that they have raised.

Chairman SHAW. Thank you. Mr. Herger?

Chairman HERGER. Thank you. Commissioner Barnhart, one of the great satisfactions I have as I travel around my Northern California district is to periodically be able to observe those individuals who have disabilities that are out working and to be able to witness the great sense of self-worth and satisfaction that these individuals have of being involved in the process. I know that while you are currently working on improving the disability determination process, you also are conducting demonstration projects to help these people with disabilities be able to return to work. The idea that people with disabilities can work rather than collect disability benefits for years and years is an important concept that needs to be made a more integral part of the Social Security disability system. If you could, Commissioner, could you bring us up-to-date on work-related demonstration projects and any other progress that has been made in helping more disabled beneficiaries be able to work?

Commissioner BARNHART. Yes. Let me say, first of all, I share your strong belief that return-to-work issues are extremely important in providing adequate services, and incentives and removing disincentives in these programs to help people with disabilities be able to continue to work or start to work if they choose to do so is definitely a priority of ours, and certainly the Ticket to Work legislation that was passed several years ago with the leadership of

this Committee has made a big difference in terms of reorienting, I think, the mission of the SSA in that regard.

As part of the new approach, I actually outlined four different demonstrations that would not wait until an individual was adjudged disabled but, rather, would start from the very beginning of the process. Not to take the time to explain each of them, they all looked at the central theme was providing services and benefits earlier in the process to allow people to continue working, not necessarily to go on full-time disability benefits. I would be happy to provide a write-up of those for the record again. None of those have actually started yet, but we are in the process of working through in several locations hopefully being able to start some of those as early as next year.

I want to emphasize that all of those demonstrations, as we contemplate them, would be voluntary. They are not mandatory. It would be up to the individual person with disabilities to make the decision if they want to avail themselves. The reason for delay in some cases is we have to develop a predictive model that would tell us whether people with certain kinds of conditions and disabilities could be expected to improve, would benefit from the kinds of services that we would offer in those demonstrations. Right now we have been working with the State of Florida, and the State of Florida, in my understanding, in January intends to implement the Florida Freedom Initiative. This is something that I know that, Chairman Herger, you have an interest in, we talked about this I think this summer when I testified before your Subcommittee, where we actually modify SSI rules to allow, along the lines of individual development accounts that have been created in the welfare system to encourage people to go to work and to remove the disincentive that occurs from accumulation of resources.

The Youth Transition Program is another demonstration that is actually up and running. Six different States are involved in that, Mr. Chairman, and this is very important because I feel very strongly about this. In a prior life, I was the Assistant Secretary for Children and Families and had a lot of interaction with the foster care system and the whole issue of when children age out of a particular program and oftentimes there is a gap in service. The issue here is to make sure that when children would age out of SSI for disabled children that we have actually taken steps to help move them into making the transition to work. So, I have a complete report I could submit that details what is happening with every single one of our demonstrations that I would be happy to submit for the record in addition.

Chairman HERGER. Without objection, I would like you to do that.

[The information follows:]

Updates of Demonstration Projects

Benefit Offset Demonstrations

Description: The Ticket to Work legislation requires the Commissioner to "conduct demonstration projects for the purpose of evaluating . . . a program for title II disability beneficiaries . . . under which benefits payable . . . based on the beneficiary's disability, are reduced by $1 for each $2 of the beneficiary's earnings that is determined by the Commissioner."

The National Benefit Offset Demonstration will test a range of employment support interventions in combination with a $1 reduction in benefits for every $2 in earnings, with the goal of enabling more beneficiaries to return to work and maximize their employment, earnings, and independence. At the same time, we are developing plans for a 4 state demonstration that could be run at a lower cost (and in an earlier timeframe). Our intent is to gather information for the national demonstraton.

Status: We plan to conduct this project in two distinct phases: an initial four-state pilot project (Connecticut, Utah, Vermont, and Wisconsin), and the national study. The purpose of the initial project is to collect early information on the demonstration that will be useful in developing the national study. We expect to enroll participants in the four-state pilot by the end of the calendar year or early in 2005. We awarded the contract for the national study on September 30, 2004 to Abt Associates.

Early Intervention (EI)

Description: With the EI project, SSA will, for the first time, conduct a demonstration focused on applicants. The concept underlying the EI project is that providing services and supports as close to disability onset as possible will enable individuals to remain in or return to the workforce.

The project will offer interventions to a sample of Social Security Disability Insurance (SSDI) applicants with impairments that may reasonably be presumed to be disabling (i.e., they are likely to be awarded SSDI benefits) and who are likely to return to work as a result of the program. The interventions will include access to a wide range of necessary employment services, a 1-year cash stipend equal to the applicant's estimated SSDI benefit and Medicare for three years.

Status: SSA released a solicitation on the process demonstration project on August 2, 2004. We hope to award a contract in November 2004 and begin enrolling participants in early CY 2005.

Disability Program Navigator (DPN)

Description: SSA and the Employment and Training Administration (ETA) of the Department of Labor (DOL) are jointly funding approximately 200 DPN positions in 17 states (Arizona, California, Colorado, Delaware, Florida, Iowa, Illinois, Maryland, Massachusetts, New York, Oklahoma, So,uth Carolina, Vermont, and Wisconsin in the first year; and Mississippi, New Mexico, and Oregon in the second year). DPNs operate in DOL's One-Stop Career Centers and provide seamless employment services to individuals seeking to enter the workforce. DPNs also provide an important link to the local employment market and facilitate access to programs and services that impact the success of individuals with disabilities who are seeking employment.

Status: The DPN project is in its second year of operation. In June 2003 DOL awarded cooperative agreement funding to 14 states to establish DPNs. In June 2004, DOL continued funding to the 14 original states and awarded funding to 3 additional states. DOL's technical assistance contractor is conducting a process evaluation in all states and will review and evaluate outcomes in selected states. SSA expects a final report from the DOL contractor in fall 2005.

Mental Health Treatment Study (MHTS)

Description: The MHTS will focus on SSDI beneficiaries with mental health impairments. It will test the effect of treatment funding on the health and health-care/job-seeking behaviors of those beneficiaries. The study intervention calls for SSA to pay for the costs of outpatient mental health disorder treatments (pharmaceutical and psychotherapeutic) and/or vocational rehabilitation that are not covered by other insurance for those individuals.

Status: As a first step in a three-part process (design, pilot, and larger demonstration), a pre-design contract was awarded to the Urban Institute in September 2003. SSA and the Urban Institute have selected a Technical Advisory Panel (TAP) (consisting of national experts on the subject) to provide recommendations on demonstration interventions. The first TAP meeting was held in June 2004 and the second meeting is scheduled for late October 2004.

Homeless Outreach Projects and Evaluation

Description: Congress provided $8 million in both FY 2003 and 2004, for SSA to conduct outreach to "homeless and under-served populations." SSA used this earmarked funding to establish the Homeless Outreach Projects and Evaluation

(HOPE) in support of the President's initiative to end chronic homelessness within 10 years.

The HOPE initiative is focused on assisting eligible, chronically homeless individuals in applying for Supplemental Security Income (SSI) and SSDI benefits. The HOPE projects will help SSA to demonstrate the effectiveness of using skilled medical and social service providers to identify and engage homeless individuals with disabilities as well as assist them with the application process.

Status: SSA awarded $6.6 million in cooperative agreement funding to 34 public and private organizations in April 2004 and conducted an Orientation Conference for the organizations in August 2004. We awarded an evaluation contract on September 17, 2004.

Youth Transition Process Demonstration (YTPD)

Description: To further the President's New Freedom Initiative goal of increasing employment of individuals with disabilities, in September 2003, SSA awarded cooperative agreements to six states (California, Colorado, Iowa, New York, Maryland, and Mississippi) for the purpose of developing service delivery systems to assist youth with disabilities to successfully transition from school to work. During this critical period of transition to adulthood, the services provided to youth with disabilities can prepare them for postsecondary education, employment and economic self-sufficiency.

The states will establish partnerships to improve employment outcomes for youth ages 14–25 who receive SSI or Social Security Disability Insurance (SSDI) payments on the basis of their own disability. The projects will provide a broad array of transition-related services and supports to SSI and SSDI applicants and children.

Status: The demonstration projects are at various stages of implementation. Most projects currently are testing their designs while others began pilots at the start of the 2004 school year. A technical assistance contract was awarded September 30, 2004 to the Virginia Commonwealth University. An evaluation solicitation will be released by the end of the calendar year. The second year of funding for YTD projects was awarded September 30, 2004.

State Partnership Initiative (SPI)

Description: SSA and the Rehabilitation Services Administration (RSA) funded a combined total of eighteen demonstration states in 1998. SSA provided 5-year funding to twelve states (California, Illinois, Iowa, Minnesota, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Vermont and Wisconsin) to develop innovative projects to assist individuals with disabilities in their efforts to reenter the workforce. These awards helped states develop state-wide programs of services and support for their residents with disabilities that increased job opportunities for them and decreased their dependence on benefits, including SSDI and SSI. California, Vermont, New York and Wisconsin implemented SSI waivers to test alternative rules.

Status: The SPI projects are in the sixth and final year. Eleven of the twelve states received no-cost extensions to phase out the projects by the end of September 2004. As of August 2004, the states testing waivers received no-cost extensions for three to nine months to complete waiver closeout and outcome evaluations.

Florida Freedom Initiative

Description: The Florida Department of Children and Families has a CMS waiver program which allows individuals to obtain cash instead of certain Medicaid services to allow participants greater control in the planning and purchase of supports and services. SSA has waived certain SSI Program rules to allow our beneficiaries to participate in the FFI.

Status: SSA signed an IAA with ASPE/DHHS to provide $100,000 in support of the evaluation activities.

Ongoing Medical Benefits

Description: This project will test the effects of providing ongoing health insurance coverage to beneficiaries who wish to work, but have no other affordable access to health insurance.

Status: The design of a national project is under development and we expect to start a pilot project (focusing on HIV–AIDS) in 2005.

Interim Medical Benefits

Description: This project will provide medical benefits to individuals with no medical insurance (no "treating source" evidence) whose medical condition would

likely improve with treatment. This intervention will facilitate the development of the necessary documentation for disability adjudication while providing the applicant needed services.

Status: The projects still are in the preliminary stages of development and no specific information is available at this time.

Accelerated Benefits

Description: These demonstration projects will provide immediate cash and medical benefits for a specified period (2–3 years) to title II disability applicants who are highly likely to benefit from aggressive medical care. This 4-year project will provide immediate access to both DI benefits and Medicare coverage by utilizing a predictive model currently under development. This project was formerly called the "Temporary Allowance" demonstration project.

Status: The projects still are in the preliminary stages of development and no specific information is available at this time.

Again, I thank you for working in that area, very important to the lives of many people who want to be able to be productive as well. So, thank you very much for your work.

Commissioner BARNHART. Thank you.

Chairman SHAW. Mr. Cardin?

Mr. CARDIN. Thank you very much, Mr. Chairman. Commissioner Barnhart, again, welcome. I noticed several times that you complimented the workforce at the SSA, and I just want to underscore that. I have the opportunity frequently to visit and see the workforce. I know how hard they work under extremely difficult circumstances. The volume of work continues to increase, and yet the additional resources for staff has not really kept up. I very much appreciate your advocacy for adequate support for the SSA.

Commissioner BARNHART. Thank you.

Mr. CARDIN. Just to follow up on Mr. Herger's point very quickly, it would seem to me that one of the things we could do to encourage people who are on SSI to be able to be gainfully employed is to deal with the disregard, the wage earnings disregard. That has not been changed in a long time from $65.

Commissioner BARNHART. That is right.

Mr. CARDIN. It seems to me that that may be one way that we really could encourage people to work without the adverse consequences if they are unable to maintain gainful employment.

Commissioner BARNHART. Certainly that is an issue that has been discussed, periodically. I think it came up at the Subcommittee hearing with you all this summer, and we would be happy to provide any kind of technical assistance we can to you or Members of the Subcommittee who are interested in looking at that issue.

Mr. CARDIN. I have been told it has been over 30 years since we made any adjustment on that.

Commissioner BARNHART. It has been a very long time.

Mr. CARDIN. It is time for that to keep up. Again, if we really want to have a coordinated effort to try to encourage people who can to work——

Commissioner BARNHART. If I may say, Mr. Cardin, that is precisely the point of the Florida Freedom Initiative. One of the waivers there, it waives that $65. I think that we will get some good empirical evidence as a result of that demonstration that may show us the effect it has.

Mr. CARDIN. That is good. Also, your demonstration programs, at least some of the ones that I have looked at, will also be providing other services to SSI recipients so that they have some help in their effort to be gainfully employed, which is one of the points that I really want to underscore. It is one thing about cash assistance. It is another thing about supplementing cash assistance with additional services so that individuals can become more independent. So, I think that you are going about that the right way, and we will wait to see what, of course, they are voluntary, and I think that also is helpful.

There are 36,000 elderly disabled refugees who will face termination of their SSI benefits because of the 7-year restriction that was imposed in law. The chief obstacle for these individuals of maintaining their benefits toward becoming citizens has been basically the time delays in these applications being approved. The Administration has recommended an extension. There is a bipartisan bill that I am part of in Congress that would extend so these low-income refugees would be able to continue their SSI benefits.

My reason for mentioning it at this hearing is that we are anticipating that Congress will adjourn next week, and come back for a session in the middle of November. I expect a rather short session. I am just reaching out to you whether we can find some vehicle, some way, some strategy to make sure that before Congress adjourns this year that we extend that SSI limitation; otherwise, we are going to be faced with thousands of individuals being really subject to a hardship. There is also, by the way, support in the U.S. Senate. So, we have broad bicameral support.

Commissioner BARNHART. Yes, Mr. Cardin. I certainly agree with you. As you stated, we have our own proposal for an extension. I think yours allows one more year of extension than ours. There are some other relatively minor differences. I feel confident that if we got together, we could sit down and work out some sort of agreement between us. I do agree that because of the fact the clock is ticking for these individuals, it is important that we take action. So, I would, certainly like to extend the offer to work with your staff to do whatever we can to make that become a reality before the Congress adjourns.

Mr. CARDIN. I appreciate that, and, Mr. Chairman, or Mr. Chairmen, both, I just really want, I hope we can find a vehicle. Again, this is bipartisan. The Administration supports it. I am confident that our leadership would be prepared to support a suspension bill if we cannot find another vehicle for it to go forward on, and we are certainly willing to work out the language between the Administration and the legislation that is pending both in the House and the Senate. This should be non-controversial. I would just hope that we would find a way that we could move that before Congress adjourns this year. Thank you.

Commissioner BARNHART. If I may mention, too, Mr. Cardin, you may be interested to know that we at SSA will be doing an annual notice to the individuals who are subject to that provision to let them know the number of years that they have left of eligibility so that they are aware that they need to move to file for citizenship in the future.

Mr. CARDIN. The problem, of course, is that many have, and it is in the, in fact, this is the leading cause. They have applied for citizenship. It just takes a long time for the process to work its way.

Commissioner BARNHART. Yes. I realize that.

Mr. CARDIN. Thank you.

Chairman SHAW. I would say to my friend from Maryland, by way of a history on that particular piece of legislation, without criticizing your position at all, it was that it was originally 5 years, and then we figured that the people needed an extra 2 years to complete the application for citizenship. Maybe there is some middle ground for those that have already applied or something of that nature. The whole thought was that we don't want that to be a reason for people coming to our shores, and that was the reason for that legislation.

Mr. CARDIN. I appreciate that, Mr. Chairman, and you are absolutely correct. I would just bring to your attention that I think the Administration has been convinced that the need for the delay, for extending it is not because individuals were delinquent in seeking citizenship. It is the process taking a lot longer, and that is why the Administration suggested an extension. That is why I think you have both houses and both parties wanting to do this. So, I would just urge you to take a look at the reasons why. It is not because these individuals have not tried to become citizens. They have. It is just taking longer than we had anticipated for I think some obvious reasons, not least of which was September 11th.

Chairman SHAW. Well, if we are looking for inefficiencies, I think the immigration process in this country is probably about as inefficient as you could possibly get.

Mr. Lewis.

Mr. LEWIS OF KENTUCKY. Thank you, Mr. Chairman. Good afternoon.

Commissioner BARNHART. Good afternoon.

Mr. LEWIS OF KENTUCKY. Our staff contacted the JCUS of the United States (JCUS) to request their attendance at this hearing, and they were unable to provide a witness, but they did submit a letter, which is in each Member's packet. I would like to request that be inserted into the record. This letter highlights the fact that annually about 77,000 claimants request review by the Appeals Council. In addition, last year more than 17,000 disability cases were filed in U.S. district courts. According to the letter, this suggests that a substantial number of cases are being resolved at the Appeals Council level without claimants' having to seek judicial review. Commissioner, should you eliminate the Appeals Council, what will be the impact on the U.S. district courts?

[The information follows:]

Committee on Federal-State Jurisdiction
United States District Court
Wheeling, West Virginia 26003
September 28, 2004

Honorable Frederick P. Stamp, Jr. Chair

Honorable Susan H. Black; Honorable Kathleen A. Blatz; Honorable Glen H. Davidson; Honorable Charles E. Jones; Honorable Kermit V. Lipez; Honorable Howard D. McKibben; Honorable James D. Moyer; Honorable Michael R. Murphy; Honorable Robert E. Nugent; Honorable Loretta A. Preska; Honorable Linda Copple Trout; Honorable Gerald W. VandeWalle; Honorable Roger L. Wellman

Hon. E. Clay Shaw, Jr.
Chairman, Subcommittee on Social Security Committee on Ways and Means
United States House of Representatives B–316 Rayburn House Office Building
Washington, DC 20515–6353

Dear Mr. Chairman:

I am the Chair of the JCUS Committee on Federal-State Jurisdiction.The Committee is responsible for making recommendations to the JCUS onproposals regarding the elimination, modification, or creation of Federal jurisdiction. This advisory responsibility encompasses proposed changes to the manner in which administrative claims are screened and the posture in which they become subject to review in Federal court.

I understand that the Subcommittee on Social Security will be holding a hearing onSeptember 30, 2004, regarding the proposed revisions to the disability claims process. Although the JCUS has not adopted a formal position in response to the current proposal and therefore is unable to provide a witness as requested by your staff, I would like to take this opportunity to share with the Subcommittee the status of the JCUS's consideration of this topic.

The Committee on Federal-State Jurisdiction is guided, as your Subcommittee is certainly guided, by the principle that disability claimants are entitled to a fair and prompt resolution of their claims. The Federal courts have a role in pursuing that principle, albeit a limited one. We intend to do what we can to work with you and Commissioner Jo Anne B. Barnhart to make a positive contribution to the Commissioner's current reform process.

In April 1994, the Social Security Administration (SSA) launched an initiative to revise the administrative process governing Social Security disability claims. At that time, the plan called for reducing the number of decisional steps from four to two, including the elimination of the requirement that a claimant request review by the Appeals Council prior to seeking judicial review in Federal district court. The resulting two-level administrative review process would have consisted of (1) an initial disability determination by a "disability claim manager" and (2) a hearing before an administrative law judge (ALJ). Although the Appeals Council would have continued to exist, it would have only been authorized to selectively review cases after they had been filed in U.S. district courts.

In response, the JCUS determined to communicate to SSA its seriousconcerns regarding the restructuring of the Appeals Council, noting that the proposed role for the.Appeals Council could create jurisdictional problems and could have significant caseload ramifications. *Report of the Proceedings of the JCUS of the U.S. at 38* (September 1994). Through its many communications to SSA over the next several years, the judiciary urged serious reconsideration of the proposed elimination of the requirement that a dissatisfied claimant must request review by the Appeals Council prior to seeking judicial review in the district court. The judiciary stated that the proposed acceleration of district court review of disability claim denials was likely to be inefficient and counter-productive. It pointed out that while about one-third of claimants before the Appeals Council received favorable relief at that stage (either through reversal or remand), only approximately 10 percent of those appeals in which the Appeal's Council granted no relief to the claimant were then submitted for Federal judicial review. Thus, the JCUS felt that substituting immediate access to the district courts prior to Appeals Council review could potentially create a significant increase in the caseload of the district courts. The judiciary encouraged SSA to seek to streamline and expedite the Appeals Council review process rather than to bypass it. The Conference also noted that the screening function performed by the Appeals Council furthered consistency and accuracy of decisions within SSA while lessening the need for claimants to pursue more costly review in Federal district court.

Recognizing the importance of providing thorough review of benefit-type claims at the agency level, the judiciary addressed this issue in its 1995 *LongRange Plan for the Federal Courts.* That *Plan* supports measures to broaden and strengthen the administrative hearing and review process for disputes assigned to agency jurisdiction, and to:Facilitate mediation and resolution of disputes at the agency level. The Plan also supports efforts to improve the adjudicative process for Social Security disability claims both by establishing a new mechanism for administrative review of ALJ decisions and by limiting; the scope of appellate review in the Article III courts. In addition, the *Plan* recognizes that agencies need the requisite authority and resources to review and, where possible, achieve final resolution of disputes within their jurisdiction.

When Commissioner Barnhart announced in September 2003 plans to restructure the disability claims process, our Committee began to analyze her approach, to seek additional information, and to determine whether another JCUS position was warranted. On February 12, 2004, the Commissioner and her staff met with me and staff of the Administrative Office of the U.S. Courts. In addition, on June 10, 2004, the Commissioner met with our Committee, along with Martin H. Gerry, Deputy Commissioner of the Office of Disability and Income Security Programs. We: appreciate her efforts and those of her staff to take the time to explain her ideas and to solicit comments from us.

Many of the details and components of the Commissioner's proposal regarding initial agency operations are not directly within the scope of our inquiry. As mentioned above, the JCUS has set forth a general statement supporting measures to broaden and strengthen the administrative hearing and review process for disputes assigned to agency jurisdiction and to facilitate the resolution of disputes at the agency level.

The Committee on Federal-State Jurisdiction is particularly interested in the component of the Commissioner's current approach to abolish the Appeals Council, thereby apparently allowing, although it is not clear, ALJs' decisions to become the agency's final decision subject to judicial review. (*See 42* U.S.C. § 405(g).) At the same time, SSA intends to create a quality control entity to review certain ALJ decisions. As we understand it, if a claim is selected for review and the quality control staff disagrees with an allowance or disallowance determination, the claim would then be referred to an Oversight Panel (two ALJs and one administrative appeals judge), which could affirm or reverse the ALJ's decision. In those instances, the decision of the Oversight Panel perhaps would be the final agency action. These are the details that we now have.

Under this proposal, however, it is unclear how the agency's disability decisions would become "final" for purposes of judicial review if an optional quality review stage existed. In addition, we do not know what standards would apply in selecting; cases for the proposed quality assurance phase and how often ALJ decisions would be chosen for such optional review. These and other questions that our Committee raised at the June meeting; and shared with the Commissioner presently remain unanswered, possibly because those decisions have not yet been made.

'We recognize that the Commissioner's efforts are directed toward improving the administrative process so that more citizens receive an accurate assessment of' their claim for benefits as soon as possible and that management accountability can be strengthened. The Commissioner apparently views elimination of the Appeals Council as contributing to that goal. We have been informed by SSA that approximately 77,000 claimants currently request review each year by the Appeals Council, with approximately 2% of the claims being allowed and 25% being remanded. During the last fiscal year, 17,127 Social Security disability insurance and Supplemental Security Income cases were filed in U.S. district courts. This suggests that a substantial number of cases are being resolved at the Appeals Council level without claimants having to seek judicial review. Therefore, before a decision is made on whether to eliminate the Appeals Council, we would hope that the new claims process would be adequately tested. It may be that substituting Appeals Council consideration with judicial review in the Federal courts would result in more costs and further delay for many claimants.

I hope the Subcommittee on Social Security finds this information helpful. If the JCUS of the United States takes action with regard to the changes to the disability claims process now under discussion, the Conference will promptly notify your Subcommittee.

Sincerely,

Frederick P. Stamp, Jr.

Commissioner BARNHART. Well, let me say, as I indicated in my opening statement, certainly this is an area where there has been substantial concern expressed by many parties throughout the system. I would like to mention that I had the opportunity to work with the Subcommittee of the JCUS and actually did go to New York and meet with them for several hours to answer their questions, to present the new approach and answer their questions. I saw the letter that the Conference submitted that you requested be submitted to the record, and it absolutely reflects the concerns they expressed to me, and it is this issue of opening the floodgate, as they put it, of cases to the courts. At the same time, I tried to use as a guiding point in developing the new approach not only making the right decisions as early in the process as possible and doing that, improving the quality of the record at every step, but also making sure that every step of the process added value to the process, value particularly commensurate in terms of commensurate with the delay that it produced in the time.

The Appeals Council now takes somewhere around 250 days to complete its work. I would like to say that is a huge improvement. When I came into this post, it took 447 days for a case to go through the Appeals Council, so the staff there has worked very hard and are really doing a good job in terms of speeding it up. Even so, when one looks at the results of the cases that are reviewed by the Appeals Council, what one sees is 2 percent of the cases that move to the Appeals Council are allowed, approximately 25 percent of the cases are remanded, and the remainder of the cases are denied.

The remand one can say in large measure are due to mistakes that were made earlier, inadequacies in the record, and documentation, those kinds of things, all of which the new approach seeks to address. We substituted at that stage of the process an oversight panel which would conduct a full and comprehensive quality review of all the decisions that are made by the ALJs, allowances and denials both, not just one or the other. Those recommendations and the findings of that quality review unit go to an oversight panel comprised of ALJs and administrative judges to make the final decision on whether or not the case decision as rendered by the ALJ should stand or be reversed.

I understand the concerns that the JCUS has, and I guess when I talked to them, I tried to explain, and one of the things I think is very difficult for all of us to do is when you step back and look at the new approach, if you look at the results we get today at each step of the process and simply apply those to the new approach, then one would say it won't make any difference. What I am suggesting is with the new approach we will not see the same number of cases moving through what we call the waterfall at each step. I am well aware of the JCUS's concerns, and for that reason, as we move to make final decisions, the whole issue of the Appeals Council will be one that is taken very carefully.

Mr. LEWIS OF KENTUCKY. Thank you.

Chairman SHAW. Mr. Becerra?

Mr. BECERRA. Thank you, Mr. Chairman. Commissioner, thank you very much again for being here. I think we always appreciate your testimony because it is always spoken with a lot of clarity,

and not only that, it seems like a lot of thought and I think a lot of caring involved as well. So, we thank you for that.

Commissioner BARNHART. Thank you very much.

Mr. BECERRA. You seem to be one of those people who really does know how to manage, and we appreciate that.

Commissioner BARNHART. Thank you.

Mr. BECERRA. A question regarding the streamlining of the process. The concerns that are being raised by eliminating the Appeals Council that, while we may be trying to accelerate the process, we actually may be hurting ourselves because trying to go from the ALJ hearing stage to the Federal district court is not only a big step but an expensive step. If the courts are correct in saying that it would bog them down, it could become an even more tardy step in the process. Comments?

Commissioner BARNHART. Yes, thank you. That is a concern that I have heard, and I appreciate you raising it here. The emphasis is to make the right decision as early in the process as possible, if we look at how the decisions fall out today, approximately 40 percent, around 38 percent, I believe it is, of disability claims are allowed at the initial DDS phase. About 61 percent are allowed at the ALJ phase, 61 percent of those that apply for appeal.

What I am trying to do is get the allowance level of the cases that should be allowed higher earlier in the process, and so with the RO that we have, creating the Federal position that would be accountable to a single authority at the SSA, it would improve consistency in decisions across the Nation at an earlier point, because I do not envision ROs working on a State-by-State basis. In fact, I think it is important they not take cases on a State-by-State basis so that you know that you are having more of a random assignment of cases to the ROs, which makes it a national decision, not a State-based decision.

I think what we will see more cases that should have been yeses decided at an early stage, at the RO, and then because of the prep work that the RO does, the fact they have to issue a prehearing report or a recommended disposition, and wherever we come out there, because I know some of the advocacy organizations say they just one report, they do not want a prejudicial title, and I am sensitive to those concerns. When that goes forward to the ALJ, it should allow the ALJ to have the case better laid out for them in terms of looking at what has happened to that point. So, I guess my . . .

Mr. BECERRA. Let me stop you for a second, Commissioner. I sense what you are saying is that by improving the process up front, we should be able to get better decisions from the ALJs at the later stage and, therefore, we are able to then send cases directly to the district court because we believe by that stage we really will have a controversy that should be kicked up to the highest level.

Commissioner BARNHART. That is exactly what I am trying to say.

Mr. BECERRA. I have not had a chance to thoroughly review your proposal, but having seen how the Federal courts work, it is a very imposing process, and I think for the most we are talking about claimants who are not very wealthy and who are in a dif-

ficult situation. I suspect we are going to find that, as imposing as it is to go before a reviewer or perhaps an ALJ in an administrative hearing, which is very similar in every respect to a court trial, it becomes extremely imposing on people to go directly to a district court and very expensive. We are constantly hearing from the district court judges, at least in my 9th Circuit area in the district courts that we have there, they are completely swamped. If we do end up with the several thousand cases that you currently see going to appeal from the ALJs going to the district courts, you could see a logjam occur, which could become very difficult but, more importantly, very expensive for the claimants to continue a case in Federal court. So, I have not come to any conclusions either, other than I sympathize with those who raise these concerns that bypassing the process rather than trying to come up with an even better streamlined review process of an ALJ decision could lead to more difficulty than not.

Commissioner BARNHART. I appreciate what you are saying, Mr. Becerra. I do. The concerns that you are expressing have been echoed by others involved in this process, and obviously they are concerns I take very seriously. I have greater respect for the JCUS and certainly realize that whatever action is finally taken, if it does not have the basic support of all elements in the system, including the district courts, it is not going to be a process that is headed for success.

Mr. BECERRA. Can I mention one other thing? Gosh, I wish I had more time because I would love to talk to you about some of these other aspects, because I think for the most part, I really believe that you are trying to find those ways to streamline the system and make it more consumer-friendly for the claimants. I have a feeling you are going to really run into trouble with the review process that you have for the quality assurance, where some of the ALJ decisions, it seems like you are saying after the ALJ, that is a final decision, and the only recourse you now have is to go to the district court. In some cases, you will have this quality review that will occur where, indeed, if there is a problem that is found by those who are part of this quality assurance committee, or whatever it is called, you could actually see a different decision come forward from that review, which leads to the conclusion, and I will end with this, Mr. Chairman, that you leave open the question for the courts at least to consider, if you really have a final decision by an ALJ, if there really is some other entity administratively that could still undo what was done by the ALJ, so I think you are going to run into some real issues about whether this is truly a final decision if you have this quality assurance detour.

Commissioner BARNHART. I appreciate what you are saying. The role of the oversight panel was actually to render the final decision and make it actually, that would be the final decision of the agency in the case where they decided based on the quality review that the case needed to be decided differently. To the point about which cases would be reviewed, let me say that was one area that we were looking at because I really have solicited comments from everyone I have talked to about maybe what we should do is review all the cases that go through, that go through serious——

Mr. BECERRA. You have an Appeals Council.

Commissioner BARNHART. Seriously, review all cases that go through with a quality review, and then only the ones where the quality reviewers see it differently than the ALJs saw it, those go to the oversight panel, as opposed to doing a sample of cases which then does not ensure that everybody is treated the same. So, I appreciate the comment——

Mr. BECERRA. Believe me, everyone is going to want to go through the quality review before they have to head to district court, which in essence means you have some type of administrative review before you go to the courts. Thank you, Mr. Chairman, for being very gracious.

Chairman SHAW. You are most welcome. Mrs. Johnson?

Mrs. JOHNSON. Thank you very much, and welcome, Commissioner Barnhart. First of all, I reread your testimony from last year in preparation for this hearing, and it really is impressive the degree to which you are really looking at the nitty-gritty of how government has worked in the past and trying to bring it into the modern era. It will certainly improve the quality of service for our disabled people, but in the end it will improve the quality of services as well. I was curious about your interest in having the reviewers in your central offices take over the role that currently the State DDSs are playing. They apparently are doing about 20 percent of the reviews of the quick decision cases now.

Why can't they do most of the quick decision cases? One of the things that I think was really marvelous about your proposal was this categorization of quick decision cases. Nothing has been more anguishing to my caseworkers than in an ALJ case or a child with cancer or clearly something that is an open-and-shut case. Why can't those go to the State reviewers? Why wouldn't that be faster, and why wouldn't it save us money?

Commissioner BARNHART. I appreciate your comments, Mrs. Johnson. Perhaps I should back up and say my intent in moving the quick decision out of the DDS in the new approach was to take a workload away from the DDSs but to leave the resources the DDSs currently have in the DDSs, because resources are an ongoing concern, particularly with the increase in disability claims that we have seen in recent years, and it is a trend that continues this year as we are getting about 100,000 to 200,000 more claims than we had originally anticipated.

So, the idea was if we pull the quick decision workload out, the DDSs where our more experienced and trained workers are could focus on the more difficult cases. I recognize, of course, in doing that, therefore, the allowance rate for DDSs would go down because the easier cases, the obvious cases would be done up front, and for that reason was going to combine the quick decision allowance rate with the DDS allowance rate so that it would not appear to the people in a given State that all of a sudden the DDS was denying a larger number of people.

This is an issue that I have heard a lot from the NCDDD, as well as NADE, and one of the things I am looking at is having the units in the DDS do the quick decision. I will say this: in my discussions with those organizations and their leadership, I feel very strongly if we decide to go that route, it needs to be a separate quick decision unit in the DDS, not that each DDS worker can work some

quick decisions cases, because I feel very strongly that the focus of quick decision workers needs to be the quick decisions. The idea is on the outside it would take 20 days for these decisions. Not an average of 20 days but absolutely on the outside, and so I am discussing some of these possible modifications within individuals from those organizations.

Mrs. JOHNSON. Thank you very much. I do think the issue of workload is terribly important, and there will be some areas in which we can get resources into from our end more effectively than other functions possibly. I do appreciate your continued focus on what is going to be best for the disabled person. Thank you very much. I appreciate your being here today.

Commissioner BARNHART. Thank you.

Chairman SHAW. Mr. Pomeroy?

Mr. POMEROY. Thank you, Mr. Chairman. Madam Commissioner, I want to join the comments made by other panel Members about the acknowledgment of your great work. For an agency head, especially an agency whose work is so critically linked to so many Americans all across the country, throwing yourself into these management challenges with the competence you have demonstrated has really been something to observe.

Commissioner BARNHART. Thank you very much.

Mr. POMEROY. I commend you for it. I want to specifically acknowledge a couple things and ask you about another thing. On telecommunication, I appreciate your expanding the disability application process to include being able to relay through videoconference over the telephone critically needed information without requiring people in rural areas to come vast distances. I believe these physical impediments to bringing forward an application sometimes discouraged people from pursuing that which they ought to and that which they need to. It was a telling demonstration in Dickinson, North Dakota, that you and I were able to observe on that point.

Commissioner BARNHART. Right.

Mr. POMEROY. Well done. Very important to rural America. Secondly, and feel free, I think, to elaborate on the eDIB renovation. I was not fully appreciative of the delays caused by physical management of records in the disability process until I had a chance to focus on it in a little more detail. Lost records, shipping records back and forth, misplaced files, all of these have, I believe, wreaked havoc on any untold numbers of claimants if their file gets lost or a critical piece of it gets lost. I think having it all move to an electronic format is going to really do some good there, some superb good there, and I am excited about it.

The last thing I would ask, and then I would like you to comment, but I want to be able to explore this third one most fully, and that is how you are coming on these ALJ judges. I was alarmed to hear that the pending court challenge had basically frozen everything in place on ALJs and your backlog was in part you did not have the numbers of ALJs that you needed to do that. You had a plan for bringing a number on board, but that did require the Office of Personnel Management (OPM) to also fully cooperate and execute their end of the hiring process on ALJs. It is frustrating to not be able to control that piece of the effort to get this

area staffed up, and I am interested in hearing from you in terms of how things are coming between SSA and OPM in getting us to the numbers of ALJs that we need. Thank you, and, again, it is a pleasure working with you. You are doing a great job.

Commissioner BARNHART. Thank you very much for your kind comments, Mr. Pomeroy, and I just want to say I really enjoyed my trip to North Dakota. It is quite something to visit a largely rural State like that, and with an expert on the State pointing out the specific challenges that individuals in your home State face in applying for our benefits and other programs. With respect to video hearings, I simply want to say I share your view. I think this is such an important new tool for us. We have 120 video sites up and operating across the counties, and we have a plan to move them out to all of our major hearing officers.

Just as a point of information, we actually conducted in the month of August, 953 video hearings, and the time difference for a video hearing, and this is what is so important and one of the points you were making. The time difference is this: The processing time for non-video hearings was 518 days. For video hearings, it was 352 days. So, we are talking about making significant gains, and that was just for the month of August. When I have annual data, I will be happy to provide it to you and the Subcommittee for your review.

In terms of eDIB, as I mentioned, we are right on schedule with eDIB. We said we were going to start in January of 2004, and we started in January of 2004. The State of Mississippi and the State of So,uth Carolina are both fully rolled out with eDIB. I want to commend again all the States in Region 4, and particularly the State of Florida who, despite the hurricane, the many hurricanes, Mr. Chairman, we were talking about before the hearing, went ahead and rolled out eDIB on September 20th and did not ask for an extension. I think that speaks to the confidence that the State DDSs have in this system.

We have run into issues. We have had glitches. You do with any new computer program, obviously any automated system, and we are fixing them. We are doing the same thing as we move on to the OHA. We have just a few OHA sites, hearing offices up able to use the electronic folder at this point, really at a pilot stage, but with our new case processing management system (CPMS), it has had some stumbles and trip-ups, too, since it was rolled out earlier this year, but we are making changes. In fact, several new applications to fix some of the issues that have been identified by the users are going to into effect this week. So, I think we are well on track with eDIB, and we already have over 1 million documents stored in our eDIB system.

Just to refresh everyone's memory, when this is up and fully operational, it will be the largest repository of electronic medical evidence in the entire world. I think a very impressive accomplishment for us. We will eliminate the 100 days that we spend locating cases and reconstructing files, as you pointed out, or the 60 days that we spend mailing cases back and forth from one area to another. Simply, at the push of a button, the case can come up and between viewed from anywhere in the country where people have access. So, I am very, very happy, and I am also happy to say that

we are expecting a good rate of return on it, a savings of $1.3 billion for an investment of $800 million, and we have received full funding for the eDIB up to this point. The President has requested full funding and a 6.8-percent increase for SSA. I wanted to do a plug for our budget request. My staff would kill me if I left here, my budget staff, without doing that. We have always appreciated the support we have gotten from this Committee, and without the proper resources, it is just impossible to make the gains and strides we want to make.

Finally, with respect to ALJs, you are absolutely right, we had a real problem. Part of our backlog is due to the fact we were not able to hire ALJs for several years to do the cases. That has been decided. We actually, I am pleased to say, hired 102 ALJs this year, and we are looking to hire the same number next year, assuming that we have adequate resources to do that. The issue at this point is, and you asked about the status of the new register in OPM. We have been advised by OPM that they need to redo the examination and they need to pilot it, and, therefore, we cannot expect to have a brandnew register until the end of calendar year 2005, which means that if the budget issues gets resolved, appropriation bills get passed, we get sufficient resources to continue to hire ALJs, we will be in the situation of using a register that closed actually, I believe, in 1999 but really there are people on it from as far as 1993. The issue there for us is this: there could be individuals who maybe did not score as high for placement on the register in 1993 but now, 11 years later, have much more significant experience, that would have relevant experience that would have placed them much farther in a current register. So, that is the situation.

Mr. POMEROY. Will you be able to use that old list then while they are developing the new list?

Commissioner BARNHART. We will be able to use the old list. The issue as we have gone pretty far down the register at this point, as you can imagine, because we are not the only Federal agency, obviously, that hires ALJs, although we are sort of the big gorilla on the block; in the sense that we have over 1,000 ALJs, I am pleased to say, 1,075 ALJs on duty now. We believe we need to have around 1,300. I would be happy, because of the Committee's longstanding interest, and Mr. Brady also was very active in this issue a few years ago for us, I would be happy to submit a list of where all the ALJs were hired, because many of them were hired in States that the Committee Members are from.

[The information follows:]

ALJ Hires 2004

Region & HO	Report June 1, 2004	Report August 30, 2004	Total
Region I: No New Hires			
Region II			
Bronx, NY	1	1	2
Buffalo, NY	1	0	1

ALJ Hires 2004—Continued

Region & HO	Report June 1, 2004	Report August 30, 2004	Total
Mayaguez, PR	0	1	1
Ponce, PR	0	1	1
Queens, NY	1	0	1
San Juan, PR	1	1	2
Syracuse, NY	1	1	2
Region III			
Johnstown, PA	0	2	2
Morgantown, WV	0	1	1
Region IV			
Atlanta, GA	0	1	1
Birmingham, AL	0	1	1
Charlotte, NC	0	1	1
Florence, AL	3	0	3
Fort Lauderdale, FL	3	0	3
Hattiesburg, MS	0	1	1
Jackson, MS	1	0	1
Macon, GA	2	0	2
Miami, FL	3	0	3
Montgomery, AL	0	3	3
Orlando, FL	2	0	2
Savannah, GA	0	1	1
Tampa, FL	4	0	4
Tupelo, MS	0	4	4
Region V			
Cincinnati, OH	0	1	1
Cleveland OH	3	3	6
Columbus, OH	0	1	1
Detroit, MI	4	0	4
Evansville, IN	2	0	2
Fort Wayne, IN	2	0	2
Grand Rapids, MI	3	3	6
Indianapolis, IN	0	1	1

ALJ Hires 2004—Continued

Region & HO	Report June 1, 2004	Report August 30, 2004	Total
Lansing, MI	0	2	2
Milwaukee, WI	2	0	2
Minneapolis, MN	0	2	2
Peoria, IL	0	1	1
Region VI			
Alexandria, LA	3	0	3
Dallas N, TX	0	1	1
Houston DT, TX	0	2	2
Little Rock, AR	3	0	3
Metairie, LA	2	0	2
Shreveport, LA	0	2	2
Tulsa, OK	0	2	2
Region VII			
Creve Coeur, MO	1	1	2
Kansas City, KS	2	0	2
Omaha, NE	0	1	1
St. Louis, MO	1	0	1
W. Des Moines, IA	1	0	1
Region VIII			
Billings, MT	0	3	3
Region IX			
Los Angeles DT, CA	0	2	2
Region X			
Spokane, WA	0	2	2
Total	**52**	**50**	**102**

Chairman SHAW. Mr. Ryan?

Mr. RYAN. Thank you. I actually had two questions. One was about the ALJs and the backlog, so I think you have covered that pretty well. First of all, thank you for the streamlining proposal. I think it is overdue, and I am very glad that you are implementing it. I just had a quick question. You may not be prepared to answer it. I just wanted to get an update on the Chicago-Milwaukee situation and the cleanup operation that is going on there. If you are not prepared, if you could just send me something in writing, that would be great.

Commissioner BARNHART. I would be happy to submit, provide information in writing to you, a complete update of what is going on. I can tell you some information that you may be interested in, in terms of the workload and what is going on.

[The information follows:]

Chicago File Assembly

October 2004

The total number of cases identified for file assembly is 1,375 (this number includes cases that were transferred into the hearing office (HO).

- 1,180 cases, or 86% have been decided (733 or 62% are favorable decisions and 279 or 24% are unfavorable, this number does not include dismissals or remands).
- 195 cases or 14% are at the various processing levels awaiting a decision.

Issue

A contract file assembly unit was started in the Chicago (So,uth) HO in November 2002, working cases from various hearing offices in the Chicago Region. In early May 2003, HO management discovered that significant amounts of material had been removed from the files by contract workers, allegedly because it duplicated material already in the file. Upon review, it was determined the material was original evidence, not duplicate documents.

On May 9 and May 20, 2003, respectively, both contractors, Training So,lutions and Worldwide Industries, were advised that SSA would not use their services until it completed a full investigation of the situation. On July 23, 2003, SSA subsequently terminated both contracts.

The agency decided to notify all 1,375 claimants affected by the actions of these contractors. The notices advised claimants that their file may be incomplete and discussed their remedies, including: examining their file, having a new hearing, and having a new decision.

Notification Process

- Region V (Chicago) completed initial notification to all 1,375 claimants.
- Region V sent a second notice to all claimants who failed to respond to the first notice.
- In cases where the HO did not hear from the claimant after two notices, a closeout letter was issued. The closeout letter is required before an ALJ can issue an adverse action (i.e., denial or dismissal), thus ensuring that a claimant has been notified three times.
- The Appeals Council was alerted of those cases in which an adverse decision was released by the HO before all notices were sent to the claimants.
- The Council issued a total of 101 remand orders on those cases. Most remands (87) were issued before December 31, 2003; the remaining (14) were issued by February 13, 2004.
- There are no outstanding cases pending at the Appeals Council level.

Claimant Allegations of Missing Evidence

Two claimants alleged missing evidence upon review of their files. The HO is obtaining the missing evidence in both cases.

More recently, one additional claimant alleged possible missing evidence. The allegation was determined to be unfounded, however, as the identified treating source had no record or report of any evidence that it had submitted to OHA.

Conclusion

The OHA Chicago Region took all the necessary steps to preserve the claimants' due process rights and performed the required notification process in every affected case. We are confident the matter has been completely and positively resolved to address the issues raised by all concerned. In conclusion, no claimant has been adversely affected by the events at the Chicago File Assembly Unit.

I wish I could report to you that the situation had eased incredibly in Milwaukee in terms of the backlog. Unfortunately, it has

not. We received 5,299 hearing requests this fiscal year to date. This is as of August. I will have fiscal year data in approximately another 15 days. We have actually disposed of 3,635 hearings——

Mr. RYAN. Three thousand what?

Commissioner BARNHART. It was 3,635 of those hearings. The processing time has averaged 413 days. That is an improvement from last year. It was 438 days.

Mr. RYAN. Are some of the new ALJs going to come to this area?

Commissioner BARNHART. Excuse me, that is an improvement from June. I am looking at June, July, and August. It is an improvement from June. It was 438, 464 in July, but fiscal year to date, 413. So, the average is creeping up on the processing. The pending per ALJ, we are at 843 cases per ALJ, and the total pending in the office is 8,435.

Mr. RYAN. Are some of these new ALJs coming to Milwaukee?

Commissioner BARNHART. Pardon?

Mr. RYAN. Are you sending some of your new ALJs to this region?

Commissioner BARNHART. Yes.

Mr. RYAN. Milwaukee and Chicago.

Commissioner BARNHART. Let me check and see. I can tell you where they are going. I have got a list right here. Yes, two of the judges are going to Milwaukee.

Mr. RYAN. The people who had their identities compromised, I will not go through the problem we had, but the problem with the contract employees with respect to the records that got compromised in the Chicago office, is that all but settled now?

Commissioner BARNHART. It is absolutely settled.

Mr. RYAN. I know everybody got a notice and everybody got a chance to redo their claims. Where are we in that process?

Commissioner BARNHART. To my knowledge, everything has been resolved, and no one had any adverse effect as a result of that. Actually, as of today, that contracting that we were doing, which simply was to move cases because with the onset of hearing process initiative in 2001, it really stalled our hearing process in the hearing offices, and we just needed to prepare cases. Those contracts, the remaining ones, terminate today, and the approach that I am using from this point out is we have five cadres basically, special regional units, that are going to be providing that service of case pulling that was previously done by contractors.

Mr. RYAN. Like Earl said, and others, I think the paperless, the electronic file is really the big answer here, but I look forward, and if you could just give me more details, if you have them, with respect to the Milwaukee thing, we are very concerned about the backlog. I am sure you get this from other regions as well, but I am glad you are sending some ALJs to Milwaukee because, this is our caseworkers' biggest nightmare, and I am just pleased with the reforms, but hopefully we can clean up this backlog as quickly as possible.

Commissioner BARNHART. I appreciate your concern, and eliminating the backlog in disability has been one of my top priorities since I came into this job, and the service delivery budget that I have crafted the last 2 years, and will be submitting again to OMB this year hold out as the goal the elimination of the backlogs. Un-

fortunately, despite the fact that the last 2 years we did not get the budget request that we asked for as an agency, because of productivity enhancements, the fact that, as Mr. Cardin pointed out and as he has seen firsthand many times at our Baltimore headquarters, the staff works very hard in headquarters as well as out across the country, we have managed to keep backlogs from growing greater than they have, butt they are still growing. The first step in eliminating backlogs is being able to have enough trained, experienced people on staff to be able to do the work. Of course we had the technical stumbling block of not being able to hire ALJs, but then we have the resource limitation we may face next year.

Mr. RYAN. All right. Thanks.

Chairman SHAW. Thank you, Ms. Barnhart. I couldn't help but notice the generosity with which my colleagues on the other side of the aisle were handing out accolades to you. They are not known for such generosity when it comes to——

Mr. CARDIN. I beg your pardon.

[Laughter.]

Chairman SHAW. So, I think that must be, that is probably the sincerest form of compliments that you could possibly get here in Washington. Obviously you are doing a great job, and we are very grateful for the service that you are performing, and particularly, in this area of moving this caseload and bringing the SSA into this century. I very much appreciate it. Did you want to, I have not offended you?

Mr. CARDIN. No, not at all. We always give praise when praise is due, and, of course, I think Commissioner Barnhart, because of her strong presence in the Baltimore region, there is good reason as to why she is doing such a great job.

[Laughter.]

Commissioner BARNHART. Thank you very much.

Chairman SHAW. Thank you, Commissioner. We really appreciate it. At this particular point, I have a letter from the Honorable Frederick Stamp, who is the Chair of the Committee on Federal-State Jurisdiction of the JCUS, and without objection, I would like to place it in the record. Mr. Herger?

[The information was previously published:]

Chairman HERGER. Thank you. Again, we thank you very much, Commissioner Barnhart.

Commissioner BARNHART. Thank you.

Chairman HERGER. With that, we will call up our next panel: the Honorable Hal Daub, Chairman of the SSAB, former Member of the Committee on Ways and Means; Ron Buffaloe, President of the National Council of S,cial Security Management Associations (NCSSMA); Sheila Everett, President of NCDDD; Martha Marshall, President of NADE; and Dr. C. Richard Dann, who is representing the Union of American Physicians and Dentists (UAPD), of the American Federation of State, County, and Municipal Employees (AFSCME), and is from my home State of California. Chairman Daub to testify.

STATEMENT OF THE HONORABLE HAL DAUB, CHAIRMAN, SOCIAL SECURITY ADVISORY BOARD

Mr. DAUB. Chairman Shaw, Chairman Herger, thank you very much for the opportunity to be with you, Mr. Cardin, Members of the Committee. I appreciate the opportunity to discuss the Commissioner's proposed reforms of the Social Security disability process. The independent SSAB has carefully studied the disability process over the past several years. We have made many recommendations for fundamental change. We congratulate our former colleague, who is now the Commissioner, for boldly tackling this problem. We applaud her and you for making sure that the views of all affected parties are heard and considered.

Today I want to focus on the hearing part of the overall process. That is where the greatest delays and most serious backlogs occur. Some of the Commissioner's changes will expedite the hearings process. A consultant study that the Advisory board commissioned identified inadequate development of the case record as a major reason why claims bog down. The RO position should assure that cases that go on to a hearing are fully developed and include a clear decision rationale. The RO step should result in fewer cases needing to go to the hearings level. It is crucial that the ROs be carefully selected and well trained. Other changes, like closing the record after the hearing and eliminating the additional step of the Appeals Council, may also serve to reduce timelines by sharpening the focus on the hearing itself as the final administrative step. Due process is much more assured as that RO, under the current recommendation, will be an attorney, and on our board there is strong bipartisan support to eliminate the Appeals Council. I'm looking at how to move the case and assure quality from the beginning to the end, the approach is take more time in the beginning, which should save a lot of time in the end.

I would like to make two important cautions, however. First, the proposed reforms will help in the long run, but they are still in the planning stage. Second, although the proposed changes may ultimately reduce the appeals workload, the appeals process will remain an important element of the system. The Commissioner and the Congress need to continue searching for both short-run and long-run improvements in that process.

As of June 30th of this year, there were 612,000 people waiting for hearing decisions on their Social Security claims; over 170,000 of them have been waiting for more than 1 year. The agency has become more productive, but the workloads are overwhelming. Pending levels have been rising now for 5 years. Just during the recent fiscal year, there has been a 43-percent increase in cases that have been in the hearing system for more than a year. If these backlogs continue to grow, they will make it very hard for the proposed changes to be fully effective.

I would urge both you and the agency to look carefully at the hearings process to find ways to make it operate more efficiently. The board has spoken with many ALJs, chief ALJs, and employees at the management and staff levels. We have heard many suggestions for improvements. I will mention just a few that are much more fully detailed in my longer statement, which I have submitted for the record, and I will repeat them here just in bullet points: the

absence of effective rules of procedure; the need for more extensive training of judges; the need to improve the policy base and to rethink some of the rules and regulations that many judges believe undercut their ability to deliver supportable decisions; and, last, the need for more effective management tools to encourage performance and accountability.

Also, the Commissioner quite properly designed a set of proposals that she could implement administratively. I hope, however, that you will look for ways that you might legislatively support this improved process. The board has, for example, suggested that you examine the possibility of establishing a Social Security Court, and we have also suggested looking at sharpening the hearings process by including an individual to represent the agency position.

I know that this hearing is focusing on the procedural changes that the Commissioner is recommending. My last point to you: that is an important and urgent need, and she is to be commended. However, the Advisory board also believes that the time has come for serious consideration of whether the definition of disability is consistent with our National goals for the disabled. We have issued a report on this and are continuing to look at it, and we hope that your Subcommittees will also begin to seriously examine this issue. Thank you very much.

[The prepared statement of Mr. Daub follows:]

Statement of The Honorable Hal Daub, Chairman, Social Security Advisory Board

Chairman Shaw, Chairman Herger, Mr. Matsui, Mr. Cardin, Members of the Subcommittees. I appreciate this opportunity to discuss the Commissioner's proposed reforms of the Social Security Disability Process.

The Social Security Advisory Board has carefully studied the disability process over the past several years. We have made many recommendations for fundamental change. We congratulate the Commissioner for boldly tackling this problem. We applaud her and you for making sure that the views of all affected parties are heard and considered.

The Board has always emphasized that it is important to look at the disability process as a whole, because changes in one part affect the other parts of the process. Today, however, I want to focus my comments on the hearings part of the overall process, because that is where the greatest delays and the most serious backlogs occur.

Some of the Commissioner's proposed changes will expedite the hearings process. I would begin with two important cautions, however. First, the proposed reforms will help in the long run, but they are still in the planning stage. Once a final process is decided upon, the way in which they are implemented becomes crucial. Second, although the proposed changes may ultimately reduce the appeals workload, the appeals process will remain an important part of the system. The Commissioner and Congress need to continue searching for both short-run and long-run improvements to the process.

One aspect of the Commissioner's approach will improve the quality of the case record that makes its way to the hearing process. A consultant study commissioned by the Board identified the quality of the case record as the key to fair and accurate disability determinations. A poorly developed claim at one stage not only affects the quality of the decision at that level but also burdens the process at the next level. Developing a high quality record requires the assessment of complex medical and vocational information. Unfortunately, workload pressures at the State agency level sometimes lead to decisions being made based on a record that is less than complete, and the record that makes its way to the Office of Hearings and Appeals is sometimes lacking in evidence and in rationale for the decision that was made.

When claims are appealed to the hearings level, the hearing office develops the record independently and without assuming that the State agency had all the information available. The hearing office may obtain existing medical reports from doc-

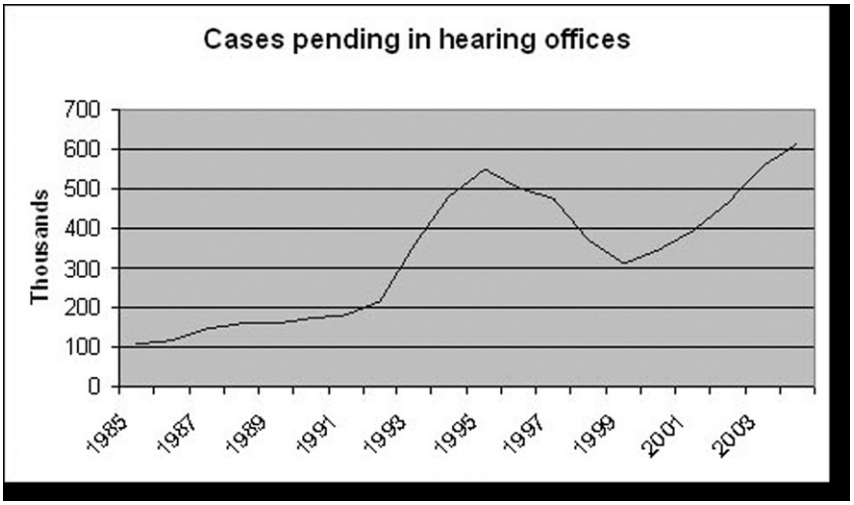
tors or hospitals and can order consultative examinations. This need for case development is one of the reasons cases get bogged down at that level.

The reviewing official (RO) position that the Commissioner has proposed has the potential to expedite the hearing process by ensuring that cases that go to a hearing are fully developed and include a clear decision rationale. The RO is also authorized to issue allowance decisions, which would both expedite decisions and reduce workload pressures at the hearings level. For claims that are not allowed, the ROs would prepare either a recommended disallowance (if they think the evidence indicates that the claimant is ineligible) or a pre-hearing report (if they think the record does not definitively show that the claimant is ineligible but is inadequate to establish that the claimant is eligible). The pre-hearing report would outline what evidence is needed to establish eligibility. If a case with a recommended disallowance goes to a hearing and is allowed, the administrative law judge (ALJ) would describe in the written opinion the basis for rejecting the recommended disallowance. If a case with a pre-hearing report goes to a hearing and is allowed, the ALJ would describe the evidence gathered at that stage to address the points defined in the pre-hearing report.

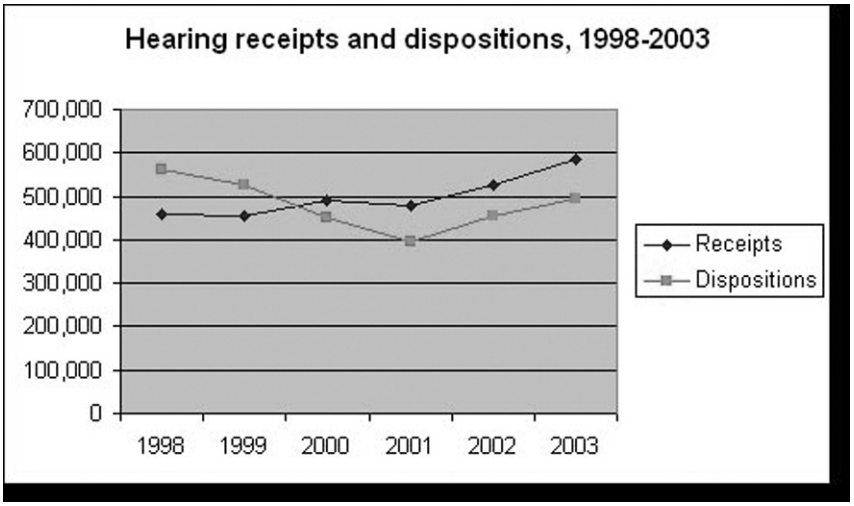
The reviewing official is clearly an important innovation that has potential for significantly improving the process. It is therefore important that the new position be implemented thoughtfully. The ROs should be carefully selected and well trained. Expectations for the new ROs should be well defined and reasonable to ensure that they have enough time to do a thorough job. And if they are selected from other parts of the agency, it will become important to backfill those positions carefully.

Reduced hearing backlogs are another condition for the success of the RO position. If the administrative law judge gets a well-developed case with a clear decision rationale, the hearing process will go more smoothly and more quickly. But if cases coming from the RO sit in a hearing office backlog for months before being heard, the case development may no longer be current and the rationale may no longer fit the facts. If the very large current backlogs in the hearing offices are not dealt with or if delays at the hearings level continue to be lengthy, they will make it very hard for the new process to be fully effective.

The number of cases pending at the hearings level has been rising for the last five years. As of June 30 of this year, there were 612 thousand people waiting for hearing decisions on their claims. Over 170 thousand of them have been waiting for over a year. Pending levels are now even higher than they were when the number of disability claims spiked in the early 1990s.



There are reasons for this that you are familiar with. The *Azdell* court case prevented the agency from replenishing its ranks of ALJs as judges retired or left for other reasons. The Hearing Process Initiative that was implemented in 2000 hurt productivity for a time and added to the backlogs. The Office of Hearings and Appeals (OHA) has become more productive in recent years, but the workload is overwhelming. OHA has been disposing of more hearings cases for the last two years, but receipts have also been climbing.



Just during the current fiscal year, there has been a 43 percent increase in cases that have been in the hearing system for more than a year. While the new process changes may help in the future, there is also a need to deal with these current large and growing backlogs. Moreover, the impact of the proposed changes to the disability process may be undermined if they have to be implemented in the context of huge backlogs.

So, in addition to the Commissioner's proposals, I would urge both you and the agency to look carefully at the hearings process to find ways to make it operate more efficiently. The Board has conducted public hearings and has spoken with many managers, judges, attorneys, and other staff at hearings offices. They have given us many suggestions for improvements to the process. Let me give you some examples of the recommendations made to us:

- Rules of procedure—Many of those we talked with have told us that the absence of effective rules of procedure contributes to unnecessary delays in the process. For example, we have heard that representatives sometimes get inadequate advance notice of hearings, and we have also heard that many hearings have to be postponed because of late submission of evidence. Implementing improved rules of procedure could make the hearing process more orderly and efficient.
- Need for training—Administrative law judges receive a short introductory course of four to five weeks, with no required ongoing training of the kind that many States require of lawyers. Although much of their work deals with medical and vocational factors, the medical training they receive is far shorter than that of State agency disability examiners.
- Improved policy infrastructure—Clearer and more objective formulation of agency policy has great potential to facilitate a quicker more efficient process. Much of the workload which now burdens the hearings process reflects an unnecessarily complex body of rules and regulations that are subject to differences of interpretation at different levels and account for much of the churning of cases through appeals and remands. We have frequently heard, for example, that the Social Security rulings put an unreasonable burden on the hearings process to have a written decision which explicitly comments on each item of evidence. In fact, we have heard from agency officials that these rules are the cause of many remands of cases that were, in fact, decided correctly.
- Management tools—Office managers and supervisors need better tools to evaluate and motivate their staffs, and chief judges need support in motivating their colleagues. Claimants are entitled to fair decisions, but they also are entitled to timely decisions. Those goals are not incompatible.

This hearing is focused on the Commissioner's proposals, all of which can be implemented administratively. I hope, however, that you would consider ways in which you might support an improved process legislatively. The Board has, for example, suggested that you reexamine the possibility of establishing a Social Security Court. Concerns about national uniformity in policy and procedures have led some to question the current arrangement for review by Federal courts. Allowance rates in Dis-

trict Courts have varied widely, and courts frequently issue decisions that vary from district to district and from circuit to circuit, resulting in the application of different disability policy in different parts of the country. Over the history of the disability program, the courts have played a major role in defining the standards for disability. Whether the existing arrangements for judicial review represent the best public policy is a question that deserves careful study.

The Board has also suggested another look at whether there should be a government representative when the agency's prior decision is being reviewed at the hearings level. One reason frequently cited for the backlogs in the appeals process is that the administrative law judge is required to assume responsibility not only for decision making but also for perfecting both the agency's and the claimant's cases. Having an agency representative participate in hearings could help to clarify issues and introduce greater consistency and accountability.

Finally, looking at the question of disability even more widely, the Advisory Board also believes that the time has come for serious consideration of whether the definition of disability in the Social Security Act is consistent with our national goals for the disabled. We issued a report on this subject last October and hosted a forum on the definition of disability in April. This report, *The Social Security Definition of Disability: Is It Consistent with a National Goal of Supporting Maximum Self Sufficiency?,* is available on the Board's website, www.ssab.gov. The papers delivered at the April Forum are also on the website. We hope to foster a continued discussion of the topic. Much has changed in the half-century since the disability program began. Medical and rehabilitative knowledge and technology have made great strides in that time. The nature of work and the workforce has changed. And attitudes about disability and work have also been revised. It is time to consider whether the old definition still fits. As an adjunct to the process changes, SSA will be piloting some different approaches to disability benefits that will encourage work, and we look forward to discussing their outcomes with you in the future.

Chairman HERGER. Thank you, Mr. Daub. Mr. Buffaloe to testify.

STATEMENT OF RONALD E. BUFFALOE, PRESIDENT, NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS, SALISBURY, NORTH CAROLINA

Mr. BUFFALOE. Chairmen Shaw and Herger, Ranking Minority Member Cardin, and Members of the Subcommittees, my name is Ron Buffaloe, and I am the Social Security District Manager in Salisbury, North Carolina. I am here today as President of the NCSSMA. Our organization is comprised of more than 3,200 managers and supervisors who work in SSA's field offices and teleservice centers in more than 1,300 locations across the country. Thank you for giving me the opportunity to come before you today to talk about the Commissioner's proposal to improve the disability determination process and to give our association's thoughts about her proposal.

The NCSSMA applauds Commissioner Barnhart for proposing a new approach to disability determinations. As an organization, we hold great hope that her proposed changes will shorten decision times and pay benefits faster to people who are obviously disabled. While our written testimony reviews our opinions on all the various aspects of the Commissioner's proposals, I am going to spend most of my time today on the part that most directly impacts field offices. We note that the Commissioner's proposal recommends as its first element, and I quote, "a quick decision step at the very earliest stages of the claims process for people who are obviously disabled." This is not only a great idea, it has been around for a long time. The presumptive disability process in the SSI Program is es-

sentially a quick decision approach. We think these existing procedures need to be refined and broadened.

We strongly recommend that claims representatives in field offices be empowered to make or recommend the quick decisions envisioned in the Commissioner's proposal and that those cases not meeting the quick decision criteria be moved to the State DDSs, without an intermediate step. We also recommend that claims representatives be given other functions such as taking the first action to secure medical evidence and claims being forwarded to the DDS for development and medical decision. This is obviously predicated on appropriate medical training being given to these field office employees.

The quick decision step is tailor-made for field offices. Many impairments meet the medical listings, and can be allowed with minimal medical evidence. This evidence can be obtained via telephone and fax, and the efficiencies inherent in local field office staff dealing with local treating sources are obvious. We also feel this arrangement is compatible with the Commissioner's desire to expedite the decision process for those individuals who are obviously disabled. We feel this approach will serve to streamline and expedite the disability process as a whole.

Well-trained claims representatives with a greater knowledge of the disability process would be able to provide DDSs with a higher-quality product, even in those cases where a quick decision is not possible. Evidence would be requested earlier in the process, allowing DDS examiners to make disability decisions in a timelier manner. So,me additional resources may be necessary to implement this recommendation.

As to the other parts of the Commissioner's proposal, we believe RERUs should be located in selected DDSs, not SSA regional offices. They would be organized in the same manner envisioned by the Commissioner's proposal and would perform the same functions. Additional resources should be allocated to the DDSs involved to compensate for this added responsibility. We recommend and endorse implementation of the in-line quality review process as well as the centralized quality control function envisioned by the Commissioner's proposal. We believe the DDS reconsideration step should be eliminated. We believe the requirement that the RO be an attorney should be eliminated. We believe the record should be closed after the ALJ decision and that the Appeals Council should be eliminated.

Finally, we believe all affected components should be staffed appropriately. Both DDSs and field offices will need additional staff if this new process is to work. The NCSSMA is committed to working with all interested parties in making the Commissioner's vision of a new and improved disability process a reality. We are hopeful our comments will be useful in streamlining this process. Again, thank you for this opportunity to appear before the Committee. I would welcome any questions you may have.

[The prepared statement of Mr. Buffaloe follows:]

Statement of Ronald E. Buffaloe, President, National Association of Social Security Management Associations, Salisbury, North Carolina

Chairmen Shaw and Herger, Ranking Minority Members Matsui and Cardin, and Members of the Committee, my name is Ron Buffaloe and I am here today rep-

resenting the National Council of Social Security Management Associations (NCSSMA). I am also the manager of the Social Security District Office in Salisbury, North Carolina and have worked for the Social Security Administration for 31 years. On behalf of our membership, I am both pleased and honored that NCSSMA was selected to testify at this joint hearing on the Commissioner of Social Security's proposal to improve the disability determination process.

NCSSMA is a membership organization of more than 3200 Social Security Administration managers and supervisors who work in SSA's more than 1300 field offices and 36 teleservice centers in local communities throughout the nation. It is most often our members with whom your staffs work to resolve issues for your constituents relative to Social Security retirement benefits, disability benefits or Supplemental Security Income. Since our organization was founded 34 years ago, NCSSMA has been a strong advocate of locally delivered services nationwide to meet the variety of needs of beneficiaries, claimants and the general public. We represent the essence of **"citizen centered"** government. We consider our top priority to be a strong and stable Social Security Administration that delivers quality service to our clients—your constituents.

The Challenge

SSA's field offices must spend a great deal of their time and resources on the disability program. Approximately two-thirds of SSA's administrative budget will be spent on the work generated by the disability program. We know that this workload will only continue to grow as the baby boom generation moves into their "disability prone" years. Field offices deal directly with disability applicants and recipients; they take disability claims, provide information to claimants and their representatives, initiate continuing disability reviews and provide the public and third parties with information about the disability program. In dealing directly with disability claimants and recipients, we hear their stories and see firsthand the impact of their impairments and our current disability determination procedures on their lives.

The most prevalent criticism heard in field offices is about the amount of time it takes to get a decision. Applicants wait an average of almost 4 months from filing to receipt of an initial decision. The almost half a million claimants who request a hearing before an Administrative Law Judge (ALJ) each year can expect to wait, on average, over a year from the date of initial filing for a decision.

The Commissioner's Proposal

NCSSMA applauds Commissioner Barnhart for proposing a new approach to disability determinations. As an organization we hold great hope that her proposed changes will shorten decision times and pay benefits faster to people who are obviously disabled.

We know that processing an increasing number of disability claims is one of the major challenges facing the Social Security Administration**.** We believe it is essential that decisions be made now on how best to process this growing workload.

NCSSMA has been actively involved in all the various projects and initiatives in the past to improve the disability process. NCSSMA representatives served on steering committees and workgroups in connection withvarious pilots. Because of the experience gained from the agency's three year Disability Claims Manager Pilot, NCSSMA believes that there is compelling evidence of significant potential for improving the speed and quality of SSA's initial disability determinations by modifying the role of the field office at the earliest point in the claims process.

While we are receptive of and encouraged by the Commissioner's proposal for a new approach to disability determination, we believe that there will be a better chance of improving speed and accuracy if we begin the new approach with a change in the role of the disability interviewer at the point the application is filed in the field office.

The Commissioner's proposal recommends as its first element a "**quick decision step at the very earliest stages of the claims process for people who are obviously disabled."** This is not only a great idea, but it has also been around for a long time. The Presumptive Disability (PD) process in the Supplemental Security Income claims process is essentially a quick decision approach. To expand this concept and make it work as part of the Commissioner's new approach the procedures need to be refined, broadened, and implemented in a manner that is both effective and takes into account the realities of the Federal-State relationship.

We strongly recommend, therefore, that field office claims representatives be empowered to make or recommend the quick decisions envisioned in the Commissioner's proposal at the field office level, and that those

cases not meeting the quick decision criteria be moved to the State Disability Determinations Services (DDSs) without an intermediate step.

We would recommend that additional disability responsibilities be assigned to claims representatives to permit such disability decision making (where arrangements can be made with individual DDSs). We also recommend that they be given other functions such as taking the first action to secure medical evidence on claims being forwarded to the DDS for development and medical decision. This is predicated on additional appropriate medical training being given to these field office employees.

There are many impairments that meet the medical listings and can be allowed with minimal medical evidence. This evidence can be obtained via telephone and fax and the efficiencies inherent in local field office staff dealing with local treating sources are obvious. The quick decision step is tailor-made for field offices.

We feel this arrangement is compatible with the Commissioner's desire to expedite the decision process for those individuals who are obviously disabled. We feel this approach will also serve to streamline and expedite the disability process as a whole. Well trained claims representatives, with a greater knowledge of the disability process, would be able to provide DDSs with a higher quality product even in those cases where a quick decision is not possible. Evidence would be requested earlier in the process, allowing DDS examiners to make disability decisions in a timelier manner.

Regarding the Commissioner's proposal to establish Regional Expert Review Units, we believe these units would be the proper place to provide expert support for all disability examiners. The Commissioner's proposal indicates that "Most of these units would be established in SSA's regional offices." This, we believe, could be a deal breaker for the DDSs. We recommend that these units be established in individual DDSs within each region. The resources earmarked for the units planned for Regional Offices can be diverted to the appropriate DDSs. The medical expertise centralized in an individual Expert Review Unit could still be made available to decision makers at all levels.

We understand that the Commissioner envisions that the role of the DDS will not diminish under her plan and in fact, anticipates that it will expand with the need for more vocational experts and the need to manage temporary allowances, early intervention and interim medical benefits. We need to point out that these factors could have an even greater impact on SSA's field offices where logically the task of dealing directly with the claimant on these issues should reside.

We strongly endorse the implementation of an in-line quality review process managed by the DDSs as well as the centralized quality control unit to replace the current SSA quality control system. In a joint proposal from the National Association of Disability Examiners (NADE) and NCSSMA entitled "The Front End of the Disability Claims Process", submitted to the Deputy Commissioner for Disability in December 2002, NADE and NCSSMA recommended that an in-line quality review process be established rather than relying exclusively on the current end-of-line review.

We also endorse the elimination of the DDS Reconsideration step. The Commissioner's proposal specifically indicates that the additional time required for the State DDS examiners to do a more complete job of documenting their initial decisions would be compensated by redirecting DDS resources freed up by the Quick Decision process. For this to be possible under our proposal to locate the Regional Expert Review Units in DDSs it is essential that commensurate additional resources be allocated to the DDSs.

The Reviewing Official (RO) position and function in the Commissioner's proposal is valid, logical and essential to an improved disability process. Here again, as a matter of selling this to the DDS community, we believe that this function does not require that the RO be an attorney. The Adjudicative Officer (AO) Pilot, which performed a similar role, established that this function does not require a law degree.

We strongly endorse the Commissioner's proposal to close the record following the Administrative Law Judge decision and to eliminate the Appeals Council.

Summary

To summarize:

- The Commissioner's proposal has the promise to be the basis for an improved SSA disability determination process.
- The role of the SSA field office in the initial stage of the disability intake process needs to be expanded and modified by assigning additional disability responsibilities to claims representatives including, where feasible, the initiation

of medical development, scheduling of consultative examinations, and recommending and/or making medical determinations in quick decision cases.
- Expert Review Units should be located in selected DDSs. They would be organized in the same manner envisioned by the Commissioner's proposal and would perform the same functions. Additional resources should be allocated to the DDSs involved to compensate for this responsibility.
- We recommend and endorse implementation of the in-line quality review process as well as the centralized quality control function envisioned by the Commissioner's proposal.
- The DDS Reconsideration step should be eliminated.
- The requirement that the Reviewing Official be an attorney should be eliminated.
- The record should be closed after the ALJ decision and the Appeals Council should be eliminated.
- Finally, all affected components should be staffed appropriately. Both DDSs and FOs will need additional staff if this new process is to work.

NCSSMA is committed to working with all interested parties in making the Commissioner's vision of a new and improved disability process a reality. We are hopeful our comments will be useful in streamlining this process.

Again, I thank you for this opportunity to appear before the Committee. I would welcome any questions that you may have.

Chairman HERGER. Thank you, Mr. Buffaloe. Ms. Marshall to testify.

STATEMENT OF MARTHA A. MARSHALL, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, LANSING, MICHIGAN

Ms. MARSHALL. On behalf of the NADE membership, thank you for providing this opportunity.

Chairman HERGER. Could you speak into the microphone, please? There we go. Thank you.

Ms. MARSHALL. To present our views on the Commissioner's proposal to reform the Social Security and SSI disability programs. The NADE believes that for people with disabilities it is crucial that the SSA reduce any unnecessary delays and make the process more efficient. However, any changes in this process must be practical and affordable and implemented in a manner that allows appropriate safeguards to assure that the current level of claimant service is improved or, at the very least, maintained. We are not convinced that all parts of the Commissioner's approach will achieve this and are concerned that some of the proposed changes will, in fact, increase both administrative and program costs. The experience of past pilots has shown that ideas that may sound good in theory have proven to be inadequate to meet the demands for service and affordability when implemented on a wide-scale basis.

We agree with Commissioner Barnhart that successful implementation of eDIB is a critical feature of any new approach to SSA disability determinations. For eDIB to be successful, however, it is critically important that adequate infrastructure support and proper equipment be in place. The eDIB implementation issues must be addressed quickly and efficiently in order to make the process work as intended and not cause real delays in the program and in the system. Experience with eDIB to date has shown that proper equipment has not always been provided to the DDSs, and while technology can produce some processing time efficiencies, it is

merely a tool. It cannot replace the highly skilled and programmatically trained DE and DDS medical consultant.

The Commissioner's approach envisions that quick decisions for those who are obviously disabled would be adjudicated in RERU. The NADE believes that the DDSs are better equipped in terms of adjudicative experience, medical community outreach, and systems support to fast track claims and gather evidence to make a decision timely, accurately, and cost-effectively. Establishing a RERU to handle this workload constitutes an additional hand-off with no improvement in the process.

In addition, at the present time, if an SSI claimant presents with a condition that is likely to be found disabling, the statute provides for a presumptive disability decision. Therefore, currently, an obviously disabled SSI claimant can immediately begin receiving cash benefits and medical benefits while the DDS obtains the supporting evidence. Unfortunately, there is no such provision for Social Security claimants. A person found disabled under the SSI Disability Program must complete a 5-month waiting period before they can receive cash benefits. An allowance, no matter how quickly it is processed, will not benefit the individual if he or she has to wait 5 full calendar months before receiving benefits. The NADE strongly opposes any proposal to remove on-site MCs from the DDSs. These MCs interact daily with DEs and offer advice on complex cases.

The Commissioner has proposed establishment of a Federal RO as an interim step between the DDS decision and the OHA. We agree that an interim step is necessary to reduce the number of cases going to OHA as much as possible. We do not, however, believe that this must be handled by an attorney. Decisions made at all levels of adjudication are medical-legal ones. Disability hearing officers who are programmatically trained in disability adjudication as well as in conducting evidentiary hearings can handle the first step of appeal between the DDS initial decision and the ALJ hearing. Using trained hearing officers instead of attorneys will be substantially less costly.

In addition, we do believe that the single decisionmaker model should be implemented throughout the new approach, that MCs should be basically used to consult with on cases without requiring sign-off in every case, unless required by the statute. We appreciate the Commissioner's emphasis on quality as described in her new approach. We support closing the record after the ALJ decision and elimination of the Appeals Council. The NADE believes that any proposal to reform the Social Security and SSI Disability Programs must balance the dual obligations of stewardship and service, and we look forward to working with the Congress and with the Commissioner as she refines this process. Again, thank you.

[The prepared statement of Ms. Marshall follows:]

Statement of Martha A. Marshall, President, National Association of Disability Examiners, Lansing, Michigan

Chairman Shaw, Chairman Herger, and members of the Subcommittees, thank you for providing this opportunity for the National Association of Disability Examiners (NADE) to present our views on the Commissioner's proposal to reform the Social Security and Supplemental Security Income (SSI) disability programs.

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 and thus are on the "front-line" of the disability evaluation process. However, our membership also includes SSA Field Office, Regional Office and Central Office personnel, attorneys, physicians, and claimant advocates. It is the diversity of our membership, combined with our extensive program knowledge and "hands on" experience, which enables NADE to offer a perspective on disability issues that is both unique and pragmatic.

NADE members, whether in the state DDSs, in SSA or in the private sector, are deeply concerned about the integrity and efficiency of both the Social Security and the SSI disability programs. Simply stated, we believe that those who are entitled to disability benefits under the law should receive them; those who are not, should not. We also believe decisions should be reached in a timely, efficient and equitable manner. Any change in the disability process must promote viability and stability in the disability program and maintain the integrity of the disability trust fund by providing good customer service while protecting the trust funds against abuse. Quality claimant service and lowered administrative costs that the American taxpayer can afford should dictate the structure of any new disability claims process. In addition, to rebuild public confidence in the disability program, the basic design of any new process should ensure that the decisions made by all components and all decision-makers accurately reflect a determination that a claimant is truly disabled as defined by the Social Security Act.

In her September 25, 2003 testimony before the Subcommittee on Social Security, Commissioner Barnhart presented her approach to improving the disability determination process designed to "shorten decision times, pay benefits to people who are obviously disabled much earlier in the process and test new incentives for those with disabilities who wish to remain in, or return to, the workforce". NADE supports these goals. We appreciate the Commissioner's focus on improving the disability program and her willingness to tackle the monumental task of improving the disability process and are fully committed to working in partnership in this effort.

NADE believes that for people with disabilities, it is crucial that SSA reduce any unnecessary delays and make the process more efficient. However, any changes in the process must be practical and affordable and implemented in a manner that allows appropriate safeguards to assure that timely claimant service is improved, or at the very least, maintained. *NADE is not convinced that all parts of the Commissioner's approach will achieve this and is concerned that some of the proposed changes will, in fact, increase both administrative and program costs.*

For the past decade, SSA has attempted to redesign the disability claims process in an effort to produce a new process that will result in more timely and more accurate decisions. Results of numerous tests undertaken by SSA to improve the disability process have not produced the results anticipated. The experience of past pilots has shown that ideas that may sound good in theory have proven to be inadequate to meet the demands for service and affordability when implemented on a wide-scale basis.

There is a pervasive public perception that "everyone" is denied disability benefits twice and their claim is allowed only when they reach the Administrative Law Judge (ALJ) level. In fact, nearly 80% of those currently receiving benefits were allowed prior to going before an ALJ. In addition, in Fiscal Year 2000, 78% of all cases were finally decided in the DDS and were completed in an average case processing time of about 85 days at the initial level and 63 days at the reconsideration level. *The processing delays that appear to be of the greatest concern to the Commissioner, and to the public, are delays that occur, not at the DDS, but in association with the appeals process. Wholesale changes at the DDS level do not address these concerns.*

Both formally and informally, NADE has provided extensive feedback to the Commissioner on her "New Approach to SSA Disability Determinations". Our comments are summarized below. In addition, a flow chart incorporating NADE's suggestions accompanies this testimony.

NADE fully supports all efforts to allow earlier access to health care, treatment and rehabilitation needs of disabled individuals, as well as efforts to assist those individuals who wish to return to work by providing them the needed services to allow them to do so. We believe that early intervention efforts will provide improved service to disabled individuals by providing needed treatment and services earlier in their disease process. This early intervention has the potential to decrease the lifelong disability payments that some individuals receive once they have been determined eligible for benefits. Although there are still few details available in the Commissioner's approach regarding potential demonstration projects, it appears that individuals chosen for participation in these projects could be screened based upon age, education, work history and claimant allegations. This type of data is currently collected in the initial disability interview; using these types of screening criteria would not require system changes or other modifications to the existing process.

Therefore, NADE believes that a trained "technical expert in disability" in a SSA Field Office could screen applicants for disability into these demonstration projects. Oversight of these projects could be done on a regional basis by Regional Expert Review Units as proposed by the Commissioner.

NADE agrees with Commissioner Barnhart that successful implementation of eDIB is a critical feature of any new plan to improve the disability program. NADE remains supportive of these new technologies as a means for more efficient service to the public. We believe that SSA's goal of achieving an electronic disability claims process represents an important, positive direction toward more efficient delivery of disability payments. *However, while technology can be expected to reduce hand-offs, eliminate mail time and provide other efficiencies, technology is merely a tool.* It cannot replace the highly skilled and trained disability examiner who evaluates the claim and determines an individual's eligibility for disability benefits in accordance with Social Security federal rules and regulations.

In order for eDIB to be successful, it is critically important that adequate infrastructure support and proper equipment to make the process work effectively and efficiently is in place. Until eDIB is fully implemented nationwide, it is impossible to determine critical service delivery issues that impact on daily case processing. If DDSs are pushed to meet arbitrary deadlines without the necessary hardware and software, there will be delays in case processing and no improvements in customer service. It is an absolute necessity that eDIB implementation issues be addressed quickly and efficiently in order to make the process work as intended and not cause real delays in service to our most vulnerable citizens. Experience with eDIB to date has shown that proper equipment has not always been provided to DDS disability examiners to allow for optimal use of this new technology.

NADE strongly supports the Commissioner's emphasis on quality as described in the new approach. National uniform decisions with consistent application of policy at all adjudicative levels requires a consistent and inclusive quality assurance (QA) review process. A well-defined and implemented QA process provides an effective deterrent to mismanagement, fraud and abuse in the disability program. By including both in-line and end-of-line review, accountability can be built into every step. We believe that this will promote national consistency that, in turn, will build credibility into the process. In addition, NADE supports requiring similar medical training for all decision-makers at all steps in the disability claims process. Making disability decisions can be extremely difficult without sufficient medical training. Disability is based on a physical or mental medical condition and the assessment of how such a condition impacts on a claimant's ability to work must be based on an understanding of how such conditions normally affect an individual's ability to function. Adequate training of all decision-makers in the medical program requirements is essential to ensure quality decisions and integrity in the disability program.

Although the Commissioner's approach envisions that "quick decisions" for those who are obviously disabled would be adjudicated in Regional Expert Review Units, NADE believes that the DDSs are better equipped in terms of adjudicative expertise, medical community outreach, and systems support to fast track claims and gather evidence to make a decision timely, accurately, and cost effectively. DDSs already process at least twenty percent of allowance decisions in less than twenty-five days. In addition, DDS disability examiners are well versed in the evaluation of disability onset issues, unsuccessful work attempts and work despite a severe impairment provisions to quickly and efficiently determine the correct onset for quick decision conditions. Establishing a Regional Expert Review Unit to handle this workload constitutes an additional hand-off of a claim with no value added to the process. We see no need to add another layer of bureaucracy to process quick decisions when such cases are already "triaged" and handled expeditiously by the DDS disability examiners. In order to implement a Regional Expert Review Unit for quick decisions, SSA would need to change its existing infrastructure to make these decisions and provide for hiring, training and housing staff. In addition, business processes would have to be developed to secure and pay for medical evidence of record.

In addition, a person found disabled under the Social Security disability program must complete a five month waiting period before they receive cash benefits. ***A disability allowance decision, no matter how quickly it is processed, will not solve the problem of having to wait five full calendar months before being able to receive any cash benefits.*** The SSI disability program does not require such a waiting period. In fact, if an SSI claimant presents with a condition that is likely to be found disabling, the statute provides for a presumptive eligibility decision on the case before obtaining any additional supporting evidence. This provision allows the claimant to immediately start receiving cash benefits and medical benefits while the DDS obtains the supporting documentation needed for the final eligibility decision. There is no such provision for Social Security claimants, and even

if a final eligibility decision is made earlier, they still have to wait five full calendar months before being able to receive any cash benefits and, with the exception of individuals diagnosed with ALS or undergoing dialysis, twenty-four calendar months before becoming eligible for Medicare benefits. *This waiting period has caused many claimants and their families to suffer severe economic and emotional hardship while waiting to receive benefits. It also fosters a perception that SSA is denying cash benefits to disabled workers when they need these benefits the most.* This is especially true for claimants who suffer from a terminal illness and have a short life expectancy.

NADE is strongly opposed to any proposal to remove onsite Medical Consultants from the DDS. ***The DDS medical consultant interacts with disability examiners on a daily basis and offers advice on complex case development or decision-making issues.*** As an integral part of the DDS adjudicative team,DDS medical consultants play a vital role in the disability evaluation process, not only in reviewing medical evidence and providing advice on interpretation, but also in training and mentoring disability examiners, as well as performing necessary public outreach in the community. He/she maintains liaison with the local medical community and has knowledge of local care patterns and the availability of diagnostic studies and state regulations to facilitate the adjudication process within the complex Social Security system. Most disability applicants have multiple impairments involving more than one body system and require a comprehensive view of the combined limitations and resultant impact on function. Specialty consultants with limited scope and experience cannot fully assess the combined effects of multiple impairments on an applicant's functioning. The SSA programmatically trained DDS medical consultant has the education, clinical experience and decision-making skills, along with expertise in evaluating medical records and disease conditions and making prognosis predictions regarding a claimant's function and future condition, to more accurately assess the case as a whole.

DDS medical consultants are not only medical specialists—physicians, psychologists or speech/language pathologists—they are also SSA program specialists. *There is a very real difference between clinical and regulatory medicine and it takes at least a year to become proficient in Social Security disability rules and regulations.* The DDS medical consultant's unique knowledge of SSA's complex rules and regulations and regional variants of those regulations, their medical expertise in many fields and knowledge of local medical sources, and their familiarity with DDS examiner staff, quality specialists and supervisors, make them an invaluable asset to the DDS's and the SSA disability program as a whole. It is critical that this expertise be on-site in the DDSs and readily available to the disability examiner for case consultation and questions, particularly in those more complex cases and, if as proposed under the Commissioner's plan, disability examiners are to, "more fully document and explain their decisions".

The Social Security and SSI disability programs are unique among disability programs. The disability examiners who evaluate claims for Social Security and SSI disability benefits must possess unique knowledge, skills and abilities. Those who adjudicate Social Security and SSI disability claims are required, as a matter of routine, to deal with the interplay of abstract medical, legal, functional and vocational concepts. Disability examiners are required by law to follow a complex sequential evaluation process, performing at each step an analysis of the evidence and a determination of eligibility or continuing eligibility for benefits before proceeding to the next step. Adjudication of claims for Social Security and SSI disability benefits requires that disability examiners be conversant (reading, writing and speaking) in the principles of medicine, law and vocational rehabilitation. The disability examiner is neither a physician, an attorney nor a vocational rehabilitation counselor. Nevertheless, he or she must extract and employ major concepts that are fundamental to each of these professions. The disability examiner must appropriately and interchangeably, during the course of adjudication, apply the "logic" of a doctor, a lawyer and a rehabilitation counselor. A disability examiner must have knowledge of the total disability program as well as proficiency in adult and child physical and mental impairment evaluation, knowledge of vocational and job bank information and the legal issues which impact on case development and adjudication. It takes years before an individual becomes adept at this complex task.

NADE has long supported an enhanced role for the disability examiner and increased autonomy in decision-making for experienced disability examiners on certain cases. We were pleased, therefore, that in NADE's discussions with Commissioner Barnhart we were told that it was her intent in the new approach to enhance the disability examiner's role in the disability process. In order to achieve that, we believe that the Single Decision Maker (SDM) from the highly successful Full Process Model project and currently operating in the prototype and ten other states

should be fully integrated into the new approach. (Under the SDM model, medical sign-off is not required unless mandated by statute.)

Decisions regarding disability eligibility can be considered to be on a continuum from the obvious allowances on one end, through the mid-range of the continuum where only careful analysis of the evidence by both adjudicator and medical consultant can lead to the right decision, and finally to the other end of the continuum where claims are obvious denials. It is at both ends of the continuum where the disability adjudicator can effectively function as an independent decision-maker. Use of the SDM to make the disability determination, and retaining the availability of medical consultant expertise for consulting on cases without requiring medical sign off on every case, promotes effective and economical use of resources. It is prudent to expend our medical and other resources where they can most positively impact the quality of the disability claim.

Of all the "reengineered" disability processes proposed or piloted in the past, the SDM process has been the most successful. It has had a more positive impact on cost-effective, timely and accurate case processing than any other disability claims initiative in many years. Statistical results have shown that disability examiners operating under the SDM model in the twenty states where this concept was tested have the same or better quality than disability examiners operating under the traditional disability adjudication model. Studies of the SDM have demonstrated its value as an integral part of the Social Security Administration's disability claim adjudication process. ***NADE strongly believes that the SDM model should be integrated fully in any new initial claims process, expanded to Continuing Disability Reviews and adopted as standard procedure in all DDSs.***

The Commissioner, in her Approach, has proposed establishment of a federal Reviewing Official (RO) as an interim step between the DDS decision and the Office of Hearing and Appeals (OHA). NADE agrees that an interim step is necessary to reduce the number of cases going to the OHA as much as possible. An interim step laying out the facts and issues of the case and requiring resolution of those issues could help improve the quality and consistency of decisions between DDS and OHA components. NADE supports an interim step because of the structure it imposes, the potential for improving the consistency of decisions, reducing processing time on appeals, and correcting obvious decisional errors at the initial level. The establishment of uniform minimum qualifications, uniform training and uniform structured decision-writing procedures and formats will enhance the consistency and quality of the disability decisions. *NADE is not convinced, however, that customer service is improved from the current process if this remains a paper review at this interim step.*

NADE believes that this interim step should include sufficient personal contact to satisfy the need for due process. We do not believe that it needs to be handled by an attorney. There is little, if any, data that supports a conclusion that this interim step needs to be handled by an attorney. In fact, a 2003 report commissioned by the Social Security Advisory Board to study this issue recommended that this position *NOT* be an attorney.

Decisions made at all levels of adjudication in the disability process are medical-legal ones. NADE believes that Disability Hearing Officers (DHOs) can handle the first step of appeal between the DDS initial decision and the ALJ hearing. DHOs are programmatically trained in disability adjudication as well as in conducting evidentiary hearings. ***Using trained Disability Hearing Officers instead of attorneys will be substantially less costly.*** In addition, there is currently an infrastructure in place to support DHOs and using such a structure will prevent creation of a new costly and less claimant friendly federal bureaucracy. Since this infrastructure is already in place, national implementation of the DHO alternative can occur very quickly.

NADE supports closing the record after the Administrative Law Judge's decision since this decision will, under the Commissioner's proposed approach, represent the final decision of the Commissioner of Social Security before any subsequent appeal to the federal courts. We support providing the assistance of programmatically trained medical and vocational experts to the Administrative Law Judges.

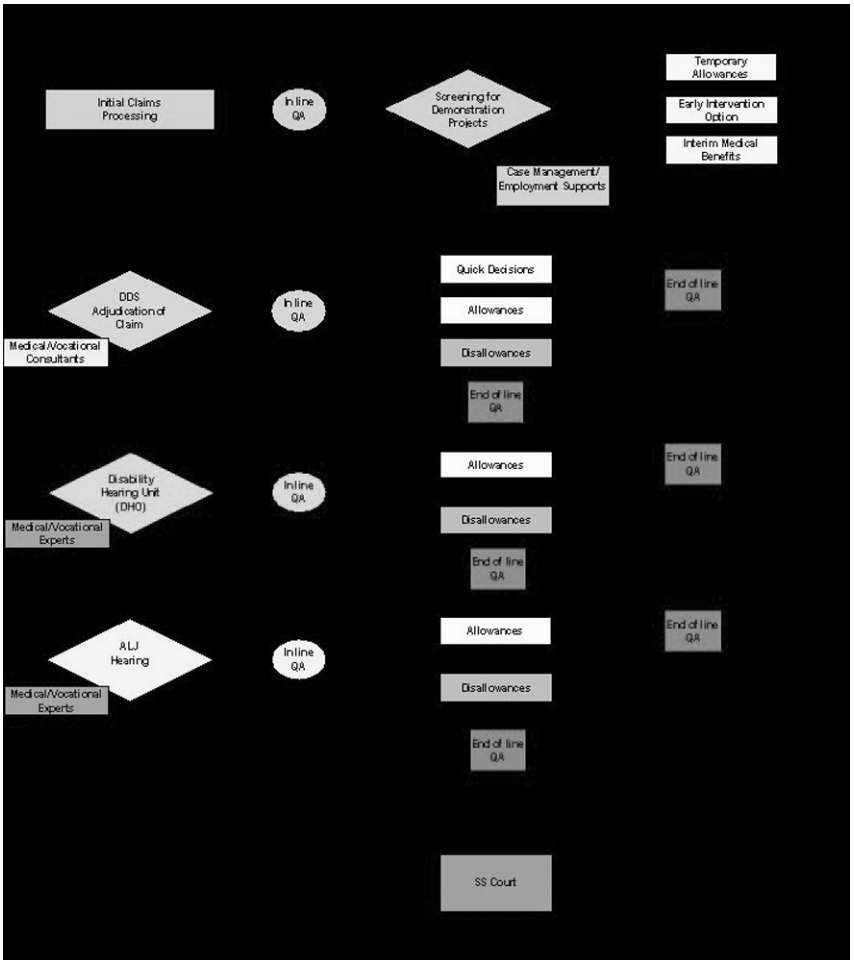
NADE supports elimination of the Appeals Council review step. We continue to advocate for establishment of a Social Security Court. As long as judicial review of disability appeals continues to occur in multiple district courts across the country, a bifurcated disability process will continue to exist as different DDSs operate under different court rulings and regulations depending upon where the claimant lives.

In summary, NADE's key recommendations are to implement only strategies which balance the dual obligations of stewardship and service. These are:

- Implement eDIB only with adequate infrastructure support and proper equipment.

- Keep Quick Decisions in the DDS.
- Eliminate or reduce the five month waiting period for Social Security beneficiaries.
- Extend Presumptive Disability provisions to Social Security disability claimants.
- Maintain Medical Consultants on-site in the DDS.
- Fully integrate the Single Decision Maker into any new disability process.
- Utilize the current infrastructure of DDS Disability Hearing Officers as an interim appeals step.
- Require training in the medical program requirements for all decision makers in all components.
- Include both in-line and end of line review at all levels of the process.
- Recognize that technology is only a tool. It does not replace the highly skilled trained disability examiner.

NADE appreciates this opportunity to present our views on the Commissioner's New Approach to SSA Disability Determinations, and we look forward to working with the Social Security Administration and the Congress as the Commissioner continues to refine her approach to improve the disability process.



Chairman HERGER. Thank you very much. Dr. C. Richard Dann, please, to testify.

STATEMENT OF C. RICHARD DANN, M.D., UNION OF AMERICAN PHYSICIANS AND DENTISTS, AND AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AUBURN, CALIFORNIA

Dr. DANN. Mr. Chairman and Honorable Members of the Subcommittees, thank you very much for the opportunity to present my views on Social Security's new approach to disability determinations. I am Dr. Richard Dann from the Roseville, California DDS. I am a DDS medical consultant (MC) with 21 years experience in disability medicine. I am testifying on behalf of the UAPD as well as the AFSCME. Of 2,100 DDS MCs nationwide, I represent 160 in California and hundreds in other States.

The new approach eliminates the DDS medical consultant, replacing us with nurses. At proposed ratios of about 2 to 1 in current wages, two nurses would actually cost more than the DDS MC replaced. The statutes require MC signatures on denials of certain claim types. The DDS MCs fulfill those requirements. It is unclear who will make the medical assessments and sign medical decision documents if we are eliminated from the DDS. New Approach sends easier quick decision cases to a regional unit. Currently, DDSs decide 20 percent of all claims in under 25 days. Skimming quick decision cases from the DDS will concentrate a more complex caseload into the DDS. This seems an inappropriate time to replace the medical consultant with nurses.

Abandoning the DDS reconsideration step for a regional RO is somewhat troubling. An attorney does not have adequate medical knowledge to make a better medical assessment than the DDS MC. The DDS MCs provide convenient, close on-site medical support to the DE. Adding a nurse and a computer between the DE and the medical resource will hinder its use. The DDS MC is an educator, training DEs, MCs and exam vendors. Off-site regional medical experts would have trouble fulfilling these DDS support roles. Medical licensure is a problem with New Approach. State medical licensure is required for doctors to make diagnoses and order diagnostic tests routine parts of casework at the DDS. Nurses and attorneys cannot do this. State licensure costs a lot and can be difficult to obtain due to a lack of reciprocity between States. Regional medical experts would not be licensed in every State of their region. Case development will be impossible without the State-licensed DDS medical consultant.

The DDS MCs save millions of dollars each year by obtaining medical evidence by phone. Regional medical experts would lack familiarity with local medical providers and consultative examiners. Regional medical experts would be less able to obtain phone evidence.

The DDS MC approaches cases strategically and saves time and cost by recognizing and allowance early. Disability examiners consult casually with the on-site medical consultant. I can allow cases early that might wrongly be denied by a nurse or attorney. I have

done this with multiple throat cancer claims by using my knowledge of anatomy to technically review an operative report and find evidence for an allowance. Off-site regional experts would not as user friendly to the DE.

To summarize, the DDS medical consultant should be retained in New Approach. Social Security Disability is defined, quote, "Due to a medically determinable impairment," unquote. There is no one better to assess this than a physician. The medical consultant has superior medical knowledge to a disability evaluator, nurse or attorney. Our accessibility and knowledge of Social Security regulatory medicine make us a unique asset. Federally measured DDS accuracy is greater than 90 percent. The DDS MC assessments are more legally defensible than those from a DE, nurse or attorney. The DDS medical consultant provides unparalleled professional training for the next generation of DEs, MCs and vendors.

Eliminating the DDS medical consultant will waste millions of dollars on wrong allowances and fraud, delay true allowances, and weaken legal defense, and also impede the DE. Importantly, it will erode public confidence in the Social Security Disability decision. The DDS stakeholders, UAPD, AFSCME, NADE and NCDDD, have all voiced solid support for retaining the on-site DDS medical consultant; 2,100 MC jobs are threatened by New Approach. Experienced DDS MCs will soon begin leaving. We have obligations that will force us to seek secure jobs. Many groups have worked diligently to show how Social Security goals can be better achieved retaining the DDS MC. We are an unparalleled resource to the DDS and Social Security and our clients. Let us not let that resource disappear. Thank you very much.

[The prepared statement of Dr. Dann follows:]

Statement of C. Richard Dann, M.D., Union of American Physicians and Dentists, and American Federation of State, County, and Municipal Employees, Auburn, California

Mr. Chairman and distinguished members of this Subcommittee;

We appreciate the opportunity to testify today regarding the Social Security Administration's New Approach to Disability Determinations plan.

I am Dr. Richard Dann, MD, from the Roseville, California Disability Determination Service, (DDS). I am a DDS Medical Consultant (MC) with over 21 years experience in disabilitymedicine. I am testifyingon behalf of the Union of American Physicians and Dentists (UAPD) and the American Federation of State, County and Municipal Employees (AFSCME). I am one of approximately 2,100 DDS MCs nationwide. I am testifying on behalf of the 160 DDS MCs in California and several hundred more represented by AFSCME nationwide. I am a shop steward and Board Member of UAPD.

I enjoy my job and obtain great satisfaction performing an important medical, fiscal and civil service. I am here to explain why the DDS MC is a critical resource in the adjudication of Social Security Disability Claims and why MCs should remain in the State DDS. In my judgment, eliminating the DDS Medical Consultant will waste millions of dollars on erroneous allowances, encourage fraud, delay bona fide allowances, weaken legal defense of decisions, and further burden the Disability Examiner (DE). But most importantly, it will erode the integrity of the SSA disability decision, along with the public trust of the American people.

My job is to act like a medical detective, seeking accurate medical assessments to determine if a claimant is disabled under SSA regulation by a "medically determinable impairment." I save costs by making physician to physician phone calls to treating sources, obtaining high quality evidence at no cost. I help to develop local vendor sources and monitor their quality. The DDS MC helps provide initial and ongoing training of the DE and new MC staff.

On Sept. 25, 2003, Commissioner Barnhart announced her New Approach to Disability Determinations plan. The Commissioner stated that applicant service would

improve, and that "no SSA employee would be adversely affected by my approach," explaining that included DDS employees and Adjudicative Law Judges. The Commissioner then noted that she planned to eliminate the position of the DDS MC, later elaborating we would be replaced with nurses. The DDS nurse would liaison between the DE and a Regional Medical Expert. At the staffing ratio proposed by SSA and current wage scales, two nurses would cost more than the MC replaced. Many operational specifics have not yet been shared with stakeholders and the public. Statutes require DDS MC signatures on denials of pediatric and mental health claims. Under the New Approach, who will sign these claims? Where would all of these disability trained nurses come from? I have helped write several position papers on elimination of the DDS MC for UAPD, AFSCME, and the National Association Disability Examiners (NADE), all of which have been submitted to this Subcommittee.

The Commissioner seeks faster disability decisions in her "Quick Decision" plan, where cases of obvious severe disability would be sent to a planned Regional Quick Decision Unit rather than to the DDS. There are already mechanisms in place to expedite DDS claim review for the obviously disabled and for those in dire need (E.G. PD or Presumptive Disability and TERI cases). The speed of the decision must be weighed against the accuracy of the decision; speed and quality tend to be inversely proportional. Excessive emphasis on speed erodes quality substantially. DDS administrators juggle these two factors constantly. Very minor regulatory changes at the DDS would accomplish the goals of the "Quick Decision" part of "New Approach" with considerably less expense, staff training and change in procedures. The DDS team of Disability Examiner and MC currently do quite well in this area, with a mean DDS processing time of approximately 85 days nationwide and 75 days in California. About 20 percent of claims are adjudicated in less than 25 days. Only a half hour or so is spent in review by the DDS MC; the value added with that short step is enormous. Removing "Quick Decision" cases will concentrate a more complex caseload into the DDS. Accordingly, replacing the DDS MC with nurses at the same time as concentrating more difficult cases into the DDS does not make sense.

The accuracy and quality of the disability decision are heavily influenced by the DDS MC. Local DDS inline review and Regional quality review keep DDS decision accuracy above 90 percent. Accuracy is important; an allowance costs SSA between $100,000 and $200,000. Erroneous allowances are very difficult to reverse due to SSA statutes, and no one wants to wrongly deny benefits. This is a decision worth getting right, for both the claimants and the budget. The quality of the DDS decision is excellent, and more, rather than less, reliance should be placed on it.

At the DDS, the MC provides medical knowledge at the doctorate level rather than nurse level, peer level review of treating source evidence, and inline quality review of the DDS decision. I have been able to allow brain cancer cases to proceed quickly where the grade of the tumor was not clearly stated, but my knowledge of histopathology enabled me to support an allowance. Due to my knowledge of neck anatomy and my ability to analyze operative reports, I have been able to promptly allow claims for throat cancer that the DE would have denied. Conversely, I have prevented inappropriate allowances for claims involving multiple traumas due to my knowledge of fracture sites and expected bone healing times. MCs recognize functional impacts of cumulative impairments as well as potential disease complications a DE or nurse cannot.

Many times every day, I carefully rationalize why a treating source's diagnosis or assessment of capacity is inconsistent with the medical evidence of record. The claimant's physician may not be as objective as SSA would like. A treating doctor's functional capacity statement is often noncritical in nature, based solely on what the patient tells them. Applicants can distort the truth, deliberately or unwillingly, and treating physicians are variably skilled at detecting this. They are their patient's advocate, not their judge. Frequently, I see statements from treating sources stating that their patient cannot walk two hours or sit for six hours a day. Yet, the record shows that the claimant lives alone, rides a bike, vacuums, and does his or her own grocery shopping. Deliberate exaggeration of symptoms is common, involving many cases every day.

Preventing fraud is a substantial part of our DDS job. There is a big difference to SSA between "uses a cane" and "needs a cane." The DDS MC is best suited to evaluate those diagnoses and statements of capability with the case findings. Careful assessment of evidence by the DDS MC frequently reveals inconsistencies. DEs and nurses lack the scope and depth of a medical doctorate to detect various subtle exam and diagnostic findings and critically review treating source statements. In Prototype states and under the Single Decision Maker (SDM) models, the DE may make the medical assessment on some claims without the input of a DDS physician;

if the DE has questions or concerns regarding aspects of the case, he or she consults with the DDS MC. The SDM pilots and Prototype studies have shown at least a 70 percent rate of consultation with the MC. In non-Prototype DDSs, currently the vast majority, the DE summarizes their findings in a consult to the MC, who then completes the medical assessment on every claim. It is not yet clear in the Commissioner's "New Approach" exactly what percentage of cases will have MC review or who will prepare and sign medical decision documents.

UAPD and AFSCME continue to strongly support DDS MC assessment for every single claim. Statistics have shown absolutely no improvement in processing time or accuracy under SDM or Prototype, and a 70 percent rate of MC consultation. The continued need for the DDS MC's input is clear. In fact, the Agency's own report, #A–07–00–10055, published in June 2002, noted increased claim processing times, appeal rates, case pending numbers, and an erosion of quality in SDM and Prototype DDSs. Current SSA promotional materials assure the public that doctors are involved in the disability decision process, and the public expects doctors to be utilized on most if not all claims. Imagine the response of the public and the courts to denials of benefits by a DE or nurse, despite endorsement from treating physicians.

The "New Approach" proposes using offsite Regional Medical Expert Units to provide case consultation to DEs via DDS nurse and computer, adding a computer and nurse between the DE and medical expert. This change complicates the process without any apparent value added, and causes some substantial problems. The DEs and DDS Directors have been asked for input and have replied universally that remote Regional Medical Experts will be much less efficient and user friendly than walking down the hall to the familiar MC.

Medical licensure is another big problem with "New Approach." MCs are licensed by state. Most states require state medical licensure to make diagnoses and order diagnostic tests, all very routine parts of developing cases at the DDS. State medical licensure costs hundreds of dollars a year and can be difficult to obtain due to lack of reciprocity between states. Regional Medical Experts would find it difficult and expensive to be licensed in every state of their Region; Region 9 contains California, Hawaii, Arkansas, and Nevada. When further testing needs to be ordered, this will be a major problem under the "New Approach" if there is no state licensed DDS MC onsite.

The proposed replacement of the DDS Reconsideration Step by a Regional Reviewing Official is especially troubling. How can a single attorney better assess medical disability than the DDS team of MC and DE? How will this attorney obtain adequate medical knowledge to make a better medical assessment than the DDS? The low reversal rate of the Reconsideration Step certainly does not devalue it. To the contrary, it affirms the high quality of initial DDS decisions. With DDS accuracy rates averaging above 90 percent, one should not expect substantial reversal rates. Reconsideration reversals generally occur when new evidence is presented or when disease progresses, not because of errors. The DDS MC is a graduate of medical school as well as a specialist in SSA disability. They are better qualified than an attorney or nurse to do medical assessments of disability. The DDS Reconsideration Step maintains integrity of the SSA Disability process by providing a prompt second medical evaluation of the claim by DDS DE and MC, and should not be exchanged for an attorney Reviewing Official.

Cost control is another fundamental role of the DDS doctor. The DDS MC saves SSA millions of dollars every year. As noted earlier, doctor-to-doctor phone contact obtains critical medical evidence from treating sources quickly and at no cost. The DDS MC applies a strategic approach to case processing, and development can cease as soon as a fully favorable allowance can be made. Several times a week, I am able to allow a case early in development by identifying a single impairment severe enough to allow the claim. In cases involving multiple diagnoses, early review of the medical evidence by the DDS MC frequently leads to prompt allowance without costly time consuming consultative exams. Nurses are untrained in this area, and Regional Medical Experts would be less able to obtain phone evidence.

The DDS MC is an educator, training Disability Evaluators, new MCs, and Consultative Exam vendors. He or she provide initial and refresher medical training to the DEs and provide critical peer training to new DDS MC. The MCs help the DDS find and train local CE vendors in program requirements, then help monitor for quality. It is not clear how Remote Regional Medical Experts might fulfill this important educator role.

In summary, the DDS MC is an invaluable component of the Social Security Disability Program and should be retained in the "New Approach." Contrary to the goals stated, the elimination of the DDS MC will increase errors, promote fraud,

slow processing time, increase expenses, make the DE's job tougher, and degrade the integrity of the process.

MC contributions to decision accuracy are critical, preventing many inappropriate allowances and denials at both initial and reconsideration levels. The current DDS team of DE and MC is the most effective way to accomplish the job. By statute, disability must be from a ***medically determinable impairment***, and no one is better suited to assess this than a physician. The DDS MC provides strategic professional case review and has medical knowledge deeper and broader in scope than a DE, nurse or attorney. The MC is able to assess SSA disability better than most treating sources and provides legally defensible medical assessments, more defensible than those of a DE, nurse or attorney. The DDS MC provides unparalleled professional training to DEs and Consultative Examiners. Those stakeholders most closely involved in the DDS process, UAPD, AFSCME, NADE, and NCDDD, have voiced solid support for retaining the DDS MC onsite. Their knowledge and experience in regulatory medicine and SSA regulations makes them uniquely qualified to make this judgment.

If the DDS MC jobs remain threatened, overwhelming numbers of valuable experienced DDS MCs will soon leave due to job uncertainty, before any Regional Medical Experts even exist. Many groups have worked diligently to show the Commissioner how to achieve her goals without eliminating the DDS MC. For over a year now, 2,100 MCs have felt their jobs threatened. We have obligations that will soon force many of us, myself included, to seek more secure positions. DDS MCs take pride in providing the best possible service to our SSA clients and training to the next generation of DDS MCs and DEs. We offer an unparalleled resource to the DDS and SSA. Let's not let that resource disappear!

I thank the Chairman and members of the Subcommittee for the opportunity to present this statement and am pleased to answer any questions you may have.

Chairman HERGER. Thank you. Ms. Everett to testify.

STATEMENT OF SHEILA EVERETT, PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS, JACKSON, MISSISSIPPI

Ms. EVERETT. Thank you, Mr. Chairman, for the opportunity to provide written testimony today and comments before the panel. I am the Director for the Mississippi DDSs, and as President of NCDDD, represent the disability directors and managers in over 54 DDS State agencies and over 16,000 State employees. We too applaud the Commissioner's bold vision for changes and want to thank her for inclusion of NCDDD in part of the process to decide the final plans. We believe that DDSs are in an excellent position to offer the Commissioner solutions as we are considered to be a very cost effective, productive and efficient part of the disability programs. Let me talk about our solutions.

In the area of quality we do concur with the Commissioner's definition that quality should be a combination or a balance of accuracy, customer service, timeliness, cost and productivity. Our solution will deliver consistency and quality across and among all components. Our quality plan begins with sound disability policy. We will work with the SSA to ensure that their policy for disability is concise, clear and communicated across all lines. For example, Social Security Disability policy has evolved over the last several years from a purely medical model to one that has more functioning in the listing and in the policy. This has added inconsistency and increased administrative costs.

Our solution would focus on consistently and adequately communicating and applying policy to all components. We would align the quality reviews with the policy component. We would centralize

end-of-line reviews. We would review all components from the field office to the DDS to the proposed regional officials, as well as OHA under the same rules. We would institute and end-line or end-process reviews to ensure quality at all steps in the process, and we would address the different standards of evidence, for example, preponderance of evidence standards used by the DDSs and substantial evidence standards used by the ALJs. The results of our plan would improve consistency and quality among all components and reduce administrative cost.

Regarding quick decisions, we believe we can improve upon the current infrastructure already in place in the State DDSs. Our data shows that 19 percent of cases are allowed by DDSs in 25 days or less already. Our solution is to improve the profile. We have identified to the Commissioner almost 50 impairments that would fit this category. We would have highly trained and skilled examiners process these cases with curtailed and expedited development independent of medical consultant input, saving them for more complex cases. Therefore, our result would improve the numbers of quick decisions, reduce the times to process these, and process these cases 26 million fewer dollars than a Federal component. Regarding medical experts, the NCDDD solution does leave MCs in the DDSs to process and rate cases along with all the other duties that they perform. We would place these MCs in electronic queues so that medical specialists could be shared among all components. Our solution does make MCs available also to OHA and ALJs for medical ratings so that we could improve consistency and decrease administrative costs.

We also propose a service delivery expert. This is a highly trained DE that would be able to make independent decisions on denial claims, also saving medical consultant time for more complex cases. We have recognized in the process that it does take extra test time for MCs. This would be a great way to balance and use those MCs and to decrease administrative costs.

We concur with the elimination of Recon, and creation of a RO. However, we believe that State employees such as our current disability hearing officers could also perform this job at a cost savings to the agency. We concur with the need for vocational specialists that are consistently trained the same skill set from the same training used at all components to improve consistency in the process. We also concur with all demonstration projects and "return to work." In summary, I would like to thank the Commissioner for her bold vision, her inclusion of NCDDD, and given the proper resources, we believe that we could deliver her goals. Thank you.

[The prepared statement of Ms. Everett follows:]

Statement of Sheila Everett, President, National Council of Disability Determination Directors, Jackson, Mississippi

Mr. Chairmen, thank you for your invitation to participate in this hearing on our thoughts about Social Security Commissioner Jo Anne Barnhart's "New Approach to Changing the Disability Process".

Before commenting on specific issues on the topic of today's hearing, as the representative of the National Council of Disability Determination Directors (NCDDD), I would like to restate the purpose of our organization and reaffirm all our previous commitments to participate in finding and implementing responsible solutions with accountability by all stakeholders.

The NCDDD is a professional association of Disability Determination Services (DDS) Directors and managers of the agencies of state government performing the disability determination function on behalf of Social Security. NCDDD represents 54 state Disability Determination Services (DDS) agencies and over 16,000 staff nationwide. NCDDD's goals focus on finding ways to establish, maintain, and improve fair, accurate, timely, and economical decisions to persons applying for disability benefits.

We applaud Commissioner Barnhart's bold vision for a new Disability process. The Commissioner stated that she was guided by three questions from the President as she considers changes to the Social Security Disability program:

- Why does it take so long to make a disability decision?
- Why can't people who are obviously disabled get a decision immediately?
- Why would anyone want to go back to work after going through such a long process to receive benefits?

Together with those questions, Commissioner focused on two over-arching operational goals:

1. To make the right decision as early in the process as possible.
2. To foster "return to work" at all stages of the process.

The NCDDD had nearly every DDS Director's involvement in formulating our response, reaction, and recommendations to the proposed changes. We presented our position to Commissioner Barnhart and her staff on April 7, 2004. At that time, we also discussed the need for further research and input in several areas related to this new position. Our membership is working to complete those assignments. We have a meeting scheduled with the Commissioner and her staff in October to discuss our findings. In addition, the NCDDD Officers have begun meetings with the Office of Disability Policy to work together on common solutions on disability policy. We are actively working with the Commissioner and SSA to achieve our common goals in these areas.

NCDDD has offered several solutions and recommendations to the Commissioner to help her achieve her goals and ensure consistency in decision making. I will outline the recommendations we believe will achieve the Commissioner's goals, best utilize the existing resources and staffing, achieve consistency in the program, and allow us to be good stewards of the trust funds. DDSs are the most efficient, productive, and cost-effective component of the disability process.

Quality

NCDDD supports the Commissioner's plan to provide quality disability decisions. We support her definition of Quality as accuracy, customer service, timeliness, cost, and productivity. We concur with this "balance" in case processing and believe that all components should operate under this same definition. We support the concept that quality reviews should be centralized and that the policy component must play a central role in the review and assessment of quality. We further support the concept that quality must be instilled at every step in the process and quality measures should be applied consistently within and across components. We support the Commissioner's plan to instill an in-line, or in-process quality system that would address the consistency between the DDS and Administrative Law Judge's (ALJ) decisions, the variations among DDSs, and the variation among ALJs. Most importantly, it would result in the right decision being made as early in the process as possible.

NCDDD feels that any quality review process should be aligned organizationally or in function with SSA's Policy component. Policy must be written that is clear, concise, and which lends itself to a consistent quality process. We recommend a culture change in which all SSA components (Operations, Disability and Income Security Programs, Quality Assurance and Performance Assessment, and Systems /eDib) are committed to the same intent and definition of Quality. Currently, DDSs operate under a preponderance of evidence standard while ALJs operate under a substantial evidence standard. All components should focus on the same outcomes. Currently some of these components stress competing outcomes which result in problems within the program. For example, stressing certain workload numbers at one component at the expense of another component contributes to cost and time delays in the overall process. Another example concerns policy that is written without regard to the operational impact on case processing. Over the past few years SSA Disability Policy has developed from a medical model to one where there is emphasis on the functioning which is subjective and which adds unnecessary costs, time delays, and inconsistency to the decision.

We are willing to work with SSA's Policy Component to ensure that SSA disability policy is clear, concise, and consistent among DDSs and across all components. We

want to work with SSA to ensure an operational success in this area and to help the Commissioner achieve her goals. We strongly believe that the DDSs need the adequate resources to achieve the Commissioner's definition of quality and consistent application of policy.

Lastly, we believe that specific measures of success for these quality outcomes should be **SMART**:

Specific
Measurable
Attainable
Relevant
Time based

Quick Decisions

We concur with the Commissioner that there ought to an expedited decision making process for those cases where there is an obvious disability. The NCDDD has identified nearly 50 impairments that might potentially fit this category. We believe that the documentation requirements have grown over recent years to include an expanded role of the claimant's functional ability as opposed to a purely medical model. This change in the documentation requirements has resulted in increased documentation of claims and has decreased the consistency of the process. We applaud the Commissioner's approach to identify those "Quick Decisions" and render these decisions expeditiously.

We believe that the DDSs already achieve this goal in the current model and that with further definition of the criteria, the DDSs are the best place to make these decisions. We believe that the placement of this process at any other component adds an unnecessary level of bureaucracy. In fact, even with the current process an NCDDD study revealed that 19% of allowance decisions are made in less than 25 days. We believe that we can surpass this goal with the current trained disability staff and a refined and streamlined process of "Quick Decisions".

We further propose that these decisions be given to the DDSs' most experienced Disability Examiners so they can correctly and timely make as many of these decisions with curtailed development and documentation and independent of MC input. Using the current electronic environment of case processing (eDib) these cases can be queued to the DDS electronically, flagged for a "Quick Decision" review, and assured of case processing of less than ten days in many instances.

The DDSs are willing to conduct the disability interview on these cases provided we are given the adequate staffing and resources. Our cost analysis shows that the DDSs can process these cases $26 million dollars less than a federal component.

Medical Experts

The NCDDD's solution to the Commissioner's use of Medical Experts is that we leave the DDS Medical Consultants (MC) in the DDSs so that they can continue to provide medical ratings and continued to provide the necessary ongoing medical training to adjudicator staff, assist with medical/public relations, work with medical source recruitment, and provide medical consultant training. We propose an electronic model to pool and share DDS and other trained disability medical experts. Currently, the process requires all of the DDS MCs as well as the SSA Regional Office MCs to process the disability workload.

Early information has demonstrated increased task time in reviewing the medical evidence on-line and preparing the electronic medical ratings that are required in the eDib process. However, it is hoped that some of this will be offset by the "end-to-end" time required of the total disability process. The benefits gained by having the ability to share these resources in an expanded electronic pool will further add consistency to medical ratings. To further enhance consistency, we propose these medical experts provide medical ratings to all components: DDSs, Reviewing Officials, and Administrative Law Judges (ALJs). Currently, resources are expended with the purchase of consultative examinations and medical source opinions requested by ALJs. We recommend making trained disability MCs available to ALJs who will provide medical ratings. This will ensure the consistency of medical evaluations and provide the best usage of the Agency's resources.

We believe that leaving these MCs in the DDS can maximize the efficiencies, accountability, and productivity of this staff. By placing cases for these MCs in an electronic queue, SSA gains the added benefit of ensuring consistency and of providing specialists to those areas where currently there is none. DDSs support this opportunity for expanded MC specialists availablility across the nation and to all compontents.

Service Delivery Expert Proposal

DDS Directors strongly support an enhanced role for experienced Disability Examiners (DE) in the decision making process. While we support an expanded Quick Decisions process, we maintain that this is just one area whereby a highly skilled and experienced DE should be able to recommend disability decisions. NCDDD recommends a triage decision making process whereby experienced DEs are able to make decisions on those obvious allowances and denials. This reserves valuable agency resources and MC time to be devoted to those more complex medical decisions. We believe that this is an integral step in the process ensuring that the trained medical resources are best utilized at the appropriate steps in the process.

Currently, using a test model, there are DDSs who utilize a similar model which has demonstrated efficient, cost effective, and quality decisions on those cases. We are requesting that the remaining DDSs be allowed to participate in this process. We will work with SSA to develop and maintain the training to ensure quality and consistency in this area.

Elimination of Reconsideration and Creation of Reviewing Official

NCDDD supports the elimination of the Reconsideration step as it currently exists.

While the Commissioner's plan calls for a federal Reviewing Official position as the first level of appeal, NCDDD proposes that this function could be achieved by a state Reviewing Official that would perform an on-the-record review of the file, give an expanded explanation of the reasoning for a denial, process expedited decisions in allowance claims, and provide feedback to the quality component for purposes of policy and decisional accuracy. While the Commissioner's proposed plan calls for an attorney to handle this appeals step, we propose that experienced DDS staff with the appropriate skill-sets can also be effectively employed to achieve this goal. For example, the DDS Disability Hearing Officers currently conduct evidentiary hearings that have received very good feedback from various components, including OHA.

The DDSs have long been under-resourced in terms of providing an expanded rationale. However, previous tests demonstrated effectiveness in this area. The DDSs support the expanded rationale but would also need the necessary resources to implement this. We believe that there is already a structure in place at the state DDS level that can address this appeal level within the parameters outlined above and we are very concerned about adding another administrative layer and the increased cost associated with this. The state model for appeals saves over $21 million in administrative costs for SSA.

Vocational Specialists

NCDDD supports the use of Vocational Specialists (VS) throughout the disability process. We propose the following process across all components:

- Updated vocational policy
- Vocational training for all adjudicators and VSs for all components
- Develop a curriculum and training plan for VSs
- VS certification by SSA
- Identification of VS in all components available for consultation
- Electronic queue of VS via the electronic process

The current model is lacking since SSA has not devoted the resources to a comprehensive vocational training package such as the basic training model available for DEs. This has been left up to the various DDSs to develop their own vocational training packages, leading to variations among DDSs in this area. There are even greater differences between DDSs and ALJs in regard to Vocational Specialist training, causing inconsistency between components. We advocate a consistent training module for all VSs and that this staff should be utilized consistently among DDSs and across all components via the eDib process. NCDDD will work with SSA to develop a Vocational Specialist training curriculum. We believe this would ensure consistency within and across components. While this expanded vocational training would require resources, we believe that overall administrative costs can be curtailed as all components use the same vocational criteria. As vocational evidence and analysis is consistently applied earlier in the process, the agency will realize consistency in case processing as well as administrative cost savings.

Demonstration Projects

NCDDD supports the various "return to work" initiatives endorsed by a new disability plan and we welcome the opportunity to participate in demonstration

projects of this nature. Since these demonstration projects do not require the electronic infrastructure for implementation, we recommend that SSA begin this process immediately. We support the notion of early intervention in this area and believe that such efforts are not only cost-effective but also serve as a social/psychological boost to potential disability applicants involved in the process. We support the added resources needed to fully fund such endeavors, since we believe that such outreach would also increase disability applications.

We strongly support the transitional (youth) initiatives and believe that public Vocational Rehabilitation should play a major role in such efforts. We further support ongoing continuation of medical benefits as part of the claimant's rehabilitation process and any other changes that would entice disabled individuals to return to work.

In conclusion, we support the Commissioner's desire to structure a disability program that renders the right decisions as early in the process as possible and that fosters "return to work" at all stages in the process. We share Commissioner Barnhart's definition of quality and her goal of improved consistency in decision making within and across components. We are appreciative of the fact that Commissioner Barnhart has solicited input from NCDDD in an active manner. We are continuing to provide information to her that will help her to achieve her stated goals. We are also appreciative of SSA's recent efforts to include NCDDD in active discussions regarding disability policy. The DDSs will need the necessary resources to effectively implement these changes. It is our understanding that an average DDS cost-per-case is $400 as compared to the nearly $2000 cost-per-case at the OHA level, making us the best value in the entire SSA disability process. We are confident that by working together we can achieve our common goal of improved service to current and future disabled Americans.

Mr. Chairmen, thank you for the opportunity to provide this testimony today.

Chairman HERGER. Thank you, Ms. Everett. The gentleman from Florida, Chairman Shaw, to inquire.

Chairman SHAW. Thank you. Hal, it has been 24 years since you and I first came to Congress. We look a little different. I never thought at that time that either one of us would have the word "Chairman" before our name for anything.

Mr. DAUB. I enjoyed being your classmate, and I enjoy being on this side of the microphone now. It is a pleasure to be with you today, thanks. I hope you didn't take too much time to calculate that 24-year figure.

Chairman SHAW. I am pretty quick about that. Hal, looking at this, and maybe you are not the right person to direct this question to, but do any of the Commissioner's recommendations require congressional action to implement them?

Mr. DAUB. In my view, none of them.

Chairman SHAW. So, these are all administrative processes? So, none?

Mr. DAUB. That can be done without further authorization. My last point in my testimony was the electronic claims processing, the eDIB system, as we are referring to is fundamental. That has to be in place as the launching pad for this to work. Assume that that gets done, then reforming the process administratively in generally the way that the Commissioner is attempting to suggest would be helpful. It is still going to run up against a wall of needing to look at the one problem that we have, which is, if you look at the inconsistencies between the Americans with Disabilites Act (P.L. 101–336) goals, and the definition, the 50-year-old statutory definition of "disability," which has never been changed, and if you look at the improvements that have been made in medications, rehabilitation, and therapy, we have made so much progress, and we have

a very different workplace, but we are still saying to people, you are disabled, you cannot work, and if you try to work and have a little dignity and a little extra money, you are going to lose your health benefits. So, Congress does have, as the next step, a very important opportunity to look at the statutory definition, which in turn, relates back to this whole idea about whether people get hung up for, sometimes, 4 and a half years in this current process that is pretty much based on an old definition.

Chairman SHAW. The appellant process, which the Commissioner proposes to shorten by removal of one step, that is not in the statute, that is in the regulations?

Mr. DAUB. The appeals process, everything flows inside of the current Commissioner's prerogative.

Chairman SHAW. That is what I wanted, to have that in the record. Ms. Marshall, while NADE supports the Commissioner's proposal to replace the reconsideration step of appeals with a decision by a RO, you are not convinced that such a step improves customer service. How would you change the Commissioner's proposal so that it would improve customer service?

Ms. MARSHALL. We are not sure exactly what role the RO is going to be taking right now. We do think that having this person as an attorney rather than having the current process that we have with the State Disability Hearing Officers, would make it more adversarial, which would be less customer friendly we think. The current system, where we have disability hearing officers who are programmatically trained, as well as trained in the process, would work, we feel, would be more friendly to the claimant, more customer friendly and more effective, and because we think that medical input, and attorneys are not, necessarily are not trained in the medical aspects of the disability program, they would not, the decisions they make would be, we think, probably less accurate.

Chairman SHAW. Ms. Everett, the Commissioner, in her testimony, mentioned some of the things that were, in a very favorable light, I might say, to the Mississippi office, I assume that is your office in Jackson?

Ms. EVERETT. It is.

Chairman SHAW. Congratulations.

Ms. EVERETT. Thank you.

Chairman SHAW. In your testimony you suggest that having State disability determination staff conduct certain disability interviews, that was on page 6, and appeals processes, that was on page 8 of your testimony, would save about 26 million and 21 million respectively in administrative costs for the SSA. You also suggest the need for additional resources to implement such a plan. Could you explain how you arrive at these figures, and what level of additional staff and resources that you have in mind?

Ms. EVERETT. We are basing our information on the best data that we have. We certainly would welcome any independent review and assessment of that by SSA, who would have more access to data. We certainly take the opportunity to compare current infrastructures already in place in the DDSs, and the current infrastructures which would need some additional resources, but if you had to create independent Federal components to set up both independent units with all the ancillary functions at the salary dif-

ferences between the State and Federal levels is how we determined the cost differences there. Of course, we need the additional resources primarily if we take on additional tasks in addition to keeping up with the additional workload.

Chairman SHAW. Thank you. Mr. Chairman?

Chairman HERGER. Thank you. The gentleman from Maryland, Mr. Cardin, to inquire.

Mr. CARDIN. Thank you, Mr. Chairman. In the interest of full disclosure, let me acknowledge that I was trained as an attorney. I notice some of you are recommending that we change some of the requirements here. As I said in the beginning, I am concerned about how long it takes to get through the process. All of you have expressed the same concern. The Commissioner has expressed the same concerns. I also am concerned about the independent review and the fact that we try to maintain a truth-seeking process rather than an adversarial process.

With that in mind, I want to concentrate on two of the suggestions that have been made by the Commissioner that causes me at least to want more information about. The first is that the ALJ, if he or she disagrees with the ROs, has to document or show the difference as to how he or she reached that judgment. I am concerned that that could compromise the de novo or independent review by the ALJ if that person has the burden to justify a change from the RO.

The second, and many of you have talked to this, is the elimination of the Appeals Council. I have been told by staff that the statistics show that about one out of every four matters that go through the Appeals Council, there is some relief to the claimant. In many cases it is remanded, but there is some relief. I am concerned that the District Court is not well suited to deal with truth seeking, is more adversarial, and it might be more difficult for that type of relief to be granted at a District Court level rather than within the agency at the Appeals Council. So, I would welcome comment from any of our panelists in regards to these two issues, whether they share these concerns or can help me in alleviating these issues. Dr. Dann?

Dr. DANN. Thank you. I would like to reply to that. With the current DDS statistics of 90 percent accuracy and above, as noted by Federal agencies, I am very concerned that after typically two runs through the DDS at 90-percent accuracy, the case then proceeds on to the ALJ and we have a reversal of the DDS decision 61 percent of the time. There currently is no critical quality review of ALJ decisions, and I believe that is what the Commissioner was getting at by having a panel of people to review the ALJ decision. I definitely admire your quest for the truth, and I think that is what we are all here for.

I would just note that, unfortunately, having been a physician for 24 years now, medicine is not an exact science. There is a lot of subjectivity to it, and unfortunately, not everybody can assess their own capabilities accurately, in fact not even their own physician necessarily assesses their capabilities accurately. When I was practicing clinical medicine I was my patients' advocate and did whatever I could for them. I was not their judge, and so I think that it is very important to have a review of what we get from commu-

nity physicians by a physician to make sure that what is being stated about a person's capabilities is accurate.

Mr. CARDIN. Appreciate that. Hal?

Mr. DAUB. At the Appeals Council, about 2 percent of the cases get approved, which is about 1,500 cases out of 77,000 get approved. I need to go back and look at this point that you make that it is one out of four, I haven't looked at it that way before, who get relief. I think it proves the point when you see the reversal rate, and when you look deeper into that reversal rate and you see the great disparity between jurisdictions as to how cases are resolved. That reversal rate does raise questions of consistency, when you take someone who is well trained and has been deciding these cases in DDS for 20 years with great knowledge, particularly of the larger caseload, which is mental impairments. It is not like in the old days when it was physical, broken arms and bad backs and things of that sort. Now, much more of the caseload is mental impairment, that are subjective. You begin to ask yourself how do you step back from the existing system and adapt what we have, given the constraint of keeping a fair process. Certainly we can do better than putting somebody through 5 months to wait from point of onset, then 2, 3, or 4 years in a process, knowing that if they stay in the system long enough and appeal it long enough, with the record never being closed, that they are probably going to get a reversal and probably going to get their benefits.

Mr. CARDIN. Understand that first.

Mr. DAUB. So, the RO then fills a need here to do a couple of things I think. This is so, whether they are attorneys or not; I happen to think that we will get a better quality of a file moved into the ALJ system if they are attorneys. They may not have as much medical knowledge, but neither does the judge who is going to ultimately look at that case. We have trusted the judge to be able to deal with the medical evidence, so we can trust the RO to put together a more objective file, and the judges will tell you, I think, that one of the biggest problems they have is that the cases, when they come on appeal, are not complete. So, I think that that is a wise step, and it is worth the risk to get an overall better result.

Mr. CARDIN. That is a good point. I just wanted to underscore the ALJ is still the first opportunity independent of the agency, and that that is important to maintain that. I think you make a good point though that it is important that the ALJs have the opportunity to do this objectively, and having a good complete file in some orderly way is important as long as there isn't additional pressure, because there are some who already think the ALJ has pressure from the agency, as long as there isn't the pressure for conformity to the agency's position more so than to what the ALJ thinks is the appropriate,

Mr. DAUB. We put the judge in a tough position, Congressman, to wear the hat of a judge in the hearing, not the courtroom but the hearing room, and then also have to assure a completeness of the record as if they were sort of adversarial to the claimant who is sitting there in the ALJ hearing room. It is an awkward situation we put the judge under, in a way, to wear two hats like that since it is not adversarial, but 90 percent now almost I think or 85

percent of all the claimants that come, come with an attorney into that hearing room.

Mr. CARDIN. Thank you. Thank you, Mr. Chairman.

Chairman HERGER. I thank the gentleman. The gentleman from Texas, Mr. Brady, to inquire.

Mr. BRADY. Well, thank you, Mr. Chairman, and thank you for holding this hearing. I apologize that I missed the earlier testimony, but I got to look at it last night for a period. Throughout all the discussions on making this a better system, I continue to hear the complaint that the disability cases and the information is not complete early enough in the process, and it seems in some way that I keep looking for an incentive or some requirement that forces these cases really to be complete at every stage, each stage in the process. It seems that it is better for the claimant, it is better for you as decisionmakers, and my question, a simple layman's questions, is what can be done to sort of front-load the completeness and accuracy of a claimant's record, both medical, occupational, all that? Ideas from the panel?

Mr. BUFFALOE. If I may start on that since I represent the managers and the supervisors in the Social Security field offices where the claim is taken. Certainly that has been an issue as long as we have had disability claims. Part of the problem is we do have two components involved, obviously, but field office claims representatives who are responsible for initiating the application have no medical training. That is part of why my organization feels that on the quick decision piece certainly, that with some additional training, rather than having that handoff and then starting the process after we have handed it off to the DDS, that with some additional medical training we could avoid that hand-off in many, maybe most, of the quick decision cases, and then only later hand off the ones that have to go on for additional review and start the normal DDS, ALJ process, but that has been something that has been with all of us that deal with the disability programs, the fact we initiate the claim, our claims representatives, but they don't have the medical training. So, we do the shotgun approach. We try to gather information on all possible disabilities even though there may be only one or two they have that actually may be pertinent to a disability decision. We would have to gather everything, and then when the DDS gets involved, they can focus in on what are the key things that may in fact turn out to be an approval of a decision.

Mr. BRADY. Isn't one of the roles of the claimant's representatives or attorney to create as complete a package as early in the process? Yes, ma'am?

Ms. EVERETT. Sometimes we have competing goals. I mentioned that we concur with the Commissioner's definition that quality be the combination or the balance between all those components. Sometimes the DDS's productivity expectations drive some of this. Part of what I reference, I talk about the quality all throughout the process. It must begin with the field office. It must be consistently applied all throughout is part of the problem also. The policy speaks to some of it.

In the past few years, the policy evolved from a more purely medical model to one in which there is more subjectivity and func-

tioning in the listings in the policy. Mr. Daub referenced the fact that we see more mental claims now. We see more allegations of mental claims. Whether or not we see more mental patients is another area for discussion, but as you evolve this policy from a more purely medical model to one that has introduced more functioning, therefore more subjectivity, it becomes harder to define what is a complete record. Then of course we all recognize that between the time a case is decided at the DDS, and the 18 months or 2 years that it is seen by the ALJs, it is a different case.

Mr. BRADY. Sure.

Ms. EVERETT. So, it is a very complex picture.

Mr. BRADY. Yes, sir?

Dr. DANN. Congressman, you have hit one of the nails on the head. One of our difficulties in the DDS is obtaining good quality evidence, and in a timely manner. Right now, the way this is done is requests go out to treating physicians for their information. That is completely voluntary, whereas in other legal, medical-legal programs, a subpoena goes out and the record comes. There is no choice of whether or not to send that in. I would ask that at some point the Commissioner and Congress consider whether or not the medical records for a Federal decision like this might be worth a subpoena to obtain. You could certainly get better records faster.

Mr. BRADY. In real life, what kind of impact would that have, timely return of requested medical records?

Dr. DANN. I can tell you on both sides of the coin. I practiced occupational medicine for a long time before I joined the DDS, and I can tell you in my very fast-paced clinic that when record requests came in for Social Security information, we would try to get to them, but they were very low on our priority list. There was not a substantial amount of reimbursement for those records, and unfortunately, they did not always go out when they should have, because of that, I think that we really should consider the possibility that these records are important legal documents, and that maybe they are something worth a subpoena.

Mr. BRADY. Thank you.

Mr. DAUB. Congressman, let me comment, just briefly. It probably is always going to be a very frustrating process at the early stage of intake, but the eDIB process of electronically building the input more thoroughly and more consistently will help. Then, it will improve even more with Secretary Thompson's idea of moving to electronic medical records. We are starting to see new forms of communicating. Physicians now can dictate and have their audible voice actually computer type the report. I have watched this myself in some offices. Our independent board goes out twice a year to field offices, and I have tried to read through a paper file. You have to be a magician to read the handwriting that comes, not only in original form, but over the fax. To decipher it, you spend hours, for nurses, physicians, and consulting groups, to just try to figure out what somebody wrote, even if you get the records. So, a lot of the things we have to do are just to improve the gathering and the clarity of information. I think one of the things the Commissioner is saying is that if we spend more time in the beginning on that, then a lot of the rest of the process isn't going to be so prolonged and so costly.

Mr. BRADY. If you think the handwriting is bad, wait until that software tries to decipher a Texas accent.

[Laughter.]

The only other point I would make, Mr. Chairman, is I think, one, those are good ideas. Two, I still think there is a way, especially, I think it is great, I think it is important and vital really that claimants have the ability to have representatives or attorneys moving their case through this process. I think it is that attorney's and representative's responsibility to make that document, an application as complete and thorough as early as possible in the process. I sometimes hear comments on the opposite side of that where that may not be happening. At some point I think we need to explore their role, if you are getting paid to advocate and complete, then we probably need to require that type of job be done so that the other decision makers can hopefully reach a decision faster and more accurately. So, thank you, Mr. Chairman.

Chairman HERGER. I thank the gentleman. His time is expired. The gentleman from California, Mr. Becerra, to inquire.

Mr. BECERRA. Thank you, Mr. Chairman. Thank you to all of you for your testimony. Let me see if I can focus on just a couple of items that were discussed with the Commissioner a bit, and perhaps, Chairman Daub, you could help me a little bit here because of the recommendations made by the board itself, the Advisory board. My understanding is that the board also recommended or at least suggested consideration of this idea of going straight from the ALJ determination to the District Court for review.

Mr. DAUB. A Social Security Court.

Mr. BECERRA. A Social Security Court, right, which would be a totally new entity within the Federal Court system.

Mr. DAUB. Maybe very responsive to your concern a moment ago.

Mr. BECERRA. Yes, and I think that could be.

Mr. DAUB. That takes a statutory change, though. That is something you all are going to have to do.

Mr. BECERRA. Did the Advisory board say where we would get the money to establish a fully new court system?

Mr. DAUB. We think that if you look at the way that happens now, if there is time to answer your question?

Mr. BECERRA. Please.

Mr. DAUB. You are looking at a huge amount of time and resources being absorbed now in this whole process of constant appeal over time. With no closing of the record, you just keep adding a little to it and it changes, and the medical condition changes. So, there is a lot of efficiency that can be added. When that case gets to a District Court or to a magistrate under the current process, they sort of describe it as a shoe box. I have talked to magistrates, and they say they get the case and it is in sort of a confused state. Then they look at it, and it is not nearly in the shape they want it in, so they automatically order a remand of the case. Back it comes up through the system, and the lawyer got $2,000 simply for going for 5 minutes and saying, "Let us have a remand." Federal judges don't want to look at these cases. So, it will go to a specialized court.

Mr. BECERRA. What about trying to streamline the process after the ALJ before the District Court, where you have a functioning administrative review of the ALJ's decision, in essence, the appeal of the ALJ's decision, but handled administratively so you do it in-house with the expertise that you have without creating an entirely new court system or using the Federal Court.

Mr. DAUB. I would certainly be open to that approach, except a lawyer is also going to say there was no lawyer in there in that hearing room on the other side of that case to start with.

Mr. BECERRA. I think that trying to avoid the adversarial conditions that exist in a District Court or in most of these settings to begin with, I think it is always good to try to have this be as consumer friendly as possible.

Mr. DAUB. We agree.

Mr. BECERRA. No one is trying to deny someone benefits if they are entitled to them. What we are trying to do is develop the best record, so it seems to me that we almost lose the spirit of what we are trying to do in these disability claims if we make it too adversarial, because this should not be a hostile setting. We are not trying to prove that you are not disabled. We are trying to get the best evidence to prove whether or not you are entitled to the benefits, and to me, again, knowing how the courts work and how bogged down they already are, and how expensive they are, especially for a claimant to use, it seems to me to jump directly to a court level, rather than trying to refine the decisions, I think the idea that the Commissioner has of making sure that up front decisions are made competently, so that from thereon in you are developing a good record is obviously the best approach first. I would hope that we would avoid trying to circumvent the process or shorten it to try to expedite a final decision, and instead, take something to the Federal Court level, where the rules are much more rigorous, it will not be consumer friendly because there it is a court, so it is naturally adversarial. There is where the claimant will lose all touch with any humanity that exists in a system where hopefully you are not trying to undo a claimant's benefits claim.

Mr. DAUB. With 5 or 6 million people that are on the disabled rolls today, costing the Federal Insurance Contributions Act Trust Fund about $100 billion, and when you begin then to look to 1 person who spends the agonizing 4 to 4-and-a-half years in that appeals process today.

Mr. BECERRA. Absolutely, I don't think anyone.

Mr. DAUB. So, the cost of the court that we are talking about should not be all that.

Mr. BECERRA. I don't think anybody should go through a process that runs, that is why we are here. Let us not try to accelerate a process and send them to purgatory at the same time that we are telling them we are trying to get them benefits. Let me ask one last question, and, gosh, it is always the case that you run out of time.

Chairman HERGER. The gentleman's time has just about expired.

Mr. BECERRA. Chairman, I will just ask this last question. The record is closed after the ALJ makes a determination under the proposal made by the Commissioner. Right now there are certain

circumstances under which a record can be, additional evidence can be supported for the record even after the ALJ has submitted his or her decision. It seems to me that there is a good claim that can be made that we should at least have an exception, a good cause exception to closing the record.

A quick example would be you have an individual who has Multiple Sclerosis (MS) or claims to have MS, and is therefore disabled. At the point that the ALJ makes the determination, the determination is, no, that is not enough of a disabling condition to stop you from being able to function. Time goes by. The appeals process goes by. All of a sudden at this stage now the medical determination is that this person is disabled as a result of MS, but because the record is closed once the ALJ decided, that new evidence can't be considered. It would seem to me that any recommendation, they should have some latitude for the claimant so that at least good cause, if there is good cause, then why reject good evidence from being considered?

Mr. DAUB. That should always be the case, and I think even under the Commissioner's proposal that will practically be the case because a judge will still have the authority at some point to find good cause. The problem is now that even if it is past the ALJ and is up at the Appeals Council, they can still enter the evidence in. In most cases that ought not to be allowed. You will never get finality at any stage of the proceeding.

Mr. BECERRA. Well, that is why you say it has to be good cause.

Mr. DAUB. I think you are correct.

Chairman HERGER. The gentleman's time has expired.

Mr. DAUB. I think you make a good point, Congressman.

Mr. BECERRA. Thank you very much.

Chairman HERGER. Dr. Dann, if you could please provide us with more information regarding your statement that eliminating the DDS medical consultant will waste money, encourage fraud, delay legitimate allowances, and further burden DDS examiners? Also, do you have any suggestions that could be implemented right away that would further discourage disability applicants from attempting to defraud the system?

Dr. DANN. Yes. The DDS medical consultant saves money in a great number of ways, number one, we frequently are able to avoid further development of the case. We basically have enough evidence to come to a decision and can avoid a consultative exam. Those typically cost $100 to $150 per claimant. We can avoid erroneous allowances. An allowance in today's Social Security system averages a value of $100,000 to $200,000. Unfortunately, allegations and subjective evidence are not always the truth, and they do need to be critically assessed. There is a large difference to us whether a patient uses a cane or needs one. We need to look for objective findings to support the subjective allegations, swelling, atrophy, deep tendon reflex changes.

The DDS MC avoids fraud by looking for that type of findings in the record and looking for inconsistencies. It is not unusual for me to get a statement from a treating physician that their patient cannot sit more than 6 hours a day, or not even 6 hours a day, and cannot walk or stand 2 hours a day. That would make them an automatic allowance by our standards, and yet in the same record

I find evidence that they live alone, keep house, do their grocery shopping and ride a bicycle. Unfortunately, exaggeration of symptoms is a part of multiple claims every day. That is what I do for a living.

On continuing disability reviews, it is very important to be familiar with the statutes here. There is a medical improvement review standard. We are not necessarily reviewing how a patient is doing today. We are actually reviewing how their condition today compares to when they were allowed. It is an important legal principle because we do not want to clutter the courts with decisions going back and forth, disabled here, not disabled there.

It turns out, unfortunately, that if a bad decision takes place, that decision is perpetuated literally ad infinitum, because I have seen cases, I assure you, of patients that had normal examinations and were assessed by the DDS as having very little impairment, no disability, or maybe even a medium level capacity for work, and because of some very compelling subjective complaints given to an ALJ, or possibly a note from their doctor saying that they can't do these things, the decision of the DDS was ignored, and the ALJ allowed the claim. Erroneous denials, on the other hand, certainly are not only a huge disservice to the disabled individual, but they end up costing us a great deal later in reconsideration and OHA process. It is important to have a physician looking at the record to come up with the true medical assessment. Most importantly, we are already in place, and I feel that we have a lot of experience and a lot of good skills to offer to the system.

Chairman HERGER. Thank you very much, Dr. Dann. Certainly while we want to ensure that those who legitimately are deserving of the services, we also by the same token want to make sure that those who are not, are not defrauding the system and the American taxpayers. Thank you very much. I want to thank each Member of this panel for your testimony, and you are excused.

Chairman SHAW. For the final panel this afternoon, we have Marty Ford, who is a Co-Chair of the Social Security Task Force, Consortium for Citizens with Disabilities (CCD); Thomas Sutton, who is Vice President of the National Organization of Social Security Claimants' Representatives (NOSSCR) from Langhorne, Pennsylvania; James A. Hill, who is President of the National Treasury Employees Union (NTEU), Chapter 224, Cleveland Heights, Ohio; Laura Zink, who is a member of the Federal Managers Association (FMA), Social Security, Chapter 275, Phoenix, Arizona; and Ronald Bernoski, who is President of the Association of ALJs from Milwaukee, Wisconsin. Thank all of you for being here with us today. We have your full statement which will be made a part of the record, and we would ask you to summarize as you see fit. Ms. Ford, we will begin with you.

STATEMENT OF MARTY FORD, CO-CHAIR, SOCIAL SECURITY TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES

Ms. FORD. Chairman Shaw, Members of the Subcommittee, thank you for this opportunity to testify. Improving the disability determination process is critically important for people with disabilities, and we applaud Commissioner Barnhart for establishing this as a high priority. We also applaud her work in making the

design process an open one. She has sought the comments of all interested parties including beneficiaries and consumer advocacy organizations. We believe the resulting discussions will have a positive impact on the final proposal. We have submitted a detailed written response to the Commissioner, and I will highlight our key recommendations here.

We strongly support efforts to reduce unnecessary delays and to make the process more efficient so long as changes do not affect the fairness of the process to determine entitlement to benefits. Emphasis on improving the front end of the process is appropriate since changes could substantially improve the quality of decision-making and possibly reduce the need for appeals in some cases. However, any changes to the process must be measured against the extent to which they ensure fairness and protect the rights of people with disabilities. We have made the following major recommendations.

There should not be a separate appeal from the reviewing official to the ALJ level. The record should not be closed after the ALJ decision. If the record is closed, there should be a good cause exception to submit new and material evidence. The claimant's right to request review by the Appeals Council should be retained. Any changes considered for the Appeals Council should be postponed until SSA determines whether the electronic folder and other changes improve the timeliness and quality of the work at the Appeals Council stage. The independence and quality of medical experts, consultative examiners and vocational experts need to be ensured.

We strongly support efforts to implement the eDIB folder since it has great potential for improving the adjudication process and is critical to the success of the proposed changes. An overarching concern is whether claimants and their representatives will have appropriate access to the files. We have also urged the SSA to ensure protection of original documents by requiring that exact, unalterable electronic copies of all originals be permanently maintained in the electronic folder.

The Commissioner's proposal would create a new RO position prior to review by the ALJ. We support the RO's ability to obtain additional evidence, narrow issues in the claim, and issue a fully favorable decision. However, we recommend that there not be a separate appeal from the RO level to the ALJ level. Further, to guarantee the claimant's right to a de novo hearing at the ALJ stage, the RO's decision should not be entitled to more weight or a presumption of correctness when considered by the ALJ.

The Commissioner's proposal would close the record to new evidence after the ALJ decision. While we strongly support the submission of evidence as early as possible, there are many legitimate reasons why evidence it not submitted earlier and why closing the record could be harmful to claimants, including changes in the person's medical condition, and the fact that the ability to submit evidence is not always in the claimant's or representative's control. We believe that the claimant should retain the right to submit new and material evidence after the ALJ decision.

The Commissioner's proposal would eliminate the Appeals Council and establish an oversight panel to review decisions by ALJs.

We believe that the claimant's right to request review by the Appeals Council should be retained. The Appeals Council has important functions that benefit claimants, such as the ability to allow new and material evidence, review of improper ALJ dismissals and denials of reopening requests, review of ALJ unfair hearing allegations, and review of non-disability issues. If the Appeals Council is not retained, we believe that its function should be carried out by some other appropriate entity within the SSA. We fear that elimination of the Appeals Council and its important functions could increase the caseload of the Federal Courts. In any event, consideration of eliminating the Appeals Council should be postponed because proposed changes earlier in the process, combined with the electronic folder, may relieve pressure on the Appeals Council. Again, thank you for this opportunity to testify, and I am happy to answer any questions you may have.

[The prepared statement of Ms. Ford follows:]

Statement of Marty Ford, Co-Chair, Social Security Task Force, Consortium for Citizens with Disabilities

Chairman Shaw, Chairman Herger, Ranking Member Matsui, Ranking Member Cardin, and Members of the House Ways and Means Social Security Subcommittee and Human Resources Subcommittee, thank you for this opportunity to testify regarding the Commissioner's proposal to change the disability claims process.

I am Director of Legal Advocacy for The Arc and UCP Public Policy Collaboration, which is a joint effort of The Arc of the United States and United Cerebral Palsy. I am testifying here today in my role as co-chair of the Social Security Task Force of the Consortium for Citizens with Disabilities. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title XVI Supplemental Security Income program and the Title II disability programs.

We applaud Commissioner Barnhart for establishing as a high priority her administration's efforts to improve the disability determination process. We also applaud her work in making the design process an open one. She has sought the comments of all interested parties, including beneficiaries and consumer advocacy organizations, in response to her initial draft. We believe the resulting discussions will have a positive impact on the proposals as they are refined into official proposals for rulemaking. We have submitted a written response to the Commissioner on her initial draft proposal and I will highlight our key recommendations here.

For people with disabilities, it is critical that SSA improve its process for making disability determinations. People with severe disabilities who by definition have limited earnings from work often are forced to wait years for a final decision. This is damaging not only to the individual with a disability and his or her family, but also to public perception and integrity of the program.

We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as the steps proposed do not affect the fairness of the process to determine a claimant's entitlement to benefits. Further, changes at the "front end" can have a significant beneficial impact on improving the backlogs and delays later in the appeals process, by making correct disability determinations at the earliest possible point. Emphasis on improving the "front end" of the process is appropriate and warranted, since the vast majority of claims are allowed at the initial levels. Any changes to the process must be measured against the extent to which they ensure fairness and protect the rights of people with disabilities.

Our comments primarily address the proposed changes at the reviewing official and later stages, with the following major recommendations:

- **There should not be a separate appeal from the Reviewing Official to the Administrative Law Judge level.**
- **The record should not be closed after the ALJ decision.**
- **If the record is closed, there should be a good cause exception to submit new and material evidence.**

- **The claimant's right to request review by the Appeals Council should be retained. Any changes being considered for the Appeals Council should be postponed until SSA determines whether, once in place, the combination of Ae-DIB, the electronic folder and other changes planned for earlier stages of the process improve the timeliness and quality of work at the Appeals Council stage.**
- **The independence and quality of medical experts, consultative examiners, and vocational experts needs to be ensured.**

Before addressing these areas, we would like to address our support for two other features in the Commissioner's proposal: (1) the Electronic Folder: AeDIB and (2) retaining access to judicial review in the federal court system.

The Electronic Folder: AeDIB

We support the Commissioner's efforts to implement technological improvements, including the electronic disability process, AeDIB. These improvements have great potential for improving the adjudication process and are critical to the success of any changes. We believe that it will reduce delay caused by moving and handing-off files, allow for immediate access by any component of SSA or DDS working on the claim, eliminate the problems created when paper files become "lost" in the system, and allow adjudicators to organize files to suit their preference.

An over-arching concern is how claimants and their representatives will have access to the files. We have been told that CDs will be burned and provided upon request. To know what is in the record at any given point during the process, we believe that optimum meaningful access requires secure online access with a "read-only" capacity.

In addition, claimants should not be precluded from presenting available evidence in any format. We urge SSA to ensure protection of original documents, which are valuable and sometimes irreplaceable evidence, by requiring that exact, unalterable electronic copies of all originals be permanently maintained in the electronic folder.

Retaining current access to judicial review in the federal court system

The Commissioner's proposal retains the current process of judicial review by the federal courts and does not make any recommendations regarding creation of a Social Security Court. However, other stakeholders have recommended creation of such a court.

We support the current system of judicial review and strongly oppose creation of a Social Security Court. We believe that both individual claimants and the system as a whole benefit from the federal courts deciding Social Security cases. Proposals to create either a Social Security Court to replace the federal district courts or a Social Security Court of Appeals to provide for consideration of appeals of all Social Security cases from district courts have been considered, and rejected, by Congress and SSA over the past twenty years.

It is important to consider the impact of the Commissioner's proposals on the workload of the federal courts. For example, elimination of the Appeals Council could dramatically increase the number of cases being filed in federal court, as there would be no opportunity for a claimant to see review of an ALJ's decision within the agency. While neutral on its face, this step would, in all likelihood, result in federal district courts urging creation of a new court to hear these cases, as a way to reduce their overall caseloads. This is another reason why it is so important to move more slowly in consideration of the Commissioner's proposal to eliminate the Appeals Council.

I. ***Reviewing Official (RO)***

In general, we support the proposal to create a "Reviewing Official" (RO) position. The RO has features similar to those employed in the Senior Attorney Program in the 1990's: the RO would be a federal employee and would be an attorney; the RO should have a level of expertise and training similar to the OHA senior staff attorneys; and the RO should be able to obtain additional evidence, narrow issues in the claim and, if warranted by the evidence in the record, issue a fully favorable decision. And, like the rest of the administrative process, the RO stage would not be viewed as an adversarial process, a position we support. We do, however, have several concerns about this stage.

- **A Separate Appeal To The ALJ Level Should *Not* Be Required.**

To create a more streamlined process, we have supported elimination of the reconsideration level and adding some type of predecision contact with the claimant. We are concerned that, as initially proposed, the RO stage will become a replacement

for reconsideration and, as a result, will not streamline the process. Further, by requiring a separate appeal to the ALJ level, many claimants will be discouraged from appealing denials and drop out of the process. We recommend that one appeal from the initial decision stage should cover review by both the RO and the ALJ (if a fully favorable decision on the record cannot be issued by the RO).

- **The RO Should Issue Only One Type Of Decision In All Cases That Are Not Fully Favorable To The Claimant, The "Pre-Hearing Report."**

We are concerned that issuing more than one type of RO decision will be confusing to claimants and could discourage them from pursuing an appeal, if a separate appeal to the ALJ is ultimately required. While we understand the distinction between the two types of decisions outlined in the proposal, we recommend that there should be only one title for all decisions, preferably the more neutral and less intimidating title, "pre-hearing report."

- **The RO Decision Should Not Be Accorded A Presumption Of Correctness.**

The proposal describes a process where the ALJ must describe in detail the basis for rejecting the RO's Recommended Disallowance or respond in detail to the RO's description of evidence needed in the Pre-Hearing Report. This could build in a bias to deny a claim, because it will be easier to issue an unfavorable decision, especially if there are administrative demands to reduce processing times.

To guarantee a claimant's right to a *de novo* hearing before an ALJ, the RO's decision should not be entitled to more weight than other evidence in the folder or be given any presumption of correctness. As a *de novo* process and to ensure the ALJ's independence, the ALJ should not be required to explain why he or she is not following the RO's report. However, in order to provide accountability and to provide a record for the next reviewing level, we understand the need for every adjudicator to explain the rationale for his or her decision.

II. ***The Right to a Full and Fair Hearing Before an ALJ***

A claimant's right to a hearing before an ALJ is central to the fairness of the adjudication process. This is the right to a full and fair administrative hearing by an independent decision maker who provides impartial fact-finding and adjudication. As described above, in order to guarantee a claimant's right to a *de novo* hearing before an ALJ, the RO's decision should not be entitled to more weight than other evidence in the folder.Since there is a need to avoid a built-in bias for denial (by making it easier for ALJs to adopt the RO decision than to issue a different decision), the ALJ should not be required to respond in more detail than required by the current regulations.

III. ***The Record Should Not Be Closed After the ALJ Decision***

- **The Claimant Should Retain The Right To Submit New And Material Evidence After The ALJ Decision.**

We strongly support the submission of evidence as early as possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record is not beneficial to claimants including: (1) the need to keep the process informal; (2) changes in the medical condition which forms the basis of the claim; and (3) the fact that the ability to submit evidence is not always in the claimant's or representative's control. For these reasons, the record should not be closed to new and material evidence submitted after the hearing decision.

- **Keep the process informal**

For decades, Congress, the United States Supreme Court, and SSA have recognized that the informality of SSA's process is a critical aspect of the program. Closing the record is inconsistent with Congress' intent to keep the process informal and with the intent of the program itself, which is to correctly determine eligibility for claimants, awarding benefits if a person meets the statutory requirements.

The value of keeping the process informal should not be underestimated: it encourages individuals to supply information, often regarding the most private aspects of their lives. The emphasis on informality also has kept the process understandable to the layperson, and not strict in tone or operation. SSA staff should be encouraged to work with claimants to obtain necessary evidence and better develop the claim earlier in the process. But, to the extent that important and relevant evidence becomes available at a later point in the claim, the claimant should not be foreclosed from submitting it, since this is not an adversarial process but a "truth-seeking" process.

- **Changes in the medical condition**

Claimants' medical conditions may worsen over time and/or diagnoses may change. Claimants undergo new treatment, are hospitalized, or are referred to different doctors. Some conditions, such as multiple sclerosis, autoimmune disorders or certain mental impairments, may take longer to diagnose definitively. The severity of an impairment and the limitations it causes may change due to a worsening of the medical condition, e.g., what is considered a minor cardiac problem may become far more serious after a heart attack is suffered. It also may take time to fully understand and document the combined effects of multiple impairments. Further, some claimants may be unable to articulate accurately their own impairments and limitations, either because they are in denial, lack judgment, or simply do not understand their disability. By their nature, these claims are not static and a finite set of medical evidence does not exist.

- **The ability to submit evidence is not always in the claimant's or representative's control.**

Claimants always benefit by submitting evidence as soon as possible. However, there are many reasons why they are unable to do so and for which they are not at fault. Closing the record penalizes claimants for factors beyond their control, including situations where: (1) DDS examiners fail to obtain necessary and relevant evidence and do not use forms tailored to specific impairments or the SSA disability criteria; (2) Neither SSA nor the DDS explains to claimants or providers what evidence is important, necessary and relevant for adjudication of the claim; (3) Claimants are unable to obtain records either due to cost or access restrictions; (4) Reimbursement rates for providers are inadequate; and (5) Medical providers delay or refuse to submit evidence.

The current system provides a process to submit new evidence at the ALJ hearing and, if certain conditions are met, at later appeals levels (see discussion below). So that claimants are not penalized for events beyond their control, the opportunity to submit evidence should not be eliminated in the name of streamlining the system.

Filing a new application is not a viable option. Requiring claimants to file a new application simply to submit new and material evidence does not improve the process and may in fact severely jeopardize, if not permanently foreclose, eligibility for benefits.

By reapplying rather than appealing: (1) benefits could be lost from the effective date of the first application; (2) in Title II disability cases, Medicare benefits could be delayed, since eligibility begins only after the individual has received Title II disability benefits for 24 months; (3) in Title II disability cases, there is the risk that the person will lose insured status and not be eligible for benefits at all when a new application is filed; and (4) if the issue to be decided in the new claim is the same as in the first, SSA will find that the doctrine of *res judicata* bars consideration of the second application.

In the past, SSA's notices misled claimants regarding the consequences of reapplying for benefits in lieu of appealing an adverse decision and Congress responded by addressing this serious problem. Since legislation enacted in 1990, SSA has been required to include clear and specific language in its notices describing the possible adverse effect on eligibility to receive payments by choosing to reapply in lieu of requesting review.

Apart from these harsh penalties, a claimant should not be required to file a new application merely to have new evidence considered where it is relevant to the prior claim. If such a rule were established, SSA would need to handle more applications, unnecessarily clogging the front end of the process. Further, there would be more administrative costs for SSA by creating and then developing a new application. While AeDIB may make the application procedure more efficient, it also may make it more reasonable for SSA to take new evidence at later stages of the process.

Current law already sets limits for submission of new evidence after the ALJ decision. Under current law, an ALJ hears a disability claim *de novo.* Thus, new evidence can be submitted and will be considered by the ALJ in reaching a decision. However, the ability to submit new evidence and have it considered becomes more limited at later levels of appeal. At the Appeals Council level, new evidence will be considered, but ***only*** if it relates to the period before the ALJ decision and is "new and material." At the federal district court level, the record is closed and the court ***will not consider*** new evidence. Under the Social Security Act, the court can remand for additional evidence to be taken by the Commissioner (***not*** by the court), but only if the new evidence is (1) "new" and (2) "material" and (3) there is "good cause" for the failure to submit it in the prior administrative proceedings.

We recommend that these rules be retained. In any event, changes would require congressional action.

- **Recognize "Good Cause" Exception For The Post-ALJ Decision Submission Of New And Material Evidence.**

While it benefits claimants to submit evidence as soon as possible, there are many reasons, as discussed earlier, why they are unable to do so and for which they are not at fault. If SSA's rules are changed to provide that the record is closed after the ALJ level, there should be a good cause exception that allows a claimant to submit new and material evidence after the ALJ decision is issued.

We recommend an approach similar to that which already exists in SSA's regulations for extension of time to file an appeal if the claimant can show "good cause" for missing the deadline. The regulations are constructed so that SSA has general discretion in making the "good cause" determination with several criteria that must be considered: the circumstances that led to missing the deadline; whether SSA actions were misleading; whether the claimant did not understand the requirements; and whether the claimant has any physical, mental or linguistic limitations.

This construct could be adapted to "good cause" determinations for submitting new evidence. It is important that the regulations do ***not*** include an exhaustive list of reasons since each case turns on the facts presented.

IV. ***Retain the Claimant's Right to Request Review of Unfavorable ALJ Decisions***

Under the proposal, the Appeals Council would be eliminated. Centralized quality review staff would review a sample of ALJ allowances and denials. If the staff disagrees with the ALJ decision, the claim would be referred to an Oversight Panel for review. The claimant would have no opportunity to request administrative review of unfavorable ALJ decisions. The next level of appeal would be to federal district court.

We recommend retention of a claimant's right to administrative review of an unfavorable ALJ decision. Because of the important functions provided by the Appeals Council (discussed below) and because it is at the end of the administrative appeals process, we also recommend that any consideration of elimination of the Appeals Council be postponed while the changes at the earlier levels of the process are implemented. These changes may result in less pressure on the back end of the process, making it unnecessary to consider implementing the proposed change at this level. As described below, the Appeals Council plays an important role in protecting the rights of claimants and beneficiaries:

- **The Appeals Council Can Provide Efficient Review And Effective Relief To Claimants.**

The Appeals Council currently provides relief to *over twenty-five percent* of claimants who request review, either through outright reversal or remand back to the ALJ. The Appeals Council has made significant improvements in reducing its backlog and processing times. When it is able to operate properly and in a timely manner, the Appeals Council provides claimants with effective review of ALJ decisions.

A major basis for remand is not the submission of new evidence, but rather legal errors committed by the ALJ, including the failure to consider existing evidence according to SSA regulations and policy, the failure to apply correct legal standards, and the failure to follow procedural requirements. By providing relief in these cases, the Appeals Council allows the Commissioner to rectify errors administratively, rather than relying on review in the federal courts. As recognized by the Judicial Conference of the United States, the Appeals Council can act as an effective screen between the ALJ and federal court levels and prevent a significant increase in the courts' caseloads.

In addition, the procedure to request review is relatively simple. SSA has a one-page form that can be completed and filed in any Social Security office, sent by mail or faxed. In contrast, the procedure for filing an appeal to federal district court is much more complicated and, unless waived, there is a filing fee, which may be cost-prohibitive for a claimant. Under the current process, there is a large drop-off in appeals from the Appeals Council to federal court. As a result, having an administrative mechanism to correct injustices is essential.

- **The Ability To Submit New And Material Evidence**

Claimants can submit new evidence at the Appeals Council level in appropriate situations, as described earlier. There is no provision in the Commissioner's proposal

that would allow submission of new evidence after the ALJ decision; therefore, a procedure for addressing such circumstances would be lost.

Asking the ALJ to reopen his or her decision to submit new evidence is problematic from a claimant's perspective. First, the claimant needs to affirmatively request the reopening which creates another hurdle for pro se claimants. Second, a claimant cannot appeal the ALJ's decision to deny the request for reopening (see discussion in next section).

Also, eliminating the right to request review would prevent review of situations where the ALJ should have obtained the evidence in the first place.

- **Review Of Improper ALJ Dismissals And Denials Of Reopening Requests**

Current regulations provide that an ALJ can dismiss a request for a hearing under certain circumstances, such as: lack of good cause of both the claimant and representative for failing to appear at the hearing; lack of good cause for failing to request a hearing within the 60 day time period; and application of res judicata (which precludes consideration of an issue because of a prior, final decision on that issue). When an ALJ dismisses a hearing request, a notice of dismissal must be sent, stating that there is a right to request that the Appeals Council vacate the dismissal action.

Dismissals generally are not subject to judicial review. However, by regulation, claimants have the right to request review of ALJ dismissals by the Appeals Council. A significant number of appeals to the Appeals Council are for inappropriate dismissals and many of these claims are remanded. If the right to request review by the Appeals Council is eliminated, many claimants will essentially be unable to have these improper decisions reviewed. As a result, they would be ineligible for benefits, perhaps forever.

- **Reviewing Allegations Of Unfair ALJ Hearings.**

The Appeals Council (AC) reviews allegations that a claimant's right to a full and fair hearing has been violated. If the allegation is supported, the AC will either reverse the denial of benefits or remand the case to a different ALJ for a new hearing.

A recent report by the Government Accountability Office (GAO), *SSA Disability Decision Making: Additional Steps Needed to Ensure Accuracy and Fairness of Decisions at the Hearing Level*, GAO–04–14 (Nov. 2003), emphasizes the necessity of providing a viable process to review allegations that an ALJ hearing was unfair. Eliminating the current review mechanism provided by the AC would be a step backwards.

- **Review Of Nondisability Issues**

The AC reviews cases that do not involve a claim for disability benefits, such as survivors' eligibility. Also, many disability claims will have related nondisability claims, e.g., whether the claimant has engaged in SGA, overpayments due to earnings. The process must continue to accommodate the need for these reviews.

V. ***The Proposed Oversight Panel Does Not Provide Fair and Adequate Review of ALJ Decisions***

The Oversight Panel would consist of two ALJs (who will rotate onto the panels) and one Administrative Appeals Judge (member of the Appeals Council). In addition to the loss of the important functions of the Appeals Council, we are concerned that the Oversight Panel (OP), as proposed, does not provide fair and adequate review of ALJ decisions.

We seriously question whether a process in which ALJs review the decisions of other ALJs will offer a neutral review of each case. Are ALJs likely to reverse another ALJ when their roles might be reversed in the future, with the other ALJ now considering the quality of their decisions? In addition, we have several concerns about the impact of the proposed review process on claimants. How will the claimant know that the decision is final or that it is under review? Will the same due process safeguards currently provided when the Appeals Council intends to reopen a claim be afforded by the Oversight Panel?

When would the decision be "final" for judicial review purposes? It seems that a fair amount of confusion will arise to determine whether a decision is final for the court's purposes. Given the costs involved in filing a court action (and the additional time without needed benefits), it would be especially unfair to the claimants to eliminate their opportunity to seek review within SSA.

How will SSA address cases in which it determines that additional evidence should have been secured by the ALJ? There is no process for remand in the pro-

posal. Would the OP secure the additional evidence and make the final decision? As the OPs will be ad hoc panels, basically meeting electronically from their offices anywhere in the United States, it is difficult to see how that process would permit securing additional evidence.

VI. ***Maintain The Independence And Ensure The Quality Of Medical Experts, Consultative Examiners, And Vocational Experts***

- **Changing the role of medical advisors.**

Under the Commissioner's proposals, the medical advisors currently located in the state DDSs would be moved to regional medical expert units. They would be available to provide advice to DDS staff, reviewing officials, and administrative law judges. In clarifying the proposal, SSA has indicated that the same medical advisor would not be used at the ALJ stage that was used at the DDS or RO level in a case.

We generally support this approach but have several concerns: Advocates in the field have raised questions and concerns about this portion of the SSA proposal. These concerns include: By concentrating medical expertise in a few locations, will the agency's medical advice be too insular? Is it realistic to expect that SSA will be able to create the walls between medical experts at the DDS and RO levels and those at the ALJ level, especially if they are all located in regional units? Will the interactions among experts in the regional offices make it less likely that they will feel comfortable disagreeing with or second-guessing their colleagues? Will it be more difficult to determine whether a medical advisor has the appropriate expertise? Will this change create a sealed system of medical expertise that will not seek the advice of medical experts in the claimants' own communities? Will it be more difficult to ensure that people with multiple impairments have their cases reviewed by physicians with the type of crosscutting expertise needed to evaluate the combined effect of their impairments?

- **Improving the quality of consultative examinations**

One important theme in the Commissioner's proposal is the emphasis on securing higher quality and more comprehensive evidence earlier in the process, preferably at the DDS level. We are very concerned that steps be taken to improve the quality of the consultative examination (CE) process. There are far too many stories about inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's. This is wasted money for SSA and unhelpful to low-income individuals who do not have complete medical records documenting their conditions and who need a high quality CE report to help establish their eligibility.

Another concern is increased use of volume providers for CEs. SSA has a long and troubling history of using such examiners. Congress last devoted its attention to the problems with use of volume provider CEs in the early 1980s. SSA's goal should be to improve the quality of CEs used—past experience in these programs shows that using volume providers is antithetical to securing high quality examinations. In order to secure quality examinations and reports, SSA may need to increase its payment for CE examinations. As having quality information early in the process should improve the decisionmaking and may shorten the process, purchasing higher quality CE examinations would be a cost-effective investment.

Another very significant concern is that the regionalization of the medical advisors will lead to increased use of volume provider CEs, possibly even to national volume provider CE contracts.

- **Consideration of vocational evidence earlier in the administrative process**

The Commissioner has indicated her intention to better incorporate vocational expertise into the DDS stage. A significant number of ALJ decisions are based on medical-vocational factors. A certain percentage of these cases could be allowed earlier in the process if the medical-vocational rules were applied properly. Also, it may result in greater agreement between DDS and ALJ decisionmaking, as ALJs already generally consider vocational evidence and expertise in making their decisions.

Conclusion

As organizations representing people with disabilities, we strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient. However, these changes should not affect the fairness of the process to determine a claimant's entitlement to benefits. As changes are made to the proposal and as

more details become available, we look forward to working with SSA to ensure that the new process meets the needs of both the agency and people with disabilities.

ON BEHALF OF:
American Association of People with Disabilities
American Council of the Blind
American Foundation for the Blind
BazelonCenter for Mental Health Law
Brain Injury Association of America
National Alliance for the Mentally Ill
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Association of Protection and Advocacy Systems
NationalLawCenter on Homelessness & Poverty
National Organization of Social Security Claimants' Representatives
National Rehabilitation Association
NISH
The Arc of the United States
United Cerebral Palsy
United Spinal Association

Chairman SHAW. Thank you, Ms. Ford. Mr. Sutton?

STATEMENT OF THOMAS D. SUTTON, VICE PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES, LANGHORNE, PENNSYLVANIA

Mr. SUTTON. Thank you, Mr. Chairman, for inviting us to testify. I am Thomas Sutton. I am Vice President of the NOSSCR. We are over 3,400 attorneys and other advocates representing claimants for benefits across the United States before both the agency and the Federal Courts. Our written testimony that has been submitted for the record conveys our view that the Commissioner's goals and many of her proposals are worthwhile. We share her goal of reducing the processing time required to decide disability claims and will continue to work with her to accomplish that goal. At the same time, however, we have very serious concerns about some aspects of her proposal, especially the plan to eliminate the Appeals Council. I will focus my brief remarks entirely on this issue.

The elimination of the Appeals Council with nothing to replace it for claimants seeking review of their cases would be virtually certain to create an explosion in the number of cases filed in the District Courts. This is obviously a major concern to an already over-burdened Federal Judiciary as evidenced by this week's letter to your Subcommittees from Judge Stamp, which you have already admitted to the record, Mr. Chairman.

Judge Stamp points out in his letter from the JCUS that in the last fiscal year about 77,000 claimants requested review by the Appeals Council. Approximately 2 percent of the claims were allowed outright and 25 percent were remanded to an ALJ for a new hearing. In the same fiscal year 17,000 Social Security cases were filed in the U.S. District Courts. To quote Judge Stamp, "This suggests that a substantial number of cases are being resolved at the Appeals Council level without claimants having to seek judicial review. Therefore, before a decision is made on whether to eliminate the Appeals Council, we would hope that the new claims process would be adequately tested. It may be that substituting Appeals

Council consideration with judicial review in the Federal Courts would result in more costs and further delay for many claimants."

We could not agree more with Judge Stamp from JCUS. I can personally attest from conversations with judges in the court in which I practice most often, that is the U.S. District Court for the Eastern District of Pennsylvania, that the judges are extremely concerned about the impact that the abolition of the Appeals Council would have on their dockets. The numbers cited by Judge Stamp provide a stark illustration of the problem we have. Using this current reversal and remand rate as a benchmark of the Appeals Council is overturning 27 percent. This would mean that of the 77,000 cases filed with the Appeals Council in the last fiscal year, we would expect over 20,000 would be reversed or remanded because they were not correctly decided by the ALJs. However, under the Commissioner's proposal, if because they could no longer request review by the Appeals Council, all of those claimants filed suit in the courts, as they should because the Commissioner erroneously decided their claims, we know that, the Social Security caseload of the courts would more than double. It is currently about 17,000 cases. That would add another 20,000 or so cases.

However, the situation is actually worse than that. Under current regulations the vast majority of claimants who are denied by the Appeals Council accept the outcome and do not file suit. However, if claimants know that over a quarter of the cases denied by ALJs would have been overturned by the Appeals Council if it still existed, they will obviously be more inclined to file suit in hopes that theirs are among the 27 percent which the Commissioner would agree have merit. As a result of that effect, the actual impact of Appeals Council elimination could easily be a tripling of the number of cases filed in the courts. This would obviously be an unacceptable outcome for both the courts and claimants, as the backlogs which have plagued the SSA would simply be shifted to the District Court.

The Appeals Council backlog has been a major problem, as this Committee well knows, for us and our clients. Under the Commissioner's leadership the backlog has greatly declined over the last couple of years. At this point the average wait to a decision is about 8 months, which is still too long for us, but is certainly a vast improvement. Moreover, we are getting decisions from the Appeals Council on cases that should be made by the agency and should not have to go to the courts.

I want to give you just a few examples from my own firm's case files. Miss M was a young woman with a bright future until she suffered a catastrophic head injury. She was granted disability benefits immediately, but was later terminated in a decision she did not understand how to appeal. After several appeals, the Appeals Council acted earlier this year to reinstate her benefits retroactive to the date she was terminated, based on their rulings protecting claimants who are mentally unable to pursue their appeal rights. Had the Appeals Council not acted, Miss M would have been forced to appeal again to a Federal Court, which almost certainly would have remanded her case to an ALJ again, resulting in even more delay in her ability to receive the benefits that never should have been cut off in the first place.

In another case, Mr. H was denied benefits by an ALJ despite his documented mental retardation. After the Appeals Council received new evidence showing that he had also had a foot amputated due to severe diabetes, it awarded benefits to Mr. H outright, it didn't remand for a new hearing, just awarded him. Had the record been closed to new evidence at the time of the ALJ decision, a new application, which is all Mr. H could have done, if successful, would have resulted in a loss of 5 years worth of retroactive benefits for Mr. H who was disabled all along. These are just a couple of examples, Mr. Chairman. As these cases illustrate, the Appeals Council has played an essential role in providing relief to claimants, by considering new evidence, by obtaining their own medical expert opinions and resolving cases that did not need to be filed in the Federal Courts, thus saving time and expense for claimants.

On their behalf, we urge the Commissioner to reconsider her proposal to abolish the Appeals Council, or at the very least, to retain the right of claimants to request review of ALJ decisions by some component of the SSA, the review panels that she has spoken of, for example, without having to file suit in Federal Court. Without such appeal rights, the Federal Courts will be inundated with disability cases which could and should have been resolved by the agency. Thank you.

[The prepared statement of Mr. Sutton follows:]

Statement of Thomas D. Sutton, Vice President, National Organization of Social Security Claimants' Representatives, Langhorne, Pennsylvania

Chairman Shaw, Chairman Herger, Ranking Member Matsui, Ranking Member Cardin, and the Members of the Social Security and Human Resources Subcommittees, thank you for inviting NOSSCR to testify at today's hearing on the Commissioner's proposal to improve the disability claims process. My name is Thomas D. Sutton and I am the vice-president of the National Organization of Social Security Claimants' Representatives (NOSSCR).

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income (SSI) benefits. NOSSCR members represent these individuals with disabilities in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of 3,400 members from the private and public sectors and is committed to the highest quality legal representation for claimants.

I currently am an attorney in a small law firm in the Philadelphia, PA area. Adding to my experience in legal services programs, I have represented claimants in Social Security and SSI disability claims for the past 18 years. While I represent claimants from the initial application through the Federal court appellate process, the majority of my cases are hearings before Social Security Administrative Law Judges and appeals to the Social Security Administration's Appeals Council. This also is true for most NOSSCR members. In addition, I represent claimants in federal district court and in the circuit courts of appeals.

We agree with the Commissioner that reducing the backlog and processing time must be a high priority and we urge commitment of resources and personnel to reduce delays and make the process work better for the public. We strongly support changes to the process so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits.

NOSSCR is a member of the Consortium for Citizens with Disabilities Social Security Task Force and we endorse the testimony presented today by Marty Ford on behalf of the Task Force. Specifically, we support CCD's major recommendations in response to the Commissioner's proposal:

- There should not be a separate appeal from the Reviewing Official to the Administrative Law Judge level.
- The record should not be closed after the ALJ decision.
- If the record is closed, there should be a good cause exception to submit new and material evidence.

• The claimant's right to request review by the Appeals Council should be retained.
• Any changes being considered for the Appeals Council should be postponed until SSA determines whether, once in place, the combination of Ae-DIB, the electronic folder and other changes planned for earlier stages of the process improve the timeliness and quality of work at the Appeals Council stage.
• The independence and quality of medical experts, consultative examiners, and vocational experts needs to be ensured.

My testimony today will focus on two provisions of the Commissioner's proposal: (1) closing the record after the ALJ decision; and (2) eliminating the Appeals Council. Like CCD, we believe that the record should remain open and that claimant-initiated review by the Appeals Council should be retained.

Before addressing these two issues, I would like to state our full support for several provisions in the Commissioner's proposal.

• **A *de novo* hearing before an ALJ is retained.**

A claimant's right to file a request for hearing before an Administrative Law Judge (ALJ), which is central to the fairness of the adjudication process, will continue under the Commissioner's proposal. This right affords the claimant with a full and fair administrative hearing by an independent decision-maker who provides impartial fact-finding and adjudication, free from any agency coercion or influence. The ALJ asks questions and takes testimony from the claimant, may develop evidence when necessary, considers and weighs the medical evidence, evaluates the vocational factors, all in accordance with the statute, agency policy including Social Security Rulings and Acquiescence Rulings, and circuit case law. For claimants, a fundamental principle of this right is the opportunity to present new evidence in person to the ALJ and to receive a decision from the ALJ that is based on all available evidence.

• **The process will remain nonadversarial and SSA will not be represented at the ALJ level.**

We support the Commissioner's decision to retain a nonadversarial process. This will keep the disability determination process informal and focused on the intent of the program itself, which is to correctly determine eligibility for claimants. Past experience, based on a failed project in the 1980's, demonstrated that government representation at the hearing level led to extensive delays and made hearings inappropriately adversarial, formal, and technical. Based on the intended goals of better decision-making and reducing delays, the pilot project was an utter failure. In addition, the financial costs could be very high. Given the past experience and the high costs, we believe that the limited dollars available to SSA could be put to better use by assuring adequate staffing and developing better procedures to obtain evidence.

• **Review in the federal court system is retained.**

We support the current system of judicial review. Proposals to create either a Social Security Court to replace the federal district courts or a Social Security Court of Appeals to provide appeal of all Social Security cases from district courts have been considered, and properly rejected, by Congress and SSA over the past twenty years.

We believe that both individual claimants and the system as a whole benefit from the federal courts deciding Social Security cases. Over the years, the federal courts have played a critical role in protecting the rights of claimants. The system is well-served by regular, and not specialized, federal judges who hear a wide variety of federal cases and have a broad background against which to measure the reasonableness of SSA's actions.

Creation of either a single Social Security Court or Social Security Court of Appeals would limit the access of poor disabled and elderly persons to judicial review. Under the current system, the courts are geographically accessible to all individuals and give them an equal opportunity to be heard by judges of high caliber.

Rather than creating different policies, the courts, and in particular the circuit courts, have contributed to national uniformity by helping to establish the standards for termination of disability benefits, denial of benefits to persons with mental impairments, rules for the weight to give medical evidence, and evaluation of pain. The courts have played an important role in determining the final direction of important national standards, providing a more thorough and thoughtful consideration of the issues than if a single court had passed on each. As a result, both Congress and SSA have been able to rely upon court precedents to produce a reasoned final product.

Finally, the financial and administrative costs of creating these new courts must be weighed against their questionable effectiveness to achieve the stated objectives. The new courts, if created, would involve new expenditures. We believe that with limited resources, the focus should not be on the end of the appeals process but, rather, on the front end. Requiring claimants to pursue an appeal to obtain the justice they are due from the beginning will only add to the cumulative delay they currently endure.

We share concerns about the growth in the number of civil actions filed in federal court. We believe that there are ways to lessen the workload impact on SSA and the courts, and that in many cases, claimants should not be required to appeal to the court level to obtain relief. We also believe that the technological improvements discussed later in my testimony will help to alleviate this problem.

We are ready to work with SSA and the courts to find ways to make the court process more efficient for all parties involved.

THE RECORD SHOULD REMAIN OPEN FOR NEW EVIDENCE AFTER THE ALJ DECISION

The Commissioner's proposal would close the record to new evidence after the ALJ decision. In the past, similar proposals to close the record have been rejected by both SSA and Congress because they are neither beneficial to claimants nor administratively efficient for the agency. We recommend retention of the current process for submission of new evidence.

NOSSCR strongly supports the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record will not help claimants, including: (1) worsening or clarified diagnosis of the medical condition which forms the basis of the claim; (2) factors outside the claimant's control, such as medical provider delay in sending evidence; and (3) the need to keep the process informal.

Under current law, new evidence can be submitted to an ALJ and it must be considered in reaching a decision. Contrary to assertions by some that there is an unlimited ability to submit new evidence through the court levels, the current regulations and statute are very specific in limiting that ability at later levels of appeal.

At the Appeals Council level, new evidence will be considered, but *only* if it relates to the period before the ALJ decision and is "new and material."[1] While the Appeals Council remands about one-fourth of the appeals filed by claimants, it is important to note that the reason for most remands is not the submission of new evidence, but rather legal errors committed by the ALJ, including the failure to consider existing evidence according to SSA regulations and policy and the failure to apply the correct legal standards.

At the federal district court level, the record is closed and the court *will not consider* new evidence. Under the Social Security Act, the court is only allowed to remand under specified circumstances.[2] The Act provides for two types of remands:

1. Under "sentence 4" of 42 U.S.C.§ 405(g), the court has authority to "affirm, modify, or reverse" the Commissioner's decision, with or without remanding the case; and
2. Under "sentence 6," the court can remand (a) for further action by the Commissioner where "good cause" is shown, but only before the agency files an Answer to the claimant's Complaint; or (b) at any time, for additional evidence to be taken by the Commissioner (not by the court), but only if the new evidence is (i) "new" and (ii) "material" and (iii) there is "good cause" for the failure to submit it in the prior administrative proceedings.

Because courts hold claimants to the stringent standard in the Act, remands occur very infrequently under the second part of "sentence 6" for consideration of new evidence submitted by the claimant. The vast majority of court remands are not based on new evidence, but are ordered under "sentence 4," generally due to legal errors committed by the ALJ.

Several examples from cases handled by NOSSCR members emphasize the importance of new evidence obtained after the ALJ decision. These examples demonstrate that the ability to submit new evidence and have it considered is beneficial to the claimant and the agency:

- The Appeals Council awarded benefits based on new evidence related to the claimant's multiple sclerosis. The new evidence consisted of a four page Mul-

[1] 20 C.F.R. §§ 404.970(b) and 416.1470(b).
[2] 42 U.S.C. § 405(g).

tiple Sclerosis Questionnaire from the treating physician and a medical journal article.
- The Appeals Council affirmed the allowance in a subsequent application filed in 2000 and found that the claimant also met the disability criteria for mental retardation in a prior application. The Appeals Council considered and admitted new evidence submitted by the claimant's attorney, and obtained a medical opinion from a staff consultant who agreed with the finding of disability.
- The Appeals Council awarded benefits to a claimant with bipolar disorder. His condition had deteriorated after receiving the ALJ denial. He became more depressed and his judgment and insight lapsed. He rationalized that since the ALJ found him able to work, he must not be mentally ill or need his medications. He had another psychotic break that progressed from disposing of a recent inheritance impulsively to engaging in some dangerous behavior and he eventually was involuntarily hospitalized.

"Good cause" exception. If the Commissioner decides to close the record, there should be a "good cause" exception that allows a claimant to submit new and material evidence after the ALJ decision is issued. The statutory provision for sentence 6 court remands could be adopted. The "good cause" exception for district court "sentence six" remands for new and material evidence is well-developed. A review of published court decisions shows a wide variety of reasons why evidence was not submitted prior to the court level, including:

- Medical evidence was not available at the time of the hearing.
- The claimant was unrepresented at the hearing and the ALJ did not obtain the evidence.
- Medical evidence was requested but the medical provider delayed or refused to submit evidence earlier.
- The claimant underwent new treatment, hospitalization, or evaluation.
- The impairment was finally and definitively diagnosed. The claimant's medical condition deteriorated.
- Evidence was thought to be lost and then was found.
- The claimant's limited mental capacity prevented him from being able to determine which evidence was relevant to his claim.
- The existence of the evidence was discovered after the proceedings.
- The claimant was unrepresented at the hearing and lacked the funds to obtain the evidence.

CLAIMANT-INITIATED REVIEW BY THE APPEALS COUNCIL SHOULD BE RETAINED

The Appeals Council, when it is able to operate properly and in a timely manner, provides claimants with effective review of ALJ decisions. The Appeals Council currently provides relief to nearly one-fourth of claimants who request review of ALJ denials, either through outright reversal or remand back to the ALJ. The Appeals Council has made significant improvements in reducing processing times and its backlog. The Commissioner has recently testified that in November 2003, the average processing time was 252 days, down from 467 days in November 2001.

In addition, elimination of Appeals Council review could have a serious negative impact on the federal courts. As long ago as 1994, the Judicial Conference of the United States opposed elimination of the claimant's request for review by the Appeals Council prior to seeking judicial review in the district courts, stating that such a proposal was "likely to be inefficient and counter-productive."[3] The Judicial Conference also recognized the Appeals Council's role as a screen between the ALJ and federal court levels, noting that "[c]laimants largely accept the outcome of Appeals Council review." Further, the Conference expressed concern that allowing direct appeal from the ALJ denial to federal district court could result in a significant increase in the courts' caseloads. As a result, the Judicial Conference concluded:

From the perspective of both unsuccessful litigants and the federal courts, the present system of Appeals Council review as a precondition to judicial review is sound. The right of judicial review by Article III courts for all claimants remains intact under the present system. To the extent that the process of Appeals Council review is thought to be too time-consuming, despite the high degree of finality that results, it would be wiser to seek to streamline and expedite the process of review rather than to bypass it as a precondition to federal judicial review.

[3] Comments dated May 26, 1994,of Chief Judge John F. Gerry, Chairman of the Judicial Conference of the United States, in response to SSA's April 1, 1994 "Disability Reengineering Project Proposal."

We agree with the conclusion of the Judicial Conference of the United States. Access to review in the federal courts is the last and very important component of the hearings and appeals structure. Court review is not *de novo*, but rather, is based on the substantial evidence test. We believe that both individual claimants and the system as a whole benefit from federal court review. The district courts are not equipped, given their many other responsibilities, to act as the initial screen for ALJ denials.

The CCD testimony has outlined a number of reasons why it is important to retain the important functions of the Appeals Council that benefit claimants such as: the ability to submit new and material evidence; review of improper ALJ dismissals and denials of reopening requests; review of ALJ unfair hearing allegations; and review of nondisability issues. Cases handled by NOSSCR members demonstrate the critical role of the Appeals Council in providing fair and effective administrative review of ALJ decisions:

- ***Substantive review of claim***
  - The Appeals Council awarded benefits to a claimant with a diagnosis of bipolar disorder with depression. The treating physician noted that medications were only partially effective and that the claimant had not been able to cope with normal stress.
  - The Appeals Council awarded SSI benefits under Listing 12.04, relying on their medical consultant's report that the claimant had bipolar disorder of lifelong duration with an overlapping diagnosis of Post Traumatic Stress Disorder. Evidence indicated significant limitations.
  - The Appeals Council remanded because the ALJ erred in finding that the claimant had no "severe" mental impairment. The treating source evidence showed that the claimant had post-traumatic headaches and was incapable of even low stress jobs due to symptoms of visual disturbances, mood changes and hallucinations.
  - The Appeals Council remanded, finding that the claimant's work as a data entry clerk more than 15 years earlier was not past relevant work. Further, although the vocational expert (VE) testified that there were transferable skills that the claimant had learned from vocationally relevant work, the VE did not mention the specific skills. Given her mental residual functional capacity, the claimant would not be able to perform the jobs identified by the VE.
- **ALJ bias**
  - The Appeals Council reversed, finding that the ALJ was biased and demonstrated prejudice by statements made throughout the hearing, including inappropriate use of words and phrases regarding the claimant's weight and evidence from the treating physician.
  - The Appeals Council reversed an ALJ denial in an SSI childhood disability claim. The Appeals Council found that the ALJ was biased, noting that "certain lines of questioning directed at the claimant's mother during the hearing were inappropriate and lacked objectivity."
  - The Appeals Council remanded the case to a different ALJ, finding that the claimant was denied a full and fair hearing because the ALJ was abusive.
- ***Review of hearing dismissals***
  - The Appeals Council found good cause for the claimant and her representative's failure to attend the hearing, and remanded for a new ALJ hearing. The ALJ had dismissed the first hearing request. The claimant had moved to a different state before the hearing and had asked to have the claim transferred. She was unaware the hearing had been dismissed, which was supported by the notice of hearing being returned by the post office as "address unknown."
  - The Appeals Council found good cause based on the dislocation in the claimant's affairs caused by her hospitalizations, and based on the prompt action by her attorney in faxing the appeal.

The ALJ erroneously used the date that the request for hearing arrived at the district office as the date of appeal, and dismissed the appeal as filed one day late. The ALJ made no attempt to contact the claimant or her representative about submitting evidence of good cause or timely filing. The claimant's attorney showed that the request was timely faxed and that the claimant was psychiatrically hospitalized.

- ***Review of other procedural issues***

- **Post-hearing evidence**
  - The Appeals Council remanded because the ALJ failed to consider the claimant's request for a supplemental hearing and failed to rule on the claimant's objections to post-hearing interrogatories to the VE as required by agency policy.
  - The Appeals Council remanded because the ALJ obtained additional medical evidence after the hearing and did not proffer the evidence to the claimant's representative for review and comments as required by agency policy.
  - The Appeals Council remanded because the ALJ failed to submit material to the claimant or representative for a post-hearing, pre-decision review and comment according to agency policy, and also for his inadequate explanation for rejecting the treating physician's opinion.
- **Right to appoint legal representative**
  - The Appeals Council remanded after finding that a minor in state foster care had the right to appoint a legal representative to pursue an appeal of a disability cessation and overpayment determination. The ALJ had determined that the minor had no right to a hearing because she was in the legal custody of the state and the state had not signed the appeal form. The Appeals Council found that the minor had properly appointed a legal representative who properly had filed a hearing request. Further, good cause had been shown for filing an untimely appeal (the State/Guardian had not appealed a 1998 disability cessation) because the minor was not notified of the initial cessation and overpayment determinations. On remand, the ALJ ruled that the minor's disability continued and the overpayment from the cessation was eliminated.
- Reopening
  - The Appeals Council remanded, finding that the ALJ did not provide adequate notice in the Notice of Hearing that, as required by regulations, he intended to reopen the favorable portion of a partially favorable DDS decision. An ALJ may consider new issues, but only after proper notice.
  - The Appeals Council decision found that a subsequent application, filed just 2 months after the initial determination on the prior claim, constituted an implied request for reopening. A prior final determination may be reopened for any reason within 12 months of the date of the notice of the initial determination.

OTHER ISSUES

A. Provide SSA With Adequate Resources To Meet Current And Future Needs

To reduce delays, better develop cases and implement technological advances, SSA requires adequate staffing and resources. We urge commitment of sufficient resources and personnel to resolve the waiting times and make the process work better for the benefit of the public. To this end, NOSSCR supports removing SSA's administrative budget, like its program budget, from the discretionary domestic spending caps.

B. ***Technological Improvements***

Commissioner Barnhart has announced major technological initiatives to improve the disability claims process. NOSSCR generally supports these initiatives because they have the potential of dramatically reducing processing times for disability claims.

- ***The Electronic Folder***

In several states, SSA has begun to process some disability claims electronically. Evidence from medical sources, including consultative examinations, is received either in electronic form or in paper form, which is then scanned and turned into an electronic document. The project is enormous in scope and ambitious in both design and implementation. This initiative has the prospect of significantly reducing delays by eliminating lost files, reducing the time that files spend in transit, and preventing misfiled evidence.

We want to thank the Commissioner for her inclusive process to seek comments about these changes, which will help to ensure that claimants benefit from these important improvements. Several NOSSCR members recently were invited to an Office of Hearings and Appeals in Mississippi, the first state to implement the elec-

tronic folder and eDIB, for an explanation and demonstration. Our members reported back that they had a very productive meeting and we appreciate this valuable opportunity to provide input.

Several of our concerns regarding eDIB have been answered through these meetings. First, advocates can continue to submit evidence that is on paper. It will then be scanned into the system by SSA. Advocates also can choose to submit evidence by email.

Second, advocates can continue to request copies of the file. SSA will "burn" a CD and send that to the appointed representative and to unrepresented claimants as well. Representatives can then print out the file or view it on their own computers. In addition, at some point in the future, SSA plans to set up a special, secure website for the use of appointed representatives. With their assigned identification numbers, they will be able to go online to see the contents of their clients' folders.

- ***Video teleconferencing***

The Commissioner has announced her plan to expand the use of video teleconferencing (VTC) for ALJ hearings. The initiative has the potential to reduce processing times and increase productivity.

Where available, ALJs can conduct hearings without being at the same location as the claimant and representative or the medical or vocational experts. In general, we support the use of video teleconference hearings, so long as the right to a full and fair hearing is adequately protected and the quality of video teleconference hearings is assured.

NOSSCR members who have participated in VTC hearings have reported a mixed experience, depending on the travel benefit for claimants, the quality of the equipment used, and the hearing room set-up. Also, some have raised concerns that the ALJ's inability to see the claimant in person will be disadvantageous.

We are in the process of surveying our members regarding their participation—or nonparticipation—in VTC hearings. To date, the surveys we have received indicate that receptivity remains mixed. We would be glad to share the results and comments with you and the Commissioner when the survey is final.

- ***Digital recording of hearings***

Another important component of technological improvement is digital recording of ALJ hearings. Currently, hearings are taped on obsolete tape recorders, which are no longer even manufactured. If copies are needed, they must be transferred to cassette tapes, which is time-consuming. Tapes are frequently lost because they are stored separately from the paper folder. Given the age of the taping equipment, the quality of tapes is often quite poor, which also results in some remands from the Appeals Council or the district court. A digitally recorded hearing would not only be of high audio quality but would be easy to copy for representatives or transfer to the district court as part of the administrative record.

CONCLUSION

For people with disabilities, it is critical that the Social Security Administration address and significantly improve the process for determining disability and the process for appeals. We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits.

We are pleased to see Commissioner Barnhart take on this task as a major goal of her tenure as Commissioner. We support her view that this is a vitally necessary course of action for the agency and we look forward to working with the Commissioner in meeting the challenges.

Thank you for this opportunity to testify before the Subcommittees on issues of critical importance to claimants. I would be glad to answer any questions that you have.

Chairman SHAW. Thank you, Mr. Sutton. Mr. Hill?

STATEMENT OF JAMES A. HILL, PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224, CLEVELAND HEIGHTS, OHIO

Mr. HILL. Good afternoon. My name is James Hill. I have been employed as an attorney advisor at the Cleveland OHA for over 21

years. I am also the President of Chapter 224 of the NTEU that represents attorney advisors and other staff members in approximately 110 OHA hearing and regional offices across the United States. I thank Chairman Shaw and Chairman Herger for inviting me to testify at this hearing. Testifying today is a pleasure. I have testified before the Subcommittee on Social Security on numerous occasions over the past 10 years. On most of those occasions I criticized the SSA for failing to effectively deal with the backlog problem at OHA. I do not enjoy public criticizing the SSA. The major initiatives formerly advanced by the SSA, the disability process redesign and hearings process improvement plan were, as I predicted, failures.

The only effective program at reducing the backlog, the Senior Attorney Program, which was terminated by HPI, was a temporary solution that did not address long-term systemic problems. The salient fact is that for the last 10 years the Social Security Disability Program has been in crisis. It still is, but now for the first time a plan has been advanced that addresses its systemic shortcomings and will finally end the crisis.

Perhaps the most important factor in successfully dealing with crisis situations is leadership. I believe that the leadership provided by the Subcommittee on Social Security, particularly its Chairman, Clay Shaw, and Ranking Member Robert Matsui, has provided a stable environment in which wide-ranging improvements in the process can be instituted. I also note with pride the role that my congressional representation, Stephanie Tubbs Jones is playing in improving the disability process. Of course, the need for dynamic leadership does not end here at the Hill. The quality of leadership at the SSA will be a major factor in determining whether the agency can meet the expectations of the American public. With Commissioner Jo Anne Barnhart and her executive staff, the SSA finally has the leaders with the vision, the will, the intelligence and the courage to solve the long-term disability crisis at the SSA.

The SSA leaders are confronting a disability adjudication system that is fundamentally flawed. It is clear that wide-ranging systemic changes are necessary. However, these changes must address the actual flaws, and not, as in the past, simply be the result of philosophical leanings and the bureaucratic inclinations of senior SSA officials. To this end, Commissioner Barnhart and Deputy Commissioner Martin Gerry, conducted an objective review of the entire disability system, resulting in a remarkably accurate picture of its strength and weaknesses. I believe that for the first time senior SSA officials truly understand the deficiencies and strengths of the current system. This insight, combined with the Commissioner's commitment to create a process which serves the needs of the public rather than the dictates of the bureaucracy, has led her to propose a plan for implementing fundamental process changes that will provide a level of service of which we can all be proud.

The plan is comprehensive and involves extensive changes such as the replacement of paper folders with electronic folders, the formation of a quick decision process to service those with obvious disabilities, the elimination of reconsideration determination, the elimination of the Appeals Council, a completely revamped process-

wide quality assurance system, the creation of three-judge panels to review ALJ decisions, and the creation of the RO position to provide an intermediary step between the State agency and the ALJ. These are fundamental changes that address fundamental flaws in the current system.

I am convinced that this plan, if implemented, will result in an efficient, effective and most importantly, a fair adjudicatory process. The plan advocated by Commissioner Barnhart will finally end the disability crisis and provide the American public with a level of service it deserves. Of course, implementing such a comprehensive plan will require adequate funding. I urge the Congress to provide the funding necessary to implement this plan as expeditiously as possible. Thank you.

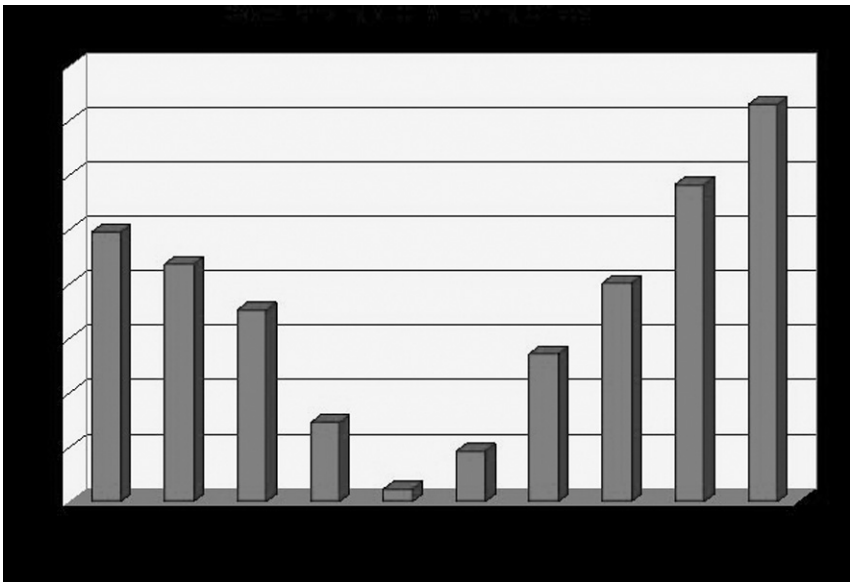
[The prepared statement of Mr. Hill follows:]

Statement of James A. Hill, President, National Treasury Employees Union, Chapter 224, Cleveland Heights, Ohio

My name is James Hill. I have worked as an Attorney-Adviser in the Office of Hearings and Appeals for over 21 years. I am also the President of Chapter 224 of the National Treasury Employees Union (NTEU) that represents Attorney-Advisers and other staff members in approximately 110 OHA Hearing and Regional Offices across the United States. I thank the Subcommittees for allowing me to testify regarding Commissioner Barnhart's proposal to reform the disability determination process.

The Backlog at OHA—A Problem Inherited by Commissioner Barnhart

The current disability backlog problem at OHA is neither recent nor unique. Nonetheless, a quick review of the history of the number of cases pending at OHA demonstrates that the backlog problem is not altogether intractable. The backlog problem in the SSA disability program began in the early 1990s. Primarily as a result of increased receipts and SSA inaction, cases pending at OHA hearing offices rose from approximately 180,000 in 1991 to approximately 550,000 cases nationwide by mid-1995. However, by October 1999 the number of cases pending was reduced to 311,000. Since 1999, a number of factors including the termination of the Senior Attorney Program, increased receipts, and the implementation of the disastrous Hearings Process Improvement Plan (HPI) have resulted in a record number of cases pending. Currently, there are approximately 660,000 cases pending at OHA hearing offices and processing times in some hearing offices are significantly in excess of one year.



As discouraging as the increase in cases pending may be, it does not fully reflect the harmful effect of the inefficient disability process on the public. Average processing time at OHA was approximately 270 days in 2000; it is currently nearly 400 days. This is an unconscionably long wait for a disability decision, and it is causing untold harm to some of the most vulnerable members of society. None will dispute that the public deserves far better service than SSA is presently providing.

There is no question that the current disability system is fundamentally flawed and that wide ranging systemic changes are necessary. SSA recognized this as early as 1993 and in response proposed the "Disability Process Redesign" (DPR), a plan so complex and misguided that despite the expenditure of millions of dollars, it was never implemented. By 1995 the backlog problem at OHA had become so severe SSA empowered its experienced Attorney Advisors to review cases and issue fully favorable on-the-record decisions where justified. This was known as the Senior Attorney Program. During the period from 1995 through 1999 Senior Attorneys produced over 220,000 fully favorable on-the-record decisions with an average processing time of just over 100 days. It is not a coincidence that during the time the Senior Attorney Program was in operation the number of cases pending at OHA hearing offices dropped from 550,000 to 311,000.

The Senior Attorney Program was focused on a specific problem: the many cases coming to OHA that could be adjudicated favorably to the claimant without the need for an ALJ hearing. It was a small, low cost program that addressed a specific operational reality. It did not address the systemic problems plaguing the disability adjudication process. Nonetheless, the termination of the Senior Attorney Program was a bureaucratic blunder.

SSA's next foray into solving the "disability crisis" was the disastrous Hearings Process Improvement Plan. Unfortunately, HPI was implemented with catastrophic results. SSA Management believed that the Hearings Process Improvement Plan (HPI) obviated the need for the Senior Attorney Program. Since the advent of HPI the number of cases pending in OHA hearing offices has more than doubled. The implementation of HPI disrupted nearly every aspect of hearing office functioning with predictable results. A persistent lack of vision and leadership at SSA resulted in programs such as DPR and HPI that did not realistically address the root causes of the problems. Not surprisingly, they failed to improve the disability process, and in fact, wasted resources while actually harming the adjudicatory process.

The Beginning of a Solution

At the beginning of her term, Commissioner Barnhart was confronted by a discredited disability process with severe structural and operational problems at all levels. Commissioner Barnhart and Deputy Commissioner Martin Gerry conducted

a truly objective review of the entire disability system resulting in a remarkably accurate picture of its strengths and weaknesses. I believe that for the first time senior SSA officials truly understand the deficiencies at each level of the current system. This insight combined with the Commissioner's commitment to create a process which serves the needs of the public rather than the dictates of the bureaucracy, has led her to propose a plan for implementing fundamental process changes that will provide a level of service of which we all can be proud.

It is apparent that a considerable amount of research and insight went into the process of formulating this plan. The systemic problems that have plagued the disability adjudicatory process have been identified and politically plausible and operationally sound solutions have been advanced. Specifically, problems including the State Agencies' inadequate development of the record, their cursory rationale for unfavorable determinations, and their chronic failure to award many deserving claimants are all addressed and potentially solved through the "Quick Decision Process", the elimination of the Reconsideration Determination, and the creation of the Reviewing Official. Additional problems including long delays at the hearing level, the lack of adequate development prior to the ALJ hearing, closing the record after the ALJ decision, the lack of decisional consistency at the various levels of adjudication, the excessive number of voluntary remands from the U.S District Courts, and the lack of an effective appellate process are also addressed and potentially solved.

Other mechanisms which will be employed to improve the adjudication process are the elimination of regional Disability Quality Bureaus (DQBs) and the introduction of an integrated quality control process, the placement at the regional level of medical and vocational experts who are available to adjudicators at all levels, and the replacement of the Appeals Council with three judge review panels.

Commissioner Barnhart recognizes that the SSA disability adjudication system must be a truly integrated system that better utilizes the expertise of its various components in the most efficient manner. To view or analyze each component individually without considering its role in the entire system leads to a distorted view and introduces needless inefficiencies. The Commissioner's Approach must be viewed in its totality, recognizing the effects changes at one level have at the other levels.

Quick Decision—An Excellent Idea

In order to provide benefits to those who are "obviously disabled", the Commissioner has proposed "The Quick Decision Process" It will significantly improve the disability adjudication process for those claimants with specified medical conditions that normally result in a finding of disability. A Panel of Medical Experts that will be located in various regional offices will review those with verified medical conditions and quickly determine whether these claimants should receive disability benefits. The Commissioner projects that approximately 10 % of initial claims can be handled through this process. The Quick Decision process will perform a valuable service in identifying those "obviously" disabled claimants.

The Role of the State Agency

The disability adjudication process is an integrated process that should promote the efficient, accurate, and fair adjudication of disability claims. An efficient disability adjudication process must recognize that some adjudicatory tasks are better performed by one component than by others. The Commissioner has proposed changes that will permit State Agencies to focus on fully developing the record thus improving the efficiency of the entire process as well as improving their own decision making.

The State Agencies are far better situated to develop the record than either the Reviewing Official or the OHA Hearing Office. They have the facilities and expertise to efficiency acquire medical evidence. The Commissioner's plan recognizes and utilizes this expertise. Consequently, primary responsibility for developing the record should be placed upon the State Agencies. Securing possession of the medical documents necessary to adjudicate a claim is a difficult and at times a time-consuming process.

Accurate adjudication of disability claims requires a relatively complete compilation of the record. Decisional consistency is significantly enhanced if, at the different levels of adjudication, the adjudicators are considering essentially the same record. The Commissioner's plan places emphasis on the full development of the record at the earliest practicable time—at the State Agency level. The elimination of the Reconsideration Determination eases the time constraints under which the State Agencies currently operate, and will permit more complete development at the initial level. The Commissioner's Plan includes feedback mechanisms and in extreme cases,

a remand process that will combat the lack of a realistic incentive to properly develop the record before sending the case to OHA. More complete development initially will lessen the necessity of expending considerable time and resources developing the record at OHA and permit more timely adjudication.

Better development at the State Agency means better decision making at that level, fewer cases being appealed to OHA, and fewer resources being expended at the OHA level to develop cases. It also permits both the State Agency and OHA to make the right decision as quickly as possible.

The overall efficiency of the adjudication process is enhanced by the changes suggested by the Commissioner.

The Commissioner's Approach will provide the resources for the State Agencies to more completely develop a case. The Commissioner has promised that the appropriations provided to the State Agencies will not be decreased. The State Agencies will receive 10% fewer cases because of the Quick Decision Process. This combined with the elimination of the Reconsideration Determination will permit more resources to be directed toward more completely developing the record.

The Role of the Reviewing Official (RO)

Perhaps the most innovative initiative contained in the Commissioner's approach is the creation of the Reviewing Official (RO), a federal attorney with complete adjudicatory authority placed between the State Agency and the ALJ. The RO process does more than replace the current Reconsideration Phase. The Reconsideration Determination has very little credibility with the public or with ALJs because it is viewed as a mere rubber stamp of the initial determination. One of the recommendations from the Association of Administrative Law Judges, and one that we fully support, is that the RO and the ALJ use the same standards for adjudication. Past experience with the Senior Attorney Program and the current ALJ review of unpulled files demonstrates that the application of those standards results in a fully favorable decision in approximately 30% of the cases reviewed. The review and decision making by the RO will result in many disabled claimants being awarded benefits in as little as 30 days rather than subjecting the claimant and the Agency to the time and resource consuming activities associated with conducting a full ALJ hearing.

One of the most important aspects of the RO process is to introduce an element of credibility that is presently lacking prior to the ALJ hearing. Currently, the State Agencies provide almost no rationale for their unfavorable determinations which seriously undermines their credibility. The Commissioner recognizes that it is essential to the success of her Approach that the decisions made by the RO be recognized as independent decisions by an individual who has the discretion to award or deny benefits as justified by the record. To ensure the credibility of the RO decision, it must be a well reasoned, comprehensive and literate explanation of why a claimant is or is not entitled to disability benefits. To be effective the RO must establish its credibility with claimants, the State Agencies, Administrative Law Judges and most importantly with the American public. The importance of attaining this credibility cannot be overstated.

The Commissioner's Approach demands that the RO issue an accurate, complete, convincing, and legally defensible decision that explains in detail the rationale for each finding of fact and conclusion of law. This necessitates that the RO have extensive legal and disability program knowledge and experience. This requires the legal expertise of an attorney to apply the rules, regulations and law to the evidence and to make and issue a legally defensible decision. It also demands extensive knowledge and experience in evaluating the functional effects of medical impairments. Fortunately, SSA already employs personnel with the education, training, and experience to decide and draft disability decisions necessary to assure the success of the RO process—OHA Attorney Advisers. Attorney Advisors have many years of experience in deciding and/or drafting disability cases, and with minimal training and expense, can effectively perform the functions of the RO from its inception.

Another objective of the Commissioner is to facilitate decisional consistency at all decisional levels. The inconsistency of decision-making between the State Agencies and the ALJs is undeniable. Through the Process Unification effort, the agency did take some measures to attempt to create a higher level of consistency. Despite some level of success, primarily represented by an increase in payment rates by some State Agencies, decisional consistency still eludes the Agency.

The introduction of the RO will significantly improve decisional quality as well as consistency through all the levels of adjudication. The Commissioner's Approach requires substantial interaction between the RO and the State Agencies. If the RO decision is different from that of the State Agency, the RO's written decision will explain to the State Agency why a different decision was reached. In extreme cases,

the RO will be able to remand cases to the State Agency. This level of communication, both formal and informal, between the RO and State Agency will result in improved decision making by both entities and promote decisional consistency without adversely affecting the claimants.

The increased level of decisional consistency promoted by the RO will result in the reality and perception that the proper decision is being made at the lowest possible level. The RO decision will present the ALJ and the claimant with a comprehensive explanation of why the Agency denied the claim. While it imposes no limitation on the ALJ, it does help focus the issues in controversy leading to a more efficient hearing process. By providing the claimant with a detailed explanation of why his/her application was denied, the RO assist the claimant in marshalling evidence needed to establish disability.

The ALJ Hearing

The Commissioner's approach wisely retains the Administrative Law Judge hearing process essentially unchanged. Hearing offices will continue to prepare cases for hearing, Administrative Law Judges will continue to conduct due process hearings, and the decisional independence of the ALJ continues to be protected by the APA. However, concern has been expressed about the relationship between the RO and the ALJ. The Commissioner has made it clear that the RO decision is not entitled to any deference on the part of the ALJ. The Commissioner's Plan recognizes that the reality of the *de novo* hearing must be maintained and the freedom of the ALJ to decide cases based upon his/her evaluation of the evidence and the appropriate law and regulations must be preserved.

Elimination of the Appeals Council

Another bold initiative proposed by the Commissioner is the elimination of the Appeals Council and the claimant's right to make an administrative appeal of the ALJ decision. While on its surface the elimination of the Appeals Council appears to be detrimental to claimants, that is not the case. The effect of the elimination of the Appeals Council must not be viewed in isolation, but in the context of the entire adjudicatory process. Improvements in the decision making process at the State Agency level, the introduction of the RO, and the quality assurance program proposed by the Commissioner render the administrative review of ALJ decisions unnecessary. We believe that considering the Commissioner's New Approach in its totality, an additional administrative appeal of the ALJ decision is unnecessary.

As currently constituted the Appeals Council serves two distinct purposes. It serves as an appellate body and as a quality assurance entity, but performs neither with distinction. This is not intended to disparage the hard-working employees at the Appeals Council, but rather its basic concept and design. The Commissioner's approach replaces the Appeals Council with an end-of-line review by a centralized quality control staff and a potential review by a Commissioner's Oversight Panel. The Agency, in its effort to improve quality assurance at the ALJ level of adjudication, should take care not to repeat its mistakes of the early 1980s when it attempted to interfere with ALJ decisional independence. In order to avoid the appearance of interference with ALJ decisional independence, it is essential that ALJs be intimately involved in any quality assurance program.

There is concern that the lack of a right of administrative appeal of the decisions of Administrative Law Judges will result in a substantial increase in the caseload of the District Courts. We agree that any action that significantly increases the caseload of the district courts is unacceptable. However, we believe that the assumption that eliminating the Appeals Council will significantly increase District Court caseload is unwarranted. While such an assumption is sustainable if one considers the elimination of the Appeals Council in isolation, it is far less sustainable when one considers the whole breadth of the Commissioner's plan. In that light, we expect that after a period of adjustment, the increased quality of the adjudication system will actually decrease the number of cases filed at the District Court. It will certainly significantly decrease the number of voluntary remands.

Currently, the State Agency unfavorable determinations are given little credibility due to their nearly complete lack of a comprehensive explanation to the claimant and his/her representatives why he/she is not entitled to the disability benefits. Consequently, it is commonly believed that the first step at which an individual can receive fair consideration of his/her application is at the ALJ level. Therefore, appeal to the Appeals Council represents the second time that the claimant's application receives fair consideration. The lack of credibility of the determinations made prior to the ALJ decision virtually mandates an additional (second) level of appeal.

The Commissioner's approach contains an entirely new step, the review and decision by the Reviewing Official. As noted earlier, the RO will bring a level of credibility far in excess of that of the current Reconsideration Determination. The RO will apply the same adjudicatory standards as the ALJ. For those cases in which the RO cannot issue a decision favorable to the claimant, the Commissioner's Approach mandates that the RO prepare a detailed explanation of why the claimant is ineligible for benefits. It is essential that the explanation of why the claimant is, or is not, entitled to disability benefits be thorough, fair and unbiased. The decision of the RO will be the first step at which the claimant receives a detailed and credible explanation of why he/she is not entitled to disability benefits. Under the Commissioner's approach, the ALJ decision will be the second level at which a claimant receives a detailed decision from an independent decision maker. In as much as the ALJ process involves a *de novo* hearing rather than the appellate review currently performed by the Appeals Council, dissatisfied claimants actually have more substantial review and greater opportunity to achieve a favorable result than provided by the current system. The combination of the RO process and the ALJ hearing renders an additional administrative appellate step unnecessary in most circumstances. The claimant always retains the right to appeal to the District Court.

While appealing unfavorable decisions to the District Court is appropriate, claimants should not have to file an action in the District Court to contest a dismissal of a Request for Hearing. We believe a three judge panel should consider appeals of dismissals. If the claimant is dissatisfied with the decision of that panel, then appeal to the District Court would be appropriate.

The Commissioner's Approach introduces major changes to the SSA disability process, and if properly implemented, it will result in substantial improvement in disability adjudication. However, it will require substantial changes in both organization and systems. The Commissioner has made it clear that inauguration of her new approach is predicated upon the successful implementation of Ae-DIB. SSA has had sufficient experience with implementing substantial process changes without ensuring the necessary system improvements are in place to know the dangers of premature implementation. Fortunately, Ae-DIB is progressing as well as can reasonably be expected. While the Commissioner's prudence in this matter is welcomed, the transition to her "New Approach" should begin as soon as practicable.

Ae–DIB

The years 2004 and 2005 will be notable in SSA history for a number of reasons, not the least of which are the changes in business processes driven by Information Technology (IT). This year saw the introduction of a new case tracking system (CPMS), and the change from analogue to digital recording of hearing proceedings, the further expansion of video teleconferencing for conducting hearings, and the implementation of the electronic folder are all in the immediate future. Each of these programs, once installed and operating properly will improve Agency operations. By far the most far reaching change will be brought about by the electronic folder. The savings, both in time and money, that can be realized by converting from paper folders to electronic folders are substantial and will result in improved service to the public. The electronic folder will significantly increase the Agency's flexibility in managing its workload and permit cases to be processed more expeditiously.

These innovations recognize the advances in information technology and demonstrate SSA's commitment to maximize the efficient use of its limited resources. NTEU is concerned that the hardware and software currently in hearings offices is inadequate to the demands that the electronic folder will place upon them. We are further concerned that not enough effort has been expended in considering the needs of the end user in using the electronic folder. The functionality of that interface will have a significant impact on the functionality of the entire system.

Conclusion:

Since 1993 SSA has been aware that its disability adjudication process has been fatally flawed. It was not designed to process the workload now imposed on it. Previous attempts to improve the process, the Disability Process Redesign and Hearings Process Improvement Plans were fundamentally flawed and actually degraded the level of service provided to the public.

SSA, under the leadership of Commissioner Barnhart and Deputy Commissioner Gerry, has proposed a new process which if properly implemented will result in an adjudicatory process that serves the needs of the claimants and as well as the public at large. Given the magnitude of the problems facing SSA, only a program that is bold and innovative will achieve the desired result. Commissioner Barnhart has de-

livered such a plan. NTEU recommends that SSA implement the Commissioner's proposal to reform the disability determination process as quickly as practicable.

Chairman SHAW. Thank you, Mr. Hill. Ms. Zink?

STATEMENT OF LAURA ZINK, MEMBER, FEDERAL MANAGERS ASSOCIATION, SOCIAL SECURITY ADMINISTRATION, CHAPTER 275, PHOENIX, ARIZONA

Ms. ZINK. Chairman Shaw and distinguished Members of the Subcommittees, thank you for this opportunity to voice some of the concerns managers and supervisors at the Social Security OHA have with the SSA Commissioner's proposal for reforming the disability process. I am here as a member of the FMA, which represents the interests of nearly 200,000 managers, supervisors and executives serving in the Federal Government. Within FMA we represent executives, managers and supervisors in all Social Security Program Service Centers, the Office of Central Operations and the OHA.

Last year Commissioner Barnhart unveiled her proposal for restructuring the OHA, and the appeals process. We at the FMA support the Commissioner's overall mission to support the disability adjudication process, including her commitment to retention of the due process hearing and the modernization of the disability claims process, including migration of the eDIB folder, otherwise known as eDIB. However, there are some remaining challenges and concerns that need to be addressed while the reforms move forward. The most significant concern to managers and supervisors agency side is a lack of meaningful performance management system. Our employees have vague and nearly unenforceable performance standards. Supervisors are not permitted to document performances, good or bad, in personnel files. The pass/fail appraisal system is a disservice to our employees and to the American people. There is no incentive for excellent performance because every employee gets the same appraisal. Moreover, our performance award system is disconnected from performance appraisals of necessity, because when you look at their appraisals, you cannot tell one employee from another, and nobody likes it.

In a September 2003 poll, many Federal employees expressed their dissatisfaction with the current system. Seventy-six percent of respondents do not believe that the pass/fail system is an improvement over the more traditional multi-tiered performance appraisal system. Sixty-eight percent indicated that the biggest problem with pass/fail was that outstanding performers get the same rating as low performers. Where is the incentive to excel in that?

In addition to the need for an appropriate performance management system, we're still woefully short on meeting staffing needs of the current workload seen by the OHA. At the hearing office level we are devoting extensive resource to the preparation of a more automated system. However, we must recognize that we are facing a workload crisis today which will continue into the foreseeable future. Between 2002 and 2012, SSA expects the disability rolls to grow by 35 percent. Currently OHA has 600,000 cases pending at the hearing level. That is more than a year's worth of

work. Even though our production has increased year after year, we are unable to keep pace with the increasing receipts. We will not fully realize the benefits of automation for at least 2 to 3 years. In the meantime we must deal with the paper claims that are with us now, and that will continue to come to us for the next year or 2. In order to address this shortfall, we need additional staff.

It is widely recognized that Social Security and the Federal Civil Service in general is facing a huge retirement wave. Sixty percent of Federal managers and 50 percent of the overall Federal workforce will be eligible for retirement in the next few years, including me. It makes sense for us to hire employees, both ALJs and support staff now to reduce the backlog of cases now and over the next several years. Attrition will bring the staff levels back down over time. The OHA affects the lives of millions of Americans. With increased staffing and funding the agency would be able to improve its service to its customers, the American public.

Last, the Commissioner's proposal to eliminate the Appeals Council and replace it with decentralized oversight panel is particularly troubling. The Appeals Council is the only body that reviews cases from the entire Nation, and is responsible for the implementation of the Commissioner's policies. In a disability program that is supposed to be uniform and consistently administered nationwide, it is extremely valuable to have one body that can spot trends, regional variations and potential problems. We are concerned that without the Appeals Council our National perspective may be lost.

Additionally, the Appeals Council performs a number of crucial functions. It provides the only recourse and dismissal cases, and provides protection for unrepresented claimants who would otherwise have to navigate their way through the Federal Courts. The council further deals with a number of due process issues which arise at the hearing level, and handles allegations of bias and unfairness from claimants. Last, it plays a vital role in the preparation of cases for court review and performs nationwide quality assurance. These functions are essential and best performed by one central body. Thank you for your time and for allowing me to speak on behalf of the many dedicated and hardworking OHA managers and supervisors.

[The prepared statement of Ms. Zink follows:]

Statement of Laura Zink, Member, Federal Managers Association, Social Security Administration Chapter 275, Phoenix, Arizona

Chairman Shaw, Ranking Member Matsui, Chairman Herger, Ranking Member Cardin and Members of the Subcommittees on Social Security and Human Resources:

Thank you for allowing us at the Federal Managers Association (FMA) to testify about the challenges and opportunities facing the implementation of the Social Security Commissioner's proposal to improve the disability process as it relates to the Office of Hearings and Appeals (OHA) in the Social Security Administration (SSA).

FMA represents the interests of the nearly 200,000 managers, supervisors and executives serving in the Federal government. Within FMA, we have Conferences divided along agency lines, one of which is the FMA–Social Security Administration (SSA) Conference representing executives, managers, and supervisors in all Social Security Program Service Centers, the Office of Central Operations, and the Office of Hearings and Appeals.

Last year, Social Security Commissioner Jo Anne Barnhart unveiled her proposal for restructuring OHA and the appeals process. While FMA supports certain aspects

of the Commissioner's plan, we cannot support her proposal to eliminate the Appeals Council in favor of the creation of Oversight Panels. The Appeals Council is the only body that reviews cases from the entire nation and is responsible for the implementation of the Commissioner's policies. In a disability program that is supposed to be uniform and consistently administered nationwide, it is extremely valuable to have one body which can spot trends, regional variations and potential problems. We are concerned that, without the Appeals Council, our national perspective may be lost.

Additionally, the Appeals Council provides the only recourse in dismissal cases, deals with a number of due process issues which arise in the hearing process, and handles allegations of bias and unfairness from claimants. These are important workloads that can best be performed by one central body. Moreover, we continue to have concerns about underlying problems in the hearings and appeals process, which, if not specifically addressed, will continue to inhibit the success of any reform plan.

Briefly, FMA supports the:

- Due Process Hearing;
- Recommendation to close the hearing record following the decision by the Administrative Law Judge (ALJ);
- Acceleration of the use of the Electronic Disability Folder (eDIB), video teleconferencing, digitally recorded hearings, and a strong management information system;
- Need to aggressively address the staffing issue in the Social Security Administration (SSA);
- Agency's efforts to make meaningful improvements to the OHA process;
- Elimination of the reconsideration step only after the full implementation of the Reviewing Official (RO) position; and,
- Establishment of the Regional Expert Medical Units.

The most significant underlying problems we see include:

- The lack of a meaningful performance appraisal system;
- Severe staffing shortages and imbalances; and,
- The cumbersome and lengthy process to hire and assign ALJs.

While we believe that some of Commissioner Barnhart's proposals may have a positive impact on OHA processes in the long term, others, such as the elimination of the Appeals Council, should not be implemented. It is also important to note that full implementation of other aspects of the proposal will take time. The plan is predicated on the successful implementation of eDIB, which even the most optimistic forecasts indicate will take two to three years. Additional changes will then be followed by the necessary learning curve for affected employees. This two to three year process is expected to see initial disruptions in office operations and a decrease in productivity. The July 2, 2004 GAO report, *Social Security Administration: More Effort Needed to Assess Consistency of Disability Decisions* (GAO–04–656), noted that SSA should proceed with caution in implementing e-DIB, to avoid rushing into practices that are not sufficiently tested.

Meanwhile, OHA is facing a growing backlog of pending hearing cases which needs immediate attention. Over the past two years the hearing offices have made tremendous strides in improving the disposition rate and efficiency, and the Appeals Council has significantly reduced its pending workload. However, because of the aging of the American population, OHA is receiving more new cases than ever before, but we have not been given staff increases to keep up with the ever-growing workload. The rate of receipts is projected to continue to rise. At the end of Fiscal year 2003, we had 556,369 pending SSA cases at the hearing level. At the end of August, 2004, we had 625,587; an increase of more than 69,000 cases. The backlog will not decrease until staffing levels are increased. OHA desperately needs some short-term relief in the form of additional employees to deal with the current situation.

In recent years, OHA has reached a number of milestones:

- In FY 2002, we produced the largest number of dispositions in history, 532,106.
- In FY 2003, OHA exceeded that performance with 571,928 dispositions.
- This represents an increase of almost 40,000 cases.
- In FY 2004, OHA piloted and then implemented nationwide the transition to CPMS, the case-management piece of Ae-Dib.
- In FY 2004, despite the challenges of CPMS, OHA has produced 503,384 cases through August 2004 (final numbers for the FY are not yet available).

In spite of these accomplishments, we continue to fall behind because of the increasing receipts. The solution must be increased human resources as well as increased flexibility for managers to assign those resources.

Meaningful Performance Measurement

As we previously mentioned in testimony submitted to the Subcommittee in September 2003 the development of a meaningful performance management system should be a top priority for SSA and OHA. The success or failure of any initiatives will be directly related to management's ability to hold all employees accountable for their work. Without meaningful performance measurements, we will achieve only limited success at best.

Many of the problems within the disability process parallel the deterioration of our performance management system. Our performance management system began to decay in the late 1980s and has steadily regressed. Group-based accountability, introduced under HPI, only moved us further from individual accountability. The current Pass/Fail appraisal system does not provide incentives for high performance, and we continue to see the grave consequences of this failed structure.

Each year the Social Security Administration presents its Government Performance and Results Act Annual Performance Plan. This plan describes specific levels of performance and outlines the means and strategies for achieving those objectives. The objectives are supported by indicators, which are used to measure the agency's success in achieving the objectives. The performance indicators are translated into goals that are shared with SSA executives. These goals are then clearly presented to managers and supervisors as expectations for performance. At OHA, for example, the indicators are expressed in terms of dispositions per day per ALJ, processing time, percent of aged cases, etc. As noted above, SSA holds managers and supervisors responsible for communicating performance goals to agency employees. However, when the goals are communicated to the employees, managers are required to communicate in very generic terms due to the absence of numeric standards.

Our current performance management system in SSA addresses these elements, but at an organizational level rather than an individual level. We certainly have set performance expectations (**Planning**), but these are agency goals, not individual goals. As directed by the system, progress reviews are held (**Monitoring**), but since there is no individual measurement, the discussions are generic. Ideally, we would spend time training (**Developing**) our employees, but in reality, most of our offices suffer from significant staffing imbalances and struggle just to accomplish our most basic missions. We rate (**Rating**) our employees on a Pass/Fail appraisal system, which fails to distinguish individual performance. Finally, our rewards (**Rewarding**) system is essentially a "do-it-yourself" process. Rewards are currently determined by regional and national panels, which make their decisions almost exclusively using written recommendations with little knowledge of the offices or the nominees. The recommendations—written by the employees themselves—do not always provide an accurate view of an employee's workload or their ability.

In a September 2003 poll conducted by FedNews Online, many Federal employees expressed their displeasure with the current Pass/Fail appraisal system that is used throughout the government. Seventy-six percent of the poll's respondents do not believe that the Pass/Fail system is an improvement from the more traditional five-level performance appraisal system. Sixty-eight percent of respondents indicated the biggest problem with the Pass/Fail system was that outstanding employees were given the same performance rating as mediocre employees.

Our current performance management system sends the message that performance does not need to be individualized. Because the standards are so generic, performance cannot be measured on an individual level. The labor-management contract requires that data focus on the process, not the individual. For all intents and purposes, the system is one of non-accountability. In spite of an employee's best effort, the employee will simply "pass" under current criteria. Award money is distributed according to a formula based on the number of employees on the payroll. This distribution is completely devoid of any recognition for performance, even at the office level. Since we have no individually measurable standards (numerics) that can be taken into consideration, overtime/credit hours/flexiplace must be given to anyone interested.

It is absolutely critical that our employees are provided with clear goals. These goals must be understandable, measurable, verifiable, equitable, and achievable. An Associated Press article dated May 27, 2002 describes how the Department of Veterans Affairs has succeeded in slashing their backlog of pending claims. VA Secretary Anthony Principi was quoted as saying, "We decided to really declare war on that backlog and took some rather bold steps to address it. We're really getting this backlog under control, and we did it through sheer focus and discipline, performance

measurements and production goals." When employees know what is expected of them, they are better able to focus their efforts.

There is an old adage that states, "What gets measured gets done." Implementing an effective performance plan within SSA given the current culture will be difficult. But if the Agency expects to meet its objectives it must be done. OPM has prepared *A Handbook for Measuring Employee Performance*. This Handbook outlines the guiding principles for performance measurement as follows: 1) performance management must be viewed as a valuable tool, not as an evil; 2) acceptance of the process is essential to its success; 3) we must measure what is important, not what is easy; 4) the plan must be flexible enough to allow for changes in goals to keep the process credible; 5) we must rely on multiple measures; 6) employees must perceive that performance measurement is important; and, 7) management must demonstrate that performance is critical to organizational and individual success. These are the principles, which must guide efforts to reform the current system.

In October 2003, a Human Resources Management Consortium of forty-six organizations—most of them Federal agencies—asked the National Academy of Public Administration to conduct a comprehensive review of the use of broadband pay in the public and private sectors. The Academy's Human Resources Management Panel oversaw this important effort. Over a 19-month period, the Panel worked with a three-member Academy project team to produce four reports, culminating in *Recommending Performance-Based Federal Pay* in May 2004. The final report's recommendations include:

- Transition to the integrated band structure should be completed within five years. Individual agencies should be allowed to develop their own schedules based on their human capital plans, budgets and performance management systems.
- Individual agencies should be accountable for planning and implementing performance management systems that identify outstanding performers, those who meet performance expectations and employees who fail to meet expectations. The systems should demonstrate a clear linkage or "line of sight" to the agency's mission and operating goals.
- Each agency should define a new position to provide support to managers in implementing new performance systems and dealing with day-to-day pay and performance issues.
- Agencies should provide extensive performance training for managers who are responsible for the implementation and effectiveness of the new system.
- OPM and agencies should both develop linked communications strategies, which are key to the system's success. These strategies should delineate the process used to develop policies and practices.
- New system rollouts should be managed as organizational change.

A strong performance management system will go a long way in restoring the Social Security Disability Program to the status of a premier program. Our current leadership is committed to reforming our performance management system, but we realize it will take several years to have an effective system in place. Nonetheless, any initiative implemented prior to having a meaningful performance management system will have minimal impact.

Staffing Imbalances

In an April 18, 2003 letter sent to A. Jacy Thurmond Jr., Associate Commissioner of OHA, we outlined a number of issues related to the staffing of hearing offices. Since the late 1980s, OHA has used the employee-to-ALJ ratio of 4.5-to-1 to determine staffing. This ratio is basically applied to all hearing offices regardless of individual office dynamics. However, since the ratio was established, conditions have changed at OHA offices. Staffing of OHA offices should reflect the current needs of those offices.

We at FMA fully recognize that there must be a general formula in place in order for a central office to be able to compare the regions' staffing levels. However, a useful staffing formula must be derived by performing work studies on various positions to determine the amount of time that is required on average to support an ALJ. Since the current 4.5: 1 ratio was established, OHA's technology capabilities have advanced significantly and these advancements have dramatically altered numerous work functions and, correspondingly, the time it takes to perform the functions. Furthermore, we feel that it is shortsighted to use such a formula in the strictest sense, regardless of how much effort was devoted to work-studies. Focusing only on the pre-set, "ideal" ratio—without considering other internal or external factors that impact an office's ability to serve the public—will prevent OHA from placing itself in the best position to meet coming challenges. The formula needs to be

reviewed and updated as procedures, technologies, and dynamics change to ensure a true staffing picture. We believe that our actual staffing needs will be better realized with the following changes:

- Regions should have the flexibility to staff based on "actual" needs and not just "predetermined" ratios.
- Position mix must be considered in any staffing determination.
- Ratios or guidelines have their place, but must be reviewed and updated as advancements in technology are realized. In addition, the regions should have the flexibility to surpass the pre-determined ratio when office dynamics warrant additional staffing.
- For purposes of a general guideline ratio, only "pure" production employees should be included.

In order to be in a position to handle the anticipated increase in workload, we must have the flexibility to staff offices according to their actual needs. Should the agency move forward with its proposal to eliminate the reconsideration step, the workload of OHA will likely increase immediately. This is currently the experience in prototype states which operate with no reconsideration step. Reviewing officers should be in place and fully trained before the reconsideration step is eliminated nationwide. Consideration should be given to not restrictin the RO position to attorneys only. There are many qualified and knowledgeable paralegal analysts who would increase the pool of candidates available. If this does not occur, employees new to their positions will be faced with the inevitable increase in receipts that will follow the elimination of this step. In our view, this could create another backlog situation. It is critical that new staff is already on board, trained, and ready to meet the challenge of this anticipated spike in workload.

Automation Initiatives

Potentially, these initiatives—including eDIB, video-teleconferencing, and voice recognition software, will have the greatest impact on productivity and will significantly alter the way we do business. Sufficient resources need to be devoted to testing and implementing e-DIB, as it will ultimately eliminate manual case preparation, in addition to providing significant savings on mail & storage costs. As we move closer to this reality, we need to look at the entire structure of the hearing offices and the positions within. We cannot start too early on this project considering the impact on the senior case technicians (SCTs) and the potential to easily distribute work to where the resources are. The positive impact that eDIB can have on the SCTs who now spend much of their time preparing the cases for ALJ review would be substantial. The full implementation of eDIB will allow SCTs to spend time on other functions that will help to decrease the backlog OHA currently faces.

We have been very pleased to see the advance of video hearings. This has been implemented in more locations, and more sites are slated. This initiative is already saving time and money in providing more timely hearings for claimants who live a distance from their servicing hearing office. We applaud the Commissioner's actions in putting this important initiative on the fast track.

Appeals Council

We are very concerned with the Commissioner's proposal to eliminate the Appeals Council and create Oversight Panels consisting of two ALJs and one Administrative Appeals Judge. As part of the plan outlined in her testimony a year ago, the Commissioner concluded that the Appeals Council level of the current process should be eliminated because it "—adds processing time and generally supports the ALJ decision." We disagree with that conclusion, and submit rather that the Appeals Council level of the process contributes to the achievement of the Commissioner's stated goals and provides important benefits to disability claimants.

While it does require some time for the Appeals Council to consider requests for review, great strides have already been made in more effectively processing the Appeals Council workload. Pending requests for review have decreased dramatically and now number approximately 50,000 cases. Average processing time has been reduced significantly, standing at 251 days at the end of August 2004. At that time, nearly half the requests for review received by the Council were worked to completion within 105 days. Technological changes currently being developed (e.g., digital recording of hearings and the development of an electronic folder) and policy changes being considered (closing the administrative record after the hearing) will result in further significant improvements.

The benefits added to the disability adjudication process by Appeals Council review make a substantive positive contribution to achieving the goals stressed by the Commissioner:

- Three to four percent of requests for review result in the issuance of a favorable decision without the necessity of the much longer appeal process to Federal court. The Council also remands about 24 percent of the request-for-review cases it considers, ultimately resulting in additional favorable decisions without court action or unfavorable decisions more likely to withstand court scrutiny on appeal.
- Review by the Appeals Council is the only recourse available to claimants who have had their requests for hearing dismissed. The Council grants review in a large percentage of these cases, providing an avenue for these claimants to receive due process and a substantive decision.
- Many claimants are not represented. The Appeals Council is the last recourse for those who lack the understanding or resources to pursue their case in Federal court. For them, the Council provides an avenue to appeal the Administrative Law Judge's decision in a non-adversarial setting.
- The Council's workload also includes review of favorable hearing decisions that have not been appealed. Exercise of this function prevents payment of benefits in cases where an allowance is not warranted by the law and facts of the case.
- The Council also plays a vital role in the preparation of cases for court review, processing requests for voluntary remand, preparing court remands, and reviewing final decisions after court remand. These functions are essential to the efficient processing of the civil action workload.

In her testimony last year, the Commissioner stressed the need for disability claims to be better developed and indicated the need for consistency in disability adjudication. The Appeals Council contributes to the achievement of both these objectives. By remanding cases, the Council sets a higher standard for case development. The Council is the only body that reviews disability cases on a national basis. The Council has developed principles and guidelines that have insured consistent actions by Administrative Law Judges throughout the country. If national consistency is the objective, the Appeals Council is the logical body to be tasked with continuing oversight of this effort.

Stakeholders in the disability process, including claimants' representatives and advocacy groups, value the contribution of the Appeals Council and support retention of the request for review. Previous studies dealing with the elimination of the request for review indicated that the workload of the courts would increase dramatically if the Appeals Council review level were to be abolished. Reports by the Judicial Conference of the United States have indicated that most claimants do not seek judicial review after Appeals Council action, and that Appeals Council review lessens clogging of court dockets. The Conference viewed the prospect of eliminating Appeals Council review unfavorably.

The Office of Hearings and Appeals Management Association (FMA Chapter 275) agrees that the disability adjudication process needs to foster fully developed case records to support accurate and timely decisions which are consistent and of high quality. For 64 years the Appeals Council has contributed to the achievement of these goals by providing a final level of appeal and review within the Social Security Administration. Such experience and public service are invaluable. The Council should continue to be a driving force in improving the disability adjudication process.

Conclusion

The Office of Hearings and Appeals within the Social Security Administration affects the lives of millions of Americans with its disability services. With increased staffing and funding, the Agency would be able to improve its service to its customers—the American public. The missions performed by OHA could be completed at an even higher level of proficiency if a meaningful performance management system were instituted within the Agency. These changes would allow OHA to provide to the public the level of service that is both expected and deserved by taxpayers.

FMA has long served as a sounding board for the Legislative and Executive branches in an effort to ensure that policy decisions are made rationally and provide the best value for the American taxpayer, while recognizing the importance and value of a top-notch civil service for the future. We at FMA would welcome the opportunity to do the same for any initiatives that Congress, as well as SSA, would like to develop that would further enhance the mission of the Office of Hearings and Appeals.

We want to thank you again, Chairman Shaw, Ranking Member Matsui, Chairman Herger and Ranking Member Cardin, for providing FMA an opportunity to present our views and for the hard work and interest of the members of both Subcommittees on this very important topic.

We look forward to working with Congress, the Commissioner, and other stakeholders in finding solutions to the challenges facing SSA in our collective pursuit of sustaining excellence in public service.

Chairman SHAW. Thank you, Ms. Zink. Mr. Bernoski, you are certainly no stranger to this Committee. Welcome back.

STATEMENT OF RONALD G. BERNOSKI, PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, MILWAUKEE, WISCONSIN

Mr. BERNOSKI. Thank you, Mr. Chairman. Thank you for inviting us to testify. We commend the Commissioner for her attempt to reform the Social Security disability process. The plan is mostly simple and direct with some complex changes in eDIB. We are committed to working with the Commissioner to ensure that her program succeeds. The ALJ hearing remains at the center of the Social Security adjudication system, and we believe that the ALJ hearing should become more formal and developed. With appeals going directly to the Federal Court, it is imperative that we have an improved level of expert testimony at our hearings, and we will also need highly qualified decision writers to ensure that our written decisions pass the scrutiny of the Federal Courts. Also the staffing problems that we have talked about many times of HPI must be corrected.

The plan eliminates the Appeals Council, with the appeal going directly to the Federal Courts. We agree with this change because the Appeals Council has lost its utility to the disability process. The plan also calls for three-judge quality control panels. It is not clear how these panels will function, but it appears that they will review live cases. A decision of the panel will become the decision of the Commissioner unless appealed. We have some concerns with this proposal. There is no indication that the claimants have a right to appear before these panels or that the claimants have a right to appeal their cases to a panel. A claimant has an interest in a favorable decision, and we suggest that any such quality review be done on closed files after the appeals time has lapsed. This is to protect the claimant's right in the case.

We suggest a quality review mechanism be built into the appeal to the Federal Court from the ALJ. This can be done by providing for a delay in the perfection of the appeal for a period such as 60 days. During this period, the case could be reviewed by the Office of General Counsel to determine if the agency will defend the case. If the case is not defended, it would then be returned to the ALJ for further action. The plan also contains the new position of the RO. This person is an attorney who reviews the case on appeal from the DDS. The RO can either allow the claim or prepare a report for further action by the ALJ. We suggest that this report be a memorandum for the file and not a decisional document.

It is also important that the RO be provided with sufficient support staff to fully develop the record. Mr. Daub spoke about that

earlier. The CPMS is a new case tracking system which has gotten off to a slow start, but we want to work with the Commissioner to cure its defects. The eDIB is a larger system that is more complex. We are encouraged by this concept but have some concern with the size of the project. Now, eDIB was recently implemented on a limited basis in the Charlotte, North Carolina Hearing Office, and the information that we have received indicates that the first hearing went very well. However, much remains to be done on that system, and we should look at things such as the utility of the system for handling large cases with many exhibits, the efficiency of inputting documents into the system, determining how the claimants will use this new electronic system for the review of their files, how the system will be used at remote hearing sites, the impact of the system on the size of the hearing room, the number of computers that will be required in the hearing rooms, the impact of this system on the office users, and whether there will be a continued need for paper files.

Based on our experience with CPMS we have concern with ruling out eDIB too quickly, because we believe that there are going to be problems that can't be anticipated, and that caution is advisable. However, we are committed to working with the Commissioner to make this reform a success. We also believe that the agency must adopt the rules of procedures that were recently recommended by a Joint Rules Committee. These rules are needed to implement the Commissioner's reform plan. The agency should also deal with the use of Social Security numbers as case identifiers on documents that are electronically transmitted, as we explained in our written testimony.

Last, on the persistent issue of the OPM's lack of capacity to efficiently administer the ALJ system, we suggest that there be a joint hearing between this Subcommittee and the Subcommittee on Administrative Law in the Committee on the Judiciary. We recommend the adoption of a Conference of ALJs similar to the bill that was introduced by Congressman Gekas in the 106th Congress. Thank you very much.

[The prepared statement of Mr. Bernoski follows:]

Statement of Ronald G. Bernoski, President, Association of Administrative Law Judges, Milwaukee, Wisconsin

I. INTRODUCTION

Thank you for the opportunity to testify today. My name is Ronald G. Bernoski. I am an Administrative Law Judge ("ALJ") who has been hearing Social Security disability cases at the Office of Hearings and Appeals ("OHA") of the Social Security Administration ("SSA") in Milwaukee, Wisconsin, for over 20 years.

This statement is presented in my capacity as the President of the Association of Administrative Law Judges ("AALJ"), which represents the administrative law judges employed in the SSA OHA and the Department of Health and Human Services ("DHHS"). One of the stated purposes of the AALJ is to promote and preserve full due process hearings in compliance with the Administrative Procedure Act for those individuals who seek adjudication of program entitlement disputes within the SSA.

We commend Commissioner Barnhart for her plan to reform the Social Security disability process. During the past 15 years the agency has made several attempts to reform the disability process, but unfortunately each effort has failed. The Commissioner's proposed plan has the advantage of being simple and direct, yet it includes a significant challenge on an unprecedented scale. E–Dib, or the electronic file, is an innovative and bold change in the agency's collection, transmission, and retrieval of data. Smaller electronic systems are in existence. The SSA system will

include all of the components of the Social Security Administration as well as the fifty state agencies involved in initial disability determinations. The transition from paper files to electronic files will be a difficult, but not impossible test, for the judges who hear disability cases. However, it is vital that the Commissioner receive adequate funding to implement her entire reform plan. If only a portion of E-dib is completed, we will be left with a struggle of working with the confusion of two systems or face the dilemma of stepping back from an achievable technological advancement.

II. THE ADMINISTRATIVE LAW JUDGE HEARING

In September of last year, the Commissioner testified before this Subcommittee. She stated that claimant advocacy and claimant representative organizations strongly recommended retaining the *de novo* hearing before an administrative law judge. The Commissioner's reform plan follows these recommendations and the administrative law judge hearing is retained as the center of the agency's adjudicative process. We completely agree with this action.

The Administrative Procedure Act was enacted by the Congress in 1946 to ensure fairness in the agency adjudication system in the Federal government. The Act left the hearing examiners (now administrative law judges) within the agencies as qualified employees, but provided them with additional protections to ensure full and fair hearings for the American public [see *Ramspeck et. at*. v. *Federal Trial Examiners Conference, 345 U.S. 128 (1953)*]. We recommend that the intent of Congress be fully implemented and that the SSA hearing process be made more formal. We urge the agency to adopt, by regulation, rules of practice and procedure for ALJ hearings. Practice and procedure rules have been proposed by a joint rules committee established by the Associate Commissioner of the Office of Hearings and Appeals. Also, with a high percentage of claimants represented by counsel at our hearings we recommend the establishment of an agency representative to balance the interests of what has become one-sided advocacy. If the claimant is not represented at the hearing, the agency representative would provide assistance to the claimant.

Under the Commissioner's reform plan, the administrative law judge hearing will be the last agency action for many claimants. We support the concept of closing the administrative record after the ALJ hearing. This makes it imperative that the administrative law judge hearing is full, fair and complete with all relevant evidence included in the hearing record. The hearing decision must be prepared in a manner that is legally sufficient and meets all agency and legal standards. ALJs need highly qualified, professional decision writers to insure that our decisions pass the scrutiny required of direct appeals to the Federal district courts.

SSA actions alone will not make the ALJ hearing process more professional. Congress plays an important role. When creating the Administrative Procedure Act, the Congress vested considerable authority in the Civil Service Commission (now the United States Office of Personnel Management) and gave it the responsibility to regulate the administrative law judge function in the Federal government. The Office of Personnel Management (OPM) has the responsibility to maintain a testing system that qualifies applicants for entry upon a register that provides new administrative law judges to the agencies. Traditionally, OPM administered this responsibility through an Office of Administrative Law Judges. Regrettably, OPM has backed any from its responsibility for the administrative law judge function in the Federal government. It recently abolished its Office of Administrative Law Judges and dispersed the functions of this Office within OPM in an indefinable manner. For what we believe is the first time in its history, OPM does not have a test in place for applicants for the administrative law judge position. A new test has been promised for years. The ALJ register has been closed to new applicants for over 5 years. The lack of effective management of the administrative law judge program by OPM has made it extremely difficult for agencies, including SSA, to hire new judges. This problem must be addressed to allow the Social Security Administration and other agencies to hire the new administrative law judges needed to maintain the various programs in the Federal government.

Rep. George Gekas (R–PA) attempted to address this problem in the 106th Congress by introducing the *Administrative Law Judge Conference of the United States Act (H.R. 5177)*. This legislation would have moved the functions of the Office of Administrative Law Judges from OPM and placed them in an Administrative Law Judge Conference. The Conference was to be headed by a Chief Judge who reported annually to both the Congress and the President. The Chief Judge was to be responsible for regulating the Federal administrative law judge program and for promulgating a code of professional conduct for Federal administrative law judges modeled after the America Bar Association model code for administrative law judges. The administrative law judges remained as qualified employees of the agencies and the existing authority of the agencies and judges was not changed in any manner. The

concept was patterned after the Judicial Conference of the United States and it provided a needed organization and structure for the Federal administrative law judge system. We ask that legislation of this type be supported by each member of this joint Subcommittee.

III. APPELLATE REVIEW

The Commissioner's reform plan eliminates the Appeals Council. We agree with this change. There have been many studies and comments on the utility of the Appeals Council to the Social Security disability process. In a prior report, the Administrative Conference of the United States recommended that the Appeals Council be either improved or abolished. The main weakness of the Appeals Council is that it has not developed a true appellate function in the Social Security disability process. Its decisions do not have any precedent and its authority has not been developed. As such, it merely serves as a "pass-through" area for the claimants on their way to the Federal courts and it adds no value to the process.

The reform plan provides for a centralized quality control staff that would review administrative law judge decisions. If the quality control review disagrees with an administrative law judge decision, it will be referred to an oversight panel for review. This panel consists of two administrative law judges and one administrative appeals judge. The decision of the panel becomes the final decision of the Commissioner, unless it is appealed to the Federal court. We have considerable concern with this change. The claimant does not have any right of appeal to the panel, and it is not clear whether the claimant has any right to representation before the panel. If the claimant has received a favorable decision from the administrative law judge, he/she has a clear interest to protect in the decision before the panel. We recommend that any quality control review conducted by the agency be performed on closed files where the appeals time has lapsed. This will eliminate the problem of interfering with a "live" case where the claimant has an interest to protect.

The reform plan provides that if the administrative law judge decision is not reviewed by the panel it will become the final decision of the Commissioner, unless it is appealed to the Federal court. As is currently the case, the claimant will continue to have a right of appeal to the Federal court under existing law. We agree that the Federal districts courts should continue to have jurisdiction of Social Security disability cases. To act as a filter for appealed cases, we recommend that SSA consider a procedure to return certain cases to the administrative law judges before jurisdiction is perfected in the Federal courts. This could be accomplished by establishing a time period (e.g. 60 days) before the appeal to Federal court is perfected. During this time period, the attorneys for the agency's Office of General Counsel could review the cases and decide which cases, if any, the agency will not defend in court. The cases that the agency decides not to defend in court would be returned to the administrative law judge for further action. Jurisdiction in the Federal courts gives a safeguard to the claimant by providing a forum that is outside the agency and allows for independent judicial review of the case. In the 1980's the Federal courts proved the value of this review by protecting the claimants from widespread agency abuse.

IV. REVIEWING OFFICIAL

The plan creates a new position in the Social Security disability system. This position is the SSA reviewing official (RO) and it a Federal position. If the claimant files a request for review of a DDS determination, the claim would be reviewed by the RO. This person will be an attorney, who will be authorized to review the case and to either issue an allowance decision in the case or concur with the DDS denial of the claim. This is a review of the file, and the claimant will not appear before the RO. If the claim is not allowed, the RO will prepare a written report on the recommended disallowance which discusses the evidence in the case. We believe that this report should not be an agency *decisional document* and it should instead be a *memorandum for the file* to assist the administrative law judge. If the report is a decisional document, the claimant will have a right to *state his/her case* to the RO in writing prior to the issuance of the report. This will add time to the process and require an appeal from the RO to the administrative law judge hearing.

V. CENTRALIZED MEDICAL PANELS

The reform plan provides for centralized medical panels that would be available to disability decision makers at all levels. These units would be organized around clinical specialties, such as, musculoskeletal, neurological, cardiac and psychiatric.We are encouraged by this proposal, because we believe that any method employed to improve the quality of the medical evidence at the administrative law

judge hearing is beneficial. The reform plan provides for a "quick decision" process which could use this expert medical resource. We support the quick decision process so that pay cases can be identified as early in the process as is possible. We suggest that the medical panels for the State DDS disability reviews and the administrative law judge hearings be separate to provide a "fresh look" of the case at each level of the administrative review. However, if a needed medical specialist is present on only one of the panels, this expert should be available to all adjudicators. Heretofore hard to obtain medical testimony could be obtained at our hearings by use of the video conference system that the agency is acquiring. This new technology allows administrative law judges access to needed medical experts not otherwise available. Video testimony also gives the claimant a better opportunity to cross examine the witness as well as providing for a more efficient use of the expert's time.

VI. CPMS

Conversion to an electronic work environment needs to be well planned. The initial version of the Case Processing and Management System software did not live up to expectations. That version of CPMS made the change to this new system more difficult than it needed to be. The General Accounting Office forecast this result in a briefing and report submitted to the Subcommittee earlier this year.[1] GAO presented four main points of concern. I will address only one: the failure to adequately consult with actual end-users at the field offices of the Office of Hearings and Appeals at each step of the software design process. The feedback we receive from the field is that no judge, staff member or field manager with knowledge of our process would plan CPMS the way it was designed. I will give you just two examples since they are symptomatic of many other problems with CPMS which actually impede the ability of an OHA to get the work done. The solutions we propose will cure these and many similar problems.

The first example is: A clerk assigned to a judge cannot always run a listing of his or her assigned judge's cases.

This occurs because the Systems division at SSA, for reasons not entirely clear but seemingly in the interests of confidentiality of data, have limited access by individuals to only those cases actually assigned to those individuals.[2] This excessive internal secrecy and limited access to data impedes getting the work done. We all need to be able to work together to accomplish our mission. We recommend that CPMS be transparent at the local office level. What we urge is that every individual at a local office have access to the status of all cases within an office. CPMS' limited access policy blocked rapid responses when action was required and an employee was available to take such action except for an internal block. Such compartmentalization can also be destructive to local office morale. ALJs and members of our support staff are acutely aware of the long waits claimants endure before a disability hearing is held. When staff fields a phone call or mail inquiry for which immediate action can save a claimant days or weeks of wait but can't act because they are blocked by artificial barriers it is extremely frustrating to them.

The second example is: CPMS is unforgiving.

It is imperative that even simple mistakes are not made in CPMS. Once a mistake is entered into the system there is no easy way to correct it. If a mistake is made an employee must delete all the work to that point and start that step from the beginning. For example, a judge in Miami decided to make his own entries in CPMS to assist the office in closing out as many cases as possible. He found in favor of a claimant and established an onset date in January. When he entered the date, he mistakenly typed 11 which is November, rather than 01 for January. He then saved and closed the case. A staff member at the office discovered the mistake before the case was mailed. However, he discovered that no one in the entire agency could correct his clerical error. An entirely new file had to be recreated with all the data having to be re-entered into this new file to correct this simple error.

When the Group Supervisor in Miami complained about this problem to a Systems person, he was told the solution was simple: "Don't make mistakes." The agency must find a user friendly way to correct mistakes in CPMS. We urge greater emphasis on ongoing consultation with the employees in the field who actually use the new electronic process. This coordination and receipt of feedback from the field will become even more critical when we transition to work with electronic files.

---

[1] U.S. General Accounting Office, *Electronic Disability Claims Processing: Social Security Administration Needs to Address Risks Associated with Its Accelerated Systems Development Strategy*, GAO–04–466 (Washington, D.C.: March 26, 2004).

[2] Managers are an exception to this policy.

VII. E–DIB

Accelerated Electronic Disability Claims Processing (AeDib) is the foundation upon which the Commissioner intends to construct her Reform Plan. We know that a change of the magnitude contemplated by E-dib will not be perfectly smooth. As we have learned with the CPMS phase it is critical that there be flexibility within the agency to address problems that are highlighted by experiences in the field. The AALJ is encouraged by the efforts of SSA at its highest levels to consult with us on this monumental transformation. However, much of the nitty-gritty of implementation occurs at lower echelons of the agency as well as within hearings and appeals' management. It is at these levels that we see a need for more open communication and a new found sense of cooperation. The vision and scope of the Commissioner's plan requires more flexible and invigorating management to open effective lines of cooperation with all levels of the agency.

We believe the Electronic Disability Collect System of E-dib has great potential to assist judges in rendering decisions and to speed up the overall process. The EDCS contains structured data that unlike the data in the Electronic Folder may be searched and manipulated easily by the judge. We recommended early that the agency not simply convert standard government forms to electronic format but that they take the time to revalidate the data collected in the old hardcopy forms to make sure the data is relevant today and actually helps a judge render a decision. We continue to urge the agency to fully act on this recommendation.

The Document Management Architecture part of E-dib has not been piloted for a sufficient time to comment on its utility. However, the initial reports are promising. It is my understanding the first hearing involving a pure Electronic Folder has just taken place at the Charlotte, North Carolina OHA. However, based on our experience with CPMS, we have concerns about the rapidity of the roll-out of E-dib.

VIII. Discontinue use of SSN as a Case Identifier

Although this does not fit perfectly under any AeDib category, this issue should be addressed by the agency. First, Chairman Shaw we applaud you and your Subcommittee for your leadership role in introducing the *Social Security Number Privacy and Identity Theft Prevention Act of 2003* (H.R, 2937) and holding hearings on this most important issue to all of us. At the hearing Mr. Patrick P. O'Carroll, the Acting Inspector General of the Social Security Administration, declared in his prepared statement:

Perhaps the most important step we can take in preventing SSN misuse is to limit the SSN's easy availability. We believe legislation designed to protect the SSN must strictly limit the number's availability on public documents. As long as criminals can walk into the records room of a courthouse or local government building and walk out with names and SSNs culled from public records, it will be extremely difficult to reverse the trend.[3]

We have recommended to the agency during the AeDib process that it discontinue the use of SSNs as a disability decision and case identifier. It could be easily accomplished[4] Until this is done we might have an Electronic Folder but we cannot even e-mail the Exhibit List to an attorney because the case is identified by the claimant's SSN and the agency rightfully has a prohibition on transmitting SSNs over the internet. We will instead need to print out the list and send it by regular mail. This is inefficient.

IX. THE NEED FOR PROCEDURAL RULES

In 1969 SSA ALJs issued about 20 to 30,000 dispositons. This year we will conduct over 500,000 hearings. In 1969 few claimants were represented. Presently 88% of claimants are represented at the hearing level. The old concept of an informal hearing made sense for un-represented claimants. But today very skilled and assertive representatives effectively advocate on behalf of their clients. We work in a different judicial environment. Yet judges conduct hearings today in exactly the same manner they did thirty years ago; without procedural rules. As one example where rules would greatly assist our judges, the agency does not have a rule which requires attorneys to submit evidence in a timely manner before a hearing. The or-

[3] Statement of Patrick P. O'Carroll, Acting Inspector General, Social Security Administration Testimony Before the Subcommittee on Social Security of the House Committee on Ways and Means (June 15, 2004).

[4] Under HOTS cases could be searched using the first four letters of the claimant's last name and the last four digits of their SSN. The agency could easily use the entire last name of the claimant and the last four digits of the SSN to identify a claimant's disability claim file and decision.

derly submission of evidence is a basic requirement of any other adjudication system. Presently, attorneys can and do show up at hearings with 100 or more pages of new evidence. An ALJ is then faced with two distasteful choices. The judge can either conduct a hearing without time to adequately review new evidence or add further delay to the process by postponing the hearing. It is a terribly inefficient system with the American public paying for this inefficiency.

Adoption of procedural rules is needed to make new technologies more efficient. The video hearing system provides another example. A judge reports waiting while the attorney faxed seventy-five pages of new evidence to him which needed to be read before the hearing could proceed. We need updated procedural rules to provide the disability hearing process with an efficient system which can take full advantage of our new technology.

Thank you.

Chairman SHAW. Thank you. Mr. Brady?

Mr. BRADY. Thank you, Mr. Chairman. In the written testimony, because it shortens the time in the verbal discussion today, several of you cited what you would include in the good faith exception to closing the file after the ALJ case. Can each of you talk about sort of some key points that ought to be part of that exception?

Mr. SUTTON. Yes. Congressman Brady, if I could address that. As a practitioner who has been doing these cases for years, I will give you some examples of what that would look like. For example, we had a client who appeared before an ALJ with orthopedic injuries that caused pain that was so severe that her doctors actually considered amputating her leg to stop it, but she had no attorney when she appeared before the judge, and she did not know to go and get that evidence. It wasn't obtained until after the judge had denied her case. It was appealed to the Appeals Council by my firm. We obtained that evidence, submitted it to the Appeals Council. The Appeals Council remanded the case to the judge and said, "Look at this evidence," at which point of course the judge granted her benefits. That is a perfect example of the kind of good cause for new evidence coming in, unrepresented people who don't understand what their burden is.

There are also cases where diagnoses are unclear, people's symptoms are very well documented in the medical records, but they do not know exactly what is causing them, and then perhaps 3 months or 6 months after a judge denies a case, you find out, well, it was MS, or it was Amyotrophic Lateral Sclerosis, or it was some terrible disease. At the time the judge had the case he or she saw it as, these are unexplained complaints of pain and there is no objective documentation to explain, and so it is denied.

If you cut off the record and don't allow that opportunity to bring the evidence before the agency, it doesn't work. You really can't bring it to court, by the way. There is a statutory provision for evidence to be brought to the court if a case gets that far, but it is an extremely stringent standard there that usually is not met. The courts, of course, don't have doctors on their staffs to evaluate that new evidence. The Appeals Council does, and that is why it is so important, I think, to have that safety valve for new evidence that can come in after the point that the ALJ decides the case.

Mr. BRADY. Thank you. Ms. Ford?

Ms. FORD. I would just echo what Tom has just explained. I think Mr. Becerra used an example earlier this afternoon about a person who has MS and the documentation of that does not come in until after the ALJ has made a decision. In that situation, you would not want to force someone to start over completely, and there could be some serious implications in whether or not they could get benefits if they were not allowed to continue this case, but instead, had to start over with a new claim.

Mr. BRADY. In that case you stressed documentation. In a case like that, wouldn't the issue of MS or the illness being raised to the ALJ, wouldn't you as an ALJ want to obtain that document before you rendered a decision? There is a difference between an absence of any knowledge of an illness and the documentation that justifies it.

Mr. SUTTON. Sometimes, Congressman, in my experience, judges are conscientious and they do make an effort to try to get that evidence for a claimant, let us say, particularly one who doesn't have counsel at the hearing. There comes a point where the judge can become frustrated with the absence of certain tests, that kind of documentation. You know, if the treating physicians aren't referring that claimant for the proper tests, MS is a perfect example. There are multiple tests that have to be done. It is a triangulation effect that the clinicians have to go through to actually diagnose the disease. Unfortunately, with many claimants having little or in some cases no health insurance, getting referrals to have that kind of expensive testing is easier said than done. The ALJ could order a consultative exam, but those usually aren't going to pay for or do the kind of intensive testing or specialty referral that is really needed.

So, those things happen. They happen sometimes not when they should and not as early as they should, and we have to have a process that at least allows claimants, who are in a position where they cannot just wave the magic wand and get the referral that they need, to be able to bring that evidence to the agency when they get it, show that they had good cause for not having it before, and that may allow them, as Marty said, to get benefits when they otherwise would be cut off. We have cutoff dates in this program. There are dates when insurance expires, when you have been out of work so long. Sometimes it is no answer to a claimant to just say, "File a new application." They can never get benefits unless a decision is reconsidered and overturned, perhaps in light of new evidence.

Mr. BRADY. Any other panel members want to comment?

Judge BERNOSKI. Under the Commissioner's plan, if the case goes directly from the ALJ to the Federal Court, the current Federal statute for that appeal from the agency to the Federal Court has a case closing aspect to it. So, as the Commissioner indicated during her testimony, the case is going to close as a matter of existing law. To answer your question directly as to what the new cause standard should be, we suggest there should probably be two tests, the first one would relate to evidence that is not in existence at the time of the hearing, that would be reason for allowing that evidence be received to the record subsequent to the hearing; or second, if the claimant could offer a good explanation why evidence

that was in existence at the time of the hearing was not offered at the hearing. It would be a two-prong test.

Mr. BRADY. Thank you. I appreciate it. Mr. Chairman, I am just sort of at a point on this, it seems like our whole system is sort of a series of safety nets to catch the claimants that fall through the net in front of them in each step of the way. I think one thing the Commissioner is trying to do that I support is to tighten and strengthen those nets early on in the process, so we find and help as many claimants so that we don't build in a series of five or six different steps, but try in fact to catch the claimants who need the help as early on I the process. I think as an idea and as an approach that is a good one to take. Thank you, Mr. Chairman.

Chairman SHAW. Thank you, Mr. Brady. Mr. Sutton, you have made the argument as to the excessive litigation that would result if the Appeals Council was eliminated. Could I ask the other panel members to comment on that? Ms. Ford, you have an opinion on that? I would like to go to Judge Bernoski.

Ms. FORD. Thank you. I think that is an important point, that the Federal Courts could be swamped with cases that really don't belong there. I also fear that claimants won't be able to take cases forward. Some won't have the wherewithal to know how to get through the process. Making an appeal—or filing a case in the Federal Courts—is far more complicated and more costly to an individual, and if they haven't had legal representation up until that point, it may be beyond their ability to even consider it. So, you would have a claimant who possibly should have been entitled to benefits who doesn't get them.

Chairman SHAW. Judge?

Mr. BERNOSKI. Mr. Chairman, our suggestion does have that additional feature, it allows the agency to have the quality review system built into the appeals process. We suggest that there be a period of time between the time that the appeal is filed and the perfection of the appeal. I said 60 days, but it could be for any period that is determined, during which the agency can have another look at the case. The Office of General Counsel would look at the case and decide whether or not this is a case that should be defended. If it is, it would go on to the court. If not, it would be returned back to the ALJ for further action. This, I think, would keep a huge number of cases from moving to the Federal Courts.

Now, with relationship to the claimants having the knowledge to bring the case to the Federal Court, most of the claimants are now represented at the ALJ hearing. I think Mr. Daub indicated 80 percent or 85 percent of the claimants are represented, so that knowledge currently exists in the system. They have an attorney, and these attorneys certainly know how to bring the cases to the Federal Courts. Also the Federal Courts provide a "pauper waiver" of the filing fee where the claimants, upon filing an affidavit, can file the case in the Federal Court at no charge.

In the previous testimony there seemed to be some concern about the claimants and the complexity of the Federal Courts, and there seemed to be a belief that the case before the Federal Court is a trial. It is not. The case goes to Federal Court on certiorari, so it is simply at that point an argument before the magistrate or the Federal judge based on the record. It is not a complex hearing. The

hearing is before the ALJ, and that is why we recommend it be a more formal and complete hearing, so that the Federal Courts, if they do get the case, have a better record than is now being sent to them.

Chairman SHAW. Mr. Sutton?

Mr. SUTTON. If I could just briefly respond. I have great respect for Judge Bernoski. The problem with this proposal, as I see it, that the Commissioner has made to replace the Appeals Council with these review panels is twofold. First, as to that, claimants have no ability to request review. It is purely a matter of whether the Commissioner says, "We are going to review all claims" or a sample. It is totally at the Commissioner's initiative. Claimants have no way to obtain review, to know whether their case is being reviewed or anything of the kind, and that is the fundamental problem with it as an idea for replacement of the Appeals Council.

Judge Bernoski's testimony has noted that problem. He has suggested and his association suggested that the Office of General Counsel review all these cases to somehow decide whether they really belonged in Federal Court or not. Is that all 200,000 ALJ denials a year? Is it 3 times the 17,000 filings you now have in District Court? You are going to have those cases filed because people who are not satisfied with the ALJ denial, believe there is really a wrong and a legal error there and they have no place else to go. The Office of General Counsel, I can tell you because I litigate against them every week, has a hard enough time defending the 15,000 to 17,000 filings a year now; to tell them that they are going to essentially replace the Appeals Council to review the merits of these ALJ decisions I believe is completely untenable.

Chairman SHAW. Thank you. Mr. Hill, in your testimony you talk about the lack of consistency in decisionmaking and note that the, and I am quoting you, "inconsistency of decisionmaking between the State agencies and the ALJs is undeniable." That is the end of your quote. Given that it will take some time to implement aspects of the Commissioner's plan. Do you have any suggestions for improving the consistency of decisions right away?

Mr. HILL. Sir, that is a very difficult proposition, because I think when you hear, and we heard it earlier, the State agencies believe they are right 90 percent of the time, yet ALJs are overturning 61 percent of the cases that come to them. Overturning is even a wrong word. The cases can be very fundamentally different when an ALJ finally makes a decision because it is a year or 2 years older. One easy way is obviously to truncate the process so we do not have such a huge period of time between them. The other one I think is probably more fundamental, and it comes down to the end, two factors, one, the quality assurance program. At the State agency level, because of statutory requirements, a preponderance of payments are reviewed. At the ALJ level, because of a system of appeals, very few people who are awarded benefits appeal the award. It is primarily review of denials, and there are built in factors. It is easier at the State agency to deny a case, to get it by quality assurance. It is easier at the ALJ level to pay a case if there is some problem with it.

I think that is a very practical problem that exists, and that is something that the Commissioner is going to address by having a

process-wide quality assurance system. The other fundamental problem deals with the ALJs looking at the evidence and applying the rulings, the regulations and the statute. The State agency is applying, and the problems are much more specific and the agency will say that everybody is applying the same law, but one is very specific, the other is more general. We lawyers are used to dealing with generalities and applying facts of a specific circumstance to generalized law and regulations. That is what we do. I think that fundamental difference of what is being applied, they tried to address it with the PUTT, which was process unification. To some extent they did, but it has been very incomplete. I think it is another one of the failures that has plagued us for the past 10 years, and I really don't have a quick solution that can be done out of hand.

Chairman SHAW. Thank you very much. Thank all of you for being here and waiting. We have been in session now for 3 hours, and I appreciate your patience with us, but this is a most important subject and it is one that has plagued this Committee and I might say the Subcommittee on Social Security for many, many years. As long as I can remember looking at it, there has been a tremendous problem moving these cases along. I see from the two panels that there is quite a bit of disagreement, but I think that expediting these cases is tremendously important, and of course, at the same time maintaining fairness. Thank you for being here. The Hearing is adjourned.

[Whereupon, at 4:08 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

American Bar Association
Washington, DC 20005
October 14, 2004

The Honorable E. Clay Shaw and the Honorable Wally Herger
Chairmen, Subcommittee on Social Security and Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515–4315

Dear Chair Shaw and Chair Herger:

On behalf of the American Bar Association, I thank you and the members of your respective subcommittees for your interest in the Social Security Administration's disability determination process. The American Bar Association is well aware of the myriad challenges that confront the Social Security Administration, and we agree that few are as pressing as the need to reduce unnecessary backlogs and delays in the processing of disability claims and appeals. We have long advocated increased efficiency and fairness in this system, and we have drawn upon the experience and expertise of our membership to develop a wide body of recommendations in this area. During the past year, we have carefully examined Commissioner Barnhart's proposals, we have met with the Commissioner and her staff, and we have shared with her our positions on various elements of her plan.

We support the Commissioner's goal of making a correct decision as early in the process as possible. To accomplish this objective, the Social Security Administration must communicate with claimants at all levels of the determination process, and must provide them with the information they need to understand the process and their responsibilities as well as the availability of legal representation. We recommend that SSA increase its efforts to educate the medical community about eligibility criteria used in the disability program and the kind of evidence required to establish eligibility for benefits. In gathering medical evidence, SSA should consult a claimant's health care providers and compensate them adequately for providing relevant medical information. SSA also should give special weight to reports from treating physicians and should hold consultative examiners to the highest medical standards. We are interested in the concept of using nurse consultants as case managers to collect medical evidence and coordinate the services of medical experts, but

we do caution against sole reliance on a nurse for medical assessments, particularly where a claimant has multiple impairments.

We also support the proposal to eliminate reconsideration. We agree that the process and the claimant could be well served by a Reviewing Official (RO) whose job is to marshal all the evidence, prepare a report on the claim, and issue allowances when claims are clear. However, we do not support requiring a separate appeal to the Administrative Law Judge if the RO recommends disallowance. This requirement would simply replace reconsideration with another level of appeal. It is likely to discourage some claimants from pursuing legitimate claims, and to delay the scheduling of a hearing for others who do appeal.

We commend the Commissioner's decision to retain the claimant's right to a *de novo* hearing before an administrative law judge. Hearings should be on the record, and the administrative law judges who conduct those hearings should be appointed pursuant to § 3105 of the Administrative Procedure Act, Title 5 U.S.C., and applying standards consistent with the law and with published regulations. We also support the Commissioner's plan to preserve the non-adversarial nature of those hearings. We have cautioned against a return to the days of the "Government Representation Project," about which we have expressed concerns related to cost, effectiveness, and fairness to claimants. On the issue of when to close the record, the ABA has not taken a specific position. We recently urged that Medicare beneficiaries be provided the opportunity to reopen the record after the ALJ hearing, upon a showing of good cause. We note that current law already restricts the circumstances under which evidence may be submitted after the ALJ has rendered a decision.

The Commissioner's proposal as currently articulated eliminates the Appeals Council and replaces it with an oversight panel that reviews ALJ decisions. Claimants who disagree with an ALJ decision would not be permitted to request such a review; they would be required to appeal directly to federal court. The ABA has not taken a specific position on whether to retain or eliminate the Appeals Council, or whether to replace it with another form of review panel. However, we have long been concerned about significant delays at this level as well as agency attempts to use own-motion review by the Appeals Council to compromise the independence and impartiality of ALJ decision-making. In 1986, we urged a complete study of Appeals Council procedures and functions to determine whether review by this body is necessary and to explore possible changes in the Council's structure, methods of operation, delegation of authority, and its role as policy maker. We also recommended that if the Appeals Council fails to act upon a request for review within a specified period of time, claimants should be deemed to have exhausted their administrative remedies and permitted to seek federal court review.

We have seen improvement in the processing of cases at the Appeals Council level in recent years, and we encourage the Commissioner to consider the consequences of eliminating this level of appeal. Witnesses at the September 30 hearing discussed such issues as the need for timeliness of decision making, for fair and adequate review of ALJ decisions, for due process safeguards for claimants, and for finality of the agency decision (for judicial review purposes). They also raised concerns about the cost of court appeals, the burden on unrepresented claimants, and the burden on federal courts. We caution also that changes to this level of appeal not create additional delays or compromise the independence and impartiality of administrative law judge decision making.

Finally, mention has been made of creating Article I courts to hear Social Security appeals. The ABA has consistently opposed legislation to create Article I Social Security courts. We have observed that efforts to establish a separate court appear to be motivated by concerns over the volume of appeals and the need for uniformity of decision-making in these cases. At last week's hearing, concern also was expressed about the likelihood of an increased burden on Article III courts if the Appeals Council is eliminated. We have posited in the past that Social Security appeals are not drains on federal court resources because they are on the record reviews that in many, if not all, jurisdictions are considered by magistrates. The more significant problem is the need for accurate determinations at the agency level, particularly in the early stages of the process. Fixing the system at the front end will reduce the need for appeals. Simply shifting such appeals to another court system is not a practical solution.

We appreciate Commissioner Barnhart's efforts to address these important issues and we commend you for your ongoing efforts in this area. We respectfully request that this letter be made a part of the record of the September 30, 2004 hearing.

Sincerely,

Robert D. Evans
Director

Statement of Witold Skwierczynski, American Federation of Government Employees, American Federation of Labor-Congress of Industrial Organizations

Chairman Shaw, Chairman Herger, Ranking Members Matsui and Cardin, and members of the Social Security and Human Resource Subcommittees, I thank you for the opportunity to present this statement regarding the Commissioner Barnhart's proposals to change the process for making determinations regarding application's for Social Security disability benefits.

As the President of the American Federation of Government Employee's National Council of Social Security Field Operations Locals, I speak on behalf of approximately 50,000 Social Security Administration (SSA) employees in over 1500 facilities nationwide. The employees represented by our union work in Field Offices, Program Service Centers, TeleService Centers, Regional Offices of Quality Assurance, Offices of Hearings & Appeals, Regional Offices, Headquarters Offices, the Wilkes-Barre Data Operations Center, and other facilities throughout the country where retirement and disability benefit applications and appeal requests are received, processed, and reviewed.

The primary message our union hopes to convey to the members of the Subcommittee is that Commissioner's proposed changes to Social Security's Disability Determination Process will undermine the rights of the disabled to gain access to benefits they have earned and that the Social Security system has a duty to provide. As employees of the Social Security Administration, we have devoted our lives and our careers to making the promises of Social Security a tangible reality for our fellow citizens. We care deeply about the elderly, the survivors of a breadwinner who has perished, and the disabled. We take our responsibility of making sure that all those who are eligible to receive Social Security benefits receive them, and that in their encounters with our agency, they find our processes helpful, fair, and efficient.

Unfortunately, Commissioner Barnhart's Disability Determination "Reform" undermines those goals. Ultimately, it sets up an adversarial relationship between the SSA and those whose disabilities have led them to seek access to Disability benefits under Social Security. To make matters worse, the impact of these proposed "reforms" will fall most heavily on those who are both poor and disabled, because they are the group least likely to be successful in navigating a "reformed" system designed to require them to jump through numerous and complex legal hoops in order to gain access to the Social Security Disability benefits they have earned and that they need.

Not surprisingly, the occasion of having suffered an illness or injury that renders one disabled and in a position to apply for Social Security Disability Benefits often leaves our fellow citizens in an extremely weak position financially, physically, and emotionally. In many, if not most cases, their disabling condition inhibits their ability to seek or secure effective legal representation. The particulars of the Commissioner's proposed "reform" to the Disability Determination process would appear to exploit this fact. The inevitable result will be denial of Disability Benefits to those who meet all the program's *explicit* required criteria, but not the *implicit* required criteria of aggressive and competent legal counsel and the funds to pay for it.

The Commissioner's "Reform" the Disability Determination Process is Misguided

As SSA employees who know first-hand how the agency's policies and procedures affect beneficiaries, we can tell you that the Disability Determination Process has flaws and is thus in need of some reform. Yet the changes Commissioner Barnhart is pursuing do not address the areas that are actually in need of improvement. For example,the Commissioner's plan does little to address the need for a new quality management system that will routinely produce information the Agency needs to properly guide disability policy. Equity and consistency in disability decision-making continues to be inconsistent and problematic. Because of wide variation from state to state among the Disability Determination Service (DDS) workforce, a claimant's chances of being approved for disability benefits depends in large part on where he lives. There is also variation based upon whether a claimant has the resources to obtain medical attention.

SSA records suggest that those who have the resources to obtain medical attention early and often have a better chance of being approved for benefits than those whose income or resources make this impossible. In addition, nationwide, those applying for Social Security disability have a much greater chance of being approved than those who may only apply for the Supplement Security Income (SSI) program.

Finally, SSA records clearly expose the inconsistencies among State DDS decisions. More than 65 percent of Social Security disability claims for benefits are approved in New Hampshire, while less than 32 percent of those who file for benefits in Texas are approved. This was recently addressed in the Government Accountability Office's (GAO, formerly the General Accounting Office) report, GAO–04–552T.

GAO found that the state DDS's have:

- Two times the turnover of the federal workforce that performs similar work, resulting in increased costs to SSA for hiring and training, as well as increased claims-processing times;
- Difficulties in recruiting and hiring examiners due to state-imposed compensation limits, which has contributed to increases in claims-processing times, backlogs and turnovers;
- Critical training needs that are not being met, which have a large impact upon their examiner's ability to make disability decisions.

It seems certain that the state DDS will continue to be plagued with problems, in spite of SSA's efforts to provide additional resources. So long as inconsistent initial decisions are being made by state DDS's, we believe that it is unethical to eliminate the reconsideration process as Commissioner Barnhart's "reform" requires.

AFGE Critique of Commissioner's Plan

If inconsistency as a result of the patchwork of state DDS decisions is a problem, how can eliminating a claimant's opportunity to seek reconsideration of that decision be the solution? As preposterous as it is, taking away a claimant's opportunity to have a DDS decision reconsidered is one of the key elements of the Commissioner's anti-beneficiary "reforms." The six main components of the Commissioner's plan are as follows:

- Elimination of the Reconsideration Process,
- Creation of a "Quick Decision" Process
- Creation of a "Reviewing Official (RO)"
- Elimination of the Appeals Council Review
- Closure of the record
- Changes quality review to "end-of-line"

Eliminating the Reconsideration Process

The reconsideration process occurs after a DDS office makes an initial decision to deny a claim for disability benefits and marks the first level of appeal for a claimant. Currently, approximately one out of every five SSI recipients receives a favorable decision at the reconsideration level. Therefore, to eliminate the reconsideration process would take away opportunities for appeal at a less contentious stage and would eliminate the checks and balances of DDS examiner's decisions. Eliminating an opportunity that now proves successful for 20 percent of disabled beneficiaries who access it is unconscionable.

Creation of a "Quick Decision" Process

The Commissioner's plan to create a "Quick Decision" unit would mean that the DDS's receive and make decisions on the most difficult disability claims—a task that many DDS examiners will not be able to accomplish easily, since examiners have been found to lack the knowledge and skills to make such decisions as determined in GAO's January 2004 report on the "Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services." These "Quick Decisions" will relegate to the DDS all complex cases. They are a poor substitute for putting adequate resources into initial claim determination. The number of complex cases that will be sent to the state DDS offices will lead to backlogs and increased litigation as claimants who do not land in the "quick decision" category end up in the adversarial and litigious vortex described below.

Creation of a "Reviewing Official"

The Commissioner's decision to implement a "Reviewing Official (RO)" for the purpose of evaluating and recommending decisions to Administrative Law Judges (ALJ) will forever change our relationship with the public. Under the Commissioner's proposal, the Reviewing Official, who will be an attorney, will prepare a pre-hearing report. If the reviewing official recommends denial of the claim, the only way an ALJ can overturn the Reviewing Official's decision will be through a written legal brief that refutes every point made by the Reviewing Official.

The brief must describe the supporting evidence and basis for his/her decision if that decision conflicts with that of the Reviewing Official. Not only will this procedure result in forcing already over-worked ALJs to spend more time and resources on each case, it will also create new delays, backlogs, and litigation. Even more disturbing from the perspective of those who view the role of SSA as facilitating—not impeding—the delivery of Social Security benefits to those who meet eligibility requirements is that it places the new and increased burdens upon claimants. They will now have not only to make the case that they meet eligibility requirements, but they will also have to disprove every argument a Reviewing Official has put forth against them. This change will require the claimant to hire an attorney to pursue his/her claim for benefits, and dramatically increase the likelihood of prolonged litigation that serves neither SSA nor the claimants.

Elimination of Appeals Council Review

The Commissioner's plan is to deprive claimants of what was the last step in the appeal's process, the Appeals Council Review. In its place would be a sample end of line review and ALJ oversight that would review only a few decisions made by the Office of Hearings and Appeals. This change represents a loss in due process rights for claimants and beneficiaries, as access to end of line review and ALJ oversight is at the agency's discretion, and once a case is selected for end-of-line review, no testimony or other input on the part of the claimant is permitted.

Under the current appeal review process, approximately 28 percent of the cases reviewed by the Appeals Council have resulted in a decision either to reverse a decision to deny benefits, or to remand the case back to the DDS for further development. Of the cases remanded to DDS, approximately 75 percent result in allowances, according to SSA's own data.

Replacing the Appeals Council with an oversight panel means that once a claim has been denied, either by the ALJ or the oversight panel, the claimant must appeal to the Federal District Court. Unfortunately, this process is too expensive for most SSI beneficiaries to pursue. Claimants who live in rural areas will also be disadvantaged by the fact that few attorneys who practice near them will have been admitted to practice in Federal District Court. Once again, the ability to achieve benefits will depend on the claimant's financial resources and where he or she lives.

Closure of the Record

The Commissioner proposes closing the record after each claim has been processed. However, claimants who are disabled but do not have adequate health benefits or resources may not have sufficient medical evidence to support a claim. Under the Commissioner's "reform" even if the claimant is eventually able to obtain the proper, official medical evidence to support the claim, if it is not submitted during the life of the claim, the claim cannot be reopened for consideration. This is blatantly unfair to claimants, and flies in the face of SSA's long tradition of compassion and service.

In addition, this policy will create massive increases in duplicative workload and increases in litigation. Claimants' attorneys will recommend, prudently, that their clients file subsequent claims for benefits each and every time new medical evidence becomes available in order to protect their retroactivity. The problems that will be created by this "reform" will be enormous, as SSA's does not have the capability to house or track multiple, corresponding claims.

Changing Quality Review to "End of Line"

The Commissioner proposes that the quality review of all disability claims be accomplished at the "end-of-line." This means that after all decisions have been made, a quality review will be done, rather than the "in-line" review that has traditionally been performed. Therefore, if a decision were improperly rendered at any level, the errors will not be addressed in a timely manner. Additionally, the oversight panel responsible for conducting the "end-of-line" reviews will have the authority to overturn all decisions, approvals or denials, creating a breach of due process and a more hostile relationship with the disabled community.

If the claim has been denied, either by the ALJ or the Oversight Panel, the claimant must appeal to the Federal District Court. Unfortunately, this process is too expensive for most SSI recipients to pursue. Claimants who live in rural areas will have less access to attorneys who practice law in Federal District Courts. Once again, the ability to achieve benefits will depend on the resources available to an individual and where that person lives.

AFGE believes, based upon our long experience in serving the public, that when the disabled community begins to experience these harsh "reforms" the response

will be anger and resentment. The proposed changes by the Commissioner do nothing to improve the disability decision-making. They simply reduce processing time by eliminating steps and opportunities for claimants to make their case, and create an adversarial posture between the agency and those we should be serving.

Does the Commissioner's "Reform" Include Establishing Temporary Benefits?

There is reason to believe that the Commissioner's new approach, once fully implemented, will include an effort to introduce "time limited" or "temporary" disability benefits in Social Security. A radical move such as this is would have an enormous and detrimental impact Social Security's disability programs.

AFGE does not make this charge lightly. Earlier this year, union representatives became aware of SSA's plans to implement temporary allowance demonstration projects that would provide immediate cash and medical benefits for a specified period (12–24 months) to disability applicants. AFGE has also learned from concerned members of management who are unwilling to come forward publicly that the use the of the demonstration project authority masks the agency's intention to move directly to national implementation.

In July, 2004 meetings with SSA officials, AFGE representatives explained that we had become aware of the plan to replace the current disability system with "time limited benefits." Those officials did not deny such plans existed and seemed very concerned about the Union's awareness of these plans.

The introduction of "time-limited" disability benefits in Social Security will have far-reaching consequences for beneficiaries and the burdens and requirements that SSA places upon them in the context of the overall Social Security system. A determination by SSA regarding the length of time that an individual can be expected to remain disabled will inevitably be inaccurate for numerous beneficiaries. Further, the decision to experiment with the only source of income support that many who are both severely disabled and poor have appears to have been taken with virtually no public debate.

AFGE urges Members of these Subcommittees to seek an assessment of the economic impact of "time limited benefits." Given, the lack of clear guidelines for determining expected medical improvement, the time frames are determined at the discretion of the agency. If the Administration should follow through with plans to limit disability benefits to a 24-month period for recipients who are expected to medically recover in a 2–3 year period, it is possible that the vast majority of disabled recipients can be placed in this category.

AFGE Recommendations

AFGE believes that immediate attention needs to be given to three specific issues regarding the Social Security Disability Benefit program: 1) Provide proper staffing and resource allocations, 2) Ensure consistent disability decisions in a more expeditious manner, and 3) Maintain quality, face-to-face service and assistance at the field office level.

SSA's disability programs are at the heart of the Agency's many challenges. AFGE is just one of many voices that have insisted that SSA's disability structure has flaws that need to be addressed. The Commissioner's proposals, unfortunately, fail to address or resolve any of the systems real problems. Institutional problems continue to be overlooked. Communication between headquarters and operations in the field remains poor. SSA's approach of discouraging open discussion of problems continues to exist. Workgroups designed to address problem areas or workloads no longer include either the union or the employees who actually do the work. These employees in field offices and teleservice centers, who have been working at SSA's frontlines serving the public, know what is wrong and what is needed to solve existing problems. Although there used to be an open door policy between the Commissioner and our union, it no longer exists.

AFGE understands that long-lasting progress will only be achieved with the assistance of those who not only understand the problems, but who also have the institutional experience and knowledge to repair SSA's disability programs. Certainly much more can be accomplished in a constructive manner with open, two-way, communications. The union remains committed to such a process.

As I emphasized in previous testimony before the Social Security Subcommittee, the Disability Claims Manager (DCM) pilot (another SSA initiative) proved to be highly successful in addressing these problems in the disability program. Processing time was significantly better. In fact, the DCM processing time of 62 days was just over half of SSA's initial disability claim processing time goal of 120 days. Customer

service improved dramatically. Claimants expressed record high satisfaction rates for the DCM.

The public likes the DCM caseworker approach and wants it retained in the current process. Although SSA contended that the DCM would cost more than the current process, no valid data exists showing this conclusion. Also, the pilot was prematurely terminated, before valid statistical data could be compiled regarding full program costs. It is unfortunate that, since the last time I testified before the SSA Subcommittee, then Acting Commissioner, Larry Massanari, decided not to implement the most successful new disability initiative, the DCM. The DCM was a positive step to ensuring the public that consistent and equitable disability decisions are made. Unfortunately, no actions were taken to implement any of these successes, and the pilot was terminated. AFGE urges Congress to direct the SSA justify the elimination of this successful and innovative experiment. It is part of the answer to the disability problem.

It seems apparent that the primary reason why SSA terminated the DCM pilot was due to State resistance. Such resistance certainly was not based on a poor pilot result. Instead the decision appears to have been based on political considerations and the fear of losing work. Congress should be very concerned when SSA spends millions of dollars for a process that demonstrably improves the disability processing time, yet is rejected for political reasons. The concerns of the states are understandable in view of their unacceptably poor performance regarding decision consistency from state to state and their poor processing time in comparison to the DCM. However, the only real criteria should be the level of service that is provided to the claimant. Using customer service as a measure, the DCM exceeds State DDS performance in virtually every category.

AFGE recommended to Commissioner Barnhart that she reconsider former Acting Commissioner Massanari's decision and implement the position of the DCM at SSA as soon as possible. However, the Commissioner refuses to act on the AFGE's recommendation. AFGE is willing to work with the Commissioner in an incremental approach to achieving this goal. AFGE understands that there will need to be changes in policy, processes and institutional arrangements, as well as funding to implement this very valuable and successful position at SSA.

Legislative amendments to the Social Security Act would be necessary to allow SSA workers to make disability decisions, however the crisis in disability processing requires immediate, as well as long-term changes. When trained to make medical decisions, SSA employees can provide immediate relief to backlogged Disability Determination Agencies, and provide faster and better service to the public by serving as a single point of contact. The pilot demonstrates that the public likes the DCM, employees enthusiastically support it and that it provides substantially better service than the current disability product. We hope that Members of this Subcommittee will take the necessary action to ensure the DCM is part of the solution to the disability problem.

As a short term approach not requiring legislative change, AFGE is supportive of the "Technical Expert for Disability" position. This position would provide high quality, trained field office employees the tools to assist disability claimants in both programmatic and medical issues, provide professional, personalized, service to applicants, focus the disability interview, make or recommend disability decisions, and assist the DDS's in their development and backlogs.

Another tested initiative that would save considerable disability processing time is the Adjudicative Officer (AO). *There is no question that the AO would better serve the public than the Commissioner's proposed Reviewing Official position*. The AO, who is not an attorney, was intended to assist Administrative Law Judges to reduce the number of hearings and to prepare cases for efficient and expeditious hearings. AO's were empowered to gather additional evidence and to make favorable decisions without hearings when the evidence submitted indicated that such a decision was appropriate. The pilot indicated that many hearings requests were quickly adjudicated by AO's. These workers reduced the processing time for hearing requests. The AO's met the same fate as the DCM's. SSA cancelled the initiative. When processing time can be legitimately reduced, why did SSA terminate a methodology that achieved their objective? SSA should reexamine its decision.

The AO could be either a federal or state employee and, in fact, was located in DDS offices, ALJ Hearing offices, SSA Field Offices and Program Service Centers. By locating the position in multiple locations, the agency ensured the public more accessibility and individualized service in processing their hearing requests. In addition, by situating AO's away from hearing offices, SSA was separating these employees from the bureaucratic OHA management structure.

Although SSA never released any valid pilot results for the AO, preliminary data indicated that the AO's were able to issue favorable decisions in 17% of the hearings

cases. These cases were decided based on the evidence of record and did not require hearings before an ALJ. For the remaining cases, the preliminary data indicated that AO's did a good job of fully developing the record and preparing the case for hearing.

Many hearings offices reported that the AO's work resulted in significant time savings in cases decided by an ALJ. The preliminary data indicated that, midway through the pilot, the quality of the AO was approaching that of the ALJ's.

Unfortunately, SSA abolished the AO position in March 1999 despite the fact that AO's were responsible for quicker decisions for some applicants and a streamlined, efficient, expeditious hearing for others. AFGE suspects that management resistance to this disability improvement was centered on OHA fears of losing institutional control of a portion of the hearings process. Such fears should not be accommodated.

SSA will be unable to continue to process disability claims in a timely and efficient manner unless the Administration and Congress provide additional resources. Absent appropriate financing for additional staffing, SSA cannot guarantee provision of timely payment of benefits, correct administration of complex regulations or training and mentoring for either current employees or new workers.

Unless Congress acts to increase SSA's administrative budget, the agency's service levels will continue to decline, as SSA will never be able to hire the FTE's necessary to address its workloads. We believe that SSA's administrative budget should be set at a level that fits the needs of Social Security's taxpayers and beneficiaries rather than at an arbitrary level which fits within the government's overall discretionary spending cap. If SSA's administrative budget is not explicitly excluded from the cap on discretionary spending, SSA is forced to compete with other Federal agencies for scarce resources within the spending limits defined by law. The result will continue to erode SSA's ability to provide adequate service to tens of millions of Americans in the next decade.

Automated Electronic Disability Benefits (AeDIB)

SSA initially decided direct Offices to implement the Electronic Disability Claims System (EDCS) gradually, beginning slowly and eventually achieving 100 percent use as the DDS's gained access. Unfortunately, SSA management has been overzealous in the implementation of EDCS. This has caused tremendous problems for front line Claims Representatives (CR) throughout the country. Neither staffing nor interview appointment schedules has been adjusted to enable employees to produce the EDCS claims that management has been demanding from them. More and more employees are complaining of health and safety problems that are a direct result of excess keying involved in EDCS claims.

The recent decision by SSA to accelerate the national rollout of its AeDib initiative has resulted in many problems across the nation. Our union has conducted a nationwide survey of SSA's field office employees. Some of the problems identified include:

- Lengthier interviews due to additional keying time;
- Missed and delayed breaks and lunches;
- Prolonged waits in the reception area/delayed or missed appointments;
- Increased backlogs;
- Additional staff needed;

Lengthier interviews. Of those employees who responded to the Union's survey, 25% of offices overall reported spending an additional 30–45 minutes keying into the EDCS over the traditional paper process. 38% reported an additional 45–60 minutes. 24% reported more than an additional 60 minutes. The remaining 13% reported an additional 15–30 minutes.

Missed and delayed lunches and breaks. Overall, 72% of the offices reported missed lunches and breaks because of EDCS claims.

Prolonged waits in the reception area. 75% of the offices reported claimants were waiting longer in reception areas. 80% said appointments were frequently or sometimes delayed or missed because of EDCS, resulting in an angry public.

Increased backlogs. Increased backlogs of work were reported universally in most post-entitlement areas: re-determinations, medical and work Continuing Disability Reviews (CDR), overpayments, and worker's compensation were cited in virtually every response received.

Additional staff needed. 90% of the respondents reported they need 20–40% more staff because of the EDCS process.

While software enhancements may improve the EDCS process, they will not completely resolve the problems that are being experienced. As AFGE understands the EDCS process, the time saved will be at the back end of the disability process, not

the front end. Therefore, the time involved to input manually volumes of medical information that was once provided by the claimant in writing will always be a factor. Additionally, SSA is already moving forward to require other disability forms, such as the medical report form for appeals, to be manually input by Claims Representatives. This will only compound the problems already identified.

Conclusion

The Social Security system's Disability programs are a crucial component of the social safety net, and AFGE's Social Security members take great pride in providing service to disability beneficiaries. We are sincerely concerned about the wellbeing of disability beneficiaries, and consider our role as helping those who are unfortunate enough to have experienced a disability to obtain the Social Security benefits they have earned. We do not believe that it is proper for SSA to set up roadblocks to impede those with legitimate claims from obtaining their benefits. After careful study of the Commissioner's Disability "reform" plan, however, we believe that it is impossible to characterize it in any other way.

The Social Security Administration has a long and proud tradition of working constructively with its unionized workforce to make the Social Security system efficient, fair and "customer-friendly." That is why Social Security remains so popular and successful. The public service ethos that SSA employees have embraced will inevitably be undermined if Commissioner Barnhart's controversial Disability reforms are allowed to go forward. Instead of providing care and assistance to the disabled, the "reforms" will force us into an adversarial and litigious position against the disabled. We urge you to intervene and stop this "reform" from proceeding.

This concludes my statement. I will be happy to answer any questions that Members of the Subcommittee may have.

Statement of Robin J. Arzt, New York, New York

Mr. Chairmen and Members of the Subcommittees:

I. **INTRODUCTION**

Thank you for the opportunity to submit this statement. My name is Robin J. Arzt. I am an Administrative Law Judge ("ALJ") who has been hearing Social Security disability and Medicare cases for over ten years at the Office of Hearings and Appeals ("OHA") of the Social Security Administration ("SSA") in New York, New York, and formerly in the Bronx, New York. This statement is presented in my individual capacity.

My position as an Administrative Law Judge with the Social Security Administration is stated in this statement for identification purposes only. This statement was written in my private capacity and without the use of federal government resources or federal work time. No official support or endorsement by the Social Security Administration or the United States is or should be inferred. The views expressed in this statement are mine and do not necessarily represent the views of the Social Security Administration or the United States.

II. **COMMENTS ON COMMISSIONER BARNHART'S PROPOSAL TO IMPROVE THE DISABILITY PROCESS**

The Commissioner presented wide-ranging proposals to redesign the disability claims process from the initial determination stage through the final administrative decision step during her September 25, 2003, testimony before the Subcommittee on Social Security. At the hearing, the Commissioner proposed the elimination of the DDS reconsidered determination step. The Commissioner also proposed the creation of an SSA Reviewing Official ("RO"), who would be an attorney and would review a claimant's claim file upon the claimant's appeal from an adverse initial determination by the agency of a benefits application. The RO would have authority to grant a benefits claim but no authority to deny a claim outright If an RO does not fully grant a benefits claim, the claimant has a right to appeal for a *de novo* hearing before an ALJ appointed pursuant to APA. (On February 13, 2004, senior SSA officials publicly stated that the ROs essentially would replace the DDS reconsidered determination step and administratively are expected to be placed within the OHA but not in the OHA hearing offices.) The Commissioner also recommended the retention of a claimant's due process right, upon appeal from the agency's claim denial, to a *de novo* administrative hearing before an APA ALJ. In addition, the Commissioner also proposed to replace the Appeals Council with Oversight Panels that will include

ALJs. (The Commissioner since has stated publicly that the Oversight Panels are intended to be a quality review process, not the final administrative appellate step.)

The Commissioner is encouraging input from a wide range of stakeholders to aid in developing the details of her proposals prior to issuing proposed regulations, as she stated during her September 25, 2003, and February 26, 2004, testimony before the Subcommittee on Social Security. The Commissioner's bold proposals and inclusive process are appreciated.

It is excellent that the Commissioner is recommending the retention of the claimants' due process right, upon appeal from an RO's disability claim denial, to a *de* novo administrative hearing before an APA ALJ, who is an independent decisionmaker. The Commissioner's recognition that the APA provisions were enacted for the benefit of the claimants and to enhance the disability process should be commended. The Commissioner made her support of the ALJs and their role in the disability process clear during her September 25, 2003, testimony before the Subcommittee on Social Security. The Commissioner also reported that ALJ case "productivity rates [in FY 2003] were the highest in history" during her February 26, 2004, testimony before the Subcommittee on Social Security.

Only those proposals by the Commissioner that bear upon the SSA appellate administrative levels are commented upon in this statement. The remainder of this statement addresses the Commissioner's proposals regarding the (1) treatment of an RO's Recommended Disallowance or Pre-Hearing Report in an ALJ's decision, (2) administrative placement of the RO within SSA, and (3) replacement of the Appeals Council with Oversight Panels. My comments are made in the context of how the proposals will impact upon the consistency of case outcomes at the different decision levels, and how these proposals may be modified and implemented to maximize the consistency of disability decisions between the administrative levels and between the administrative levels and initial court level. I also make comments that address concerns about preserving the *de novo* nature of the ALJ hearing and ALJ decisional independence, the timeliness of decisions at the final administrative level, reduction of appellate caseloads at the administrative and court levels, status and use of the Appeals Council Administrative Appeals Judges ("AAJs") on the Oversight Panels, and wide acceptance of the SSA proposed regulations that may be issued to implement the proposals. I also raise APA and other due process issues that are presented.

A. **Treatment of a Reviewing Official's Recommended Disallowance or Pre-Hearing Report in an ALJ'S Decision**

The Commissioner proposes that, if an RO does not grant a disability claim, the RO will issue either (1) a Recommended Disallowance when the RO believes that the evidence shows the claimant is not disabled, or (2) a Pre-Hearing Report when the RO believes that the evidence is insufficient to determine eligibility for disability benefits. The Pre-Hearing Report will state what evidence is needed to successfully support the claim. The Commissioner also proposes that, only when an ALJ is granting disability benefits, an ALJ's decision must either state in detail why the RO's Recommended Disallowance is being rejected, or describe the new evidence added since the RO's Pre-Hearing Report that corresponds to the list of evidence that the RO said is needed for a successful claim.

There is no proposal that either requires details in the ALJ's decision regarding why the ALJ is accepting an RO's Recommended Disallowance, or requires a description of the new evidence supporting a denial of the claim in reference to an RO's Pre-Hearing Report. Therefore, the Commissioner's proposal would require that an ALJ provide a more extensive defense of granting benefits than denying benefits when discussing the RO's Recommended Disallowance and Pre-Hearing Report in the ALJ's decision. Accordingly, the proposal presumes the correctness of the RO's assessment as to what evidence is sufficient to grant or deny a disability benefits claim, which may incorrectly be interpreted as a requirement that the RO's assessment is entitled to some degree of deference.

The Commissioner told AALJ officers on October 24, 2003, that her proposal regarding how an ALJ must address the RO's Recommended Disallowance or Pre-Hearing Report in the ALJ's decision is not intended to interfere with the APA and Social Security Act requirements for an ALJ's decision. However, despite the Commissioner's good intentions for the proposal, the presumption of the correctness of the RO's assessment of the evidence that is embodied in the proposed disparity in the required treatment of the RO's documents by the ALJ that depends upon the

outcome of the case does impinge upon the *de novo*,[1] independent nature of the ALJ's hearing and decision process. Holding a *de novo* hearing means to hear a matter anew, as if it is being heard for the first time and no decision previously was rendered.[2] *De novo* review is "independent" review.[3] Accordingly, such an impingement will foster a perception of agency pressure to deny cases, unfairness, and improper deference to the RO documents in ALJ denials among claimants and their representatives that likely will result in an increase in the number of appeals from ALJ denials of benefits.

Moreover, any specific regulatory requirement that that the ALJ address the RO's documents would create the potential for erroneous arguments on appeal and appellate findings that an ALJ's decision is deficient for a failure to adequately address or defer to the RO's Recommended Disallowance or Pre-Hearing Report. The standard for a sufficient ALJ decision on appeal is whether there is substantial evidence in the record to support the decision, not whether the ALJ adequately addressed the contents of a prior decisionmaker's recommended decision or report.[4]

Therefore, augmenting the Commissioner's proposal to require such statements regarding the RO documents in all ALJ decisions, regardless of the outcome, does not cure all of the issues that the proposal raises. The creation of these issues by the proposal suggests that the proposal is not the most effective way to achieve greater consistency between the RO and ALJ decisions, since the likely increase in the number of appeals from ALJ denials and appellate error regarding how ALJs address the ROs' documents will defeat any potential for an increase in decision consistency between the RO and ALJ levels that the proposal is intended to achieve.

To preserve the independent, *de novo* nature of the ALJ hearing and decision, I respectfully submit that the Commissioner consider omitting a requirement that an ALJ address the RO's documents from her proposed regulations. (Even if the proposal is not part of the Commissioner's proposed regulations, the ROs' documents still would be helpful in developing the cases for the ALJ level.) The APA and Social Security Act already require that an ALJ discuss the evidence in rendering the decision on a disability benefits claim without reference to the outcome of the ALJ's decision or prior agency determinations.

The APA requires that all agency administrative decisions, including ALJ "decisions . . . shall include a statement of (A) findings and conclusions, and the reasons or basis therefor, on all the material issues of fact, law, or discretion presented on the record; and (B) the appropriate rule, order, sanction, relief, or denial thereof."[5] Title II of the Social Security Act sets forth the elements to be included in agency administrative decisions regarding eligibility for disability benefits:

Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, **setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based**. Upon request by any such individual or upon request by a wife, divorced wife, surviving divorced mother, surviving divorced father husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision.[6]

Decisions regarding supplemental security income eligibility under Title XVI and Medicare eligibility under Title XVIII of the Social Security Act must include the same elements as decisions regarding Title II disability eligibility.[7]

Instead of the proposal of a requirement that an ALJ address the RO's documents, which places a higher burden on ALJs to justify granting benefits than denying them, I respectfully submit that an effective way to increase the consistency of deci-

---

[1] The ALJ level of review is a *de novo* review. *Mathews v. Eldridge*, 424 U.S. 319, 339 n. 21 (1976).

[2] *Ness v. Commissioner*, 954 F.2d 1495, 1497 (9th Cir. 1992).

[3] *Premier Communications Network, Inc. v. Fuentes*, 880 F.2d 1096, 1102 (9th Cir. 1989).

[4] "The Appeals Council will review a case if (1) There appears to be an abuse of discretion by the administrative law judge; (2) There is an error of law; (3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence; or (4) There is a broad policy or procedural issue that may affect the general public interest." 20 C.F.R. § 404.970(a).

[5] 5 U.S.C. § 557(c).

[6] 42 U.S.C. § 405(b)(1) (emphasis added).

[7] 42 U.S.C. §§ 1383(c)(1)(A), 1395ff(b)(1).

sionmaking between the RO and ALJ decision levels would be to require that the RO use the same legal standards for determining disability as those by which the ALJs are bound, rather than the current practice of having the initial agency decisionmakers use a different and primarily medical set of standards. Since the ROs will be attorneys, implementation of legal standards for their decisionmaking will be met with a success that demonstrably has not been possible with non-attorney decisionmakers, such as the failed Process Unification Training for DDS decisionmakers and Adjudication Officer initiatives in the 1990s.

B. **The Administrative Placement of the Reviewing Official within SSA**

As is stated above, senior SSA officials recently stated that the ROs essentially would replace the DDS reconsidered determination step and administratively are expected to be placed within the OHA but not in the OHA hearing offices. If an RO does not fully grant a benefits claim, the Commissioner's proposal would provide a claimant the right to appeal for a *de novo* hearing before an ALJ. Accordingly, the RO's action on a benefits claim would be the last step of the Commissioner's initial decision of the benefits claim, an adverse decision from which the APA and Social Security Act provide for an appeal with reasonable notice and opportunity for a hearing on the record before an APA ALJ.[8]

Since the ROs would make the Commissioner's initial decisions of benefits claims, I respectfully submit that the Commissioner is required by the APA to administratively place the ROs outside of OHA. The APA requires a separation of the adjudication function of a federal administrative agency from its investigative and prosecutorial functions to preserve the decisional independence of ALJs when conducting a hearing or deciding a case. "[An ALJ] is not responsible to, or subject to the supervision or direction of, employees or agents engaged in the performance of investigative or prosecution functions for the agency.[9] "The APA separation of functions doctrine [set forth in 5 U.S.C. § 554(d)] requires only that the prosecutor and the adjudicator each be responsible to the agency head by a separate chain of authority."[10] This provision safeguards against undue agency influence and ensures that claimants receive independent adjudications of their claims. Therefore, SSA may not place its ROs in the same chain of command to the Commissioner as the ALJs, since the ROs perform SSA's investigative and prosecutorial functions in rendering initial determinations of benefits claims.

C. **Replacement of the Appeals Council with Oversight Panels**

The Commissioner's proposals include replacing the Appeals Counsel with a "Centralized Quality Control Review" ("CQCR") function within SSA with the final step of administrative review being by "Oversight Panels" of two ALJs and one Administrative Appeals Judge ("AAJ") upon referral of cases by CQCR staff. The individual ALJ's decision will be the final Commissioner's decision, if it is not reviewed by the CQCR or if it is affirmed by an Oversight Panel. If an Oversight Panel changes the outcome of the decision, then the Oversight Panel decision becomes the final Commissioner's decision. A claimant may appeal any final agency action to a United States District Court, but no claimant's right of appeal from an ALJ's decision to an Oversight Panel is stated. AAJs are subordinate employees who currently serve on the SSA Appeals Council.

I offer the following information regarding the ALJ appellate panel concept as AALJ has been proposing it to explain the many demonstrated benefits that a fully developed appellate panel system will bring to increase consistency between the final SSA administrative decision and initial court decision.

The Commissioner's Oversight Panel proposal borrows from my proposal for local appellate panels of three ALJs as the final step to replace the Appeals Council in the Social Security Act claims administrative process. The appellate panel proposal is part of a detailed proposal by AALJ that I authored for an ALJ-administered independent adjudication agency for Social Security Act benefits cases with the exclusive jurisdiction to make the final administrative decisions of Social Security Act Title II, XVI and XVIII benefits claims. (The detailed adjudication agency proposal is embodied in an AALJ policy position paper and my below-mentioned forthcoming law review article, which are available upon request. A summary of the adjudication agency proposal was submitted to the Subcommittee on Social Security as AALJ President Ronald G. Bernoski's statement for the record of the June 28, 2001, hearing on Social Security Disability Programs' Challenges and Opportunities.)

---

[8] 5 U.S.C. § 554(a); 42 U.S.C. §§ 405(b)(1), 1383(c)(1)(A), 1395ff(a)-(b)(1).
[9] 5 U.S.C. § 554(d)(2).
[10] *Columbia Research Corporation v. Schaffer,* 256 F.2d 677, 680 (2nd Cir. 1958).

Under the AALJ proposal, the claimants and the SSA would have a right of appeal of an individual ALJ's decision to an appellate panel staffed by ALJs that would consist of three ALJs who would review the cases regionally or locally. The appellate panels would be akin to the Bankruptcy Court appellate panels. Based upon the Bankruptcy Court experience, the appellate panel model (1) is an appellate system that can handle a large caseload, (2) results in higher quality decisions because of expertise, (3) results in substantially fewer appeals to the courts and a substantially lower reversal rate by the courts because of the bar's and courts' confidence in the high quality of the decisions, which reflects a higher degree of decision accuracy by three expert decisionmakers working together, (4) results in a substantially reduced federal court caseload, (5) results in a shorter disposition time because the large pool of about 1,000 SSA ALJs permits the timely determination of appeals that cannot take place with a small body such as the Appeals Council, and (6) affords the claimants access to a local appellate process. The elements and merits of the Bankruptcy Court appellate panel process are discussed in detail at the end of this statement.

The AALJ proposal for local ALJ appellate panels to replace the Appeals Council was favorably and extensively commented upon and recommended for use within SSA OHA in a March 2002 report commissioned by the SSAB.[11] It is the SSAB report that apparently brought the AALJ appellate panel proposal to the Commissioner's attention, given the Commissioner's reference to one of its authors, Professor Jeffrey Lubbers, as a source during her September 25, 2003, testimony before the Subcommittee on Social Security.

I am gratified that the Commissioner is proposing the panel approach to replace the Appeals Council. However, so far, it does not appear from the Commissioner's September 25, 2003, testimony and subsequent public statements that a claimant may appeal an individual ALJ's decision to an Oversight Panel. This is a major departure from AALJ's recommendation that would eliminate many of the benefits of the appellate panel concept, including much greater decisional consistency between the final administrative and initial court levels and fewer appeals to the federal courts. The Commissioner states that the CQCR and Oversight Panels are a quality review process, not an appellate step, as an explanation for why there is no claimant's right of appeal to an Oversight Panel. Another departure from the AALJ proposal is the use of an AAJ, a subordinate SSA employee with no protections for decisional independence, as one member of the three-member Oversight Panels. Also, the Commissioner has not yet determined whether the Panels will be regional or local for better access to the claimants, as AALJ recommends. Finally, the Commissioner has not yet determined whether Panel membership will rotate among the SSA ALJ workforce.

I respectfully submit that the quality review step posited by the Commissioner to the Oversight Panel level is an appeal, not only quality review, since the outcome of the case may change and, if it does, the Panel decision becomes the final decision of the Commissioner. Quality review usually involves a post mortem review of closed cases. The claimants must have a right to appeal to the Panels in order for the claimants, SSA, the courts, and the American public to receive the many demonstrated benefits to the Social Security disability process of an appellate panel process, including faster appellate decisions, increased consistency between the final SSA administrative decisions and initial court decisions, and fewer federal court appeals.

Without claimant appeals to the Oversight Panels, the District Courts will be inundated with appeals from the individual ALJ decisions, and will not have the benefits of the higher quality decisions and reduction of caseloads that would result from the better decisions by the Panels. There are about 100,000 claimant appeals to the Appeals Council per year, which would be a burden for the District Courts.

Also, permitting the agency appellate review of an ALJ's decision by an Oversight Panel, which is relatively easier, faster and lower cost than a District Court appeal, but limiting the claimants to only a District Court review of an adverse ALJ decision, raises substantial fairness and due process issues. The omission of the claimants' right to access the final administrative appellate step to review an ALJ's decision increases the risk that erroneous denials of benefits will not be corrected because some claimants, particularly *pro se* claimants, who would be able to pursue

---

[11] Paul Verkuil and Jeffrey Lubbers, *Alternative Approaches to Judicial Review of Social Security Disability Cases* 19–21, 56, 63–68 (March 2002), available at www.ssab.gov/verkuillubbers.pdf. This article includes an exhaustive survey of the many recommendations over the last 20 years to abolish the Appeals Council and suggested replacement mechanisms, including the AALJ proposal.

a relatively simple administrative appeal will not have the wherewithal to bear the additional burden of prosecuting a court appeal.

So that Social Security claimants, SSA, the federal courts, and the American public reap the benefits of a Bankruptcy Court appellate panel-style process, I respectfully submit that the Commissioner consider modifying her Oversight Panels proposal and issue regulations that provide that (1) a claimant has a right of appeal to the Oversight Panels, (2) the Oversight Panels is the final step of administrative review that must be taken by a claimant in order to seek judicial review of the Commissioner's decision in the claimant's case, (3) only independent decision makers may serve on the Oversight Panels, meaning ALJs who have the protections of the APA that have been put in place for the benefit of the claimants, (4) the Oversight Panels will be constituted regionally or locally for claimant access, (5) the Oversight Panels will be constituted from the full nationwide SSA ALJ workforce to ensure nationwide ALJ participation, and (6) there will be rotation of Oversight Panel duty among the ALJs in the SSA ALJ workforce to ensure that the Panel ALJs have recent line experience with hearing and deciding cases. All of these suggested modifications are the elements of the Bankruptcy Court appellate panel process that have made that process a demonstrated success.

The 27 AAJs from the Appeals Council may be afforded protections for decisional independence for the benefit of the claimants by grandfathering the AAJs into ALJ status, as was done in the 1970s for the administrative judges who heard SSI cases.[12]

The appellate panel system should result in faster and much higher quality decisions than those produced by the Appeals Council, but only if it functions as an appellate step for both the claimants and agency. A fully developed appellate panel process greatly will enhance the consistency of outcome between the final administrative step and District Court step, and thus reduce the number of appeals, just as it has between the Bankruptcy Court appellate panels and next level of judicial review.

My law review article, which is based upon the AALJ independent adjudication agency proposal,[13] includes a detailed statement of the ALJ appellate panel proposal and description of the successful Bankruptcy Court experience with the appellate panel process that I reprint as follows for the Subcommittees' reference as the remainder of my statement.[14] (Minor edits have been made to make the footnote references internally consistent.)

"Final Administrative Appellate Review by the United States Office of Hearings and Appeals

"PROPOSED TERMS FOR: FINAL ADMINISTRATIVE APPELLATE REVIEW BY THE UNITED STATES OFFICE OF HEARINGS AND APPEALS

"The Chief Judge shall establish a Social Security Appellate Panel Service in each region composed only of ALJs in the hearing offices in each region who are appointed for a period of years by the Chief Judge to hear and determine appeals taken from ALJ decisions issued pursuant to 42 U.S.C. §§ 405(b), 1383(c), and 1395(b). ALJs who are appointed to a Social Security Appellate Panel Service by the Chief Judge shall be appointed and may be reappointed. The Chief Judge shall designate a sufficient number of such panels so that appeals may be heard and disposed of expeditiously. Multi-region panels may be established to meet the needs of small regions. An appeal under this section shall be assigned to a panel of three members of a Social Security Appellate Panel Service, except that a member of such service may not hear an appeal originating in the hearing office which is the member's permanent duty station or the hearing office where the member is on a temporary detail assignment.

---

[12] "In 1977, Congress enacted Public Law Number 95–216, containing a section entitled Appointment of Hearing Examiners, which deemed the temporary ALJs to be permanent ALJs appointed pursuant to 5 U.S.C. § 3105 of the APA." Robin J. Arzt, *Adjudications by Administrative Law Judges Pursuant to the Social Security Act are Adjudications Pursuant to the Administrative Procedure Act*, 22 J. Nat'l Ass'n Admin. L. Judges 279, 304 & n. 96 (Fall 2002) (citing, Social Security Amendments of 1977, Pub. L. No. 95–216, 91 Stat.1509, 1559 (1977)).

[13] Robin J. Arzt, "Recommendations for a New Independent Adjudication Agency to Make the Final Administrative Adjudications of Social Security Act Benefits Claims," 23 J. Nat'l Ass'n Admin. L. Judges 267–386 (Fall 2003).

[14] *Id.,* at 356–361.

"EXPLAINATION OF PROPOSED TERMS FOR: FINAL ADMINISTRATIVE APPELLATE REVIEW BY THE UNITED STATES OFFICE OF HEARINGS AND APPEALS

"The USOHA will have a two tier appellate process: first, a decision after a hearing by an ALJ, and then an appeal to a local panel of three ALJs akin to the Bankruptcy Court Appellate Panel model. The Appellate Panels will be required to give deference to the individual ALJs' decisions, if they are supported by substantial evidence in the record. This proposal is modeled in p principle on the Bankruptcy Court Appellate Panel statute.[15]

"The Bankruptcy Court Appellate Panels were made permissive, not mandatory, and thus are not used in all Circuits, because of a Constitutional issue whether the use of the Panels is an improper delegation of Article III court jurisdiction over private rights in bankruptcy from the District Courts. Bankruptcy Court Appellate Panel review is a substitute for District Court review only upon all parties' consent and appeals go directly to the regional Circuit Courts of Appeals. Because there is no Constitutional jurisdiction issue for administrative cases involving entitlement to public rights that were created by statute, such as administrative determinations of entitlement to Social Security Act benefits, the Bankruptcy Court Appellate Panel model may be modified to make it mandatory for Social Security Act benefits cases.[16]

"The appellate panel system is one of the key features that makes the self-governing ALJ model superior to the current structure and commission model in providing high quality service and decisions for the claimants. The Bankruptcy Court system is another nationwide network of tribunals that hears a high volume of cases in a specialized area that are generated mostly from individual petitioners. There are ninety-two Bankruptcy Courts situated in proximity to the District Courts.[17] There are 140 Social Security hearing offices.[18] Over 1,500,000 cases were filed in Bankruptcy Court in 2002.[19] As is stated above, over 500,000 cases are brought before Social Security ALJs every year. Accordingly, Social Security claimants can benefit from the use of an appellate system that has proven to work on a large scale.

"In addition to being an appellate system that can handle a large caseload, the appellate panel system has several other benefits that would afford timely, high quality service to the Social Security claimants and Medicare beneficiaries and providers and likely reduce the requests for judicial review:

1. First and foremost, appellate panel decisions result in higher quality decisions. A survey of bankruptcy practitioners revealed that two-thirds of them believed that the appellate panel decisions were "better products" than District Court decisions.[20]
2. The confidence in the high quality of the appellate panel decisions by the bankruptcy bar has resulted in less than half as many appeals to the Circuit Courts as there are from District Court decisions.[21] In the Ninth Circuit in 1987, only 10% of appellate panel decisions were appealed compared to 25% of the District Court decisions.[22] Also, appellate panel decisions are reversed at the Circuit Court level less often than District Court decisions.[23] Thus, appellate panels substantially reduce the federal courts caseload, which reflects a higher degree of decision accuracy.
3. Appellate panels have a short average disposition time, which was only 75 days in the Ninth Circuit in 1994.[24]
4. Appellate panels afford access by the claimants, Medicare beneficiaries, and providers to a local appellate process.

---

[15] 28 U.S.C. § 158 (1993).

[16] Thalia L. Downing Carroll, *Why Practicality Should Trump Technicality: A Brief Argument for the Precedential Value of Bankruptcy Appellate Panel Decisions*, 33 Creighton L. Rev. 565 (2000); Hon. Barbara B. Crabb, *In Defense of Direct Appeals: A Further Reply to Professor Chemerinsky*, 71 Am. Bankr. L.J. 137 (1997); Tisha Morris, *The Establishment of Bankruptcy Panels Under the Bankruptcy Reform Act of 1994: Historical Background and Sixth Circuit Analysis*, 26 U. Memphis L. Rev. 1501 (1996); Thomas A. Wiseman, Jr., *The Case Against Bankruptcy Appellate Panels*, 4 Geo. Mason L. Rev. 1 (1995).

[17] 28 U.S.C. § 152 (2003).

[18] *See* Social Security Online, available at http://ftp.ssa.gov/oha/hearing__process.html.

[19] *Judicial Facts and Figures of the United States Courts: 1988–2002*, Table 5.1, *available at* http://www.uscourts.gov/ judicialfactsfigures/table5.1.htm.

[20] Wiseman, *supra* note 17, at 7.

[21] Morris, *supra* note 17, at 1509, 1517–19 (*citing*, *Final Report of the Federal Courts Study Committee*, 74–76 (1990); Wiseman, *supra* note 17, at 7).

[22] *Id.*

[23] *Id.*

[24] Morris, *supra* note 17, at 1530.

5. The large pool of over 1,000 ALJs permits the timely determination of appeals, which has not occurred with the SSA Appeals Council, as stated above in part III(C). Timely and high quality review cannot occur with a commission, which likely will not have more than twelve members and would have to resort to hiring SSA Appeals Council-type reviewers to handle the caseload.
6. Appellate panel work fosters the development of expertise by the panel members, which leads to better decisions.[25]
7. The opportunity for appellate work increases judges' morale and is viewed by judges as an honor and an opportunity to "improve judicial service to the litigants."[26]
8. Although the panel work would increase the workload of the ALJs,and thus additional judges likely will be required and additional travel and other administrative costs incurred,[27] given the elimination of the Appeals Council,with its staff of 27 AAJs and over 800 support personnel and substantial facilities,[28] and the elimination of the DHHS Medicare Appeals Council, the costs for the appellate panels, which can meet in already established local facilities, likely will be less than the cost of the two Appeals Councils. The SSA Fiscal Year 2000 Annual Performance Plan states that the annual cost of the Office of Appellate Operations, which includes the SSA Appeals Council, was $575 million.[29] The SSA Fiscal Year 2000 Performance and Accountability Report states that the unit cost for the SSA Appeals Council to hear a case is $440.[30] Since the SSA Appeals Council processed 146,980 appeals in fiscal year 2000, the cost of the SSA Appeals Council process apparently was $64,671,200 in fiscal year 2000.[31] Thus, unlike the Bankruptcy Court Appellate Panel Service, which was a new process in addition to the appellate step that already was available, the Social Security Appellate Panel Service is replacing a failed appellate review step that already exists and is funded.

"Thus, in summary, based upon the Bankruptcy Court experience, the appellate panel model (1) is an appellate system that can handle a large caseload, (2) results in higher quality decisions because of expertise, (3) results in substantially fewer appeals to the courts and a substantially lower reversal rate by the courts because of the bar's and courts' confidencein the high quality of the decisions, which reflects a higher degree of decision accuracy fromthree expert decisionmakers working together, (4) results in a substantially reduced federal court caseload, (5) results in a shorter disposition time because the large pool of about 1,000 ALJs permits the timely determination of appeals that cannot take place with a small body such as the SSA Appeals Council or a Commission, and (6) affords the claimants access to a local appellate process.

"A final point that should be considered is whether the appellate panel decisions should be given precedential value by the individual ALJs sitting in either the hearing office or entire region where the appeal originated.[32] However, the policy-making authority of the SSA and DHHS cannot be usurped."

(My position as an Administrative Law Judge with the Social Security Administration is stated in this statement for identification purposes only.)

---

[25] *Id.* at 1509 (*citing*, *Final Report of the Federal Courts Study Committee*, 74–75 (1990)).

[26] *Id.* (*quoting*, Federal Courts Study Commission, *Working Papers and Subcommittee Reports*, Vol. 1, 364 (1990)).

[27] *Id.* at 1512–13, 1520–22.

[28] *See* Social Security Online, *available at* http://www.ssa.gov/oha/about_ac.html.

[29] SSA Fiscal Year 2000 Annual Performance Plan 35, *available at* http://www.ssa.gov/budget/app/00appfin.htm#WorldClass.

[30] Fiscal Year 2000 Annual Performance and Accountability Report 119, *available at* http://www.ssa.gov/finance/fy00acctrep.pdf.

[31] *Id.*

[32] Downing Carroll, *supra* note 17, at 571–77.

Dothan, Alabama 36301
September 28, 2004

Congressman E. Clay Shaw, Jr.
Chairman, Subcommittee on Social Security
Congressman Wally Herger
Chairman, Subcommittee on Human Resources
United States House of Representatives
Ways and Means Committee
1100 Longworth House Office Building
Washington, D.C.

Dear Congressmen Shaw and Herger:

This letter is to be placed in the record of the above-referenced hearing. I am an attorney in Dothan, Alabama. I represent numerous individuals with claims for social security disability. I have some concerns and comments regarding the proposed changes in the claims administration process.

1. The record should be fully developed by a fully staffed Disability Determination Service. Currently, there is a great lack of uniformity in obtaining and reviewing claimant's medical records. Regional Expert Review Units should be accessible to all claimants.
2. Adequate compensation and information regarding the standards for assessing disability should be given to doctors who respond to requests for narrative letters.
3. The eDIB should require the scanning and notation of all documents contained in the claimants file, and should be backed up off site. A copy should be transmitted to the claimant or representative free of charge, and a paper copy should be provided to unrepresented claimants.
4. Digital recording of hearings should be required and available to the claimant or representative upon request. The use of video teleconferencing should be discouraged unless requested by the claimant. The lack of personal contact in assessing disability and inaccessibility of the judge, hearings officer (assistant) and experts to the claimant and counsel is simply too damaging to utilize this process.
5. The reconsideration level should be omitted in all states, whether under the present designation or a Reviewing Officer. It has been very successful in Alabama and the other states in which it was eliminated. Very few cases are allowed on reconsideration. It is more feasible to proceed directly to the ALJ for a hearing.
6. The hearing before the ALJ should be the next step after initial denial to expedite the process.
7. There is no need for SSA to have staff attorneys at hearings or reviewing the record, such as a Reviewing Offical. However, staff attorneys could review cases for on the record decisions.
8. Favorable decisions should be issued with a brief form stating the basis for the decision but without the great detail required when the claim is denied. This would allow approved claims to be issued more rapidly to people who desperately need the help. Issuance of decisions from the bench in appropriate cases would help as well.
9. The record should be held open for evidence that could not be submitted prior to the hearing.
10. Appeals council review upon request of the claimant should be retained as a useful buffer to the district court. Other review of determined cases is not appropriate barring an appeal.
11. The Federal District court should be retained as the court of last resort, pending review by the normal means.

Thank you very much.
Very truly yours,

Bryan S. Blackwell

Statement of Emily Stover Derocco, Employment and Training Administration, U.S. Department of Labor

Mr. Chairman, thank you for the opportunity to provide the Employment and Training Administration's (ETA) perspective on "return to work" efforts for individuals with disabilities.

ETA supports the return to work efforts carried out by the Social Security Administration (SSA), which has been a subject of this hearing. We also believe that the One-Stop Career Center system established under the Workforce Investment Act can play a vital role in helping individuals with disabilities enter jobs or return to work.

Striving for Full Engagement in the Labor Market

On February 1, 2001, President Bush announced his New Freedom Initiative, an effort to eliminate barriers to equality that many Americans with disabilities face. One of five key components of this initiative is "Integrating Americans with Disabilities into the Workforce." This includes expanding educational and employment opportunities and promoting full access to community life for people with disabilities. ETA is committed to achieving this goal.

Although it is critically important that individuals with disabilities have the opportunity to become fully engaged in the labor market, unfortunately, unemployment and underemployment remain unacceptably high for people with disabilities. According to the 2000 Census, among the civilian non-institutionalized population age 21–64, only 57% of individuals with disabilities are employed, compared with 77% of individuals without disabilities.

Meanwhile, the demand for skilled workers in our nation is outpacing supply, resulting in attractive high-paying jobs that go unfilled. It is necessary that we tap into new or previously untapped or underutilized skilled labor pools, such as individuals with disabilities, to help ensure that industries have the supply of skilled workers they need in order to successfully compete in today's economy. Through our efforts surrounding the President Bush's High Growth Job Training Initiative (HGJTI), we have been hearing directly from employers about the importance of this critical issue.

The HGJTI is a strategic effort to prepare workers to take advantage of new and increasing job opportunities in high-growth/high-demand and in economically vital industries and sectors of the American economy. The foundation of this initiative is partnerships that include the workforce investment system, business and industry, training providers and economic development entities working collaboratively to develop solutions to workforce challenges facing industries and to develop maximum access for American workers to gain the competencies they need to obtain jobs and build successful careers in these industries.

To date, ETA has focused on 12 "high-growth" industries. These industries have high growth in new jobs, a high rate of change in workforce skill needs, or are industries with new and emerging careers. The targeted industries include: automotive, advanced manufacturing, biotechnology, construction, energy, financial services, geospatial technology, health care, hospitality, information technology, retail, and transportation sectors.

Through the HGJTI we have conducted executive forums to identify the challenges these industries face. Through these forums, I have personally had the opportunity to meet with these industry leaders and listen as they identify their greatest workforce challenges. Although different industries may face unique challenges, one clear, overarching challenge faced by these diverse industries is finding a sufficient pool of skilled labor.

In response to the challenges that are identified, ETA holds "solution forums" to help these industries find solutions to the challenges they face. Representatives from all sectors have agreed with ETA that one "solution" to the shortage of skilled labor is finding access to new and/or previously untapped or underutilized labor pools, including individuals with disabilities. ETA believes that the One-Stop Career Center system can play a strong role in brokering relationships between these industries and the skilled labor they need, including individuals with disabilities, and helping individuals with disabilities obtain the current skills needed for gainful employment.

Interagency Coordination

In addition to our efforts under the HGJTI, we are also working closely with other federal agencies to develop coordinated strategies designed to move individuals with disabilities into competitive employment. These efforts support President Bush's

New Freedom Initiative by addressing several policy issues surrounding integrating Americans with disabilities into the workforce.

To enhance coordination across agencies, ETA has convened an *Inter-Agency Coordinating Forum for Individuals with Disabilities and the Workforce.* The forum offers an arena in which federal leaders can develop strategies, share information, and coordinate efforts around serving individuals with disabilities. Participants in this *Forum* include high-level participation from DOL's Office of Disability Employment Policy (ODEP), Veterans Employment and Training Services (VETS) and ETA; the Department of Education's Office of Special Education and Rehabilitative Service (OSERS); the Social Security Administration's Office of Disability and Income Support Programs; and the White House Domestic Policy Council.

At our most recent *Forum*, we had the opportunity to meet with employers to discuss strategies that the federal government can undertake to help employers hire individuals with disabilities. They identified challenges and activities, including:

- Making the "business case" for hiring people with disabilities, and letting other businesses know the value of hiring individuals with disabilities.
- Integrating information at the Federal level to provide tools, resources, and promising practices.
- Not only making information available, but also conducting an awareness campaign around hiring individuals with disabilities.
- Helping employers access and recruit individuals with disabilities, and, conversely, helping persons with disabilities understand the pathway through the public workforce system to employers with good jobs with career ladders and good benefits.

ODEP, working with its DOL colleagues, is engaged in activities that address a number of these challenges. ODEP is currently compiling promising disability employment practices from both the federal and private sectors and providing the information and resources that employers need to successfully recruit, develop, retain, and return individuals with disabilities to work. Through its Employer Assistance Referral Network (EARN), ODEP is in the process of developing the "business case." This work will help employers access, recruit and retain individuals with disabilities. Furthermore, ODEP's Job Accommodation Network (JAN) provides free, nationwide technical assistance and training on accommodation strategies for new and returning workers.

Moreover, over the past 18 months ODEP has partnered with HHS' Office on Disability (OD) to address, with other federal partners (Education, Commerce, Justice, Transportation, HUD, SSA, and Interior), the comprehensive service needs, including employment, of young adults with disabilities between the ages of 16 to 30. ODEP, in conjunction with ETA, has also worked with the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) as a key federal partner in helping to develop and implement SAMHSA's mental health systems transformation plan pursuant to the report of the President's New Freedom Commission on Mental Health.

Efforts to Enhance the Capacity of One-Stop Career Centers

In order for the One-Stop Career Center system to fully assist individuals with disabilities and the industries who seek to hire individuals with disabilities, One-Stop Career Centers must be physically and programmatically accessible. Although there is still work to be done, the One-Stop Career Center system has become increasingly accessible through initiatives such as the Disability Program Navigator, Work Incentive Grants, and the issuance of the Workforce Investment Act (WIA) Section 188 Disability Checklist.

First, the Disability Program Navigator (DPN) is a collaborative effort funded by DOL and SSA. The DPN is a position in the One-Stop Career Center that helps people with disabilities "navigate" through the enormous challenges of seeking work. Complex rules surrounding entitlement programs, along with fear of losing cash assistance and health benefits, can often discourage people with disabilities from working. DOL and SSA have established the DPN to better inform beneficiaries and other individuals with disabilities about the work support programs now available through One-Stop Career Centers, including facilitating access to counseling on the impact of employment on the individual's cash assistance or health benefits.

Navigators work closely with other programs funded by SSA. Examples include the Benefits Planning, Assistance, and Outreach (BPAO) program, which helps SSA beneficiaries make informed choices about work, and Area Work Incentives Coordinators (AWIC) whose duties include assisting with public outreach on work incentives, training on SSA's employment support programs for personnel, and monitoring disability work-issue workloads in their areas.

Through grants to seventeen states, approximately 120 Navigator positions were established in One-Stops in program year 2003, with another 80–100 positions to be added in program year 2004. These navigators are building the capacity of the One-Stop Career Center system to serve individuals with disabilities and to help these individuals find and retain employment.

Also, Work Incentive Grants have helped local areas increase the employability, employment and career advancement of people with disabilities through enhanced service delivery in the One-Stop Career Center system. These grants have been used to support physical access to services for people with disabilities.

In addition, DOL's Civil Rights Center (CRC), in cooperation with ETA and ODEP, developed a "WIA Section 188 Disability Checklist" to help ensure One-Stop Career Centers are accessible for individuals with disabilities. The Checklist is designed to ensure meaningful participation of people with disabilities in programs and activities operated by recipients of financial assistance under WIA.

Finally, there is opportunity for One-Stop Career Centers to participate more fully as Employment Networks in the Ticket-to-Work program, authorized by the Ticket to Work and Work Incentives Improvement Act (TTWWIIA). Through this program, eligible individuals are given a ticket that can be voluntarily used to obtain employment-related services at Employment Networks (EN) or State Vocational Rehabilitation (VR) agencies. The purpose of the Ticket program is to give SSI and SSDI beneficiaries greater choice of service providers, beyond the traditional VR agencies. An EN or VR agency that accepts a ticket assumes responsibility for coordinating and delivering employment-related services to the beneficiary.

To date, One-Stop Career Center participation as Employment Networks has been minimal. ETA is committed to continue working with SSA to maximize One-Stop Career Center participation in the Ticket-to-Work program.

Conclusion:

In conclusion, ETA is working to carry out the mandates of the President's New Freedom Initiative, to meet the needs of employers and to help individuals with disabilities integrate into the labor force. As such, ETA strongly supports SSA in its return to work efforts. ETA and SSA continue to work collaboratively to help individuals with disabilities enter the workforce for the first time or return to work. Further, the One-Stop Career Center system can play a strong role in helping individuals with disabilities find or return to work, through community connections, connections to employers and the system's pulse on the labor market.

Federal Bar Association
Washington, DC 20037
October 13, 2004

The Honorable Clay Shaw, Jr.
Chairman
Subcommittee on Social Security
U.S. House of Representatives
Washington, D.C.20515

Dear Chairman Shaw and Chairman Herger:

The FBA Social Security Section appreciates your leadership in holding the joint hearing on September 30 on the Commissioner of Social Security's proposal to improve the disability process. We request the inclusion of this correspondence in the record of that hearing.

As you know, the Federal Bar Association is the foremost national association of private and government lawyers engaged in practice before the federal courts and federal agencies. Sixteen thousand members of the legal profession belong to the Federal Bar Association. There are also within the FBA over a dozen sections organized by substantive areas of practice, including the Social Security Section. The Federal Bar Association's Social Security Section, unlike other organizations associated with Social Security disability practice and representing the narrow interests of one specific group, encompasses all attorneys involved in Social Security disability adjudication, including attorney representatives of claimants, administrative law judges, Appeals Council judges, staff attorneys in the SSA Office of Hearings and Appeals and Office of General Counsel, U.S. Attorneys and U.S. Magistrate Judges, District Court Judges and Circuit Court Judges.

The Social Security Section of the Federal Bar Association generally applauds the September 25, 2003 proposal of Jo Anne Barnhart, Commissioner of Social Security, to improve the disability adjudication process. The Commissioner is appropriately concerned about speeding up accurate determinations of disability. The FBA is hopeful that the Commissioner's initiative can be implemented to achieve these goals while preserving the claimant's right to a fair hearing.

The Commissioner has documented what our experience has confirmed: the current system devotes excessive time to waiting for substantive administrative action. The elimination of review levels and the addition of procedural innovations like the Reviewing Official can enhance the prompt, accurate determination of disability.

Our specific comments in this statement address the merits of five components of the Commissioner's proposal: the elimination of the reconsideration level; the establishment of the reviewing official; preservation and improvement of the ALJ hearing; elimination of the Appeals Council; and the closing of the record.

Elimination of Reconsideration Level

The elimination of the reconsideration review level is a meritorious proposal to speed up the accurate adjudication of disability claims. As suggested by the Commissioner, in too few adjudications do reconsideration reviewers accurately distinguish obviously disabled claimants from unentitled applicants. The FBA supports the Commissioner's proposal to save time and money by eliminating the reconsideration level and permitting claimants to proceed to the hearing level sooner.

Establishment of the Reviewing Official

The Reviewing Official (RO) concept is also a well-conceived improvement to speed up the adjudication process. Hopefully, the RO will be able to promptly identify claimants whose medical records establish that they are disabled, but were not awarded benefits at the initial level for whatever reason. The RO can approve these individuals' claims without the necessity of a full hearing. The RO also may be able to obtain additional documentation either from treating medical professionals or from consultants to establish disability without the need for hearing.

We believe the RO should be an attorney familiar with due process, who by legal training remains open to new evidence and legal persuasion. The incumbent of this important position must be sensitive to the rights of the claimant and the independence of the ALJs, as well as the administrative requirements of the Social Security system. We believe an attorney's legal training will help to assure that the RO can administer these conflicting demands.

However, we believe if the RO cannot allow the case, the RO should issue a prehearing report, rather than making some sort of "denial". This action will preserve the *de novo* review nature of the hearing process; a prehearing report will act as a road map to the claimant and the administrative law judge (ALJ) at the hearing. The Commissioner's idea of a "recommended disposition" encroaches on the independence of the ALJ, and the claimant's right to a fair hearing with full administrative due process.

We believe the Commissioner's proposal should make explicit that the RO's decision is not entitled to more weight than any other evidence in the administrative record. There should be no presumption that the RO's disposition is an adjudication, unless it is fully favorable to the claimant. Moreover, determinations that are not fully favorable to the claimant should be automatically reviewed by the ALJ. That is, the claimant would not need to file a second request for hearing after the RO's denial in order to have his case heard by an ALJ. These modifications, as well as the RO's issuance of a prehearing report, would serve to preserve the independence of the Administrative Law Judge and the claimant's right to a fair hearing with full administrative due process.

Preservation and Improvement of the ALJ Hearing

We applaud the Commissioner's preservation of the role of ALJs. The Federal Bar Association has consistently supported the role of the Administrative Law Judge in the adjudication of Social Security disability appeals. The ALJ presides over a non-adversarial process in which the claimant is present, but the government official who rejected the claim for benefits is not. The claimant may well be wary of such a system and may doubt that the ALJ will impartially and independently hear the claim for benefits. Yet that is exactly what is expected of the ALJ. It is for this reason that the FBA is gratified that the Commissioner's plan preserves the independence of the ALJ in the adjudication process, and recognizes the pivotal role played by the ALJ in providing process due every American seeking fair and accurate de-

terminations of disability. The ALJs are key to the effectiveness of the adjudicatory process.

We believe the independence and quality of both medical experts and consulting medical professionals utilized throughout the administrative system must also be assured. Such independence is essential to the success of the hearing process and will promote accurate determinations. Expert, impartial, professional examinations and testimony are crucial to the goal of accurate determinations of disability. The Commissioner should assure that medical professionals are truly independent, knowledgeable witnesses who testify to the claimant's impairments and resulting abilities and limitations. Their examinations and testimony will permit the ALJ to accurately determine the entitlement of claimants to disability benefits.

Elimination of the Appeals Council

While we agree with the Commissioner that the abolition of the Appeals Council will result in a faster adjudicatory process, we fear there will be a significant loss to the administrative process without the Appeals Council determinations and an inundation of the Federal Courts with disability cases. According to the Social Security Administration, the Appeals Council receives about 77,000 requests for review each year. The Appeals Council remands 25% of the appeals back to the ALJ. That represents over 19,000 cases that are filtered out and do not reach federal court. According to Judge Frederick Stamp, chair of the Committee on Federal-State Jurisdiction of the Judicial Conference of the United States, 17,127 Social

Security disability insurance and supplemental security income cases were filed in federal district courts during the last fiscal year. Without the Appeals Council filter, that number could well have doubled. In light of these caseload ramifications for the federal courts, we are concerned by the proposal to abolish the Appeals Council without knowing further details about the operation of the optional quality review stage. Without these details, it is difficult to criticize the Commissioner's proposal.

We foresee significant administrative difficulties by simply abolishing the Appeals Council and permitting dissatisfied claimants to proceed to District Court. The ALJs' mistakes of law or fact will not significantly decline merely because of the new administrative process. The Commissioner's proposed quality assurance Oversight Panels may correct some of these errors. However, we fear that in doing so, they may unintentionally interfere with or undermine ALJs' authority and independence. (For example, it is unlikely that a quality Oversight Panel that did not see and hear a medical or lay witness would overrule an ALJ's credibility finding.) Moreover, the Oversight Panels apparently do not provide claimants a procedure to correct or even raise gross errors contained in ALJ decisions. Timely submitted, definitive evidence that was not seen or considered by the ALJ, for example, could well change the administrative outcome. Under the Commissioner's proposal, a claimant's only recourse is to go to federal court. Unless administrative procedures ameliorate the likelihood of these probable outcomes, federal courts will be inundated with Social Security litigation.

The Commissioner's quality assurance program is intended to prevent a tidal wave of cases surging into the federal courts. Yet the Commissioner has not explained how the Oversight Panel will: select cases for review, how many cases will be reviewed; whether the claimant can request review (petition for certiorari); or whether the panels will consider new and material evidence. The devil is in the details, and the stakeholder community needs to know these details before we can adequately respond to the proposal of the Commissioner to abolish the Appeals Council.

Closing the Record

There should always be a "good cause" exception that authorizes a "late" submission of evidence to the administrative proceedings. Sometimes after a decision, a claimant further undergoes a medical test, responds to a new treatment, or sees a new specialistwho clarifies the claimant's medical condition. Sometimes an ALJ's decision transforms seemingly irrelevant information into relevant evidence. If the evidence is new and material, and there is good cause for the failure to produce it previously, then the evidence should be made part of the administrative record and considered. The federal courts regularly grapple with determining whether the evidence meets this standard. The meaning of the existing law, 42 U.S.C.§405(g), is clear. Such a "good cause" exception should similarly apply at the administrative level, just as it already does at the federal court level, and become part of the improved disability appeal process.

We appreciate the opportunity to offer these comments and continue to remain available to you and your staff in your conduct of oversight of these important matters.

Very truly yours,

Gary Flack
Chairman
Social Security Section

Statement of Sudhir Jaituni, Roseville, California

Subject: Record for submission on DDS Medical Consultants (MC)

I am a Physician who works as MC at Roseville branch DDS in CA for almost a year. Although I am relatively new in this position, I am very impressed by the high quality of my co-workers, both the MCs and Disability Examiners (DE). There is great amount of dedication and hard work by both these professionals to maintain the quality. Also a sense of helping disabled in our community pervades in the culture of work environment.

I believe the team work between the MC and DEs has worked with enormous success to achieve outstanding quality both in terms of timeliness and accuracy. The contribution of MC towards both of these goals is invaluable and cannot be replaced by regional experts or by other professional such as Nurses on day by day basis or cost efficient manner.. This is because an MC provides timely, on-site consults to his/her team of DE, who he/she knows well. MC also acts as specialist in medical field of his/her training (e.g. I have in-depth knowledge of cancer). We have a broad mix of medical specialties at our branch and we regularly take advantage of each other's expertise by informal consults. MCs also save money by judicious approach to the process, based on evaluation of objective medical findings both via review of medical records and consultation with treating doctors with whom we tend to reach great rapport.

I spend anywhere from 15 minutes to an hour on each case for the MC component of disability determination so there is no delay or back log of work due to MC consultation. Instead it helps DE in avoiding over or under development of case in reaching favorable decision. Many cases are expedited by using presumptive disability or TERI route.

I hope my comments will be helpful to the committee and I apologize for an informal way of writing. Thank you for allowing my input.

Edmonds, WA 98026
September 28, 2004

U.S. House Ways & Means Committee
Joint Hearing on SSA Disability Determination Proposals
1100 Longworth HOB
Washington, DC, 20515

Dear Committee Members,

Thank you for this opportunity to comment on the issues before Ways & Means as you begin formal discussions of Commissioner Barnhart's proposals. As a medical consultant to the DDDS offices here in Washington and a concerned citizen, I cannot overemphasize the importance of these proceedings. Primarily I would like to declare my support to the testimony you will hear from the National Council of Disability Determination Directors (NCDDD) and the National Assn of Disability Examiners (NADE). My own perspective is also shared here for the record.

The Commissioner's objectives are honorable and ambitious. Like most of my DDDS colleagues, I share her goals of improving service to our claimants and speeding up the application process. In documents available to you from NCDDD and NADE, we who serve on the front lines of the determination process have some areas of agreement with Commissioner Barnhart, and some areas of deep concern. These organizations represent those of us who do the daily work, making the complex decisions that provide disability benefits to the neediest of America's needy. I urge you to consider their testimony.

Following are some highlights of the issues before you. I direct these comments to you as a citizen, a family physician, a taxpayer, a cancer survivor, and as some-

one with three years of experience with DDDS; enough to know the system, but not long enough to lose my public perspective.

1. NCDDD and NADE support the proposal to bring the disability determination process into the electronic age. I wholeheartedly concur. Implementation of 'eDib' has already begun, and Commissioner Barnhart will speak highly of these efforts. However,

   - Rolling this system out to the states is, at least by some accounts, proving more difficult than expected, consuming significant time & resources.
   - The software and systems utilized are already behind the times. If we are to improve efficiency in the long run with this system, updates and improvements will be needed that may be more costly than anticipated, pulling money away from already strained areas.
   - Likewise, full implementation of eDib will be such a fundamental change for DDDS and SSA, it is unlikely our system will tolerate any other large-scale changes in the near future.

Suggestion: The online/electronic conversion is the priority. If this is properly completed, many of the Commissioner's goals will be met (reduced processing time, improved accuracy and better documentation). Almost everything else should be considered very low priority.

2. NCDDD and NADE strongly oppose reorganization of the DDDS Medical Consultants ("MCs"). The Commissioner hopes to improve efficiency and accuracy by removing the MCs from the DDDS offices and placing a few of us in regional offices (Regional Expert Review Units), accessible for online or perhaps chart-based consultation in select cases. It may not be an exaggeration to say that this will paralyze the DDDS offices, though I don't suspect NCDDD or NADE will use quite so strong a term in public.

   - Presently, DDDS MCs have several important roles—reviewing initial, reconsideration-level and continuing disability claims, improving documentation, mentoring both new and experienced adjudicators, providing quality assurance, and interacting directly with treating providers to get additional, often vital information for a claim. These services disappear under the current proposal for restructuring.
   - DDDS adjudicators are a well-trained, motivated, altruistic group, but their job is already difficult enough. Moving the MCs off site will be yanking the proverbial rug out from under their feet. Even the most experienced, well-trained adjudicators (15 years and counting) have difficulty with the depth of medical information MCs interpret every day. Our high staff turnover brings less experienced folks to my desk even more frequently. Even if our adjudicators are given more time to process each case, the fact is many cases hinge on careful medical review of the application. Asking our staff to bear this burden alone, with only nurse (one of the initial proposals) or occasional online specialist review is asking too much. Quality, accuracy, documentation and adjudicator retention will nosedive.
   - The Commissioner implies that only medical specialists will have a role in her new system, again with the hope of improved accuracy and efficiency. NCDDD, NADE and I instead support the continued involvement of primary care physicians. Rarely these days are applications based on one alleged condition. Generally we consider the combined impairment of things like heart disease, musculoskeletal conditions and neurologic findings. While we value the occasional input of an orthopedic or cardiac specialist, moving such cases from desk to desk hardly improves efficiency, especially when the great majority of cases fall within my expertise as a primary care MD well-trained in Social Security policies.
   - Keeping MCs on site not only preserves the fundamental service we provide with individual claims, it keeps us available for questions from QA staff, supervisors, trainers and managers. Removing us shifts the entire paradigm and will dismantle the support network within the DDDS offices. The resulting errors will further burden the review and appeal system, counter to one of the clear long-term goals of our process. For what little may be gained by centralizing the MCs, much will be lost.

Suggestion: Leave the Medical Consultants, from both primary care and specialty backgrounds, on site at the DDDS offices. Establishment of the electronic determination process will provide unprecedented access to needed specialty and reviewer input, while maintaining the critical and complex role of on-site MCs.

3. NCDDD and NADE do not support the proposal to develop Quick Decision units. The Commissioner believes these new units, staffed by 'medical experts', will speed service for claimants who are obviously disabled. I am concerned that this expenditure of resources may actually fragment our process, and do little to speed up claims.

   - There are three steps to our process—gathering of information, decision, and review/appeal. Quick Decision units will not affect the first or the third. The second is not at all time consuming, and (as suggested by NCDDD & NADE) can be kept within the DDDS offices. Cases brought to an MC with adequate documentation of entities like widespread cancer, severe renal failure, and incapacitating stroke require only minutes to process.

Suggestion: Improving our tools for evidence gathering will do far more to reduce processing time, and should receive priority. Quick Decision units are unnecessary. Consideration should also be given to improving training at SSA field offices, and even placing trained DDS adjudicators on site to identify and prioritize high probability claims.

4. NCDDD and NADE generally support the elimination of the 'recon' step as it currently exists, as well as the number of appeals available to a claimant after an ALJ hearing. As an alternative to the reconsideration step, the Commissioner proposes review by an SSA Reviewing Official. NCDDD and NADE believe this step should be left to the more qualified DDDS staff, perhaps dedicating some of our most seasoned adjudicators with a broad knowledge of the medical, vocational and procedural aspects of our policies. Compared with the more narrow experience of a social security attorney, our staff is better qualified for this task. Currently, SSA regulations require a Medical Consultant (MD or psych PhD) signature for all reconsideration claims; are we prepared to modify that standard in the name of moving a minority of cases faster?

Suggestion: If the 'recon' step is modified in the name of expediency, highly experienced DDDS adjudicators should be recruited to fill the 'RO' posts, rather than attorneys, and easy access to DDDS Medical Consultants should be maintained.

NCDDD, NADE, the DDDS staff and consultants all share the same goals. We are dedicated to providing superb service to our claimants. And we welcome efforts to improve the complicated determination process, including those proposed by the Commissioner, yet we remain acutely aware of the risks of unnecessary reform and reorganization.

Let us see how we are doing once the electronic conversion is fully in place. The additional, large-scale changes may have effects quite contrary to those predicted by the Commissioner. As our claims continue to increase in quantity and complexity, now is not the time to take apart the DDDS engine. Thank you for your time.

Respectfully yours,

Jeff R. Merrill

Statement of James R. Shaw, National Association of Disability Representatives, Framingham, Massachusetts

The National Association of Disability Representatives, Inc. (NADR) is a not-for-profit organization comprised of attorneys and professional non-attorneys representatives who provide representative services for persons seeking to obtain or maintain disability benefits from the Social Security Administration. Our goal is to continually improve the quality of representation for impaired and disabled individuals before the Social Security Administration.

We commend Commissioner Barnhart and the Social Security Administration for their hard work to redesign and improve the disability determination process. We believe that continued input from various entities whose constituents are impacted, as well as professional organizations, will provide Commissioner Barnhart with valuable "real world" information, allowing her to cultivate the original proposal into a very workable plan.

In particular, we strongly agree with other advocacy groups on the primary importance of enacting changes that reduce unnecessary delays for claimants. All parties involved in the process must continue to make this system become as efficient as possible in order to obtain the correct decision as early in the process as possible. Efficiency, however, should not impact the fairness of someone's entitlement to benefits.

Many of NADR's members have worked in a professional position for various state agencies' disability determination services or other tertiary positions such as vocational experts testifying in disability hearings. We understand the fundamental problems that exist within the programs but must stress the importance of removing claim backlogs, therefore eliminating or at least decreasing delays at the later stages of appeal. Standardization of much of the system for more consistent decisions as early as possible should be the methodology to attain this goal.

Since its inception in March 2000, NADR has strongly disputed the philosophy propounded by other organizations such as NOSSCR that only persons who have passed the bar are qualified to perform representation services. We believe that the simple possession of a Juris Doctorate has little or no bearing upon successful representation. Skills and knowledge of the Social Security process, among other traits, distinguish a good representative from one who might not be competent. Those of us who are not attorneys but who have made this our profession continue to seek parity with our colleagues who are attorneys. We believe that knowledge and experience are more important than an educational degree in determining whether an individual is qualified to provide such specialized assistance to impaired persons.

NADR is a member of the Consortium for Citizens with Disabilities (CCD) and agrees strongly with the position espoused in its Committee statement except for one issue found in Section I. *Reviewing Official (RO)*.

CCD maintains that the Reviewing Official should be an attorney. However, in keeping with our long held philosophical underpinnings of parity, NADR believes that the RO does not need to be an attorney, but should be anyone, attorney or not, who has sufficient knowledge of the Social Security disability system. We join other organizations like the National Council of Disability Determination Directors (NCDDD) and the National Association of Social Security Management Associations (NASSMA) in this view.

Our belief is that any person who by training and education has the knowledge, expertise, and experience to understand the requirements of proper adjudication of claims and can formulate written opinions that can be substantiated at higher levels of review is qualified to be an effective Reviewing Official. This may include but not be limited to:

1. Anyone who has significant expertise and experience in the representation of disability clients before the Social Security Administration;
2. Anyone who has attained senior status in an adjudicatory position within Disability Determination Services; or,
3. Anyone who has attained senior status in an adjudicatory and/or review/brief writing position within the Office of Hearings & Appeals.

In order to ensure maximum protection of claimants' rights, we vehemently stress that candidates for this position should not be exclusively limited to attorneys, as this may significantly limit the scope of the job and very well may deprive the system and clients of a better qualified person for said job.

On behalf of the National Association of Disability Representatives, I am pleased to have provided the Subcommittee with our views.

Statement of Lawrence A. Plumlee, Dallas, Texas Introduction:

I appreciate the House Subcommittee on Social Security's holding this "Joint Hearing on Commissioner of Social Security's Proposal to Improve the Disability Process". A wide range of suggestions have recently been made to improve the Social Security disability determination process, which at present is both slow in operation and non-uniform in its application.

I testify here today on behalf of myself, a physician trained at Johns Hopkins University, and a former EPA health advisor, who is president or on the board of directors of several disability groups. I wish to discuss today the experience of the determination of disability under the direction of State Agency Consultants in Texas, and the lessons that it may provide to the consideration of some of the new proposals.

I previously testified to this Subcommittee about the recent history of the Texas Rehabilitation Commission (TRC) Disability Determination Services (DDS) at the hearing of September 25, 2003. My testimony is now available at http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly &id=1847.

TRC determines nearly a quarter million Social Security disability (SSDI and SSI) claims per year at the initial, reconsideration, and Continuing Disability Review (CDR) levels on behalf of SSA at a cost of approximately $300 each. There have been a number of problems in the determination of Social Security disability in

Texas in recent years. In my 2003 testimony, I cited about 45 newspaper articles on the subject published in the Houston Chronicle during 2001–3, mostly written by reporter Alan Bernstein.

Since that time, TRC has been dissolved as an agency, with its functions taken over by the new Texas Department of Assistive and Rehabilitative Services (DARS) as a part of a reorganization of 12 agencies within the Texas Health and Human Services Commission (HHSC) into 5 departments. The centralized Texas DDS unit, however, operates under much the same external parameters as before.

II. Problems at TRC–DDS during 1996–2002:

Contributing to the problems at TRC–DDS during the late 1990's and early 2000's was the fact that SSA under-funded Texas DDS disability determinations during the period 1998–2001. (Notably, the cost of DDS disability determination is only about 2–3% of total SSA disability program costs.)

TRC Board minutes show these problems developing. The official approved minutes of the September 14, 2000 meeting of the TRC Board states on page 8:

"TRC Disability Determination Services Update:

Chairman Kane called on Mr. Dave Ward, Deputy Commissioner for Disability Determination Services (DDS) to give the DDS Report.

Mr. Ward updated the Board on DDS for Fiscal Year 2000 and on the Fiscal Year 2001 outlook, using a slide presentation (Attachment 3). He reported on the FY 2000 targets versus the FY 2000 forecasts, with respect to case receipts, case clearances, continuing Disability Review (CDR) cases, and Production Per Work Year (PPWY). He discussed hard targets (CDR cases) and soft cases. Mr. Ward noted that DDS was close to hitting its targets despite the federal government's reduction of 20 positions, the hiring freeze, no overtime, and being restricted to only 1 Disability Examiner (DE) class. He reported that DDS was 30 production points above the rest of the nation. Mr. Ward also informed the Board that DDS had been assisting the region to reach its overall workload target.

Mr. Ward discussed DDS's FY 2000 profile. He reported that DDS has initiated a Program Operations Restructure Plan and start-up of Cooperative Disability Investigation Unit in Houston. He also reported that DDS is "down" four operating units and has staged pending of 21,000 cases. Mr. Ward discussed the award structure. Persuant to Dr. Novy's request, Mr. Ward explained that DEs and the technical support staff working with them are eligible for state incentive awards. Seventy-five awards were given out. Sixty percent of DDS staff received some type of incentive award. These included lump sum merit raises.

Mr. Ward reported on DDS's 2001 Outlook and discussed the numbers for Fiscal Year 2001 SSA Targets versus Fiscal Year 2001 DDS Proposals, with respect to case receipts, case clearances, CDR case, and PPWY. Mr. Ward stated that DDS would be in a rebuilding phase for the next 18–20 months and that the preceding year had hurt its infrastructure. He reported that he had informed the "feds" that DDS needed three DE classes. . . ."

Three months later, the official approved minutes of the December 7, 2000 meeting of the TRC Board states on page 13:

"TRC Disability Determination Services Update:

Chairman Kane called on Mr. Dave Ward, Deputy Commissioner for Disability Determination Services (DDS) to give the DDS Report.

Mr. Ward updated the Board on DDS for fiscal year 2000 and on the fiscal year 2001 Profile, using a slide presentation (Attachment 9). He reported on the fiscal year 2000 targets versus the FY 2000 actual performance, with respect to case receipts, case clearances, continuing Disability Review (CDR) cases, and Production Per Work Year (PPWY). He reported that DDS exceeded all goals and targets despite the federal government's reduction of 20 positions, the hiring freeze, no overtime, and being restricted to only one Disability Examiner (DE) class. He noted specifically that DDS was 30 production points above the rest of the nation. Mr. Ward explained, however, that without overtime, DDS will be hard pressed to continue on target, unless targets are reduced. He stated that budgeting probably will not get to DDS until January 2001.

Mr. Ward discussed DDS's fiscal year 2001 profile. He reported that, according to SSA OD, the "budget will not be sufficient to handle workload."

He noted that CDRs are high priority and that a large Disability Examiners class is expected for January 2001.

Questions/Comments from the Board

Chairman Kane questioned whether this is the first time that Congress has said "we" won't be able to make our targets. Mr. Ward stated that this was correct."

After TRC–DDS posted the lowest "initial approval rate" in the nation in 2000, and the "fake examiner" scandal broke on September 9, 2001, SSA Region VI Commissioner Horace Dickerson traveled from Dallas to Austin to give the TRC Board "an update on SSA's review of TRC". The official approved minutes of the TRC Board meeting of September 20, 2001 states on page 11–14:

"Commissioner Dickerson stated that over the last two and a half years, SSA has not been able to provide all the funding needed by DDSs to process all of the claims that they have received. He acknowledged that this has resulted in backlogs this fiscal year across the nation, as well as in Texas. He stated that the $83 million in funding to Texas DDS this fiscal year will allow it to process about 230,000 claims. . . ."

"*Overtime.* He explained that earlier in the year, the Dallas Region, including Texas, recognized that the Region did not receive its appropriate share of the national Disability Determination funding. As a result of input by the Dallas Region, SSA increased the spending authorizations for Texas twice this calendar year. He pointed out that Texas DDS has escalated its hiring plans, has added over eighty DEs and over eighty adjudicators, and has implemented an overtime plan to reduce backlogs."

The failure of SSA to fund the Texas DDS contributed to a number of problems during that era. The problems included:

1. Texas had the lowest "initial approval rate" in the nation in 2000 for Social Security disability claims—29% in September 2000 compared to a national average of about 45%. (Houston Chronicle 3–18–01 C.2, 4–22–01 p4) A number of reasons have been suggested to explain the low rate, including that Texas examiners determined claims "reach different conclusions on cases that require certain judgments to be made on an individual's capacity to work" than the rest of nation. (Houston Chronicle, 6–10–01 A.8.)

The low approval rate in Texas raises issues of claimants' rights to equal protection of the laws as compared to residents of other states.

2. Texas DDS developed a backlog of about 75,000 claims in mid-2001—roughly 3 months processing. (Houston Chronicle, 5–3-01 A.1)
3. Texas DDS management responded to the backlog in 2000–1 by implementing a "waiting list" (using undisclosed selection criteria) for "overtime processing" (unequal treatment) by "fake examiners" (code name signature fraud) on about 12,000 claims. (Houston Chronicle 9–9-01 A.1,A.20) "Waiting list" claims had no single examiner assigned who understood the entirety of the case or had responsibility for its outcome. The use of "fake examiners" was ostensibly stopped several weeks after the story was published by the Houston Chronicle. (Houston Chronicle 9–26–01 A.1)

This two-tier processing raises issues of due process regarding quality of decision making and accountability, and issues of equal protection of the laws with respect to both claimants whose claims were processed differently, and Texas claimants as compared to residents of other states.

Two tier processing additionally raises a due process concern about claim prejudgment. The criteria for selection of cases for "waiting list" processing has not been disclosed. The concern is that a first-glance decision made by a file clerk rather than a Disability Examiner (DE) or State Agency Consultant (SAC) as to the validity of a claim in the absence of medical evidence while determining whether to use "waiting list" processing, and thus whether or not to process it with a single examiner, may determine the outcome of the claim irrespective of the merits of the case, which, for Pro Se claimants, may further prejudice the record subsequently submitted to an ALJ on appeal to SSA. The concern is thus that "first impressions" by a file clerk before development might have determined the ultimate outcome of the decision.

4. A 2003 audit of Texas DDS by the SSA Office of Inspector General (OIG) found that between 1998 and 2001 Texas DDS made payments to selected hospitals for Consultative Examinations (CE's) that were equal to those paid by TRC's Vocational Rehabilitation program, but in excess of the SSA's Maximum Al-

lowed Payment Schedule (MAPS) rate. (March 2004 A–15–02–12051 Audit Report.) TRC's reimbursement rates were set from TRC's creation in 1969 until 2001 by TRC's Medical Consultation Advisory Committee (MCAC), and were approved by the TRC Board. It is beyond doubt that any SSA Region VI Commissioner could fail to understand how TRC set its rates. SSA's OIG audit found, however, no written documentation that a waiver was issued by SSA Region VI to TRC–DDS. The total excess payment to hospitals during those three years was about $3.6 million plus $359,000 in TRC overhead charges on about 49,000 claims, so the per-procedure overpayment to selected hospitals was significant. In response to this audit, the new TRC Interim Commissioner blamed the problem on their immediate predecessor who had just been reassigned to HHSC, and asked that reimbursement of the money be waived. This situation, however, must be considered to be a management failure by SSA Region VI to oversee the Texas DDS properly.

5. In April 2001, Dallas Administrative Law Judge (ALJ) Christopher Lee Williams sued TRC–DDS and SSA for the failure of TRC–DDS to perform psychiatric CE's on indigent claimants whose claims he remanded back to TRC–DDS for further development. (See Williams v. Massanari, et al., N.D. TX cause no. 03:01CV816, filed 04–30 2001.) The case was dismissed for lack of standing because ALJ Williams had not been harmed.

Thus, TRC–DDS overpaid selected hospitals for CE's performed, apparently without written approval from SSA Region VI, even while some indigent claimants could not get a CE exam even when DDS was ordered by a SSA ALJ to provide one, so that those claimant's claims would necessarily be denied for lack of medical evidence of disability, which is required under the Social Security Act. Whether these claimants so denied CE's could successfully sue the Texas DDS for violation of their rights to due process and equal protection of the laws, or SSA Region VI for failure to oversee TRC–DDS, when TRC–DDS, while overpaying selected hospitals for some examinations, refused to do an examination on an indigent claimant even after an ALJ indicated that a medical examination was necessary to determine their claim properly remains, apparently remains untested.

6. "Kenneth S. Apfel, Commissioner of the Social Security Administration under President Clinton, spoke at a seminar where government officials and other experts said they were unable to completely explain the state's relatively low approval rates in disability cases. 'Half the answer is known, half the answer is not known', said Apfel, now a University of Texas professor. But Texas can start on increasing its approval rates by training case workers at the Texas Rehabilitation Commission to take a wider approach to whether disability applicants can no longer work, he said. Case workers in many other states grant disability benefits more often by looking beyond purely medical evidence to see whether people can continue to function at work, Apfel said. 'I don't think you've done enough in Texas', he said."(Houston Chronicle, 10–18–01 A.29.)

In evaluating disability claims on about $300 apiece, there is limited ability to do claimant evaluations. The inference from Kenneth S. Apfel's statement is that few Vocational Evaluations (VE's) were being done at TRC–DDS during this era. It seems logical that, on a limited disability determination budget with a total cost fixed to national rates, with TRC–DDS overpaying selected hospitals significantly for CE's, DDS might at the same time reduce VE's in order to balance their budget.

1. Texas is said to have a lower Social Security disability approval rate for "psychiatric disorders" than other states. A letter to the editor by Leslie Gerber, director of public policy, Mental Health Association, Houston stated of Social Security disability recipients in Texas that "in 1999, only 22.8 percent had a psychiatric disability, compared to the national average of 32.1 percent, which is nearly one and a half times higher."(Houston Chronicle, 3–18–01 C.3.)

It has been argued, that due to the above combination of factors, tens of thousands of otherwise legitimate Social Security claims in Texas were improperly denied during this era, with a total fiscal impact to claimants of hundreds of million dollars.

In summary, while the problems at TRC–DDS during this era were multifactorial and complex, it would appear that SSA failed to properly fund disability determinations in Texas; backlogs occurred; claim documentation suffered while payment rates to large hospitals did not, yet SSA Region VI failed to oversee payments; claim denial rates went up; a stop-gap "waiting list" program with unspecified selection criteria was instituted; and indigent claimants unable to afford documentation, and those whose claims were selected for the "waiting list", were denied due process. This was sub-

sequently followed by newspaper articles, pickets, hearings, audits, resignations, and reorganizations.

III. Compensation of State Agency Medical Consultants at the Texas DDS:

During the late 1990's, TRC–DDS began compensating State Agency Medical Consultants (SAMC's) and State Agency Psychiatric Consultants (SAPC's) working as independent contractors to advise Disability Examiners determining Social Security disability claims on a "piece work" basis.

Before TRC–DDS had the lowest "initial approval rate" in the nation, and two years before the "fake examiner" scandal broke, the minutes of the September 18, 1999 meeting of the TRC Medical Consultation Advisory Committee (MCAC) record a presentation by Elizabeth Gregowicz reviewing the operation of DDS. After a presentation on the SSA's "Redesign" pilot program for improving DDS operations and its rollout, the discussion, chronicled on page 4, turned to SAMC compensation:

"Commissioner Arrell raised the question about our payment of State Agency Medical Consultants (SAMC), indicating that TRC–DDS recently made a change in how we do that. Ms. Gregowicz noted that our budget from SSA has been shrinking in the last 10 or so years, and consequently, DDS' have been looking for ways to enhance operational efficiencies. Texas implemented a "pay-per-case" concept versus "pay-per-hour" for SAMC services. It appears that productivity has increased and there is increased efficiency. Dr. Vickers said he initially thought quality would suffer, but notes this has not happened. The Disability Examiners are more thorough and quality has improved. The SAMCs are contract workers and pay their own social security and income tax. There are no "employee" benefits since the SAMCs are not employees."

The roughly 40 TRC–DDS SAMC's and SAPC's budgeted to earn more than $100,000 per year on SAC contracts in 2002–3 were listed as contractors on TRC's web site at http://www.rehab.state.tx.us.

Some of the SAC "piece work" consultants were budgeted to earn as much as $628,000 in a year on their DDS contracts. By comparison, typical salaries for physicians employees at Texas HHSC agencies are $7–10,500 per month. This suggests that some Texas DDS SAMC's and SAPC's are evaluating a LARGE number of claims each year, and that these high-volume examiners may disproportionately affecting DDS processing statistics and claims outcomes.

Some of these consultants also held other contracts with TRC itself (e.g. perhaps with the Vocational Rehabilitation program), which are listed in the Historically Underutilized Business (HUB) database on the Texas Building and Procurement Commission web site at http://www.tbpc.state.tx.us.

It seems arguable that a physician earning over $360,000 per year doing "piece work" disability evaluations may not be spending an appropriate amount of time to consider each individual claim, particularly if they also have other contracts with the state.

Several example TRC–DDS SAMC and SAPC contracts are notable. The statistics that follow have been compiled from TRC prospective quarterly budget estimates and PBPC HUB retrospective historical data for the years 2002–3 without respect to fiscal versus calendar years, and thus the figures are somewhat approximate. (Note that some of these contracts might include a "supervisory" bonus.) These figures, however, outline the general issue:

1. SAMC ("S.S.") was budgeted to earn in both 2002 and 2003 about $550,000 a year on their DDS SAMC disability determination piece work contract, plus another $300,000 directly from TRC (e.g. which may be for examinations or other services, such as with the Vocational Rehabilitation program, which also might possibly require the services of a clinic and/or staff) in each of those years, and is budgeted to earn $628,000 on their DDS SAMC piece work contract alone in 2004.
2. SAMC ("M.D.") was budgeted to earn between $530,000 and $600,000 in 2003 on their DDS SAMC piece work contract, in addition to about $320,000 directly from TRC for other work, although in 2002 they were budgeted to earn only $330,000 in DDS SAMC piece work, plus $178,000 directly from TRC for other work, and in 2004 are budgeted to earn only $270,000 in DDS SAMC piece work fees.
3. SAMC ("F.C.") is budgeted to earn $552,000 in DDS SAMC piece work fees in 2004, although they were budgeted to earn only about $156,000 in DDS SAMC piece work fees, and $139,000 from TRC for other work, in 2003.

4. SAMC ("J.B.") was budgeted to earn $429,000 in DDS SAMC piece work fees, in addition to $39,000 from TRC for other work in 2002, but is not listed as a TRC contractor in either 2003 or 2004.
5. SAPC ("S.D."), a "Chief or Emeritus SAPC", was budgeted to earn $311,000 in DDS SAPC piece work fees, plus another $190,000 from TRC for other work in 2003, but was not listed as a contractor in 2004, and has likely become a staff member at the Texas DDS agency.
6. SAPC ("J.C.") was budgeted to earn $368,000 in DDS SAPC piece work fees, plus another $205,000 from TRC for other work in 2003, although they were budgeted to earn only $157,000 in DDS SAPC piece work fees in addition to $195,000 from TRC for other work in 2002, but are budgeted to earn $468,000 in DDS SAPC fees 2004.

There are concerns that the piece work compensation of State Agency Consultants may induce a bias in disability determinations against claimants with a) chronic conditions, b) complex conditions, c) conditions whose origin, diagnosis, or effects are obscure, d) conditions with a need to consider vocational factors in the evaluation of disability, and e) claimants who reopen claims, reapply for benefits, or have large files.

"Piece work" compensation may thus arguably result in unequal treatment both between claimants whose claims are evaluated by "high volume" as compared to "low volume" SAMC's, and claimants whose claims are evaluated by "high volume" SAMC's in Texas as compared to claimants in other states.

"Piece work" compensation might also provide a financial incentive for a SAC to decide a claim on the spot based on the evidence already in the record, rather than to request a CE or VE which may delay the decision by many weeks.

Thus, while in 2000–1 TRC–DDS management with limited funding used "fake examiner" document fraud to expedite Social Security disability claims processing—having had the lowest "initial approval rate" in the nation in 2000; Texas DDS began about 1999 to expedite disability claims by compensating State Agency Consultants on a "piece work" basis, some of whom now earn over a half million dollars per year in piece work fees.

The "piece work" compensation policy has apparently helped solve the backlog problem at Texas DDS, but one must ask: is this due process in accordance with SSA national program standards, and does this afford claimants equal protection of the laws?

The U.S. Constitution speaks directly on the issue a person's rights to due process and equal protection of the laws with respect to the actions of state governments:

"*No state shall make or enforce any law which* shall abridge the privileges or immunities of citizens of the United States; nor *shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction equal protection of the laws. "* (The Fourteenth Amendment to the Constitution of the United States, Section 1, sentence 2.)

The U.S. Constitution also speaks directly on the issue a person's rights to due process with respect to the actions of the U.S. Government:

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation. (The Fifth Amendment to the Constitution of the United States.)

IV. Lessons Learned From the Texas DDS Experience:

It would appear that when SSA cut the Texas DDS disability determination budget, in a matter of time backlogs occurred as waiting claims began to be classified as "staged pending"; claimant CE and VE documentation suffered; a "piece work" compensation program was instituted for the physician medical consultants; and as denial rates went to the highest in the nation, the waiting list went from one to three months, and management instituted a two tier "waiting list" processing scheme compromising quality and accountability. As a result, claimant rights to due process and equal protection of the laws suffered.

Overall, a budget cut of perhaps on the order of $10–20 million from what Texas DDS ought to have been funded for operational costs for proper disability claim development and determination, arguably resulted an industrial-scale degradation in determination quality, and in the denial of tens of thousands of claimants to several hundreds of millions of dollars in benefits, including to SSDI disability benefits

which disabled workers had paid insurance premiums for to the District of Columbia over their entire working careers.

In creating SSA, Congress delegated disability determinations to the states while the program was being developed during the 1930's because at the time only the states had the institutional capability to assess disability at local locations throughout the nation. This historical decision has had consequences today.

State DDS programs are subject to SSA budget constraints, while operating in virtual secrecy, a situation which can easily result in violation of claimants' U.S. Constitutional and statutory rights.

Further, state disability determination directors are often appointed by the state governor or by senior state agency officials, and are thus subject to internal state politics and domestic political agendas.

It is in this context that we review current proposed changes to the national Social Security disability determination system.

1. **We believe that control of the "initial" levels of SSA disability determination by state officials at state DDS agencies will continue to present an ongoing problem of *regional bias* in what is purported to be a national social insurance program.**
2. **We believe that SSA Regional Commissioners should have not only the authority but also the responsibility to manage the process of disability determination at state DDS agencies, including ensuring that cases are properly developed, and that CE's and VE's are properly performed.**

Claimants must be fully informed of their rights in the disability determination process, particularly as the process is being changed.

3. **We believe that claimants must be fully informed at every step in the SSA disability determination process, including their *right to directly submit medical evidence to the state agency at the time of their initial application,* and in notice of decisions of their *rights to appeal versus reapply.***

We feel that a failure by a state DDS to properly develop claims constitutes a bias against claimants with complex medical conditions, who have limited financial resources, who file Pro Se without a lawyer, who are homeless, or who have mental conditions. Failure to properly develop cases further prejudices consideration of claims on appeal to the SSA Administrative Law level. This forces claimants denied proper development out of the "nonadversarial" system created by Congress, forcing them to either forfeit rights without recourse, or to litigate a case in Federal District Court.

4. We believe that every disability claim where there is a colorable allegation of social insurance coverage ought to be *fully developed* by a state DDS Disability Examiner.
5. **We believe that *SSA should fund* state DDS agencies at sufficient levels to do *CE examinations on the majority of claimants, and VE evaluations on a substantial fraction of claimants.***
6. We believe that every disability claim developed by state DDS agency ought to be reviewed by a *physician* consultant, rather than just a nurse or a lawyer.

"Piece work" compensation may improve State Agency Consultant efficiency, but efficient does not mean fair.

7. We believe that while State Agency Consultants compensation may include production bonuses, it *should not be entirely "piece work".* We believe that "piece work" compensation institutes a bias against several classes of disability claimants.

In a complex disability claim, with medical records from multiple sources, and with continuing development of medical evidence, there may be problems with obtaining medical evidence in a timely manner.

8. **If the reconsideration step of the SSA disability determination process is eliminated, we believe that methods must be available to claimants *to ensure that the entirety of their medical records are available for consideration by the decision maker* before the initial decision is made.**

The development of an electronic case file system at SSA puts into the hands of senior DDS officials and their parent agencies—who are subject to budgetary and

political pressure—a tool which with they may do industrial-scale fraud, should they choose to use it in such a manner.

At present, a Social Security disability claimant may walk into a SSA Office of Hearings and Appeals (OHA) office after filing an ALJ appeal of a DDS denial and obtain a photocopy of their case file as developed and determined by the state DDS, take it home, and spend months analyzing it. Often an ALJ appeal is a claimant's first opportunity to review how the state DDS developed their claim. The claimant may find, for instance, that state DDS failed to request their medical records from all providers; requested medical records for the wrong dates; received and cited medical records subsequently found to be missing from the case file; and even culled medical records from the case file sent in directly by the claimant. They may also find that State Agency consultants evaluated their claim while the file was incomplete.

Disability Determination fraud by a State Agency is particularly likely when a senior official at a state DDS under budgetary or political pressure is willing to institute an official policy of fraud. This occurred for example at TRC–DDS when an official assigned a "fake name" disability determination computer account for each of the agency's 25 claims evaluation units, such as demonstrated in a memorandum published in the Houston Chronicle on September 9, 2001.

Claim documentation is presently available in paper format in most states. In computer format the destruction and forging of records would be much less obvious, and the files would be much less accessible to claimants for verification.

9. Safeguards must be built into any computerized claims system by which SSA can ensure the *authenticity* of medical records, *provenance* of documents, *decision authority* in determinations, and an *audit record* of all transactions, in order to ensure claimants due process, even should a state DDS agency head or SSA Regional Commissioner wish to officially sanction disability determination fraud for political or budgetary goals.

Nothing but the "light of day" will change the back-room tactics of the "good 'ol boys" in some state DDS agencies in trashing disability claims as their personal prejudices dictate.

10. Claimants must be allowed to *examine their computerized case file* at any time, and to obtain a personal copy of the records in order to ascertain their completeness and accuracy.

In a complex disability claim, with continuing development of medical evidence, not all medical evidence may be available within the first few years of the onset of disability.

11. **We believe that if the proposal to close the hearing record after the ALJ hearing is effected, there ought to be a good cause exception which allows the submission of additional medical records.**

Lack of proper appellate review of DDS denials exists in Texas because of the close relationship between the Texas DDS and the SSA Region VI office, the relatively small number of claims remanded by the SSA Appeals Council, and limitations on access to the Texas Federal District Courts for indigent and Pro Se persons, including limited access to legal resources due to the notoriety of the Texas Unauthorized Practice of Law Subcommittee.

12. We believe that the SSA Appeals Council has a legitimate function, in that about 25% of appealed claims nationally are either remanded or reversed. At the same time, we believe that the one year backlog at the Appeals Council is too long.

Texas DDS maintained one of the highest "accuracy" statistics in the nation, even during 1999–2001 while they had problems which included having the lowest "initial approval rate" in the nation, engaging in failure to do CE's and VE's while overpaying selected hospitals for those done, and using "fake examiners" and doing "waiting list" processing. Obviously these "accuracy" statistics have an internal bias due to the self-fulfilling effect of a state DDS agency denial of a SSA disability claim, and do not reflect the true accuracy of claims determinations.

13. We believe that the "accuracy" statistics for state DDS agencies should be revised to avoid the internal bias inherent in the current method.
14. We believe that given the number of irregularities in Social Security disability determinations in Texas from 1996 to present, claims determined during that period should be reviewed, and claims with questionable handling (e.g. failure to do a CE or VE) should be redetermined.

Let me close with the following quote:

"'It rings a very serious fire bell that the Social Security justice system is not treating all of the applicants equally or consistently' said U.S. Rep. John Culberson, R-Houston. 'And that is a recipe for disaster under our American system of law.'" From: "Judges Vary Sharply on Disability Approval: Social Security Rulings Concern Lawmakers", Alan Bernstein and Dan Feldstein, Houston Chronicle, 7–14–02 A.1.

Statement of Sheryl Schott, Los Angeles, California

I am a Pediatric Medical Consultant with LA West, whose primary objective is to make the right decision the first time, in as timely a manner as possible, and with as little expenditure as possible. In my 10 years with the program, I have educated the DEAs to refer promptly to me any case in which phone calls to Treating doctors, hospitals, labs can allow me to make a proper determination rapidly and without additional cost.

I routinely call treating doctors, getting essential information to avoid the purchase of consultative examinations, as well as Medical Record Departments and labs who did not respond to DEA efforts alone. Indeed, most Pediatricians and Pediatric specialists in this area are very well known to me, through my years of service, and VERY responsive to my phone calls and questions, again generally at no charge to the department.

I know many of my colleagues, just as concerned, who perform the same actions daily. We end up saving the state and federal government significant funds as in the following situation which has occurred quite a number of times—Lost folder case on premature infants. The DEA wanted an automatic continuance on the basis of the lost folder, but I insisted on the reconstruction, not previously done, which documented the impairment of premie/growth—the basis for the comparative point decision, the child had no new impairments in interim, and thus this altered the determination dramatically to a cessation.

Another situation which has arisen in my experience, is where the DEA incorrectly interpreted reports from Pediatric Cardiologist in the case of a child with complex cyanotic congenital heart disease, who had already undergone 2 surgical procedures. The

TP Pediatric Cardiologist reported "doing well" but it could be determined from the physical exam findings that this was "comparatively speaking" to another child with complex cyanotic heart disease, as the child continued with findings of cyanotic heart disease. This was overlooked on the DEA's review of the case. There are also many occasions where I find that the DEA has mistakenly identified different notes/ reports in the file, leading to errors in their assessment of the correct determination.

While my colleagues and I strive to educate the DEAs in our division as to all the above, and routinely answer multiple daily informal questions on the full range of medical and pediatric impairments and syndromes, as well as the adequacy of medical evidence in a certain case or the necessity for multiple consultative exams on a case, we recognize the benefits of our "team" function in making the correct determination. The interposition of a RN is not only unnecessary, but would also place an expensive extra link into a newly broken chain. Nor could the RN serve all the functions of a Medical Consultant

My colleagues and I are proud of the job that we do and our prime objective is to assist/ educate/expedite the right decision within our team.

Statement of Linda Fullerton, Social Security Disability Coalition, Rochester, New York

Our group and experiences, are a very accurate reflection and microcosm of what is happening to millions of Social Security Disability applicants all over this nation. The current Social Security Disability program and the process that an applicant endures when filing for disability benefits, causes irreparable harm and has many serious side effects including unbearable stress, depression, and in some cases the depression is so severe that suicide seems to be the only option to get rid of the pain, of dealing with a system riddled with abuses against the disabled, already fragile citizens of this country. According to past GAO reports, the SSD system is at HIGH RISK but Congress keeps ignoring the problem.

The Social Security Disability New Approach Program is a welcome change from what we have seen in decades past. Everyone that I have dealt with there has been

very courteous and responsive to our concerns and I am very grateful for that. We keep in constant communication with them as much as we are allowed to participate. But from what I can see the proposals that are being suggested so far, by the Disability New Approach Program, will not do very much to relieve this horrendous situation in the very near future. While they are doing their very best with the resources they have, they cannot do it alone, as many things needed to truly reform this system, must be legislated by Congress. In addition we ask that in future Congressional hearings, members of the Social Security Disability Coalition be allowed to actively participate instead of being forced to always submit testimony in writing, after the main hearing takes place. We are willing to testify in person before Congress and we should be permitted to do so. We want a major role in the Social Security Disability reformation process, since any changes that occur have a direct major impact on our lives and well being.

The time it takes to process a Social Security Disability claim from the original filing date is now, in many cases, at least 1–3 years or longer. If claimants provide sufficient medical documents when they originally file for benefits they shouldn't be denied at the initial stage, have to hire lawyers, wait years for hearings, go before administrative law judges and be treated like criminals on trial.The current SSD process seems to be structured in a way to be as difficult as possible in order to suck the life out of applicants in hope that they give up or die in the process, so that Social Security doesn't have to pay them their benefits. To a population that is already compromised, this is unacceptable and this issue must be made a priority for every member of Congress since it is a life and death situation for millions. Many SSD applicants are losing EVERYTHING in the process of applying for benefits, their homes, all their financial resources, their healthcare and worse yet their lives.

The current claims process is also set up to line the pockets of the legal system, since you are encouraged from the minute you apply to get a lawyer. Why should you need to pay a lawyer to get benefits that you have paid into all your working life? The SSD program is structured so that it is in a lawyer's best interest for your case to drag on since they automatically get paid a percentage of a claimant's retro pay—the longer it takes the more they get even if they do almost nothing. From the horror stories I hear from claimants many attorneys are definitely taking advantage of that situation. The stress and worry that applicants are forced to endure while applying for SSD benefits causes further irreparable damage to their already compromised health and is totally unacceptable. Many lose everything, and now in addition, are also forced into a level of poverty on top of their illnesses, which they will have to live with the rest of their lives since they can no longer earn a living. Due to the devastation on their lives and health, the Ticket to Work program, and any chance of possibly getting well enough to return to the workforce, even on a part time basis, is now out of the question.

The SSA Customer service is extremely poor and in major need of improvement across the board. If any corporation in this country did business like the SSA, the majority of employees would be fired on the spot, and the company would be shut down within a year. Here is just a small sampling of the constant complaints we receive about the Social Security Disability system and its employees:

Extraordinary wait times between the different phases of the disability claims process

Employees being rude/insensitive to claimants

Employees outright refusing to provide information toclaimants or do not have the knowledge to do so

Employees not returning calls

Employees greatly lacking in knowledge of and in some cases purposely violating Social Security and Federal Regulations (including Freedom of Information Act and SSD Pre-Hearing review process).

Claimants getting conflicting/erroneous information depending on whom they happen to talk to at Social Security—causing confusion for claimants and in some cases major problems including improper payments

Complaints of lack of attention or totally ignoring—medical records provided and claimants concerns by Field Officers, IME doctors and ALJ's.

Fraud on the part of DDS/OHA offices, ALJ's, IME's—purposely manipulating/ignoring information provided to deny claims.

Complaints of lost files and files being purposely thrown in the trash

Complaints of having other claimants information improperly filed/mixed in where it doesn't belong causing breach of security

Poor/little coordination of information between the different departments and phases of the disability process

These complaints refer to all phases of the SSD process including local office, Disability Determinations, Office of Hearings and Appeals and the Social Security main office in MD (800 number).

SOCIAL SECURITY DISABILITY COALITION—SSD SYSTEM REFORM GOALS

We want to have claimants who have actually gone through the SSD system themselves to be part of a group who actually participates in the Social Security Disability New Approach program and which has major input and influence on the decision making process before any final decisions/changes/laws are instituted by the SSA Commissioner or members of Congress. This is absolutely necessary, since nobody knows better about the flaws in the system and possible solutions to the problems, then those who are forced to go through it and deal with the consequences when it does not function properly.

We want disability benefits determinations to be based solely on the physical or mental disability of the applicant. Neither age, education or any other factors should ever be considered when evaluating whether or not a person is disabled. If a person cannot work due to their medical conditions—they CAN'T work no matter what their age, or how many degrees they have. This is blatant discrimination, and yet this is a standard practice when deciding Social Security Disability determinations and should be considered a violation of our Constitution. This practice should be addressed and eliminated immediately.

All SSD case decisions must be determined within three months of original filing date. When it is impossible to do so a maximum of six months will be allowed for appeals, hearings etc—NO EXCEPTIONS. Failure to do so on the part of SSD will constitute a fine of $500 per week for every week over the six month period—payable to claimant in addition to their awarded benefit payments and due immediately along with their retro pay upon approval of their claim. SSD will also be held financially responsible for people who lose property, automobiles, IRA's, pension funds, who incur a compromised credit rating or lose their health insurance as a result of any delay in processing of their claim, which may occur during or after (if there is failure to fully process claim within six months) the initial six month allotted processing period .

Waiting period for initial payment of benefits should be reduced to two weeks after first date of filing instead of the current five month waiting period.

Prime rate bank interest should be paid on all retro payments from first date of filing due to claimants as they are losing it while waiting for their benefits to be approved.

Immediate eligibility for Medicare/Medicaid upon disability approval with NO waiting period instead of the current 2 years.

SSD required medical exams should only be performed by board certified independent doctors who are specialists in the disease that claimant has (example—Rheumatologists for autoimmune disorders, Psychologists and Psychiatrists for mental disorders). Independent medical exams requested by Social Security must only be required to be performed by doctors who are located within a 15 mile radius of a claimants residence. If that is not possible—Social Security must provide for transportation or travel expenses incurred for this travel by the claimant.

Too much weight at the initial time of filing, is put on the independent medical examiner's and SS caseworker's opinion of a claim. The independent medical examiner only sees you for a few minutes and has no idea how a patient's medical problems affect their lives after only a brief visit with them. The caseworker at the DDS office never sees a claimant. The decisions should be based with much more weight on the claimant's own treating physicians opinions and medical records. In cases where SSD required medical exams are necessary, they should only be performed by board certified independent doctors who are specialists in the disabling condition that a claimant has (example—Rheumatologists for autoimmune

disorders, Psychologists and Psychiatrists for mental disorders). Currently this is often not the case.

All Americans should be entitled to easy access (unless it could be proven that it is detrimental to their health) and be given FREE copies of their medical records including doctor's notes at all times. This is crucial information for all citizens to have to ensure that they are receiving proper healthcare and a major factor when a person applies for Social Security Disability.

ALL doctors should be required by law, before they receive their medical license, and made a part of their continuing education program to keep their license, to attend seminars provided free of charge by the SSA, in proper procedures for writing medical reports and filling out forms for Social Security Disability and SSD claimants.

More Federal funding is necessary to create a universal network between Social Security, SSD/SSI and all outlets that handle these cases so that claimant's info is easily available to caseworkers handling claims no matter what level/stage they are at in the system. All SSA forms and reports should be made available online for claimants, medical professionals, SSD caseworkers and attorneys, and be uniform throughout the system. One universal form should be used by claimants, doctors, attorneys and SSD caseworkers, which will save time, create ease in tracking status, updating info and reduce duplication of paperwork. Forms should be revised to be more comprehensive for evaluating a claimant's disability and better coordinated with the SS Doctor's Bluebook Listing of Impairments.

Institute a lost records fine—if Social Security loses a claimants records/files an immediate $1000 fine must be paid to claimant.

Review of records by claimant should be available at any time during all stages of the SSD determination process. Before a denial is issued at any stage, the applicant should be contacted as to ALL the sources being used to make the judgment. It must be accompanied by a detailed report as to why a denial might be imminent, who made the determination and a phone number or address where they could be contacted. In case info is missing or they were given inaccurate information the applicant can provide the corrected or missing information before a determination is made. This would eliminate many cases from having to advance to the hearing and appeals phase.

The SSA "Bluebook" listing of diseases that qualify a person for disability should be updated more frequently to include newly discovered crippling diseases such as the many autoimmune disorders that are ravaging our citizens. SSD's current 3 year earnings window calculation method fails to recognize slowly progressive conditions which force people to gradually work/earn less for periods longer than 3 years, thus those with such conditions never receive their 'healthy' earnings peak rate.

A majority of SSD claimants are forced to file for welfare, food stamps and Medicaid, another horrendous process, after they have lost everything due to the inadequacies in the Social Security Disability offices and huge claims processing backlog. If a healthy person files for Social Service programs and then gets a job, they do not have to reimburse the state once they find a job, for the funds they were given while looking for work—why are disabled people being discriminated against? Claimants who file for Social Service programs while waiting to get SSD benefits, in many states have to pay back the state out of their meager SSD/SSI benefits once approved, which in most cases keeps them below the poverty level and forces them to continue to use state funded services. They are almost never able to better themselves and now have to rely on two funded programs instead of just one. This practice should be eliminated. In all states there should be immediate approval for social services (food stamps, cash assistance, medical assistance, etc) benefits for SSD claimants that does not have to be paid back out of their SSD benefits once approved.

The claims process should be set up so there is no need whatsoever for claimant paid legal representation when filing for benefits and very little need for cases to advance to the hearing and appeal stage since that is where the major backlog and wait time exists. The need of lawyers/reps to navigate the system and file claims, and the high SSD cap on a lawyer's retro commission is also a disincentive to expeditious claim processing, since purposely delaying the claims process will cause the cap to max out—more money to the lawyer/rep for dragging their feet adding another cost burden to claimants. Instead, SS should provide claimants with a listing in

every state, of FREE Social Security Disability advocates/reps when a claim is originally filed in case their services may be needed.

Audio and/or videotaping of Social Security Disability ALJ hearings and during IME exams allowed at all times to avoid improper conduct by judges and doctors. A copy of court transcript should automatically be provided to claimant or their representative within one month of hearing date FREE of charge.

Strict code of conduct for Administrative Law Judges in determining cases and in the courtroom. Fines to be imposed for inappropriate conduct towards claimants.

We have heard that there is a proposal to give SSD recipients a limited amount of time to collect their benefits. We are very concerned with the changes that could take place. Since every patient is different and their disabilities are as well, this type of "cookie cutter" approach is out of the question. We especially feel that people with psychological injuries or illness would be a target for this type of action. Some medical plans pay 80% for treatment of biological mental heath conditions, but currently Medicare only pays 50% for an appointment with a psychiatrist. This often prohibits patients from getting proper treatment and comply with rules for continual care on disability. The current disability review process in itself is very detrimental to a patient's health. Many people suffer from chronic conditions that have NO cures and over time these diseases grow progressively worse with no hope of recovery or returning to the workforce. The threat of possible benefits cut off, and stress of a review by Social Security again is very detrimental to a recipients health. This factor needs to be taken into consideration when reforming the CDR process.

NOTE: The problems with the Federal Social Security Disability program cause an extra burden on state Social Service programs, which could be greatly reduced once this Federal program is fixed, and the states along with the claimants would reap the benefits in the long run. State politicians need to put pressure on congress to put more funds into the SS system to hire more qualified claim examiners and better educate employees, doctors and the claimants themselves to speed up the process.

In closing, most of us were once hard working, tax paying citizens with hopes and "American dreams" but due to an unfortunate accident or illness, have become disabled to a point where we can no longer work. Does that mean we are not valuable to our country, or give the government and politicians the right to ignore or even abuse us? Due to circumstances beyond our control, and on top of our disabilities, we now live the American nightmare with no hope of relief in sight! Contrary to popular opinion, nobody willingly chooses this type of existence. Politicians are supposed to work FOR us not ignore us. Anyone reading this, could suddenly find themselves dealing with these issues in the future, and we are holding you accountable to fix these problems now! Nobody thinks this horrible existence could ever happen to them, but there are millions of Americans who are suffering and dying due to this negligence, and our lives depend on your cleaning up this mess immediately! Currently we are considered "disposable" people by general and government standards, so our cries and screams are ignored, they would prefer that we just shut up or die. I am here to tell you those days are over now. We are watching, we are waiting, we are disabled and we vote!

Statement of Laurie L. York, Austin, Texas

Thank you for this opportunity to provide comments to this hearing on the Commissioner's proposal to improve the disability claims process. I am an attorney in private practice representing clients in the Social Security Disability claims process.

I. Introduction:

Texas Disability Determination Services (DDS) is a fully federally funded unit operating under federal law to evaluate Social Security disability (SSDI and SSI) claims filed at the "initial" (initial and reconsideration) level in Texas at its central office in Austin as agent for the Social Security Administration (SSA). It was operated from 1969 to March 1, 2004 under the management of the Texas Rehabilitation Commission (TRC) by Texas state employees.

TRC–DDS had a number of problems during the past few years, ranging from having the lowest "initial approval rate" in the nation in 2000—a 31% approval rate compared to a 45% rate nationally, the use of two tier "waiting list" processing by

"fake examiners" (code names with forged signatures) on about 12,000 claims during a period of backlog in 2001, a widespread failure to do Vocational Evaluations and consider vocational factors in the determination of disability, the payment in excess of SSA rates for Consultative Evaluations (CE's) to selected providers, the refusal to do CE's on indigent claimants in some cases even when ordered by a SSA Administrative Law Judge (ALJ), and a low overall combined DDS and SSA approval rate for psychiatric conditions within the state.

A review of the recent history of TRC and its DDS agency may be found in the testimony of Lawrence A. Plumlee, M.D. to this Subcommittee at the hearing of September 25, 2003, which is now available at http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly &id=1847. Notably, the roughly 45 newspaper articles on the determination of Social Security disability in Texas published in the Houston Chronicle during 2001–3 are cited, mostly written by reporter Alan Bernstein.

There are also indications that TRC–DDS has demonstrated an historic bias against chemical injury claims, as described in the testimony of Stephen A. McFadden, M.S. to this Subcommittee at the hearing of September 26, 2003, which is now available at http://waysandmeans.house.gov/hearings.asp? formmode=view&id=1837.

This bias against chemical injury and treatment inconsistent with SSA national program standards is supported by statements made by Wesley Davis, the Spokesman of SSA Region VI, to the Houston Chronicle while trying to explain Texas' having the lowest "initial approval rate" in the nation in 2000, first, in March 2001, by citing a large number of disability claims by "under-educated manual laborers in the oil industry and elsewhere" who "commonly get injured on the job" as an explanation—thus admitting not only the bias against chemical injury claims at TRC but the significance of the size of the impacted group (Houston Chronicle 3–11–01 A.1.), and second, in June 2001, by the statement that Texas disability examiners "reach different conclusions on cases that require certain judgements to be made on an individual's capacity to work" than those of the rest of the nation, thus admitting a lack of equal protection of the laws in TRC's DDS operation. (Houston Chronicle 6–10–01 A.8).

The impact of these historic policies at TRC–DDS and SSA Region VI are significant. The testimony of Stephen A. McFadden, M.S. to this Subcommittee at the hearing of January 26, 2004, which is available at http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=2125&keywords=, estimates that between the 12,000 "fake examiners" cases, the bias against chemical injury claims by "oil well firefighters" cases, the failure to do Vocational Evaluations, and the bias against psychiatric conditions and those "regarded as psychiatric", in the context of having the lowest "initial approval rate" in the nation in 2001, approximately 30–50,000 otherwise legitimate Social Security claims were denied during the period from 1996–2003, or about 7–10% of the total Social Security disability claimant pool of about a half million recipients in Texas, with a total fiscal impact of about half a billion dollars during those years.

This gross failure of the Social Security disability determination process in Texas cannot be excused on grounds of budgetary constraint. Only about 2–3 percent of the total SSA disability program budget is spent on claims determination. The Texas DDS operation has a target total determination cost of under $300 per claim. Obviously, $300 will not even buy the average claimant a Consultative Evaluation by a licensed physician.

For Social Security disability claims to be determined for under $300 in Texas apparently requires a reduction in the number of Consultative Examinations and Vocational Evaluations performed by DDS, impacting claim documentation, and thus limiting the ability of decision makers (DDS DE's and SAMC's and SSA ALJ's) to make a finding of disability based on evidence of a "medically determinable impairment" as required by SSA national program standards.

Former Commissioner of Social Security Kenneth Apfel referred to the failure of TRC–DDS to do Vocational Evaluations or to train Disability Examiners (DE's) to consider vocational factors in the determination of disability in a speech at a September, 2001 conference sponsored by the Disability Policy Consortium. "I don't think you've done enough", said Apfel of the TRC–DDS' consideration of vocational factors (Houston Chronicle article 10–18–01 A.29).

Dallas SSA Administrative Law Judge (ALJ) Christopher Lee Williams sued TRC–DDS, TRC, and SSA in April 2001 because TRC–DDS refused to perform Consultative Examinations on indigent claimants whose cases he remanded back to TRC for further development, e.g. as is allowed under SSR 97–2p Prehearing Case Review, documentation without which ALJ Williams would presumably be forced to deny those claims for lack of evidence, for example due to lack of evidence of a psychiatric medical diagnosis on indigent homeless persons applying for disability. (Wil-

liams v. Massanari, et al.; N.D. Texas Case No. 03:01CV816, filed 04–30 2001) ALJ Williams' suit was dismissed for lack of standing on the ground he had not been harmed. Subsequently, a SSA audit found that DDS was paying selected providers in excess of SSA approved rates (March 11, 2004 A–15–02–12051 Audit Report.).

Since the above cited testimonies were submitted to the Subcommittee, a number of changes have occurred in the determination of disability in Texas.

- The Commissioner of TRC was replaced on November 1, 2003 after over 22 years.
- The Emeritus Chief State Agency Medical Consultant (SAMC), who had held the position of DDS Medical Director or Chief SAMC for much of the period 1974–2000, retired about that time.
- On March 1, 2004, TRC and its board were dissolved after 35 years of operation, with its DDS, Vocational Rehabilitation, and Early Childhood Intervention functions being integrated into the new Texas Department of Assistive and Rehabilitative Services (DARS), along with programs for the blind, deaf, and hard of hearing from other agencies, while internal support functions were spun off to the Texas Health and Human Services Commission (HHSC).
- The TRC Deputy Commissioner for DDS was replaced on March 4, 2004, and the new head of Texas DDS, Mary Sconci-Wolfe, was given the title of DARS Assistant Commissioner for DDS.

This reorganization occurred as part of plan to reorganize 12 state agencies with a total budget of $7 Billion into 4 new HHSC departments. As a result of these changes, TRC thus effectively ceased to exist as a government entity on March 1, 2004.

The Texas DDS operation, however, continues under the name DARS–DDS, at the same centralized office located at 6101 Oltorf, Austin TX, 78741, in the same locked facility with armed guards not open to the public, still operating under federal rules with federal funding.

As of October, 2004, the new 9-member DARS "Assistive and Rehabilitative Services Council" has yet to be appointed by the governor, and thus DARS is still operating without board oversight more than six months after its creation. The lack of board oversight is significant because the statutory authority of DARS and its Council must be reformulated from the prior state statutes governing the several agencies from which DARS was formed, minus functions which in the future will be shared with other HHSC agencies. More importantly, this means that DARS–DDS is also operating without board oversight. This is an important factor in managing an agency with a long history of claimant due process and equal protection problems.

As of October, 2004, the new DARS–DDS—now seven months old—is being operated by Mary Sconci-Wolfe, a former TRC manager, under the direction of DARS Commissioner Terrell I. Murphy (previously of head of the Texas Commission for the Blind). DARS operates under the direction of the newly appointed Texas HHSC Deputy Executive Commissioner for Social Services Anne Heiligenstein, and HHSC Executive Commissioner Albert Hawkins, who has presided over the Texas HHSC reorganization, without board oversight by the proposed Assistive and Rehabilitative Services Council, and with an incomplete statutory mandate.

In short, TRC, its Commissioner, and its Board have been dissolved, and with it accountability for the operation of the DDS agency has been compromised, yet it would appear that the Texas DDS agency continues to operate much as before.

II. TRC–DDS and SSA Region VI Policy: Backlogs, Waiting Lists, and "Fake Examiners":

In order to better understand this history, I recently obtained under the Texas Public Information Act the official approved minutes of the TRC Board meeting of September 20, 2001, which was held at DDS less than 2 weeks after the Houston Chronicle published a photocopy of an internal TRC email assigning passwords for computer accounts for 25 "fake" names of "overtime" examiners.

The TRC Board was a volunteer oversight board which nominally had six members. The newly appointed Chairman A. Kent Waldrep presided at the meeting, his predecessor having been named to the HHS Board leaving a vacancy. Board member Doyle was absent. The Commissioner of TRC, who normally attends, and TRC Medical Director did not attend, while the Associate Commissioner for Human Resources had recently "terminated his employment with TRC to relocate out of state."

The four attending members of the TRC Board heard Social Security Administration Region VI Commissioner Horace Dickerson give "an update on SSA's review of TRC." The highlighted sections of the discussion below are quoted directly from the official minutes:

"Commissioner Dickerson stated that over the last two and a half years, SSA has not been able to provide all the funding needed by DDSs to process all of the claims that they have received. He acknowledged that this has resulted in backlogs this fiscal year across the nation, as well as in Texas. He stated that the $83 million in funding to Texas DDS this fiscal year will allow it to process about 230,000 claims."

[Thus, SSA Region VI Commissioner Dickerson admitted to the TRC Board that the cause of the processing backlogs at TRC–DDS during 1999–2001, which precipitated subsequent problems, was lack of funding of DDS disability determinations by SSA. Notably, the cost of DDS disability determination is only about 2–3% of total disability program costs.]

". . . He pointed out that Texas DDS has been recognized nationally as one of the best DDSs in the country. He also noted that in May 2001, Texas DDS received a Commissioner's Citation, which is the highest honor that the Commissioner of SSA can bestow on a DDS, and this was based on their outstanding performance."

[Notably, Larry G. Massanari was Acting Commissioner of Social Security from March to November 2001, and this award was given the year after TRC–DDS had posted the lowest "initial approval rate" in the nation, while it had a backlog of about 3 months claims, just 4 months before the "fake examiner" scandal broke—a situation which was stated to exist for about a "year".]

Allowance Rate. He explained that allowance rates do not measure the quality of DDS decisions, rather they reflect the number of people who apply, as well as the type and severity of the disabilities alleged by applicants. He revealed that one out of every thirty-five Texans receive a disability check under the Social Security program. He addressed the Chronicle's comparison of Texas' allowance rate to that of New Hampshire. He explained that New Hampshire also has one in thirty-five ratio, so the comparison is not a valid comparison. Commissioner Dickerson also noted that last year, SSA published new rules for evaluating mental impairments, which were expected to increase the allowance rate. Beginning in September, the allowance rate for Texas DDS increased significantly and, except for a few months early in this calendar year, the initial allowance rate in Texas paralleled that of the national average."

[In fact, the population ratio of persons on Social Security disability reflects determinations made over many years, whereas the determinations in 2000 in Texas were lower than in previous years, and increased after the rate became a controversial political issue. It may also be that, due to the use of manual labor in agriculture and hazards in the oil industry, there are more people disabled on a per-capita basis in Texas than in New Hampshire.]

Overtime. He explained that earlier in the year, the Dallas Region, including Texas, recognized that the Region did not receive its appropriate share of the national Disability Determination funding. As a result of input by the Dallas Region, SSA increased the spending authorizations for Texas twice this calendar year. He pointed out that Texas DDS has escalated its hiring plans, has added over eighty DEs and over eighty adjudicators, and has implemented an overtime plan to reduce backlogs.

Commissioner Dickerson stated that, contrary to the media reports, SSA was aware of DDS' overtime plan and remarked that the practices used by Texas DDS are neither unusual nor improper. These are internal tracking measures used to track the processing of work. He stated that SSA has no requirements that DDS identify examiners on correspondence to claimants or attorneys. He noted that some states choose not to include examiners' names on correspondence, primarily for security reasons.

In conclusion, Commissioner Dickerson stated that SSA recognizes that there are problems in its Social Security Disability program. He noted that these problems are national in scope, and, to be succinct, there is more work than resources. This is true in Texas and the country. He stated that Deputy Commissioner Dave Ward and his management staff have done and continue to do what SSA thinks is a tremendous job for SSA and for the people of Texas and that SSA [Dallas Region] looks forward to a long association with them.

[By his testimony to the TRC Board, SSA Region VI Regional Commissioner Horace Dickerson thus admitted SSA knowledge of, and sanction of, the use of two tier "overtime" processing and "fake examiners" by TRC–DDS, as described by articles in the Houston Chronicle.]

SSA Region VI Commissioner Horace Dickerson thus sanctioned the use of these questionable techniques by TRC–DDS by claiming, in short, that DDS is an agent of SSA, SSA is authorized under the Social Security Act to do whatever it wants, and he, as Regional Commissioner, therefore authorizes their use. Given the Re-

gional Commissioner's sanction, TRC–DDS and SSA Region VI itself are arguably running rogue "cowboy" operations.

[Note that the "fake examiner" issue is not simply an internal accounting tool at TRC–DDS. The effect of a claim being placed on the "waiting list" was that no single Disability Examiner processed it, and thus no examiner understood the entirety of the claim, no examiner was accountable for the outcome, that this was different than normal claims not on this overtime plan, and that the selection criteria for placing claims on the "waiting list" has not been disclosed. There are thus major due process and equal protection issues with this practice, impacting claimants' U.S. Constitutional and statutory rights.]

TRC Board Members' Questions/Comments

Chairman Waldrep expressed his and the Board's appreciation for Commissioner Dickerson's remarks.

Chairman Waldrep asked, what is your reaction to recent newspaper articles about using coded names to assign claims on overtime?

Commissioner Dickerson explained that the methodology employed by DDS to manage overtime is an internal process, which helps staff to effectively manage the overtime. While it is not done at the direction of SSA, it does occur in other DDS Social Security field offices. From SSA's vantage point, it is not done to mislead the public or the recipient to whom the correspondence is being sent. He again pointed out that some states, in the interest of security, do not include a name or even a signature block on correspondence. Commissioner Dickerson reiterated that SSA does not have a problem with the overtime methodology used by Texas DDS.

Board member Novy asked, when a customer calls and asks for the name that was on the letter [DDS correspondence], how is the call received? Is there a specific person who takes the call? Is it based on the last name? How does this work?

Deputy Commissioner Dave Ward responded that the last name of the DDS staff noted on the correspondence is that of the person to whom the case is assigned. That named person or the person's designee, if he/she is not available, takes the call. The caseload is attended and the telephone calls are answered.

Board member Novy stated that the process, as explained by Deputy Commissioner Ward, is acceptable as long as someone is taking calls. She explained that she is from Houston and regrets the type of reporting that has been done. It was unbalanced and hurtful to the good people who are doing good work. Ms Novy expressed her appreciation to Commissioner Dickerson for his attendance and for his comments.

Vice Chairman Wilkerson stated that State Representative Coleman has requested a study of the DDS's procedures for determining who is disabled, and asked if Commissioner Dickerson is aware of any issues or any areas in which TRC–DDS does not adhere to SSA procedures?

Commissioner Dickerson responded that he is not aware of any areas in which TRC–DDS is not adhering to SSA rules. He stated that he is aware of the legislative directives surrounding this, but from SSA's vantage point the DDS is adhering to all procedures. SSA is in fact working with DDS to make sure that it is aware of the allowance rate, initial claims, and claims that are processed in DDS. SSA plans to be very vigilant in providing information to DDS so that it can share the information with the Board and with others relating to the allowance rate at the appeals level at Social Security to ensure that a full picture is in place.

Board member Stribling asked, if any differences were attributable to interpretation or whether interpretations were standardized?

Commissioner Dickerson stated that the rules are standard, but there is a great deal of room for interpretation. SSA is working to streamline the process and refine the rules so that there will be uniformity in terms of interpreting what is done at SSA, and in making the disability decisions. He explained that they are not yet where they need to be, but they are working closely with their Administrative Law Judges (ALJ), the DDSs, and all of those who make decisions on disability claims to ensure that all are following the same rules and can arrive at the same place and make the right decision.

[This statement must be considered in the light of the quote in the Houston Chronicle of SSA Region VI Spokesman Wesley Davis saying in June 2001 that Texas disability examiners "reach different conclusions on cases that require certain judgments to be made on an individual's capacity to work". Note that SSA Region VI Commissioner does not deny that there are such differences.]

Acting Commissioner Mary Wolfe stated that Texas DDS' accuracy rating should speak to this issue as SSA examines the accuracy of the case work that is being done.

Commissioner Dickerson agreed with Ms. Wolfe's statement. He further stated than not only is SSA very diligent at looking at the accuracy, it also wants to make sure that those who apply for and are entitled to benefits receive benefits, as well as making sure that those who do not meet the requirements do not receive benefits. To ensure accuracy, DDS has internal procedures to review the work that is produced. Additionally, there are pre-effectuation reviews, which are conducted before the decision is effectuated to ensure that decisions are in compliance with SSA rules. He reported that Texas DDS has the highest accuracy rate among the large states and in comparison with all other states, it has a very good rate of accuracy in production.

Chairman Waldrep thanked Commissioner Dickerson for his attendance and for the partnership that TRC has shared with SSA in carrying out the job of serving people with disabilities in Texas. He attributed Commissioner Dickerson's leadership as making the difference in that partnership and stated that the Board/TRC is grateful to have him in that position.

Commissioner Dickerson stated that he appreciates the support that SSA has long received from TRC. He also expressed his appreciation for the leadership of Chairman Waldrep and Dave Ward and his management team, his medical consultants, and all the adjudicators, of whom Texas should be proud for the way in which they daily perform their duties and responsibilities.

Chairman Waldrep stated he is very proud of DDS and all of the men and women who work hard every day to ensure that people in the state who have disabilities and who are eligible and deserve benefits receive benefits. He stated that he was disappointed in the Houston Chronicle and its reporting on DDS, which misleads the public into thinking that the agency is not doing its job. He requested that elected officials work in partnership with the agency, as Commissioner Dickerson and his office does, to ensure that DDS/TRC does its job. He stated TRC is not perfect but the history, facts, and figures conveyed by Commissioner Dickerson back up the agency's pride in trying to be the very best in delivering services to the state. He stated that it is very discouraging when someone prints non-truths. Chairman Waldrep stated that he has met with the Governor's Office and TRC has his full support.

Chairman Waldrep stated if anyone has an issue with this agency or any other agency, please go to the agency first and work with the agency to find out the facts.

Chairman Waldrep stated that he intends to write a letter to the editor of the Houston Chronicle and informed Commissioner Dickerson that he and his office have TRC's full cooperation and support.

III. TRC–DDS and SSA Region VI Policies versus SSA National Program Standards:

The TRC Board meeting of September 20, 2001 meeting was chaired by Mr. A. Kent Waldrep, author of the book "Fourth and Long: The Kent Waldrep Story", who had incurred a spinal cord injury while playing football in college, is wheelchair-bound, had been on the TRC Board since 1990, but had just been appointed as TRC Board Chairman by the Governor. This was Mr. Waldrep's first meeting as Chairman. His predecessor of 15 years had recently resigned to accept an appointment to the HHS board by the Governor just as the 2000 "initial approval rate" scandal broke at DDS. TRC Board members including the Chairman were volunteers, and had limited authority, acting only to direct the Commissioner—represented in this meeting by Acting Commissioner Mary Sconci-Wolfe. The absence of the TRC Commissioner, who had held that position for 20 years, and the TRC Medical Director from the meeting, during this controversial period is notable. Mr. Waldrep's experience with DDS was in fact quite limited, in that as late as the prior quarterly meeting he demonstrated a lack of understanding of the basic fact that DDS is fully a federally funded agency that brings money into the state rather than a state funded assistance program that takes money out of the state budget. Some might wonder if such Chairmanship of the Board in the midst of this crisis might deflect criticism from the Board's management of the agency. The effect of the letters that Mr. Waldrep speaks of writing in this passage in order to try to publicly justify TRC–DDS's position and to create harmony may be found in the Houston Chronicle on October 14, 2001 A.39 and October 17, 2001 p28.

The absence of senior TRC officials, and the effusive mutual praise lavished among the participants upon each other in the discussion of DDS operations, must both be considered in light of the seriousness of the charges that had been made. The Houston Chronicle had published copies of forged signatures by DDS examiners less than two weeks before, supporting a presumption of 12,000 counts of document fraud and Fourteenth Amendment violations of due process and equal protection of the laws by state TRC–DDS managers against Texas Social Security disability

claimants. These are acts which may arguably include civil liability under 42 U.S.C. 1985 "Conspiracy to interfere with civil rights" and 42 U.S.C. 1986 "Action for neglect to prevent", not to mention criminal civil rights violations under 18 U.S.C. Part I Chapter 13, including conspiracy, against both DDS and TRC, and Fifth Amendment due process and statutory equal protection violations by SSA Region VI officials and their managers.

Should there be any question whether these policies were in fact sanctioned by SSA, including 1) failure by SSA to properly fund the Texas DDS operation, 2) the use of two tier "overtime processing" (unequal treatment), and 3) "fake examiners" (document fraud and due process violations), 4) a bias against chemical injury claims, and 5) state disability determination standards "different" than in the rest of the nation, one need only observe that Social Security Region VI Commissioner Horace Dickerson—who stood before the TRC Board to admit the failure of SSA to adequately fund TRC–DDS determinations and to justify the use of "overtime processing" and "fake examiners", and Region VI Spokesman Wesley Davis, who admitted a bias against chemical injuries and "different" determination standards in Texas as compared to other states to a Houston Chronicle reporter, still hold those positions at SSA Region VI as of October, 2004, more than 3 years after the events described above occurred.

The references to the high "accuracy" of TRC–DDS disability determinations must be considered in the context of the limited opportunity for appeal above the ALJ level or for judicial review in the SSA disability process, particularly for Pro Se claimants in Federal District Courts (FDC) of Texas. The SSA Region VI Commissioner backed the policies of TRC–DDS, which may include policies admitted by Regional Spokesman Wesley Davis in June 2001 to be "different" than in other states, so a significant number of reversals by Region VI ALJ's acting under the direction of the Region VI Chief ALJ in Dallas would not be expected. The suit by ALJ Christopher Lee Williams might be seen as an example of this—not even a Dallas ALJ could challenge the TRC–DDS policy denying Consultative Examinations to indigent claimants in April 2001. ALJ denials may be appealed to the SSA Appeals Council (AC) in Falls Church, VA, however, as of 1995, the AC remanded cases back to the ALJ in about 24% of AC appeals nationally, and reversed decisions in only about 3% of appeals—about 1,600 SSDI and SSI reversals in 1995. In 1995 only about 680 claims were reversed in FDC reviews nationally.

IV. TRC–DDS Allowed Reimbursement Rates for Consultative Examinations in Excess of SSA Rates for Selected Hospitals; SSA Region VI Did Not Manage DDS Appropriately:

Recently, the SSA Office of Inspector General audited $247,350,859 in administrative costs that TRC reported for TX–DDS operations for the period October 1, 1998 through September 30, 2001, including the rates that Texas DDS reimbursed hospitals for Consultative Examinations (CE's), some of which were in excess of the Maximum Allowable Payment Schedule (MAPS)—although they were equal to that used in the TRC Vocational Rehabilitation program, and the management of these rates by SSA Region VI officials. (Office of the Inspector General, Social Security Administration, "The Administrative Costs Claimed by the Texas Disability Determination Services, March 2004 A–15–02–12051 Audit Report") The SSA OIG concluded, in summary, that TRC–DDS paid selected hospitals more than allowed by SSA for CE's, and that TRC–DDS felt that they had been authorized by SSA Region VI to do so, but the OIG found no records of such an authorization.

"We attempted to find out if any special waiver or privilege was provided to hospitals with RCCs. According to the SSA Dallas RO, the RCC rates were implemented a number of years ago when different SSA and DDS employees were involved in overseeing these issues. The validity of their use had never been discussed. . . ."

"We believe that the RCC is not a part of the TX–DDS fee schedule. The SSA Regional Office and TX–DDS disagreed with us. We believe that SSA needs to obtain a formal determination from its Office of General Counsel to resolve this issue. We believe that SSA should recover the payments in excess of MAPS unless the Office of General Counsel makes a formal determination that the RCC is part of TX–DDS' official fee schedule." . . .

"We compared the amount that was authorized to be paid under MAPS to the amount actually paid the hospital using an RCC. We found of the 52,692 records paid using RCC, 49,071 exceeded MAPS. The amount paid to hospital providers exceeded the MAPS allowed amount by $3,611,678. . . ."

"Indirect costs for TX–DDS are determined under a negotiated annual indirect cost rate agreement. The TX DDS computes its indirect costs by multiplying the approved percentage rate to the direct costs of the TX–DDS. Some direct costs, such

as, (capital) equipment, building alterations, and renovations are not to be included as part of the base. The annual indirect cost rate is for a State FY (September 1st through August 31st). CE costs are included in the base for the computation of indirect costs. . . .''

''We believe the SSA Regional Commissioner should instruct the TX–DDS to conform to the POMS by adhering to MAPS, the authorized fee schedule, for paying hospital provider CEs. Lastly, the RO should more closely monitor TX–DDS fees paid for CEs. . . .''

''As a result of our audit, we recommend that:

1. SSA require that TRC adhere to POMS DI 39545.210, 1.a., requiring CE payment amounts not to exceed the authorized fee schedule and specifically, discontinue selectively paying Texas hospitals higher amounts than the approved fee schedule.
2. TRC, pending the SSA Office of General Counsel's determination, reimburse SSA $3,611,679, resulting from CE payments in excess of the authorized fee schedule known as MAPS. The TX–DDS should adjust their financial reports, Forms SSA–4513, accordingly.
3. TRC, pending the SSA Office of General Counsel's determination, reimburse SSA $359,515 for indirect costs paid as a result of the overstated direct cost base (CEs in excess of MAPS.) The TX–DDS should adjust the financial reports, Forms SSA–4513, accordingly.
4. SSA's Dallas RO more closely monitor the fees paid by TRC for CEs.
5. SSA seek a legal opinion as to whether the use of the RCC method, which allows the TX–DDS to pay hospital providers a percentage of their normal customary billing amount for CEs, constitutes a fee schedule in accordance with POMS and Federal regulations. SSA should then establish a clear policy on contracts with CE vendors and ensure that policy is implemented consistently across the DDSs. (This is a new recommendation added to our final report which was not included in the draft report provided to SSA and TRC for comments.)''

''. . . For Recommendations 2 and 3, both SSA and TRC disagreed with reimbursing the excess funds drawn by the DDS. In SSA's response, the Regional Commissioner stated it is difficult to know what happened in the past since the staff making earlier decisions are no longer overseeing DDS operations and may have discussed the TX DDS' RCC method. TRC indicated that before the RCC method was established, extensive research, study, and vendor negotiations were undertaken to arrive at rates that would assure clients received quality medical services at the best price. SSA's comments, in and of themselves, do not provide sufficient evidence of whether the Regional Commissioner or his staff gave explicit or implicit approval of the TX–DDS' use of the RCC methodology. . . .''

''With respect to our recommendations that SSA seek reimbursement, the Regional Commissioner continues to request that these recommendations be removed, or at least deferred until the legal issues have been resolved.''

Notably, the above policies were undoubtedly effected during the 22 year tenure of TRC Commissioner Vernon Arrell 1981–2003, and at least continued under the tenure of TRC Deputy Commissioner for DDS Dave Ward 1996–2002. This clearly indicates that TRC–DDS engaged in purchasing expenditures in violation of SSA national program standards during 1998–2001, SSA Region VI did not either enforce the SSA standards or provide a waiver, and that Region VI and TRC–DDS have placed the blame on former managers and asked that reimbursement be waived. Note, however, that the overpayment to selected hospitals by DDS occurred even while DDS refused to do CE's on indigent claimants whose claims were remanded to DDS by ALJ Christopher Lee Williams, and thus claimants' rights to due process may have been affected.

SSA Region VI Commissioner thus sanctioned after-the-fact the excess payments by TRC–DDS to selected hospitals performing CE's in violation of SSA national program standards, against the opinion of the SSA Office of Inspector General, despite the fact that other claimants at the time were denied CE's, thus arguably denying them their U.S. Constitutional and statutory rights to due process and equal protection of the laws. A review of operations 1998–2002 thus shows that SSA Region VI and TRC–DDS were rogue ''cowboy'' operations that failed to enforce claimants rights to due process and equal protection of the laws in accordance with SSA national program standards.

V. Summary:

The failure of SSA to adequately fund TRC–DDS to do disability determinations during 1999–2001 has been admitted by SSA Region VI Commissioner Horace

Dickerson. (Testimony to TRC Board, minutes 9/20/01.) An SSA OIG Audit has shown that TRC–DDS overpaid certain medical providers for Consultative Examinations during 1998–2001. ("March 2004 A–15–02–12051 Audit Report") This occurred even while indigent claimants were denied CE's in 2001. SSA Region VI Commissioner argued against repayment. The use of two-tier "waiting list" (unequal treatment) processing and "fake examiners" (document fraud) by TRC–DDS was also sanctioned by SSA Region VI Commissioner Horace Dickerson, who still holds that position. (Testimony to TRC Board, minutes 9/20/01.)

A bias against chemical injury claims, e.g. of workers disabled "in the oil industry and elsewhere" who "commonly get injured on the job" but are not considered totally disabled by TRC–DDS was admitted in March 2001, as was the fact that Texas disability examiners "reach different conclusions" than those in other states was admitted in June 2001, by SSA Region VI Spokesman Wesley Davis, who still holds that position. (Houston Chronicle 3–11–01 A.1, 6–10–01 A.8.)

SSA Region VI and Texas DDS have demonstrated a willingness to compromise claimant rights to due process and equal protection of the laws in order to meet budgetary targets and engage in improper bias. Several tens of thousands of Social Security disability claims were denied as a result, with a fiscal impact on the disabled of on the order of several hundred million dollars during that era. According to the OIG, $3.6 million was spent improperlybetween 1998 and 2001 due to lack of oversight of TRC–DDS by SSA Region VI. It is thus clear that TRC–DDS and SSA Region VI during this era were rogue "cowboy" operations. Such injustice demands timely remedy.