



**COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY
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STATEMENT FOR THE RECORD

**BEA DISMAN
ACTING CHIEF OF STAFF
SOCIAL SECURITY ADMINISTRATION**

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

Thank you for inviting me to discuss our administration of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. I am Bea Disman, acting Chief of Staff for the Social Security Administration (SSA) for the last seven months. For nearly 20 years, I served as the Regional Commissioner for our New York Region, working closely with State Disability Determination Services (DDS), and SSA's regional hearing offices. Prior to that, I served for over seven years as that region's director of program and integrity review. My first job at SSA was on the front line and included taking disability claims applications from members of the public.

We appreciate the Subcommittee's ongoing oversight of the disability programs, and input on possible regulatory changes, hiring, and backlog reduction. In addition to providing an overview of our disability decision framework and disability adjudication process, I am pleased to provide an update on recent efforts we have made to modernize our disability criteria and expedite decisionmaking, including our recent efforts to reduce the hearings backlog.

Background

Few government agencies touch the lives of as many people as we do. Social Security pays monthly benefits to approximately 61 million individuals. During fiscal year (FY) 2017, we expect to pay about \$935 billion to Social Security beneficiaries. In addition, in FY 2017, we expect to pay over \$54 billion in Federal benefits to an average of approximately 8 million SSI recipients. We continue to be mission-focused and mission-driven as we serve millions of beneficiaries, applicants, and other Americans who need services from us.

The Social Security Act (Act) provides for benefits to persons with disabling physical and mental impairments under the SSDI and SSI programs. SSDI provides benefits to workers who meet the Act's disability criteria, and to their dependents and survivors. On average, we pay SSDI benefits each month to approximately nine million workers with disabilities and two million of their dependents. Workers become insured for SSDI based on contributions to the Social Security trust funds through taxes on wages and self-employment income.

The SSI program provides monthly payments to people with limited income and resources who are aged, blind, or disabled. Adults and children under age 18 can receive payments based on disability or blindness. On a monthly average, we pay approximately six million blind and disabled adults and over one million blind and disabled children SSI benefits. General tax revenues fund the SSI program.

Evaluating Disability Claims and Recent Improvements to Our Disability Rules

Statutory Framework

The same statutory definition of disability is used to determine whether an adult is disabled under SSDI or SSI. The Act defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can result in death or has lasted or, can be expected to last for a continuous period of not less than 12 months. In making this determination, the Act requires us to consider how a claimant's condition affects his or her ability to

perform previous work or, considering his or her age, education, and work experience, other work that exists in significant numbers in the national economy.¹

To carry out this statutory definition, we have established regulations that, among other things, describe: (1) how we evaluate medical evidence; (2) medical conditions that we consider severe enough to prevent work; and (3) how we assess whether an adult can perform other work that exists in the national economy. Below, we describe the basic framework for adjudicating disability, as well as the important steps we have taken in recent years to modernize our regulatory criteria.

Regulatory Framework for Decisionmaking

For SSDI and SSI, we evaluate adult claimants using the following five-step sequential evaluation process:

Step one: We consider a claimant’s work activity. We deny the claim if the claimant is doing “substantial gainful activity,” or SGA (i.e., a certain level of wages or self-employment income). This year, earnings of \$1,170 in a month are generally considered SGA.²

Step two: We consider the medical severity of a claimant’s impairment. We deny the claim if the claimant does not have a severe medically determinable physical or mental impairment (or combination thereof) that meets the statutory duration requirement.

Step three (Listing of Impairments): We consider whether the claimant has a severe impairment(s) that meets or medically equals a listing in the Listing of Impairments (listings), and meets the durational requirement, under our regulations. The Listing of Impairments describes for each major body system, impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. We find the claimant disabled if his or her impairment meets all of the criteria in one of the listings, or is medically equivalent in severity to a listing. A claimant whose impairment(s) does not meet or equal a listing may still be disabled.

Residual functional capacity (RFC): A claimant whose impairment(s) does not meet or medically equal a listing may still be disabled, because we must consider whether a claimant has the physical and mental capacity to perform his or her previous work or perform other work that exists in significant numbers in the national economy. Consequently, we assess what the claimant can still do despite his or her physical and mental impairments.

Step four: We consider whether a claimant can still perform past relevant work in light of his or her RFC. We deny the claim if the claimant can perform his or her past relevant work.

¹ The *Social Security Amendments of 1972* created the SSI disability program for children under age 18, using a definition of disability that was based on “comparable severity” to an impairment that would be disabling for an adult. The *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* amended the Act to create a separate definition of disability for children seeking SSI. To qualify for SSI disability benefits, a child must have a physical or mental condition that results in marked and severe functional limitations. This condition must have lasted, or be expected to last, at least one year or result in death. My testimony will focus only on the definition of disability for SSDI workers and SSI adults.

² This figure is for individuals who are not blind. For individuals who are blind, the SGA amount is \$1,950.

Step five: We consider our assessment of the claimant’s RFC and the claimant’s age, education, and work experience to determine whether he or she could perform other work that exists in significant numbers in the national economy. We deny the claim if the claimant could do so.

Keeping Disability Policy Current

We are dedicated to preserving the soundness of our disability programs, and our stewardship responsibilities make up-to-date policy a top priority. To that end, we strive to keep our rules and policies aligned with contemporary medicine, healthcare, and new technology, and to ensure policy decisions are evidence-based. We develop, in consultation with medical and other experts, new medical policies for the administration of the SSDI and SSI programs. These policy revisions reflect our adjudicative experience, advances in medical knowledge and treatment of disorders, recommendations from medical experts, and comments we receive.

Last year, we updated four listings and revised the way we evaluate treating source opinions. These changes were significant steps that aligned our disability programs more closely with contemporary healthcare. I will briefly describe those steps, and then discuss our efforts to revise our vocational criteria.

Updated Listings

We have taken significant steps in recent years to comprehensively update our Listing of Impairments for nearly all body systems. Between February 2013 and September 2016, we published 12 final rules that updated 11 of our 15 body systems listings. For instance, in 2016, we updated the listings for Neurological Disorders (prior comprehensive update, 1986), Mental Disorders (prior comprehensive update, 1985), and Respiratory Disorders (prior comprehensive update, 1993). We are currently working on completing the remaining comprehensive listings updates, including the Musculoskeletal System (prior comprehensive update, 1985 and minor updates, 2002).

When updating the listings for a body system, we consider current medical literature, information from medical experts, disability adjudicator feedback, public comments, and research by organizations such as the National Academies of Sciences, Engineering, and Medicine. Our objective is to revise the listings’ criteria on an ongoing basis, using a three to five-year update cycle. We believe we now have a process, the staff, and expertise needed to meet this objective.

Evaluating Treating Source Opinion

In addition to updating our medical criteria in the listings, we have modernized our rules regarding how we evaluate medical evidence to reflect current healthcare delivery practices in this country—including how we consider opinions regarding a claimant’s limitations offered by treating physicians.³ Under rules adopted in 1991, we established the “treating source” rule, which provided that a treating physician’s opinion about the nature and severity of a claimant’s impairment is entitled to “controlling weight” if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case. However, in the intervening years, the rule came under increasing scrutiny, as it was perceived to be outdated; eliminating or modifying the treating

³ Final rules, *Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 Fed. Reg. 5844 (Jan. 18, 2017).

source rule was considered to be a way to enhance the disability program's integrity and to prevent potential fraud. Further, a report by the Administrative Conference of the United States (ACUS) called into question whether controlling weight deference should be afforded to medical practitioners given changes in healthcare delivery. In our recently issued final rules, we stated that we are not retaining the treating source rule because:

the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this reality. Many individuals receive health care from multiple sources, such as from coordinated and managed care organizations, instead of from one treating [source]. These individuals less frequently develop a sustained relationship with one treating physician. ... [Instead], [t]he extent to which a medical source's opinion is supported by relevant objective medical evidence and the source's supporting explanation—supportability—and the extent to which the opinion is consistent with the evidence from other medical sources and nonmedical sources in the claim—consistency—are also more objective measures that will foster the fairness and efficiency in our administrative process that these rules are designed to ensure.

Occupational Information System and the Medical-Vocational Guidelines

We are also progressing deliberately on modernizing the occupational information we use to evaluate claims under steps four and five of our sequential evaluation process. Our main source of occupational information, the *Dictionary of Occupational Titles*, was last updated by the Department of Labor, (DOL) in 1991, and dates back to 1938. To ensure our decisions remain accurate, we are developing a new Occupational Information System (OIS) that will be the primary source of occupational information used in our disability adjudication process. We are working closely with the DOL's Bureau of Labor Statistics (BLS) and will have our first complete set of occupational data in 2019 after BLS completes its third year of data collection. We plan to implement the OIS in 2020 with the introduction of a Vocational Information Tool that adjudicators will use to decide claims. Working with us, BLS will immediately begin a new data collection cycle that will allow us to update the OIS at regular five-year intervals.

Parallel to our efforts to develop the OIS, we are working on updating our Medical-Vocational Guidelines, which were issued in 1978. At step five of our sequential evaluation process, we evaluate an individual's ability to adjust to other work that exists in the national economy. The Medical-Vocational Guidelines are a crosswalk used by adjudicators when considering an individual's RFC in relation to age, education, work experience, and work that exists in the national economy. We are currently considering potential evidence-based approaches to updating these guidelines to ensure we remain current with changes in medical and vocational practice, technology, and the workforce. We are closely coordinating any potential changes to how we consider vocational efforts with our development of the OIS.

Adjudicating Disability Claims and Steps We Are Taking to Decide Claims More Timely

In most cases, we decide claims for benefits using an administrative review process that consists of four levels: (1) initial determination; (2) reconsideration; (3) hearing; and (4) Appeals Council review. I will briefly describe each level of this process, as well as our efforts and proposals to improve our timeliness in deciding claims.

Initial Determination Level

At the initial determination level, claims are filed with us in field offices, over the phone, or via the Internet. Some claims may be denied for technical reasons—for instance, if a claimant is working and earning above SGA, or if a SSDI claimant is not fully insured to receive benefits. However, under the Act, most cases are sent to a State DDS, which is responsible for developing all medical evidence and initially determining whether a claimant meets our definition of disability. Nationwide, we expect to receive approximately 2.5 million initial disability applications in FY 2017. This is a decline from the level of applications we received in FY 2016 (approximately 2.6 million) and FY 2015 (over 2.7 million).

Generally, the disability examiner works with a medical or psychological consultant, or both, to determine whether the claimant is disabled. When deciding the claim, the disability examiner and medical or psychological consultant must consider all of the evidence in the file, both medical and vocational, to make a determination.⁴ For the past several years, the DDSs have allowed approximately 33 percent of the claims decided that year at the initial level. Our adjudicative teams that make disability determinations for us are highly accurate. Through July of this year, the performance accuracy rate of our initial level determinations for FY 2017 was 95 percent.⁵

We have developed several important programs to help expedite processing times, including for our most vulnerable claimants. For example, we established the Compassionate Allowance (CAL) process to quickly identify (through an automated process) and prioritize medical conditions that invariably qualify for disability under our rules. In addition, individual adjudicators also can flag an individual for CAL processing when the automated process does not identify the case. The CAL process helps deliver our services by making benefit decisions, often within days, to eligible individuals with the most serious disabilities. We currently have 225 CAL conditions, including certain cancers.

Today, we are also announcing that we have identified and vetted three new CAL conditions, and we are ready to proceed with their inclusion in our disability processing. Effective September 16, applicants afflicted with Congenital Myotonic Dystrophy, Vanishing White Matter Disease, also known as Childhood Ataxia with Central Nervous System Hypomyelination (CACH), and Kleefstra Syndrome will be quickly identified for CAL expedited review.

We maintain a public website explaining our CAL process. We are updating it to make it easier to suggest potential CAL conditions. It will also include information about our renewed outreach efforts and systematic details about how the CAL process works. We are also revising our communication plan to promote public engagement with this program. We appreciate the Government Accountability Office's (GAO) work in this area and their recommendations on how we can strengthen the CAL process.

⁴ In some States, experienced disability examiners, known as single decisionmakers, may make certain disability determinations alone under our current rules authorizing us to test, individually or in any combination, certain modifications to the disability determination procedures. However, under section 832 of the *Bipartisan Budget Act of 2015* (BBA), we are required to end the single decisionmaker test. In light of this recent legislation, we are in the process of requiring that an MC or PC review the medical portion of a DDS-level disability claim. We have phased in this requirement in over half of the States that used single decisionmakers, and we expect to complete this requirement by the end of FY 2018.

⁵ There are several reasons why a later appeal of a claim denied at the initial level may result in an allowance. For instance, a claimant's condition may worsen over time. Furthermore, a claimant may submit new medical evidence at the reconsideration or hearing level that was not previously available.

In addition to the CAL process, our Quick Disability Determination process uses a computer-based predictive model in the earliest stages of the disability process to identify and fast-track claims where a favorable disability determination is highly likely and medical evidence is readily available. Both of these programs have helped us better serve people who are so severely disabled and clearly meet our disability definition.

We are modernizing how we will collect medical evidence and will provide greater analytical tools for our adjudicators (at all levels). For instance, currently we gather most of our evidence by manually requesting it from providers. We are in the process of expanding the amount of electronic medical evidence we receive through computer-generated requests to expedite the receipt of the evidence and the processing of claims. Further, most of the evidence we currently gather is stored in fixed images (such as Tagged Image File Format (TIFF)), which is time consuming to process, review, and analyze. As we said above, we are planning to obtain additional evidence in a format that allows greater decision support, predictive analytics, and machine learning.

We created the National Disability Policy Cadre (NDPC) in the fall of 2015, consisting of DDS and Federal subject matter experts to address operational challenges associated with policy changes. NDPC input has helped with making disability policy more clear and concise, allowing us to strengthen the disability program and improve our service to the public.

These programs complement other recent initiatives to streamline the disability claims process. For example, we require our DDS examiners to use the Electronic Claims Analysis Tool (eCAT). eCAT is a policy compliant web-based application designed to assist the user throughout the sequential evaluation process. The tool aids in documenting, analyzing, and adjudicating the disability claim according to our regulations.

Moreover, as required by the Act, we perform reviews of at least 50 percent of all DDS initial and reconsideration allowances for DI claimants before payment effectuation is made. These reviews, which we call preeffectuation reviews, allow us to correct errors we find before we issue a final decision, and to provide instructional feedback to our DDS adjudicators. These reviews help ensure consistency at all levels of the process.

We also created the National Disability Quality Cadre (NDQC) in the fall of 2016, consisting of DDS and Federal subject matter experts to identify methods to sustain and improve DDS quality. The NDQC focuses on quality reviews and identifying training needs based on data trend analysis, in an effort to identify problem areas before the DDS makes the final determination.

Certainly, our disability beneficiaries comprise one of the most vulnerable segments of our society. We remain committed to finding ways to serve them compassionately, while maintaining the trust of the American taxpayer.

Reconsideration Level

In most States, a claimant who is dissatisfied with our initial determination may request a reconsideration. However, many claimants denied at the initial level may choose not to appeal; in calendar year 2013, approximately 51 percent of claims denied at the initial level were appealed. A reconsideration involves a thorough review by a different examiner of all evidence from the initial determination and any new evidence provided at the reconsideration level. Nationwide, we expect to complete approximately 581,000 disability reconsiderations in FY 2017. In recent years, the DDSs have allowed approximately

12 percent of disability claims at the reconsideration level; in FY 2016, almost 77,000 individuals were allowed at the reconsideration step.

We are exploring potential proposals that could enhance the reconsideration level. Since 1999, ten States have participated in a pilot project that does not have a reconsideration level.⁶ In those States, an appeal of an initial determination goes directly to a hearing before an administrative law judge. The President's FY 2018 Budget request includes a proposal to reinstate reconsideration in those 10 States, which we also expect to alleviate the hearings backlog. This will bring these States back into conformity with the practices used in the rest of the country. The President's FY 2018 Budget also proposes, through a possible demonstration, an enhanced disability determination screening process; the intent of such demonstration would be to evaluate ways to possibly increase adjudicative consistency at each level of appeal and also to reduce the future hearing backlog.

Hearing and Appeals Council (AC) Review Levels

A claimant who is dissatisfied with our reconsideration determination may seek a hearing, which is held by an administrative law judge (ALJ). In FY 2017, we estimate we will receive approximately 632,000 requests for an ALJ hearing. However, in total, more than 1 million people are waiting for a decision on their hearing request, and the average wait time for a hearing decision in FY 2017 is currently around 600 days. Below is a description of the hearings process, but later in my testimony I outline our plan to reduce the number of pending hearings and the average wait time for a hearing decision.

The ALJ reviews a disability case *de novo*, including evaluating evidence that was not available to prior adjudicators. Generally, an ALJ will hold a hearing, at which the claimant may elect to appear in-person or consent to appear via video. Currently, approximately 30 percent of claimants opt to appear via video. The claimant may appoint a representative who may submit evidence and arguments on the claimant's behalf.⁷ The ALJ may call vocational and medical experts to offer opinion evidence, and the claimant or the claimant's representative may question these witnesses. Once the record is complete, the ALJ considers all of the evidence in the record and makes a decision.

A claimant may appeal an ALJ decision to the AC. The AC will grant review under certain circumstances specified in our regulations. After granting review, the AC may uphold part of the ALJ's decision, reverse all or part of the ALJ's decision, issue its own decision, remand the case to an ALJ, or dismiss the original hearing request. Finally, a claimant who completes our administrative review process and is dissatisfied with our final decision may seek judicial review of that final decision in Federal district court.

Currently, we have more than 1,600 ALJs on duty. We hire ALJs through a process established by the Office of Personnel Management, which administers the ALJ examination through which agencies make competitive service appointments of ALJs.

We have taken a number of steps to improve the efficiency and timeliness of our hearings process. For example, in December 2016, we published final rules that create nationally uniform

⁶ The following 10 States are currently without the reconsideration level of appeal: Alaska, Alabama, Colorado, Massachusetts, Michigan, Missouri, New Hampshire, New York, Pennsylvania and 2 California DDS offices.

⁷ A claimant may appoint a representative prior to the hearing level as well.

hearing and Appeals Council procedures. Under the rules, we provide claimants with a 75-day advance notice of the hearing, which provides claimants more time to obtain updated medical and other records before the date of the hearing. We coupled that 75-day advance notice with a requirement that generally requires claimants to submit written evidence at least five business days before a hearing. The changes we made in these rules, coupled with rules changes we made in 2015 that require claimants to inform us about or submit all evidence known to the claimant that relates to his or her disability claim, make our hearings process more efficient and effective. We expect that they will reduce the number of hearings that we need to reschedule or postpone.

The quality of our decisions is a paramount concern for us. It is our obligation to provide every person who comes before our agency – regardless of where they live – a timely, legally sound, policy-compliant decision. We took aggressive steps to institute a more balanced quality review in the hearings and appeals process.

For example, we created better tools to provide individual feedback for our adjudicators. One such feedback tool is "How MI Doing?" This resource not only gives ALJs information about their AC remands, including the reasons for remand, but also information on their performance in relation to other ALJs in their office, their region, and the nation. We have developed training modules related to the most common reasons for remand that are linked to the "How MI Doing?" tool. ALJs are able to receive immediate training at their desks that is targeted to the specific reasons for the remand.

We also established several enhanced quality review initiatives. For example, we perform post-effectuation focused reviews of sampled ALJ decisions that look at specific issues. Subjects of a focused review may be hearing offices, ALJs, representatives, doctors, and other participants in the hearing process. Because these reviews occur after the 60-day period a claimant has to appeal the ALJ decision, they do not result in a change to the decision. These reviews, though, help us identify the most error-prone provisions of law and regulation, which allows us to design and implement our ALJ training efforts.

We believe these steps have made an impact. The number of ALJs with extremely high and low allowance rates has dropped. While we do not set target allowance rates for our ALJs and always emphasize that an ALJ's allowance rate is not a proxy measurement of his or her policy compliance, we nonetheless believe that this phenomenon is a likely indicator of better, more standardized decision-making in our hearings process.

Most of our employees who receive feedback through tools like "How MI Doing?" welcome the opportunity to improve their skills. The vast majority of our ALJ corps is conscientious and thorough. That said, there have been some recent cases in which we hired an ALJ, and it later became clear the individual would be unsuccessful at the job. The President's FY 2018 Budget request includes mention of a proposal that would amend the Administrative Procedure Act to create a probationary period for newly hired ALJs. We are working with our colleagues at OPM to formulate the details of this proposal, and how it would impact our ALJ workforce.

Hearings Workload and CARES Service Delivery

Today, more than 1 million people are waiting for a decision on their hearing request, and the average wait time for a hearing decision in FY 2017 is currently around 600 days. To reduce the backlog, in January 2016 we developed our Plan for Compassionate and REsponsive Service (CARES), which outlines business process, decisional capacity, and information technology (IT) improvements that we expect will reduce the average wait time for a hearing decision and allow us to achieve a reasonable

number of pending cases. Our CARES plan is a flexible, living document, which we recently updated in August 2017 to incorporate additional initiatives to address the backlog more aggressively. We appreciate the anomaly funding of \$90 million that Congress provided to aid us in reducing the backlog. I believe our initiatives with this funding will help us toward our goal of having a reasonable number of hearings pending. Due in part to additional ALJs, along with recent declines in hearings receipts, we are seeing initial signs of progress, as the total number of hearings pending has decreased in the last seven months. However, we recognize that reducing the hearings backlog will be a long-term challenge for the agency and that we will need to continue to refine and improve our efforts.

A complete copy of the CARES Plan is attached as Appendix A. However, I would briefly like to discuss our plans for the \$90 million anomaly funding, as well as some of our initiatives. We dedicated \$70 million of the \$90 million in anomaly funding to increasing our decisional capacity, which we are doing by hiring more ALJs and support staff while providing current staff with extra overtime hours to process critical workloads. Dedicating \$70 million of the anomaly funding to additional hiring will also allow us to rededicate staff to many of our most promising initiatives that are designed to make our business process more efficient. We plan to spend the remaining \$20 million on additional key IT projects that regular funding alone did not support.

Our updated CARES plan rests on three elements: 1) business process efficiencies; 2) increased decisional capacity; and 3) IT innovation and investments.

Business Process Efficiencies

We continue to look for opportunities to make the hearings and appeals process more efficient while ensuring decisional quality. We are also looking at ways to streamline our processes, eliminate duplication of efforts, and efficiently utilize our limited resources to provide better and faster service to the public. Our revised CARES plan includes 14 initiatives to improve business process efficiencies. Two of these initiatives are:

Pre-Hearing Conferences. We conduct pre-hearing conferences as a way to communicate with claimants to ensure they are prepared for their hearing. For this initiative, we focused on conducting pre-hearing conferences with unrepresented claimants beginning in FY 2015. Through this initiative, we aimed to reduce hearing postponements for unrepresented claimants

National-Based First-In First-Out (FIFO) initiative. This initiative involves sharing resources across the country and matching up resource availability to prioritize cases that have been waiting the longest. Through this initiative, we will pool available resources to help balance workloads and accommodate staffing shortages across offices.

Increased Decisional Capacity

We continue to advance our efforts to increase our decisional capacity through hiring strategies, while at the same time maximizing current staffing levels in order to address our wait times and backlog. In addition to ensuring the appropriate number of adjudicators, we are augmenting the size of our decision writing corps and other support staff to address and prevent bottlenecks in pre-hearing case preparation duties and decision writing. In addition, we are looking at ways to streamline the decision writing process, as well as strategies to increase productivity. We currently have eight initiatives to increase decisional capacity. Two of these initiatives are:

ALJ Hiring. We have hired almost 500 new ALJs since FY 2015 and now have more than 1,600 ALJs on duty. To reduce the backlog significantly, we will need to increase our decisional capacity even further. We hired 31 ALJs this year and we are planning to hire additional ALJs later this year. We currently project a need for an additional 300 ALJs by the end of FY 2019 to meet our backlog reduction goals.

FY 2017 Support Staff Hiring. We need to hire support staff employees to ensure that we can both prepare cases for hearing and draft ALJ decisions in a thorough and timely manner. We are currently in the process of hiring over 600 support staff for our hearings operation, including legal assistants and decision writers, so we can adequately support our ALJs and resume several CARES initiatives that we have paused. We plan to hire about 370 decision writers in FY 2017, to address delays in decision writing. Once our FY 2017 decision writers become fully productive, we expect them to begin to produce 80,000 decisions annually. We will also increase our decision-writing capacity by having headquarters, regional, management, and quality review staff with decision writing experience assist temporarily with the writing backlog. We expect to increase decisions written, leading to overall increase in dispositions using an all hands on deck approach by temporarily redeploying other staff, such as management and quality review staff, to assist in decision writing.

Information Technology Innovations and Investments

We designed our technology investments to provide faster, streamlined, and more efficient IT tools for our employees, external stakeholders, and the public. Specifically, we designed our IT improvements to help to remove inefficiencies in our case processing systems, drive policy-compliance and consistency across offices, and provide self-service options that allow us to provide customer choice and redirect staff away from manual workloads. We will measure the success of any IT investment we make in the hearings and appeals process by the extent to which that investment helps to reduce the wait time for the public and eliminate the number of backlogged cases. We have five initiatives under this category. Two of them are:

Duplicate Identifying Software. This is a CARES initiative, and will be supported by special anomaly funding. We will develop and pilot software that uses artificial intelligence technologies to automatically scan case files, identify duplicate medical evidence, currently a time-consuming manual task. We are piloting this software in three sites, Mobile, Alabama; Reno, Nevada; and Albany, New York. Assuming the pilot is successful, we would expect broader implementation to increase efficiency and decrease average wait times.

Expand Video Hearings Capacity. In FY 2016, we began replacing or upgrading old video hearing equipment and implemented a schedule to replace or upgrade equipment annually. In FY 2017, we made improvements and acquisitions for video hearing equipment, increasing our capacity to hold video hearings by adding over 200 additional units. We are also working with other agencies to use available hearing room space in their sites. We are implementing marketing efforts to promote Representative Video Project use, in which claimants can attend video hearings in their representatives' offices using special equipment.

In addition to the initiatives listed above and in our CARES plan, we are also exploring potential regulatory and other changes that would enhance our ability to manage the hearings process and deliver more timely hearings. For instance, we are exploring how we can expand the number of hearings we conduct by video, which we can offer more quickly to claimants.

Program Integrity

We have a number of program integrity and other initiatives to help ensure we are paying benefits to the right individuals. These activities include our continuing disability reviews and our Cooperative Disability Investigations (CDI) program. We periodically conduct continuing disability reviews (CDRs) to ensure we continue to pay benefits only to those who remain qualified to receive them. We estimate that the CDRs conducted in next fiscal year will yield net Federal program savings over the next ten years of roughly \$8 on average per \$1 budgeted for dedicated program integrity funding, including OASDI, SSI, Medicare, and Medicaid effects.

Our Cooperative Disability Investigations (CDI) program is a key anti-fraud initiative that prevents benefit payments from being made in cases involving fraud. CDI units consist of personnel from SSA, OIG, State DDSs, and state/local law enforcement, who review initial disability claims and post-entitlement activities when our front-line employees suspect possible fraud. CDI units obtain evidence of material fact to resolve questions of fraud.

Quality, Anti-Fraud, and Data Analytics

Our goal is to deliver more timely service to claimants using updated disability rules, while we remain committed to improving the quality of our decisions. I will provide a brief overview of our historical quality efforts, including recent efforts to improve the use of data analytics, as well as a recent organizational change that we believe will streamline and rapidly improve our oversight of the disability decision-making process.

Historically, we have established processes that provide information on, and work to improve, the quality of our decisions, and these efforts occur at all of our adjudication levels. For example, as explained earlier, we perform a review of at least 50 percent of all DDS initial and reconsideration allowances for DI claimants before payment is made. Conducted by our Office of Quality Review (OQR), these preeffectuation reviews allow us to correct errors we find before we issue a final decision, and to provide instructional feedback to our DDS adjudicators. Additionally, OQR uses a number of other types of quality reviews that monitor the accuracy of DDS decisions. We have a number of quality efforts relating to hearings decisions as well. For instance, a division within our Appeals Council conducts preeffectuation reviews on a random sample of ALJ allowances. Additionally, we perform posteffectuation, focused reviews looking at specific issues that help inform our training needs and potential policy changes.

More recently, we have begun incorporating the use of data analytics into our quality and antifraud efforts. For instance, one initiative under our revised CARES plan is expanding the use of a natural language quality assurance tool (called “Insight”) to scan draft ALJ decisions for language that could result in error. We expect to see improvements in quality by ensuring legally sufficient draft decisions that will decrease the number of remanded decisions to the hearing level. Additionally, we are incorporating data analytics and employing technology to root out disability fraud. Earlier this year, we testified at a hearing before this Subcommittee that we are in the initial stages of implementing the Anti-Fraud Enterprise Solution (AFES), which relies on software, data, and technology to more accurately identify and take action on more difficult-to-identify high-risk transactions across our programs and processes, including in our disability program. Notably, in disability cases, we anticipate that AFES will help the agency identify fraudulent transactions before payments are made.

While we have achieved success through these quality and other efforts, these efforts are led in offices that are spread across our agency. Consequently, Acting Commissioner Nancy Berryhill announced a

recent organizational change at SSA that will enhance our continued efforts to modernize the disability programs. Effective October 1, we will have a new Deputy Commissioner-level organization – the Office of Analytics, Review, and Oversight. This organization will combine all agency offices that, among other things, are dedicated to institutionalizing and fostering data analysis in all of our disability programs, and improving coordination on the oversight of the disability adjudication system. For the first time, the offices that conduct quality reviews and other oversight of our DDS and hearings process, including OQR and the AC, will be contained within one Deputy Commissioner-level organization.

Conclusion

Our disability programs serve the American public by providing a vital safety net for those who are some of the most vulnerable members of society. We are firmly committed to the development of sound management practices like the ones we have discussed today. Moving forward, we will continue to be mission-focused and mission-driven as we serve the millions of beneficiaries and applicants with disabilities who need our help. We look forward to continuing to work with you and your subcommittee.