TESTIMONY OF

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NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

to the

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

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

Thank you for the opportunity to testify on behalf of the National Council of Disability Determination Directors (NCDDD) to provide information on Social Security Disability Program policy and the challenges in its application in disability determination. NCDDD is a professional association composed of the Directors and managers of the Disability Determination Services (DDS) agencies located in each state and the District of Columbia. NCDDD's members direct the work of approximately 15,000 employees. Annually we process over 4.8 million cases, including initial claims, continuing disability reviews, and reconsideration-level appeals.

NCDDD's goals focus on providing consistent, fair, accurate, timely, and cost-efficient decisions. The DDS community works in partnership with the Social Security Administration (SSA) to provide high quality public service to individuals applying for disability benefits, and to help ensure the integrity of the disability program.

The Social Security disability criteria are very strict by design. In recent years, the DDSs have allowed 33-36% of initial claims, and 11-14% of the reconsideration-level appeals. However, the DDS allowances make up the vast majority of the allowances overall – last year, for example, the DDSs cleared 1,014,601 initial and 92,601 reconsideration allowances. In any given year, over 70% of applicants who receive a favorable disability determination receive it from the DDS, at the initial or reconsideration level, without a long wait for a decision by an Administrative Law Judge.

Both our allowance and denial determinations are very accurate. By statute, SSA reviews 50% of the allowances before the decisions are effectuated, and the DDS "PER" (pre-effectuation review) error rate has been under 3% for the past 5 years. SSA also performs a quality review sample of both allowances and denials, and the DDS net accuracy rate has been 97% or better over the last 3 years.

The DDSs also process medical Continuing Disability Reviews (CDRs) under the Medical Improvement Review Standard (MIRS). The MIRS policy protects people from being taken off the rolls without proof that

their medical condition has significantly improved. Despite a very low cessation rate under this policy, processing medical CDRs results in $9-10 of program savings for every administrative dollar spent.

The DDSs face serious challenges in maintaining high quality service and program stewardship, as greater numbers apply for benefits while a hiring freeze continues for a third fiscal year. Occasionally SSA has been able to fund a small amount of DDS replacement hiring. However, the DDSs do not recover lost capacity for two more years – the time it takes to train a new adjudicator. Without sufficient funds for advance hiring and adjudicator training, the DDSs have great difficulty processing additional stewardship workloads such as CDRs.

Initial and reconsideration cases are already sitting without being worked for months in many DDSs. As of March 8, 2013, nearly 19% of the pending initial cases and 34% of the reconsiderations (totaling almost 190,000 cases) were backlogged awaiting assignment to an adjudicator. Balancing inadequate resources between the initial/reconsideration and the CDR workloads is increasingly detrimental to both customer service and program integrity. In some states, initial and reconsideration cases may have priority over CDR completion since initial applicants have not had the opportunity to receive critical benefits and associated health care.

Budget cuts and shortfalls present challenges across all of government. Under tight regulatory and budget oversight, the DDSs historically have kept expenditures mission-critical and cost-effective. We regularly give high quality service, productivity, and return on investment for the funding we receive. We request Congress provide the funding necessary for us to serve the vulnerable population of people with disabilities and to carry out the number of CDRs necessary to bring program stewardship up to date in a carefully planned, strategic way. Along with this administrative funding, we recommend certain policy challenges be examined and where appropriate changed to improve decision-making and preserve the integrity of this important program for the future.

The following testimony provides an overview of disability evaluation and discusses specific policy areas that are problematic in their complexity and potential for inconsistency in decision-making.

Overview of Disability Evaluation for Social Security

The DDSs make complex medical determinations for the Social Security disability program in accordance with Federal law, regulations, Social Security rulings and policy guidance. The statutory definition of disability for adults is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or to last for a continuous period of at least 12 months. A medically determinable impairment must be documented by medical evidence including relevant clinical signs, symptoms and laboratory findings. While individuals provide a list of their medical providers when they apply, the DDS does the work of obtaining the medical reports and records, ordering

additional examinations or tests if needed, and obtaining sufficiently detailed reports to cover the individual's impairments according to Social Security's evidentiary requirements for disability evaluation.

In deciding claims, the DDS follows the sequential evaluation policy in the *Code of Federal Regulations*. For adult claims, this involves consecutively assessing current work activity, the severity of the impairment(s), whether the impairment meets or equals those described in the *Listing of Impairments*, the residual functional capacity for past work and finally the capacity for other work in the national economy, considering age, education and work experience. The first three steps help streamline the process and conserve administrative resources for the most difficult areas of evaluation. The first two rule out people who are currently performing substantial gainful activity or who have no medically determinable impairment imposing any significant work-related limitations. The third step – determining Listing-level severity – helps us award benefits quickly to those with exceptionally severe impairments.

The *Listing of Impairments* describes medical conditions that are considered severe enough to prevent any gainful activity. Most of the entries are not based solely on diagnosis but also require specific medical findings and associated functional limitations demonstrating great severity. These impairments are generally permanent, expected to be of lengthy duration, or cause death. Examples include terminal cancers, ALS, amputation of two hands, strokes resulting in permanent loss of use of two limbs, and chronic schizophrenia with repeated, extended episodes of decompensation.

The fourth and fifth steps of sequential evaluation require a full medical/functional/vocational assessment that is much more labor-intensive than the previous steps. The DDS must make findings of fact about the individual's remaining capacity to perform and sustain a detailed set of work-related functions, physical and mental, such as lifting, carrying, walking, standing, sitting, stooping, use of hands and arms, understanding, remembering, concentrating, persisting on task, interacting with people, and handling changes. This Residual Functional Capacity (RFC) assessment also includes the ability to work around various environmental challenges such as dust, fumes, hazards, and extreme temperatures. The RFC is derived from an in depth analysis of the medical and functional information the DDS has obtained from healthcare records, medical, psychological or other types of evaluations, and the statements of the applicant and other knowledgeable sources. RFC assessment must consider the impact of the individual's symptoms on function, the credibility of the individual's statements, and the amount of weight to give to medical source opinions.

Once RFC is established, the DDS must determine whether the individual has the capacity to perform any past relevant work performed within the prior 15-year period, either as the person performed it, or as usually performed in the national economy. If the individual cannot do any past work, then the DDS must determine

whether there are other jobs existing in the national economy that the person can perform, considering age, education and past work experience.

Policy Areas of Particular Complexity

Determining whether someone can or cannot work by nature involves more than just objective medical findings. The same diagnosis and the same or similar clinical findings may affect one person quite differently than another in their functional capacity for work, for many reasons. Accurate disability determination is not an exact science. It involves adjudicative judgments, and in Social Security disability many of the policies to be applied are often very detailed and complex. Three policy areas are particularly challenging. They are the core of disability evaluation for those individuals whose impairments are not clearly disabling on a purely objective medical basis.

1. Symptoms and Credibility

   The evaluation of pain and other symptoms and their limiting effects starts with determining whether the person has a medically determinable impairment that could cause the symptoms. Once the related impairment is established, the DDS must evaluate the intensity, persistence and functional limitations affecting basic work activities, based on descriptions provided by the applicant, the medical reports, and any other reports or observations. The assessment includes considering the credibility of the person's statements and determining the appropriate weight to give them. The policy directs consideration of various factors: description of symptom location, duration, frequency, and intensity; precipitating or aggravating factors; impact on daily activities; medications, treatments, and other measures to relieve the symptoms, their effectiveness, and any side effects. Credibility assessment is not a "gut feeling" about the person's overall truthfulness, but rather an evaluation of the consistency of the statements throughout the record and the support for them in the medical findings and other information in the file. However, we cannot disregard an individual's statements solely because the objective medical evidence does not substantiate them. While the policy provides guidance and lists the factors to consider in symptom evaluation, in the end there is no way to measure conclusively symptom severity and credibility. The adjudicator is expected to draw reasonable conclusions based on the evidence in each individual case.

2. Medical Source Opinion

   The policy requires adjudicators consider all medical source opinions, (i.e. statements about the nature and severity of the impairment/s). Different medical sources may have different observations and opinions. Controlling weight must be given to <u>treating</u> source opinions that are well supported by

objective medical evidence and not inconsistent with other substantial evidence in the file. Controlling weight should not be given to opinion without substantiation or supporting objective findings. When controlling weight is ruled out, the opinion must still be considered and weighed. Factors the policy directs us to consider include the relationship between the source and the claimant, the source's specialty, the value of the supporting evidence, and the consistency of the opinion with other evidence in the file. There is no exact formula for the relative weighing of all these factors. It can be very complicated to sort out all the opinions and facts that tend to support or contradict them, and then it can be very challenging to decide and explain the appropriate weight for each. Different adjudicators can legitimately weigh all these factors differently and come to different conclusions.

3. Residual Functional Capacity (RFC) and Sustainability

   The RFC is the administrative assessment of what work-related functions the individual can do (physically and mentally). It is based on all the evidence, including the objective medical findings, the individual's statements about limitations (to the degree the adjudicator has found them credible) and the opinion evidence (to the degree of weight the adjudicator has assigned each opinion based on how much it is supported by and consistent with the rest of the evidence). The RFC should reflect the most that a person can do on a sustained basis over time. It is particularly difficult to assess applicants who have fluctuating levels of pain or fatigue, or other symptoms that wax and wane in a variable way.

These are the most difficult judgment areas, where different adjudicators may interpret and apply the policies differently in individual cases. These are also the areas where the information being evaluated is subjective by nature, coming from applicant self-reports and opinions from different sources with different perspectives. The subjectivity of these decisions does not mean that adjudicators can decide cases based on their personal beliefs and assumptions about the claimant's impairment severity. The policies clearly direct the adjudicator to consider specific factors, and they provide some guidance about how to assign weight. What the policies do not – and cannot – do is provide a formula that directs a specific decision in an individual case. These case evaluations call for careful attention to detail and thoughtful analysis of all the information in the case file, as well as knowledge of the functional ramifications of medical findings.

SSA and the DDSs maintain programs to teach this type of decision-making, and the DDSs do an excellent job achieving sustained high accuracy of their decisions, despite the ambiguity of the policy, and the challenges of high workload, insufficient staffing, and continued loss of experienced staff. Although individual case decisions are generally found to be accurate, achieving consistency all across the country and at all appeal levels, especially in these areas of subjective decision-making, is a continuous improvement project.

The DDSs work collaboratively with SSA to improve consistency. All DDSs provide intensive training and mentoring to new adjudicators, as well as ongoing mentoring and refresher training. SSA and DDSs are working together to make the best training resources readily available to all DDSs across the nation, through organization and continual updating of online resources, video on demand training sessions, national policy dialogues and refreshers, online training case examples, and web-based state-to-state sharing of training materials. Information technology tools such as the electronic claims analysis tool (eCAT) also help to standardize the way DDS adjudicators think through the evaluation process and explain their decisions in writing. The predictive modeling software that identifies cases that are appropriate for the Quick Disability Decision (QDD) and the Compassionate Allowance (CAL) processes also help to bring consistency to the disability determination process.

Quality reviews and performance management are also important tools. SSA holds DDSs accountable for accuracy, productivity, processing time, and cost control. The DDSs translate these requirements into adjudicator performance requirements. DDSs do internal quality reviews, in addition to the quality reviews SSA performs. SSA's quality reviews are now done nationally, rather than regionally, and there is a centralized process for resolution of policy questions and disagreements. These two practices in combination have the potential over time to greatly improve consistency across all DDSs and SSA quality review offices. The database of cases with policy feedback is also valuable for identifying policy areas that generate the most questions and are particularly problematic, so that SSA can look at ways to improve the policy. The database is also helpful in assessing further training needs, both nationally and for an individual office.

Achieving national consistency is an ongoing process. Continued progress is needed and is dependent upon sufficient resources. High workloads, budgetary challenges and staff losses slow down the progress. Lack of resources to review cases for policy clarification, to analyze data and to develop training impedes progress. In the DDSs, high workloads and loss of experienced staff impedes our ability to carry out an optimal number of quality reviews or pursue quality improvement initiatives.

Although disability evaluation will always involve a certain amount of subjectivity, the policies in these most subjective areas should be reviewed and consideration given to ways they could be made less resource intensive and easier to apply consistently. This is not a simple task. It would not be right or fair to many truly disabled people to completely ignore the opinions of the doctors that know them best or discard consideration of their pain and other symptoms and the way these symptoms limit their personal capacity for work. However, we should explore ways to determine disability that could require fewer resources and yield outcomes with more consistency. This exploration should involve the collaboration of medical and policy experts and experts in the front line challenges of applying policy to individual cases.

Continuing Disability Reviews – the Medical Improvement Review Standard

The Medical Improvement Review Standard (MIRS) was developed in the mid-1980s in response to public outcry over the implementation of continuing disability reviews (CDRs) that led to many people being removed from the rolls in a problematic way. Many of these people had been on the rolls and out of the workforce for a great many years. They had been granted benefits before the establishment of the strict criteria (particularly for mental impairments) in place in the early 1980s. The CDR reviews of the early 1980s applied the strict current criteria and did not consider the impact of advancing age and many years in supportive living situations out of the workforce. Many of the people losing their benefits had no ability to cope or adapt. In 1983, a moratorium was placed on CDR processing, and in 1984, the medical improvement requirement became law.

The MIRS requires us to determine whether any of the beneficiary's impairments present at the last favorable determination have improved, and if so, whether the improvement is related to the ability to work and whether the person now has the capacity to work. Improvement must be based on changes in symptoms, signs, and/or laboratory findings, resulting in increased work-related functional capacity such that the person can now engage in substantial gainful work. In assessing current ability to work, we consider all current impairments, not just the ones present in the past. The policy requires that we also consider the effects of the aging process and the related decrease in organ function, exercise ability, and other deficits that become irreversible over time, especially with sustained periods of inactivity. In addition, we must consider the effect of time on the rolls away from the workplace. Age and time on the rolls become especially critical factors when the beneficiary has reached age 50 or older.

The policy includes some narrowly defined exceptions, which open the door to stopping benefits in a few situations even though the person's impairments have not improved, or we cannot make a determination about medical improvement. These exceptions apply when the person's ability to work has improved due to advances in medical or vocational therapy, or when new evaluative techniques show that the impairment is not as disabling as it was thought to be at the time of the previous decision. There are also exceptions for lack of cooperation with the CDR process and for proven fraud. There is an additional exception for situations when substantial evidence shows on its face that the prior allowance was in error. However, the latter can be applied only for obvious, concrete errors; current adjudicators cannot question or substitute their own judgment over the judgment of the adjudicator of the prior favorable decision.

In practice, DDS adjudicators cease benefits in only a small percentage of cases. Given that the criteria require permanent or long-term inability to do any substantial gainful work, it is not surprising that many beneficiaries continue to qualify. Even with cases where benefits were originally granted through adjudicative judgment, the

stricture against substituting judgment at the CDR limits the use of the error exception to cease benefits. In practice, this exception can rarely be applied.

We recommend a review of the statutory and regulatory MIRS policy to consider improvements that would enhance program integrity and bring greater consistency, while doing no harm to beneficiaries who continue to quality. We do not recommend discarding the policy altogether. Some consideration of the real effects of aging and time on the rolls, the impact of chronic impairment on functioning and ability to return to the workforce is reasonable. Due process and careful consideration of all the factors in each beneficiary's case are very important. Decisions about how to redesign the policy to remove the right people who really can work, while doing no harm to those who cannot, must be made very thoughtfully and carefully.

Even within the narrow limits of MIRS, the cessations the DDS makes provide substantial program savings for the investment of administrative dollars. It is unfortunate that SSA and the DDSs have not had sufficient funding to maintain CDR processing so that all cases are reviewed promptly when their diary dates come due. Nor is it appropriate service to American people with disabilities to delay the processing of current claims in favor of processing more CDRs with the available funds. Full funding for both workloads is critical.

Conclusion

The DDSs have a long record of collaboration and accomplishment working with SSA to provide high quality service and careful program stewardship. Together we have made strides in advancing consistency in the application of policy, despite the challenge inherent in deciding who really can and cannot work. There is much more that can be done with sufficient resources for strategic hiring to build and maintain an experienced, highly trained staff. The most challenging policies should be evaluated with careful consideration. NCDDD would like to play a continuing role in such policy evaluation, sharing our ideas and experiences adjudicating cases on the front line and advising on issues of policy application and workability as new policies are considered.

Mr. Chairman, on behalf of NCDDD, I thank you again for the opportunity to provide this testimony. We will be happy to provide any additional information you need and answer any questions you have.